Spring/Summer 2019
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Dear AADCAP Members:

Summer is here. Now back from the 54th Annual Meeting in Deer Valley, I wanted to share some thoughts about our organization. AADCAP continues to provide opportunities for directors of child and adolescent psychiatry programs to learn of developing trends in our field and to address the challenges ahead for division directors and as pediatric mental health providers. The meeting encouraged discussions on shared fiscal, clinical, and academic experiences and offered solutions to common problems. It was also an opportunity to examine the operation of AADCAP and identify pressing issues. For example, it came to our attention that the stipend paid to our Executive Director, Earl Magee, is not only low, given the number of hours he devotes to the job, but far below stipends paid to directors in similar organizations including the American Association of Chairs of Departments of Psychiatry. The truth is that we have not been able to give Earl a salary increase, including cost of living increases, since he began working with us in 2005 due to our tight budget. During the Executive Committee conference call on May 10, leadership recommended an increase in membership dues that is sufficient enough to cover the cost of an Executive Director in a professional organization like AADCAP. Effective January 1, 2020, dues will increase from $200 to $300 annually. Emeritus membership dues will remain at $200 annually.

We want AADCAP to serve its members and support their roles as child and adolescent psychiatry division directors. The listserv has become a very valuable resource. The newsletter will continue to present meaningful information. The Dessert Reception during AACAP’s annual meeting provides an opportunity for getting together between our meetings. Next year, the AADCAP Annual Meeting will be in Washington, DC from April 2-4, 2020, together with AACAP’s Legislative Conference and Assembly Meeting, and we are working to address issues that are relevant to being leaders in child and adolescent psychiatry. I appreciate the survey conducted by Rich Martini, MD about getting to know our field and the thoughts of members about how to better serve them. We look forward to this being presented in a Member Forum at AACAP’s Annual Meeting in Chicago in October. Additionally, please read Dr. Martini’s column in this issue about the survey and Member Forum. We look forward to future meetings at other locations in alternate years.

I am open to your comments and questions. I wish you all a pleasant summer.

Victor Fornari, MD, MS

AADCAP President
EDITOR’S COLUMN

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

Writing about burnout [1] was a “piece of cake.” It is a trendy topic complete with many database 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” [2] and not as a medical diagnosis, as reported in other stories (fake news?) [3].

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 [3], devotes a chapter in which he discusses being content vs. being happy. 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 (continued on page 13)
I have enjoyed a long tenure with the American Academy of Directors of Child and Adolescent Psychiatry (AADCAP), and have come to enjoy that the membership has afforded me different things at various points in my career path as Division Chief over the last 15 years.

I recall being invited to my first “Society of Professors” meeting as it was then called, about 2002. I was encouraged to attend by the former division chief, Norman Alessi, MD who remarked in a good humored but well-advised way “this is where it happens” for the division chiefs. I arrived as a novice knowing little about the myriad of challenges awaiting me as division chief and decided to attend the introduction session for “New Division Chiefs.”

I remember being welcomed and learning about a range of topics from the politics of divisions among departments (whether Pediatrics or Psychiatry), relationships between physicians, psychologists, social workers, leadership styles, the nature of mentorship, reimbursement challenges, access issues (present for child psychiatrists then as now), recruitment dilemmas for small, medium and large departments, equity and salary issues, HR and disciplinary issues and the many others experienced by chiefs. I found the members of AADCAP to be a welcoming and incredibly approachable group and I was thrilled to have the scaffolding support of those team leaders who had experienced all of this before.

I have used the AADCAP listserv group frequently and have been pleasantly surprised by the saying “misery loves company” and the fact that the struggles that I was facing (long waits by patients in the emergency room, and ever present shortage of faculty to staff the inpatient units, poor access and overwhelming demand for ambulatory services, reimbursement issues and recruitment issues), were prevalent across the programs. Using this group to help me figure out solutions was likewise invaluable.

As a mid-career division chief, I remember vividly attending a meeting around 2009. It was during this period that the child psychiatry access programs were beginning nationally. I listened with interest as the New York and Massachusetts programs described what they were doing and made a decision that this was going to be essential in the state of Michigan as well. This group was extraordinary in providing me with essential information to initiate our program and the Michigan Child Collaborative Care Program is now state-wide having begun in 2012. The AADCAP was also instrumental in beginning the National Network of Child and Adolescent Psychiatry Access Programs.

