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PSYCHIATRIST

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President's Column

Psychiatry in the Coming Year

Steve Soldinger, M.D.

Spring is here. With spring comes sunshine, and we begin to reflect on what this year will bring. This New Year has a lot of issues for psychiatrists in California. We have the concepts of Assisted Outpatient Therapy, and we have MICRA being challenged by the legislature and on the ballot. Of course we also have to deal with Mental Health Parity, CPT codes, ICD-10, DSM 5, and new drug formularies that are being created continually. This is only the beginning of what we have to deal with this year. We also have other problems including the Affordable Care Act; corruption in our state government; and many issues regarding diagnosis, treatment, and medication. We also have new ways of looking at healthcare regarding patient record management in both private practice and in hospitals. The new software program called "EpicCare" (also referred to as Epic) is an electronic medical record (EMR) denoting the concept of "one patient, one record." This program is now being used, which will require some education and practice for doctors. These systems are actually very helpful. I have completed the training on Epic, and I think it will be a welcomed addition to healthcare practice. This will also be of great benefit to our patients.

There are many issues facing psychiatry in the coming year. The one that I want to impart some information about is the concept of integrated care of psychiatric patients. It is important to be a member of the medical community at large. Whether that be on the hospital staff, being active in the American Medical Association, or just by consulting frequently with our colleagues. It is important that psychiatrists continue to inform our physician colleagues of the importance of mental health. Whether the presenting diagnosis is medical or psychiatric, there are components of both in all illnesses. There is never a time not to involve an integrated approach for our patients. It is important for us to be in frequent communication with the oncologist, internist or cardiologist. I have always found this form of integration in my own practice to be helpful not only for my patients, but for their other physicians and me as well. I can only hope the information I have imparted to other physicians has been helpful to them. I want to encourage all the members of the SCPS to stay in contact and interact with other physicians as a resource.

I have only scratched the surface of the different array of things we will be dealing with over the next year. Already I find myself being overwhelmed. I don't even want to think of the other items I could add to this list. I just want to remember that it is spring and we are all lucky to live in Southern California.

On March 8 we had our art event at the home of Dr. Michael Gales and Dr. Heather Silverman. This was an amazing event. We all took magazines and cut out pictures and created collages. This was done with a professional artist who was there

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In This Issue...

with us. We will have these fabulous works of art on exhibit at the installation event on April 12. These two collages turned out to be incredible. One had the theme of good, and the other had the theme of evil or darkness. Thank you to the art committee and especially to Dr. Michelle Furuta for this wonderful event. This was only the first event to come out of our newly formed Art of Psychiatric Medicine Committee. I know they have future events already being discussed and planned. I can't wait to be involved and be a part of these upcoming activities.

On March 29 we had our PER event at UCLA-NPI auditorium. Our foundation director
Dr. Maria T Lymberis did an outstanding job. We had Dr. Marvin J Southard, Director of Los Angeles County Mental Health Department, introduce the 2014 PER Advocate Award recipient, Elyn R Saks PhD, a USC Professor of Psychiatry and Law. Professor Saks is an expert in mental health law, a psychoanalyst and a person with schizophrenia. Her 2007 autobiography "The Center Can Not Hold" became an award-winning best seller. She gave an amazing presentation, where she was beyond eloquent in describing her own path, while also giving us direction in our treatment of psychiatric patients. The major take-home message was, if someone goes in the hospital for a psychiatric illness, buy them flowers just like you would any patient in a medical hospital. It is difficult enough having a mental illness, at least we can remove some of the stigma. After this talk, we had a wonderful presentation by Dr. Richard Kogan, a distinguished psychiatrist and concert pianist. He played the music of Robert Schumann and shared his biography with us. What a great way to listen to music and understand the story behind it. He discussed the impact of Schumann's disturbed moods on his work and life. All this was done in collaboration with Dr. Ken Wells and Dr. Bonnie Zima. I only hope that next year we will have a larger attendance and more involvement from the SCPS.

