

Prescribing is the culmination of extensive medical training and psychologists don't qualify

It was really disheartening to the psychiatric community that, in April 2017, the Idaho state legislature authorized prescriptive privileges to psychologists if they complete a 2-year curriculum. Apart from being medically unjustified, the legislature passed this law with the fallacious assumption that it will meet the mental health needs of rural inhabitants, despite evidence that psychologists cluster in the same urban areas as psychiatrists throughout the country.

Practicing medicine without a license is a crime, but it seems to have become a hollow law. Politicians are now cynically legalizing it by granting prescribing privileges to individuals with no prior foundation of medical training. Perhaps it is because of serious ignorance of the difference between psychiatry and psychology or MD and PhD degrees. Or perhaps it is a *quid pro quo* to generous donors to their re-election campaigns who seek a convenient shortcut to the 28,000 hours it takes to become a psychiatrist in 8 years of medical school and psychiatric residency—and that comes after 4 years of college.

I recently consulted an attorney to discuss some legal documents. When

he asked me what my line of work is, I then asked him if he knew the difference between a psychiatrist and a psychologist. He hesitated before admitting in an embarrassed tone that he did not really know and thought that they were all “shrinks” and very similar. I then informed him that both go through undergraduate college education, albeit taking very different courses, with pre-med scientific emphasis for future psychiatric physicians and predominately psychology emphasis for future psychologists.

However, psychiatrists then attend medical school for 4 years and rotate on multiple hospital-based medical specialties, such as internal medicine, surgery, pediatrics, obstetrics and gynecology, family medicine, neurology, pathology, psychiatry, ophthalmology, dermatology, anesthesia, radiology, otolaryngology, etc.

Psychologists, on the other hand, take additional advanced psychology courses in graduate school and write a dissertation that requires quite a bit of library time. After getting a MD, future psychiatrists spend 4 years in extensive training in residency programs across inpatient wards and outpatient clinics, assessing the physical and mental health of seriously sick patients with emphasis on both pharmacological and psychotherapeutic treatments for seri-



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Psychologists hold a valued role in mental health care; however, granting them prescribing privileges is medically unjustified and puts patients at risk

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ous psychiatric disorders in patients, the majority of whom have comorbid medical conditions as well. Psychologists, on the other hand, spend 1 year of internship after getting their PhD or PsyD degree, essentially focused on developing counseling and psychotherapy skills. By the time they complete their training, psychologists and psychiatrists have disparate skills: heavily medical and pharmacological skills in psychiatrists and strong psychotherapeutic skills in psychologists.

After this long explanation, I asked the attorney what he thought about psychologists seeking prescription privileges. He was astounded that psychologists would attempt to expand this scope of practice through state legislations rather than going through medical training like all physicians. "That would be like practicing medicine without a license, which is a felony," he said. He wryly added that his fellow malpractice and litigation lawyers will be the big winners while poorly treated patients will be the biggest losers. Being an avid runner, he also added that such a shortcut to prescribe without the requisite years of medical training reminded him of Rosie Ruiz, who snuck into the Boston marathon a couple of miles before the finish line and "won" the race, before she was caught and discredited.¹

Psychology is a respected mental health discipline with strong psychotherapy training and orientation. For decades, psychologists have vigorously criticized the medical model of mental disorders that psychiatric physicians employ to diagnose and treat brain disorders that disrupt thinking, emotions, mood, cognition, and behavior. However, about 25 years ago, a small group of militant psychologists brazenly decided to lobby state legislatures to give them the right to prescribe psychotropics, although they have no formal medical training. Psychiatric physicians,

represented by the American Psychiatric Association (APA), strongly opposed this initiative and regarded it as reckless disregard of the obvious need for extensive medical training to be able to prescribe drugs that affect every organ in the body, not only the brain. Psychiatric medications are associated with serious risks of morbidity and mortality.² The ability to safely prescribe any medication represents the tip of a huge iceberg of 8 years of rigorous medical school education and specialty training. Yet, one of the early proponents of prescription privileges for psychologists, Patrick De Leon, sarcastically likened the ability to prescribe drugs to learning how to operate a desktop computer!