A meeting with the group bi-annually usually in Washington, DC in association with the Academy’s Advocacy Day, also provided lessons learned to help me shape policy both at our state and federal level. Moreover, it put me in touch with the legislative power of the youth and families whose lives are touched by mental illness.

As I begin to contemplate succession planning, I intend again to use this group to think about how I might shift my career, ensure the security of our programs going forward, and continue to engage in work that is fulfilling for me. AADCAP is an invaluable organization for anyone considering the role of division chief or associate service chief. The few days a year of information sharing has proven to be an extraordinary gift that has helped to shape our service at the University of Michigan. I hope that all new (and contemplating) division chiefs take advantage of what AADCAP has to offer. You will not be disappointed!
For fifteen years or so, there has been a part of the AADCAP Annual Meeting Program set aside for new division heads. Its origins have been obscured by diverse stories as to who actually suggested it. My recollection is that it started with a discussion of Allan Josephson and myself. I think Allan initiated the idea, but maybe it was I. Regardless of this origin mythology, Allan and I ended up Chairing the first Primer which went splendidly. The concept of a session for new division directors has endured over the years with several modest modifications.

Details of “the concept” includes inviting the “new” division’s heads. There is no set definition of what “new” means, which allows the division directors to define it for themselves. This lack of definition led to the surprise of repeat attendees, even those who are clearly not “new” by any conventional standard. Perhaps there are always changes and challenges that make one always feel “new.” The addition of repeat attendees adds a richness and new dimensions to the discussions that prove valuable.

The format generally allots three hours to the Primer, which starts with a short introduction of the attendees who list issues they would like discussed, which one recent attendee called “vexing peeves,” followed by twenty minute presentations by the Primer organizers, who, along the way, have become three rather than two. This year’s organizers were Victor Fornari, MD, Sandra Sexson, and myself. These presentations include handouts that are made available to the participants and which are now available to all on the AADCAP website at http://www.aadcap.org/docs/NDDR%20handout--combined.pdf.

After these three initial presentations, the rest of the three hours is dedicated to a discussion which often start with “vexing pet peeves” and problems that were mentioned by the attendees. The time always goes by rapidly. This year, I forgot to call the scheduled break.

As we wrap up at the end, we create a list of topics that the attendees would like further discussion on. These topics are often added to the handouts for next year and used to help decide on topics for the general meeting.

I invite you to next year’s Primer regardless of whether you are actually “new” or having trouble dealing with the “new new,” to quote the title of Michael Lewis’ excellent 1999 book on Silicon Valley, or whether you would like to be involved in an enjoyable three hours at the beginning of the 2020 AADCAP meeting.
In a recent email, Victor Fornari, MD went over the mission statement of AADCAP. It reads:

The purpose of AADCAP is to provide a forum for discussion and exchange of ideas among the child and adolescent psychiatry division chiefs in medical schools in the United States and elsewhere for the purposes of:

• Enhancing the growth and development of child and adolescent psychiatry as a discipline;

• Strengthening graduate and postgraduate medical education, patient care and research in the area of child and adolescent psychiatry; and

• Providing appropriate liaison between academic child and adolescent psychiatry as represented by the membership and administrative persons and organizations in medical education (e.g., departments of psychiatry, medical school deans, specialty boards), government, research, and health care delivery to forward our objectives.

Upon review, we realized that the mission statement does not mention what we believe is the “key” actual mission of the AADCAP, that being to “enhance the growth and development of the skills needed to be effective Directors of CAP programs.”

We believe that the enhancing of such skills will allow the organization to carry out its current existing mission goals to enhance the growth and development of our field via appropriate liaison and collaboration between key entities to strength education, patient care, and research in CAP.

We believe that we have just agreed to a name change to actually clarify what we do as a group and that we now should clarify our mission, which is to help Directors to more effectively do their jobs in the very complex and changing times in which we live in.

To clarify the lack of clarity with the AADCAP’s current Mission Statement, we would note that our current three missions could easily be those of the AACAP, which already performs all of these duties, often more effectively than the AADCAP is capable, due to its smaller size and more modest resources. Would it not be better to have a mission and focus on what we can do as a group better than any other organization, that being the training, mentoring, and nourishing of those CAP’s who have chosen to be Directors of CAP Programs?