In April, we will have the California Psychiatric Association meeting and Advocacy Day. This will take place on April 6, and our meeting with the legislators will take place on April 7. This meeting is always an informative time. It is a chance for those of us from the district branches to learn issues that our state representatives are dealing with, as well as interface with some of the issues of the national organization. To top it off, we will have the opportunity to meet with people who prepare us to interact with our legislators on issues that are important to psychiatrists. As I have said in the past, if there are particular issues anyone has that they wish me to bring up, please don't hesitate to contact me. This entire process creates quite a continuity between the individual psychiatrist in the district branches working in their offices being represented at the local level, and at the state level, and then interfacing with the national level. This is an important aspect of helping to maintain and to go forward in the field of psychiatry. Without this particular structure in place it would be hard to imagine the mental health system we have in place at this time would be better. I doubt it would be even comparable to what we have at this time. It is so easy for those of us born into this system not to realize how amazing it is. I want to thank all of the people who have made this possible and continue to make this possible. This list includes our local leaders, our state leaders our national leaders as well as all of the district branch, state and national offices and their administration. They are all to be commended for the progress we have made in the field of mental health.

We have finished our election of new officers for next year. I want to congratulate those people who will be taking their offices on May 9. Our installation event at the local level will take place on April 12. I encourage everyone to come to that event to congratulate the winners of our recent election. I also want to congratulate all those people who took part in the election whether they won or not. Without people willing to serve our organization, it would wither and die. The people willing to take office and work for the rest of us, tirelessly and without compensation, are truly angels. Without our angels there can be no rewards for the profession we serve. I say once more "thank you" to all our members for their participation. This also includes the members who voted.

American Psychiatric Association convention will take place in May. This convention will meet in New York City. This is always an amazing format, however, it can be a bit overwhelming. I have been attending the APA conventions since 1977 and have only missed three or four conventions. The APA conventions offer such great opportunities. The problem is to know how best to meet the need of each individual, to identify what this need is, and how best to deal with it at the convention. I hope that my experience can be of benefit to some of you that will be attending the convention. To this end, I plan to host an APA convention boot camp for members only at my home on April 27 from 10 AM to 12 PM. This will be an informal event and coffee and bagels will be served. If you are interested in attending, please call Mindi Thelen at the district branch office (310-815-3650 or

scps2999@earthlink.net) to receive further information and to RSVP. I will try to get us all ready to receive the most out of the convention. The APA convention should be a wonderful opportunity, not an overwhelming nightmare.

My term as president is coming to an end. At the end of the APA convention, the gavel will be handed to Dr. David Fogelson. Even though I still have one last column to write for the newsletter, I want to begin to thank the members of the SCPS for electing me to this office. I must admit, I did not expect to get more out of it then I put into it, but that is exactly what happened. I have grown in many ways during this past year, and it has been a life-changing experience. I will always remember the lessons I have been taught by all of you during the past year.

Well that's it for this month. I hope you enjoy this column as much as I enjoyed creating it. Thank you.

Sincerely,

Steve Soldinger MD

Letter from the Editor

Money is Not the Root of All Evil

Colleen Copelan, M.D.

I have lately been raising money for political action and I've run into a big attitude problem: Doctors don't want to part with their money, and/or they believe money corrupts politics, and/or they don't believe politics has anything to do with the practice of medicine.

I'd like a good excuse not to part with my money too but, let's be honest, these are not good excuses.

True, money—or at least lots of it—does corrupt. But starving our political action committee will not solve that problem. Even our best ideas need money for advertisement. And our best candidates need money to compete in elections.

Politics has everything to do with medicine. Legislators define what is and what is not medicine, who gets licensed for what, and how insurance plans behave and pay for care.

In November, the voters will decide if doctors should be drug tested and lawyers should have greater access to the health care dollar.

I looked it up. It's not the money that's evil. First Timothy 6:10 reads: "For the **love** of money is the root of all evil…." (emphasis added). Don't hold on so tight. Your profession needs your support, for us and for your patients. cocopelan@aol.com

Can Good Come From Tragedy? California's Misguided Approach to Drunk Driving

By Katherine Watkins

This article was originally published in the Orange County Register.

Last month, 21-year-old Olivia Carolee Culbreath is alleged to have been driving drunk when she drove her car the wrong way down the freeway, striking two other cars and killing six people. Tragically, this was not Culbreath's first alcohol related offense; she was convicted of driving under the influence of alcohol (DUI) as a teenager and had only had her license reinstated the previous week.

While the consequences of this incident were extreme, the incident was not unusual: a disproportionate number of DUI fatalities are caused by drivers previously convicted of an alcohol-related motor vehicle offense. Specifically, in California, more than one-fourth of all DUI convictions are repeat offenders.

This tragedy exemplifies what is wrong with the way California approaches people convicted of DUI. Despite the frequency with which people are convicted of multiple DUI offenses, California continues to require that all individuals with a DUI attend a 30 or 60-hour alcohol education program.

However, these programs aren't that effective.

