Hello members of the House Committee on Health Care,

I apologize that I am unable to attend the hearing 4/5/2017 in person to testify about HB3355.

In 2005 I became a licensed physician in Oregon. I have advanced training in Internal Medicine and Psychiatry after completing a combined residency program at Dartmouth where I also served as the Chief Resident during my last year of training. I have worked extensively in the areas of geriatric medicine and geriatric psychiatry. I have supervised and worked with adult/family/geriatric/psychiatric mental health nurse practitioners, physician assistants, as well as students in these fields and medical residents. I have worked with and supervised PharmD's and social workers. I have worked with psychologists but have not been in a supervisory role with them.

There is a clear confusion in the media and the general public about the difference between a psychologist (PhD or PsyD) and a psychiatrist (MD or DO). I believe that this confusion leads people to believe the 2 professions are similar in training and experience. That is not accurate in any way. A PhD in psychology is usually a 3-6 year program after a bacherlor's degree. Medical school training is 4 years and psychiatric residency is 4 additional years. The content of the 2 types of training have little in common. The types of thought processes that are required for these roles have little in common. They are very different skill sets. I myself spent approximately 8000 hours in patient care and training while in medical school and over 25,000 hours in patient care in residency. I saw thousands of patients every year and followed hundreds in my primary care and adult, child, and geriatric psychiatry clinics. Family medicine and other primary care disciplines have similar training. I am sure that those in a PsyD program or a PhD program in psychology also have hundreds or thousands of patient contacts. But these contacts are in individual, group or family therapy sessions and in neuropsychological training.

To successfully practice medicine, the most important thing is to be able to realize that I do not know enough at this moment for this patient, to recognize when I do not know what I need to know. This key skill is learned in medical school and residency. It is also learned, albeit differently, by registered nurses. This skill is why RNs are able to become safe prescribers as nurse practitioners. This skill requires thousands of hours of patient care. It allows us to call for assistance or send a patient to a colleague with the correct training and experience

Psychologists may have a better skill set for the diagnosis of some mental illnesses then a family medicine doctor. I have not seen direct evidence of the difference on this point. However, the skill set they need to safely prescribe is around all the other areas involved in medical care. That is why a physician assistant program is a much safer route to becoming a prescriber then an online course tailored to and run by psychologists.

I will attempt to summarize my concerns about HB 3355 in this letter.

Specific areas of concern around psychologist prescribing in HB 3355

1. Current shortage of psychologists to provide psychotherapy in older adults
2. Specific concerns around prescribing for geriatric patients
3. Specific concerns around prescribing for pediatric patients

4. Concerns around monitoring psychologist prescribing outside of the Oregon Medical Board
5. General concerns around psychologists prescribing-there is already a path to prescribe: either attend physician assistant or medical school

Shortage of psychologists to provide psychotherapy, especially to older adults

It is extremely difficult to find a psychologist to do psychotherapy with an older adult in the Portland metro area or on the North Coast. I suspect it is not easier elsewhere in the state though I do not have firsthand knowledge in those areas. I have been unable to find psychologists who are willing to accept patient's with either medicare or medicaid when referring from my previous practice at the Tuality Center for Geriatric Psychiatry in Forest Grove or now that I am working in Portland. Decreasing the number of clinician's who are in even more of a shortage area than current licensed prescribers seems quite unlikely to help people who need psychological care or the overall health system, especially for seniors. Perhaps there are no other shortage areas of psychotherapists but this one is ongoing and severe. We need psychologists to work with older adults and other populations doing psychotherapy.

Specific concerns around prescribing for geriatric patients

It takes years to become proficient in all of the areas where medical (especially neurological) illnesses overlap with psychiatric illness. Without a nursing or medical background, a psychologist is going to be at a severe disadvantage in being able to fully and safely evaluate persons aged 65+. The expensive and much more in-depth military psychologist training program was limited to treating those aged 18-65. Discerning between delirium, dementia, geriatric depression with executive dysfunction, cognitive symptoms of respiratory or cardiac illness or medication side effects is quite difficult. The training program outlined in the bill and described in the literature is nowhere near sufficient. How can one even begin to master this with 3 months of supervised training? In residency, an intern I was working with nearly killed a woman with a single dose of 0.25 mg of lorazepam. This would be a trivial dose for most people but not given her other health conditions. Because the intern was still in training (only his 5th year), the patient was in a position where we could do rapid interventions to prevent a tragedy. Are you willing to expose vulnerable Oregonians to this type of risk?