We would welcome your input as to whether you agree with “Our Modest Proposal.” Even better would be ideas on how we can more effectively carry out this more explicitly stated mission. We believe that efforts in this direction will enhance the organization and make it even more helpful to its members.
IN MEMORIAM . . .

My friend Norb was simply superb. In real life a father, grandfather, raconteur, history buff, fly fisherman, gourmand, chef and watercolorist. And 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. But before the Academy, Norb was a product of the Midwest, Milwaukee, traveling on house visits with his dad, a country doctor, or canoeing across Canada. His professional education at Yale, McGill, Duke, New Orleans, and Michigan earned him degrees in medicine, pediatrics, psychiatry and child psychiatry. He was a senior architect on the boards, (child, adult, and triple.) and his career included a chairmanship, acting deanship, and head of child psychiatry.

In the early ‘70s Norb became a main thinker in manpower development, serving on the government’s 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, M.D. 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 demention 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 or poolside or lobby consultation. Because he had held every academic position, he understood the layers and the 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. Since the implementation of the plans rested on me, I was growing increasingly worried. 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 ACADEMY’S 25th and 50th anniversaries . . . always true, always great, simply superb.

In 1993 I came to UAB to create a child and adolescent psychiatry fellowship. At the time, several people suggested I speak with Norb, whom I did not know. By then he was back in Michigan. I called him out of the blue, and he could not have been more helpful and affirming. From afar he provided what I needed to build a program and understand the ACGME, avoiding emphasis on policies and rules in order to highlight the spirit of their intent. He really was my muse, “a person or personified force who is the source of inspiration”. I like this definition because Norb was a “person” in the most human, three-dimensional sense, and a “personified force” for good. Knowing I had come from Topeka, Norb shared pleasant childhood memories of summer visits to family there. I told him of my childhood summer visits to towns in Michigan too small for most people to have heard of, except Norb.

Above and beyond the knowledge Norb imparted, I am most appreciative of the values he modelled. He was patient, kind, honest and remarkably modest. His approach to children and families was always respectful, informed by empathy for what it was really like for the child and what got in the way of parents being able to follow their better angels or navigate the challenges they encountered in parenting. Norb was also the model of “generativity” as Erikson defined it, “the concern in establishing and guiding the next generation”.

Given that we shared memories of Kansas, I think of a line from the Wizard of Oz that captures what I’ve tried to describe. The Wizard attempts to explain to the Tin Man that he had always had a heart when he says, “and remember my sentimental friend, that a heart is not judged by how much you love, but by how much you are loved by others”. Norb is remembered so fondly by so many of us because he was so interested and so giving. He was loved by many and will be greatly missed.

“How much you are loved by others”  
by Lee Ascherman, MD

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A True Midwestern Gentleman  
by Wun Jung Kim, MD

Culture and Diversity was a Presidential Initiative in 1994-1996. The chairwoman, Dr. Jeanne Spurlock and the Work Group members pondered that the group should have a majority member as well to truly achieve the spirit of diversity. We all decided to invite Norb as a member of AACAP’s Work Group on Diversity and Culture, the only non-minority member of the group representing the Middle America. What an honor! It is not listed in his CV but the highest recognition by peers for his fairness, inclusiveness and leadership although unfamiliar members did not elect him for the AACAP presidency. He was an invaluable mentor to many rising academicians and psychiatric administrators, counseling them with support and wisdom but without being pompous. Another example is Boss of the Year award bestowed by Michigan State University Business Women's Association in 1996. I joked to his daughters that for a guy who loved good drinks, foods and tobaccos, he lived a long and productive life. It was fun to dine with him when we got together for AACAP committees, ABPN exams, Professors meetings, etc., and in Ann Arbor. He never uttered any gossip unless I spilled it out, and maintained his composure and respect for his colleagues even after good drinks. A true Midwestern gentleman, born in Milwaukee and died in Ann Arbor!
Norb Enzer was a wonderful man. He was friendly, approachable, and outgoing with an endearing wonderful laugh that he shared often.

A favorite story concerning Norb happened at my first official Professor’s meeting after I became Head of Child Psychiatry at LSU Medical School in New Orleans. Halfway through the meeting, he talked to me in the hallway and asked if I wanted to be Program Chair for the next year’s meeting during his first Presidential year. I was certainly surprised at the offer and did some reality testing with him. “You know, this is my first meeting as a Head?”