Indeed, a 2013 study by the California Department of Motor Vehicles showed no differences in DUI incidents and crashes between individuals attending and not attending DUI programs.

So why don't these alcohol education programs work? One reason is that many of the participants need more than education. Recent RAND research on DUI programs in Los Angeles showed that 92% of participants had an alcohol use disorder, and 67% suffered from alcohol dependence. While there are effective treatments for alcoholism, education about alcohol is not treatment and doesn't work for people with alcohol dependence. Alcoholism is a chronic and progressive illness of the brain. People with alcohol dependence experience a strong need or craving to drink and usually can't stop drinking even when they want to.

Viewed in this light, it is not surprising that California's DUI programs have been ineffective. Fundamentally policies that aim to prevent re-offense by mandating completion of a DUI program are predicated on the incorrect assumption that improving participants' understanding of the laws about, and dangers of, driving under the influence will result in participants choosing not to drink and drive.

Requiring attendance at ineffective programs is bad public policy. It wastes resources and squanders the opportunity to help people with alcoholism acknowledge their problem behavior and try to change it using interventions that work. This not only has implications for these problem drinkers and their families, it also threatens public health and safety.

To be sure, making changes will be difficult. It will require collaboration and agreement among agencies and systems that typically don't work together, including the Department of Motor Vehicles, law enforcement, the judiciary and substance abuse providers. DUI programs are a big business with gross revenues in excess of $106 million per year. Many have been providing services for decades.

This most recent tragedy should serve as a wake-up call; California can, and must, do more. So what should be done? There are science-based addiction treatments that work. New medications which reduce craving are available to treat alcohol dependence, and there are several evidence-based psychotherapies.

For those individuals without alcohol dependence who may not need treatment, there are effective abstinence probation programs like South Dakota's 24/7 Sobriety Program, which monitors alcohol consumption and provides swift, certain, and modest sanctions for violations. This program was recently added by the National Highway Traffic Safety Administration to their list of impaired driving countermeasures eligible for federal highway safety funds.

California needs to replace ineffective programs and practices with interventions that have a better chance of working.

Risky alcohol use is a leading cause of preventable deaths in the United States. Heavy alcohol use also exerts a toll on families and society, through its association with domestic and physical abuse, violence and crime. The case of Ms. Culbreath reminds us that a DUI arrest can be a missed opportunity to intervene. Alcohol abuse and dependence can have terrible consequences that go far beyond the individual who drinks. California can, and must, do more.

Katherine Watkins is a senior natural scientist at the nonprofit, nonpartisan RAND Corporation and a board-certified practicing psychiatrist.

Election Results

President-elect - Heather Silverman, M.D.
Secretary - Erick H. Cheung, M.D.
Treasurer-elect - Anita Red, M.D.
ECP Deputy Representative - Michelle Furuta, M.D.
Resident/Fellow Representatives - Devin Stroman, M.D., Galya Rees, M.D.
APA Assembly Representative - Larry Lawrence, M.D.
San Fernando Valley Councillor - TBD*
Ventura Councillor - Vanessa Lauzon, M.D.
West Los Angeles Councillor - Curley Bonds, M.D.

* A tie resulted between Robert Dasher, M.D. and Oscar Pakier, M.D. A runoff election is being held at time of publication

Congratulations to the winners and gratitude to all who are willing to serve.

Sons-in-Law

by: Walter T. Haessler, M.D.

I have three sons-in-law, which is not at all unusual since I have three adult daughters.

The guys are different in ways, and similar in others. When you consider desirable traits for sons-in-law to have, near the top of the list would be “devoted dad,” and I am pleased to say that they all exhibit that quality.

We have known my oldest daughter’s husband for a dozen years or so, and get along fine. Over the years, he has asked me several times for psychiatric opinion on different matters; and several times I have picked his ample brain (Harvard MBA) on financial matters.

Last June, over dinner, he posed this question. He had just finished a book that questioned the validity of Freud’s ideas because of a lack of scientific proof. He seemed to agree with the author, and asked my opinion. That looked like a hanging curveball right over the plate -- like a few well-chosen sentences would settle the matter. But that’s not how it went.

I replied that Freud was as scientific as he could be, given the limitations of science in his time; that he had started out as a neuroanatomist and neurologist, only later coming to appreciate the role of psychological factors in symptom formation; that he felt one day there would be somatic treatments for anxiety and depression; and that without modern medical technology his knowledge was necessarily limited to observation and introspection, and to the outcomes of his psychological interventions.

