

Caution about 'miracle cures'

I thank Drs. Katherine Epstein and Helen Farrell for the balanced approach in their article "Miracle cures in psychiatry?" (Psychiatry 2.0, CURRENT PSYCHIATRY, September 2019, p. 13-16), which discussed the new psychiatric use of stimulants, dissociative agents, and hallucinogens. (Here I distinguish 3,4-methylenedioxymethamphetamine [MDMA], ketamine, and psilocybin by mechanisms.) The frustration psychiatrists have felt in attempting to get good results from their treatment efforts has long inspired bold new strategies. While Drs. Epstein and Farrell cited the long history of misguided enthusiasms in psychiatric therapeutics, they omitted more recent backfires: bilateral electroconvulsive therapy, cingulotomy, rapid neuroleptization, and the overselling of selective serotonin reuptake inhibitors. Chronic use and long-term adverse effects are usually underestimated at the beginning of new pharmacologies. Now, with an array of new psychoactive substances being introduced as therapies, we must learn from experience (the definition of mental health?) and use caution.

We need to pay serious attention to the small sample sizes and limited criteria for patient selection in trials

of ketamine and MDMA, as well as to what sort of "psychotherapy" follows treatment with these agents. Many of us in psychiatric practice for the past 40 years have been humbled by patients' idiosyncratic reactions to standard medications, let alone novel ones. Those of us who practiced psychiatry in the heyday of "party drugs" have seen many idiosyncratic reactions. Most early research with cannabinoids and lysergic acid diethylamide (and even Strassman's trials with N,N-dimethyltryptamine [DMT])¹⁻⁵ highlighted the significance of response by drug-naïve patients vs drug-savvy individuals. Apart from Veterans Affairs trials for posttraumatic stress disorder, many trials of these drugs for treatment-resistant depression or end-of-life care have attracted non-naïve participants.⁶⁻⁸ Private use of entheogens is quite different from medicalizing their use. This requires our best scrutiny. Our earnest interest in improving outcomes must not be influenced by the promise of a quick fix, let alone a miracle cure.

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Physician assistants and the psychiatrist shortage

J. Michael Smith's article "Physician assistants in psychiatry: Helping to meet America's mental health needs" (Commentary, CURRENT PSYCHIATRY, September 2019, p. 17-20,24) recommends the use of physician assistants (PAs) to alleviate the shortage of psychiatrists in the United States, but it fails to address the underlying issue. The use of both telepsychiatry as well as psychiatric PAs are inadequate attempts at solving the pressing matter of the psychiatrist shortage. Telepsychiatry was intended to provide care to underserved populations, but it has not succeeded. It is used more frequently in urban settings rather than in needier rural

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areas. Moreover, the use of PAs in psychiatry has also failed to solve the original problem. Psychiatrists are and should be the backbone of the practice of psychiatry, not PAs.

There needs to be a multifocal approach to incentivize medical students to choose psychiatry as a specialty. Several factors have discouraged medical students from going into psychiatry. The low reimbursement rates by insurance companies force psychiatrists to not accept insurances or to work for hospital or clinic organizations, where they become a part of the “medication management industry.” This scenario was created by the pharmaceutical industry and often leaves psychotherapy to other types of clinicians. In the not-too-distant future, advances in both neuroscience and artificial intelligence technologies will further reduce the role of medically trained psychiatrists, and might lead to them being replaced by other emerging professions (eg, psychiatric PAs) that are concentrated in urban settings where they are most profitable.

What can possibly be left for the future of the medically trained psychiatrist if a PA can diagnose and treat psychiatric patients? Why would we need more psychiatrists?

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The author responds

I appreciate Dr. Carpio's comments, and I agree that the shortage of psychiatrists will not be addressed solely by the addition of other types of clinicians, such as PAs and nurse practitioners. However, the use of well-trained health care providers such as PAs will go a long way towards helping patients receive timely and appropriate access to care. Unfortunately, no single plan or method will be adequate to solve the shortage of psychiatrists in the United States, but that does not negate the need for utilizing all available options to improve access to quality mental health care. Physician assistants are well-trained to support this endeavor.

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Additional anathemas in psychiatry

While reading Dr. Nasrallah's “Anathemas of psychiatric practice” (From the Editor, *CURRENT PSYCHIATRY*. November 2019, p. 13-15), 2 additional anathemas immediately came to mind:

- **Cash-only suboxone clinics.** Suboxone was never intended to be used in “suboxone clinics”; it was meant to be part of an integrated treatment provided in an office-based practice. Nevertheless, this treatment has been used as such in this country. As part of this trend, an anathema

has grown: cash-only suboxone clinics. Patients with severe substance use disorders can be found in every socioeconomic layer of our society, but many struggle with significant psychosocial adversity and outright poverty. Cash-only suboxone clinics put many patients in a bind. Patients spend their last dollars on a needed treatment or sell these medications to maintain their addiction, or even to purchase food.

- **“Medical” marijuana.** There is no credible evidence based upon methodologically sound research that cannabis has benefit for treating any mental illness. In fact, there is evidence to the contrary.¹ Yet, in many states, physicians—including psychiatrists—are supporting the approval of medical marijuana. I remember taking my Hippocratic Oath when I graduated from medical school, pledging to continue educating myself and my patients about evidenced-based medical science that benefits us all. I have not yet found credible evidence supporting medical marijuana.

Greed in general is a strong anathema in medicine.

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