Specific concerns around prescribing for pediatric patients

Although children are much more likely to be physically healthy then older adults, they do have unique challenges that make most of us without significant experience hesitant to treat them. Again, are you willing to expose these vulnerable Oregonians to this type of risk?

Concerns around monitoring psychologist prescribing outside of the Oregon Medical Board

In the few states that have implemented this wide expanding of the psychologists scope of practice despite the nature of their original training there have been a number of different models. I am quite concerned about putting oversight of this program under the Board of Psychology rather than the Oregon Medical Board which oversees physicians and physician's assistants. Nurse practitioner's are currently under the Board of Nursing. In Iowa, which I believe was the most recent state to move forward with this type of program, they put so called prescribing psychologist's under the Board of Medicine. I would strongly advocate for this type

of supervision and oversight in Oregon. The oversight of malpractice and monitoring of prescriber's has minimal overlap with the current oversight the Board of Psychology performs because of the vastly different roles/jobs involved.

General concerns around psychologists prescribing

Psychologist's receive a PhD or Doctor of Philosophy degree. They are trained in the diagnoses of mental illness, provision of psychotherapy and neuropsychological testing. Psychologists are happy to point out the military training program to broaden psychologist's scope of practice from the philosophical realm to the medical realm. However, the military program treated only those between ages 18-65 in a team setting where psychologists worked daily with both family/internal medicine physicians and psychiatrists. This program was abandoned as too expensive and not needed. My former colleague Scott Armstrong, MD was involved in this experiment and concluded that the philosophical training of the PhD's was not at all sufficient to compensate for the complexities that face those of us who practice medicine. He found the ability to generate a differential diagnosis was lacking as was an appreciation for the underlying pathophysiological processes in patients. He reported a specific instance where they were consulted for a potential depressed patient. The psychologist could not recognize the severe thyroid disease that was leading to the symptoms. Notably, the internist also missed this and that is why they consulted psychiatry. I myself have seen patient notes with specific medication recommendations from a psychologist in the Eugene area. The suggestions were implemented by a local family medicine physician leading to a severe decline in the patient's status and their referral to my inpatient unit. I do not know what training that psychologist received nor do I know if the Board of Psychologists followed up on my concerns. I do know that the patient is the one who suffered.

As members of the state legislature, you likely are familiar with the quotes below.
From the ORS statutes pertaining to Psychologists.
"Practice of psychology" means rendering or offering to render supervision, consultation, evaluation or therapy services to individuals, groups or organizations for the purpose of diagnosing or treating behavioral, emotional or mental disorders. "Practice of psychology" also includes delegating the administration and scoring of tests to technicians qualified by and under the direct supervision of a licensed psychologist.

(1) The practice of psychology is defined to include:
(a) "Evaluation" means assessing or diagnosing mental disorders or mental functioning, including administering, scoring, and interpreting tests of mental abilities or personality;
(b) "Therapy" means, but is not limited to, treating mental disorders as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association;
(c) "Consultation" means conferring or giving expert advice on the diagnosis or treatment of mental disorders;
(d) "Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual consultation, guidance and instruction with respect to the skills and competencies of the person supervised.

(l) The core program shall include a minimum of three graduate semester hours or 4.5 or more graduate quarter hours (when an academic term is other than a semester, credit hours will be

evaluated on the basis of 15 hours of classroom instruction per semester hour) in each of the following substantive content areas:
(A) Scientific and professional ethics and standards;
(B) Research design and methodology;
(C) Statistics;
(D) Psychometric theory;
(E) Biological bases of behavior such as physiological psychology, comparative psychology, neuropsychology, sensation and perception, physical ergonomics, or psychopharmacology;
(F) Cognitive-affective bases of behavior such as learning, thinking, motivation, emotion, memory, cognitive information processing, or social cognition;
(G) Social bases of behavior such as social psychology, group processes, organizational and systems theory; and
(H) Individual differences in behavior such as personality theory, human development, personnel psychology or abnormal psychology.

This scope of practice is unrelated to the practice of medicine (or nurse practitioners) which is needed to be a safe prescriber. This is why the Oregon Medical Board is the correct place to put supervision of these prescriber's.

In summary, I am very very concerned about the safety of Oregonians. I believe that subjecting those with mental illness to be the only group of people who are prescribed psychoactive medications outside of the medical/nursing sphere is discriminatory. Psychologists have multiple avenues to pursue the ability to safely prescribe. They do not need a special one for themselves only.

I ask you to consider the above points and to vote no on this bill.

Sincerely,

Maureen Nash, MD, MS
Fellow, American College of Physicians
Fellow, American Psychiatric Association.