“Yes,” he said.

“Aren’t there many others who have been members longer and who deserve it more?” I asked.

“Just do it,” he insisted.

And so I agreed. This request was a significant boost to my career nationally. I ended up doing both meetings he was in charge of including the “n+1” meeting, during which we got NIMH funding (n.b., all done by fax in the pre-internet era) to invite six and up and coming researchers to our meeting.

Looking back, I realize that his request for me to be Program Chair and “n+1” was part of his ongoing talent at sharing, mentoring, and nurturing “young” people. (Note, at that time, I was young.)

Before I came to this conclusion, I asked Norb why he had saw fit to ask me to be Program Chair. He responded quickly, “I’m not going to tell you.”

The other episode I’d like to share deals specifically with his laugh and his sense of humor. It took place at one of my first AACAP Summer Council retreats at the Belmont Estate in Maryland. After dinner, people would congregate in small groups to talk. I chose a group that consisted of Norb and Dick Cohen (past Presidents of the Professors) and John Schowalter telling rapid fire jokes one after another. After that meeting, I went back to my room and wrote down as many as I could remember. That was the start of my collecting jokes (n.b., canonical lists).

I remember one of Norb’s jokes. It entailed a man who had fallen over a cliff and was saved from death by grabbing onto a root of a tree. Fearing for his life, he yelled for help and a voice responds. “This is God!” The man is somewhat skeptical and yells for someone to help him. “This is God! Just let go and I will protect you.” “Is there anyone else up there?” asked the man.
A proposal for a Member Forum at the 2019 AACAP Annual Meeting, written by members of the American Association of Directors of Child and Adolescent Psychiatry (AADCAP), was accepted by the Program Committee. The data that will be presented in the Forum is based on the survey of AADCAP members distributed in February 2019. AADCAP received 37 surveys, nearly a 30% response rate, from Directors across the country, whose tenure ranged from 6 months to 26 years with an average of 9.5 years in the position. The size of the programs broke evenly into three groups based on number of faculty: 60 to greater than 100, 15 to 40, and 14 or less. Seventy-three percent of the respondents have an academic rank of professor.

The following topics were selected for discussion and were included in the submission:

Revenue generation for child and adolescent psychiatry programs.

The survey noted that 37% of division income originates from professional billing, 30% from federal, state, or private contracts, and over 15% through direct support from outside sources including hospitals, the Departments of Psychiatry and Pediatrics, and the School of Medicine. Philanthropy and endowments account for less than 4% of the budgets. With this financial picture, the survey noted that 63% of the Directors believe that reimbursement is poor and 57% believe that their programs receive insufficient funding.

Dr. David Axelson will discuss how child and adolescent psychiatry programs can be financed in the future and what sources of income should be considered.

Utilization of additional pediatric mental health providers in the child and adolescent psychiatry program.

The survey noted that between 62% and 82% of the respondents have APRN’s, social workers, and/or psychologists reporting to them as Directors of Child and Adolescent Psychiatry. Several comments continue to emphasize the tension that exists between psychiatry and psychology. When asked about the presence of training program rotations at their clinical sites, 85% had rotations in psychology, 63% in social work, and 43% in advanced practice nursing. Directors were asked about current operational challenges and the most important issue, identified by 72% of the respondents, was a lack of adequate staff to address clinical needs.

Dr. Tami Benton will discuss how Directors of Child and Adolescent Psychiatry can utilize these additional pediatric mental health professionals to meet clinical demand, and the role of child and adolescent psychiatrists in these relationships.

Recruitment, retention, and career development of child and adolescent psychiatrists within Divisions and Departments.

Sixty-four percent of the Directors of Child and Adolescent Psychiatry who participated in the survey identified faculty recruitment and retention as a significant operational challenge. The role of the faculty child and adolescent psychiatrists is now primarily defined by clinical work, taking up 60% of their time, with 18% available for teaching and 11% for research. 75% of faculty are either on the Clinical Track or Clinical Educator Track, with 14% on the Tenure Track. Despite this allocation of responsibilities, salaries are determined by percentile targets from MGMA or AAAMC (78%), academic promotion (56%), and local competition (53%). Only 39% of the respondents said that salaries include productivity incentives based on WRVU’s or clinical time spent.