Not all psychologists agreed with the political campaign to lobby state legislatures to pass a law authorizing prescriptive privileges for psychologists.³⁻⁶ In fact, most academic psychologists oppose it.⁷ Most of the early supporters had a PsyD degree from professional schools of psychology, not a PhD degree in psychology, which is obtained from a university department of psychology. The National Alliance on Mental Illness is opposed to psychologists prescribing medications.⁸ Psychiatrists are outraged by this hazardous "solution" to the shortage of psychiatrists and point to the many potential dangers to patients. Some suggested that this is a quick way to enhance psychologists' income and to generate more revenue for their professional journals and meetings with lucrative pharmaceutical ads and exhibit booths.

The campaign is ongoing, as Idaho became the fifth state to adopt such an ill-conceived "solution" to increasing access to mental health care, despite valiant effort by the APA to lobby against such laws. Although New Mexico (2002), Louisiana (2004), Illinois (2014), and Iowa (2016) have passed prescriptive authority for psychologists before Idaho, the APA has defeated such measures in

continued on page 14

Medical training and psychiatric residency are required for an accurate diagnosis of a mental disorder

continued from page 12

numerous other states. But the painful truth is that this has been a lengthy political chess game in which psychologists have been gradually gaining ground and “capturing more pieces.”

Here is a brief, common sense rationale as to the need for full medical training necessary before safely and accurately prescribing medications, most of which are synthetic molecules, which are essentially foreign substances, with both benefits and risks detailed in the FDA-approved label of each drug that reaches the medical marketplace.

First: Making an accurate clinical diagnosis. If a patient presents with depression, the clinician must rule out other possible causes before diagnosing it as primary major depressive disorder for which an antidepressant can be prescribed. The panoply of secondary depressions, which are not treated with antidepressants, includes a variety of recreational drug-induced mood changes and dysphoria and depression induced by numerous prescription drugs (such as antihypertensives, hormonal contraceptives, steroids, interferon, proton pump inhibitors, H2 blockers, malaria drugs, etc.).

After drug-induced depression is ruled out, the clinician must rule out the possibility that an underlying medical condition might be causing the depression, which includes disorders such as hypothyroidism and other endocrinopathies, anemia, stroke, heart disease, hyperkalemia, lupus and other autoimmune disorders, cancer, Parkinsonism, etc. Therefore, a targeted exploration of past and current medical history, accompanied by a battery of lab tests (complete blood count, electrolytes, liver and kidney function tests, metabolic profile, thyroid-stimulating hormone, etc.) must be done to systematically arrive at the correct diagnosis. Only then can the proper treatment plan be determined, which may or *may not* include prescribing an antidepressant.

Conclusion: Medical training and psychiatric residency are required for an accurate diagnosis of a mental disorder. Even physicians with no psychiatric training might not have the full repertoire of knowledge needed to systematically rule out secondary depression.

Second: Drug selection. Psychiatric drugs can have various iatrogenic effects. Thus, the selection of an appropriate prescription medication from the available array of drugs approved for a given psychiatric indication must be safe and consistent with the patient’s medical history and must not potentially exacerbate ≥ 1 comorbid medical conditions.

Conclusion: Medical training and psychiatric residency are required.

Third: Knowledge of metabolic pathways of each psychiatric medication to be prescribed as well as the metabolic pathway of *all other* medications (psychiatric and non-psychiatric) the patient receives is essential to avoid adverse drug–drug interactions. This includes the hepatic enzymes (cytochromes), which often are responsible for metabolizing all the psychiatric and non-psychiatric drugs a patient is receiving. Knowledge of inhibitors and inducers of various cytochrome enzymes is vital for selecting a medication that does not cause a pharmacokinetic adverse reaction that can produce serious adverse effects (even death, such as with QTc prolongation) or can cause loss of efficacy of ≥ 1 medications that the patient is receiving, in addition to the antidepressant. Also, in addition to evaluating hepatic pathways, knowledge of renal excretion of the drug to be selected and the status of the patient’s kidney function or impairment must be evaluated.