Dr. Michael Sorter will discuss how child and adolescent psychiatry divisions and departments can recruit and retain child and adolescent psychiatrists, and appropriately acknowledge their contributions to the program.

The relationship between Departments and Divisions of Child and Adolescent Psychiatry and Pediatrics.

The survey noted that 85% of divisions and departments offer clinical services within children’s hospitals, more than in private, university based, or state psychiatric hospitals combined. Ninety-seven percent of child and adolescent psychiatrists in these divisions and departments offer clinical services within children’s hospitals, more than in private, university based, or state psychiatric hospitals combined.

(continued on page 14)
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 [4]. 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: [1] “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. 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 [5,6], 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 [7] that includes the following contributing factors: lack of control, unclear job expectations, dysfunction, workplace dynamics, mismatched job expectations, extremes of 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,” [8] 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 (n.b., The Superman/Superwoman doesn’t say ouch syndrome) 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 [9], 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).

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 [1].

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.

REFERENCES
psychiatry programs surveyed have pediatric consultation-liaison services, a figure equal to the percentage that offer outpatient care. Seventy-eight percent of programs are now involved in collaborative care with pediatric primary care physicians, and 80% offer emergency psychiatric care, most often in pediatric settings. When asked about training programs with rotations at their clinical sites, ninety-one percent of the Directors included pediatrics, a higher percentage than for any other program including psychology. However, when asked about reporting structure and lines of responsibility, 88% of the Directors report to the Chair of Psychiatry and only 9% report to the Chair of Pediatrics in a joint appointment. In addition, 21% report to a hospital based Chief Medical Officer, raising questions about their membership on a children’s hospital medical staff.

Dr. David DeMaso will discuss the role of divisions/departments of child and adolescent psychiatry in the administration of children’s hospitals, and how programs can collaborate with Departments of Pediatrics.

The Member Forum is an opportunity for discussion and an open exchange of ideas among all participants at the Annual Meeting. It is also opportunity for AADCAP to learn about the most pressing issues for child and adolescent psychiatry divisions and departments as we work to meet future clinical, administrative, and academic challenges. We hope to see you there.

Earl Magee:

At my first AACAP annual meeting in 2004, I wasn’t sure what to expect and was rather nervous with all these brilliant doctors coming to my city. My nerves got the best of me so I took a break from the staff office and went outside to smoke. I met this man sitting on a bench smoking a cigar. We struck up a conversation and gabbed for a long time. I told him of my nervousness and he assured me everything would be fine, just relax and enjoy. Almost every time I went out to smoke, more often than I should, I saw this man and we talked some more and, every time, I thought, “What a really nice man. Easy going. Easy to talk with. Somebody you just want to hug after talking with him for five minutes.” I always left feeling calmer.

Several months later, Ginger asked HR to show a video about the Academy to all new employees. So we all gathered in the conference room and the video started. Low and behold, the person in the video was the guy I spoke with outside the hotel, MY smoking buddy! I immediately said, “I know this guy. We were smoking buddies during the meeting.” Someone said, “That’s Norb Enzer.” I couldn’t believe it! Flabbergasted, I watched and learned as Dr. Enzer spoke so wonderfully about the Academy. Everyone should have known Norb. I periodically asked Ginger for updates on Norb. I wish I could watch that video again, if only to see Norb again.

John Walkup, MD:

What I remember most about Norb was his great leadership and his kibitzing with John Schowalter and other colleagues. It was amazing and entertaining to watch them play off each other and to experience their wisdom and humor.

Mike Jellinek, MD:

My Chair of Psychiatry at MGH, Tom Hackett, had appointed me as Chief of Child Psychiatry and the only full-time member of the unit this day after the end of my training.

I was scared and did not know exactly what to do. Sensing my anxiety and bewilderment, Dr. Hackett suggested I sit down with Norb at the 1979 AACAP Annual Meeting.

Norb put me instantly at ease. He was curious, respectful, funny, gentle, approved of my initial plan and offered to be available for advice essentially forever. His support at a critical moment and thereafter during our many conversations were a major contribution to my identity as a Child Psychiatrist. I am grateful to be one of the many people who smile with the mention of his name.
PHOTO GALLERY

2019 Annual Meeting, Deer Valley, UT

Joshua A. Gordon, MD, PhD

[Images of various group and individual photos from the meeting]