Conclusion: Medical training is required.

Fourth: Laboratory ordering and monitoring. Ordering laboratory data during follow-up of a patient receiving a

psychotropic drug is necessary to monitor serum concentrations and ensure a therapeutic range, or to check for serious adverse effects on various organ systems that could be affected by many psychiatric drugs (CNS, cardiovascular, gastrointestinal, sexual, endocrine, pulmonary, hepatic, renal, dermatologic, ophthalmologic, etc.).

Conclusion: Medical training is required.

Fifth: General medical treatment.

Many patients might require combination drug therapy because of inadequate response to monotherapy. Clinicians must know what is rational and evidence-based polypharmacy and what is irrational, dangerous, or absurd polypharmacy.⁹ When possible, parsimonious pharmacotherapy should be employed to minimize the number of medications prescribed.¹⁰ A patient could experience severe drug–drug reactions that could lead to cardiopulmonary crises. The clinician must be able to examine, intervene, and manage the patient’s medical distress until help arrives.

Conclusion: Medical training is required.

Sixth: Pregnancy. Knowledge about the pharmacotherapeutic aspects of pregnant women with mental illness is critical. Full knowledge about what can or should not be prescribed during pregnancy (ie, avoiding teratogenic agents) is vital for physicians treating women with psychiatric illness who become pregnant.

Conclusion: Medical training is required.

Although I am against prescriptive privileges for psychologists, I want to emphasize how much I appreciate and respect what psychologists do for patients with mental illness. Their psychotherapy skills often are honed beyond those of psychiatrists

who, by necessity, focus on medical diagnosis and pharmacotherapeutic management. Combination of pharmacotherapy and psychotherapy has been demonstrated to be superior to medications alone. In the 25 years since psychologists have been eagerly pursuing prescriptive privileges, neuroscience research has revealed the neurobiologic effects of psychotherapy. Many studies have shown that evidence-based psychotherapy can induce the same structural and functional brain changes as medications^{11,12} and can influence biomarkers that accompany psychiatric disorders just as medications do.¹³

Psychologists should reconsider the many potential hazards of prescription drugs compared with the relative safety and efficacy of psychotherapy. They should focus on their qualifications and main strength, which is psychotherapy, and collaborate with psychiatrists and nurse practitioners on a biopsychosocial approach to mental illness. They also should realize how physically ill most psychiatric patients are and the complex medical management they need for their myriad comorbidities.

Just as I began this editorial an anecdote, I will end with an illustrative one as well. As an academic professor for the past 3 decades who has trained and supervised numerous psychiatric residents, I once closely supervised a former PhD psychologist who decided to become a psychiatrist by going to medical school, followed by a 4-year psychiatric residency. I asked her to compare her experience and functioning as a psychologist with her current work as a fourth-year psychiatric resident. Her response was enlightening: She said the 2 professions are vastly different in their knowledge base and in terms of how they conceptualize mental illness from a psychological vs medical model. As for prescribing medications, she added that even after 8 years of extensive medical training as a physician and a psychiatrist, she feels there is still much to learn

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about psychopharmacology to ensure not only efficacy but also safety, because a majority of psychiatric patients have ≥ 1 coexisting medical conditions and substance use as well. Based on her own experience as a psychologist who became a psychiatric physician, she was completely opposed to prescriptive privileges for psychologists unless they go to medical school and become eligible to prescribe safely.

This former resident is now a successful academic psychiatrist who continues to hone her psychopharmacology skills. State legislators should listen to professionals like her before they pass a law giving prescriptive authority to psychologists without having to go through the rigors of 28,000 hours of training in the 8 years of medical school and psychiatric residency. Legislators should also understand that like psychologists, social work counselors have hardly any medical training, yet they have never sought prescriptive privileges. That's clearly rational and wise.



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