I went on to say that what educated people now take for granted (Oops! In writing this out, I see how that could have been provocative.), was pioneering work in late Victorian times. So, while not every specific Freud came up with has withstood the test of time, there are huge and enduring truths: that there is an unconscious mind; that unconscious conflicts can produce symptoms; that we share basic drives (instinct/id) with the animal kingdom; that psychological trauma in one’s formative years does damage; and that this damage can be to some degree undone by psychological intervention.

At that point I was pretty much congratulating myself for my well-articulated reply -- clearing the left field wall, to extend my baseball metaphor.

But it was not to be. Back came the comment that, as the author is said to have asserted, if scientific proof is lacking, the theory remains unproven.

So, I came up with the clincher, or so I thought, producing a clinical vignette of my cure of a case of conversion hysteria (DSM-II) as a second-year resident. I had been called to the ER in the early evening to see a teenage boy from a nearby prep school who had been brought to the ER because of a the sudden paralysis of his right (dominant) arm, which the ER physician could not make sense of.

The boy seemed a bit too calm (indifferent) for the situation, but there was nothing else in the history or examination to suggest a mental disorder. The cure came about in the process of his talking about what was going on at symptom onset: that he became very angry at a younger, smaller boy at the school and had the impulse to strike him. Then, the paralysis. And while he was telling me what had happened, the paralysis lifted -- gradually, over 15-20 minutes, which I found interesting -- and then he was as good as new.

That kind of quieted things at the table, and I was once again congratulating myself. However, son-in-law remained unconvinced as to theoretical considerations, and asked me to discuss just one of Freud’s theories that has lasted into modern times. And here I made a mistake. I think I should have just rested my case after that clinical example, which seems to me to prove the theoretical basis, and practical usefulness, of how conflict can cause a symptom and how psychological intervention (simply active listening in this case) can cure it. After all, these are Freud’s classic cases.

But knowing when to shut up has never been a particular strength of mine. So I talked a bit about the so-called Oedipus Complex, and how the mothers of sons (such as middle daughter, who was also present, and oldest daughter) would certainly endorse the idea that something sexual is going on. Well, middle daughter was not convinced; but old-

est daughter (a physician, but not a psychiatrist) jumped enthusiastically into the fray on my side, with colorful examples to help make my point.

This then led to palpable unpleasantness between oldest daughter and son-in-law. In short order, however, all combatants had the social graces and good sense to get off the subject, and so we did.

A little while later, back at home, I caught up on my journal reading. One article stood out. I'm sure it would have anyway, but the recent dinner conversation had stayed with me, and set the article in a gold frame.

The article was in the June, 2013 *AJP.* (Heim CM, Mayberg HS, Mletzko T, Nemeroff CB, Pruessner JC; Decreased cortical representation of genital somatosensory field after childhood sensory abuse. *Am J Psychiatry* 2013: 616-623) It is a multi-center study that shows how psychological trauma in childhood has not only psychological consequences, but actually alters the morphology of the adult brain. This was demonstrated by MRI-based cortical thickness analysis.

They wanted to "...test whether different forms of childhood abuse were associated with cortical thinning in areas critical to the projection and processing of specific behaviors implicated in the type of abuse." And that's how it turned out: "Exposure to childhood sexual abuse was specifically associated with pronounced cortical thinning in the genital representation field of the primary somatosensory cortex.", while "...emotional abuse was associated with cortical thinning in regions relevant to self-awareness and self-evaluation."

Wow! You like science? There's some science!

As to the "theory" that traumatic experiences in one's formative years do damage, I did not need proof. I knew that as surely as I know that water boils at 212 degrees. But I would not have known, or guessed, that the morphology of the brain could be thus altered. And think of the consequences for thinking, behavior and mood in general, and sexual functioning in particular.

We knew it was true, but didn't know the neuroanatomy and neurophysiology, and still don't know much about that part of it. We didn't know the details about what foxglove leaf was doing, but knew it helps a failing heart. Medical practice, especially including psychiatric practice, has over the years been highly empirical. This is hardly an isolated example of only later learning some of the details.

This article contains a few things I wanted to share, and then there is a suggestion. I was able to include an anecdote about an informed layman's understanding of the theoretical underpinnings of our profession; a clinical vignette which was important and memorable to me; and a brief review of a journal article which I found particularly interesting.

The suggestion is this: that we all can inform, and perhaps entertain, each other by contributing this kind of material to *Southern California Psychiatrist*. And here is the main selling point: there is no reason to think that my anecdotes and vignettes are more interesting or instructive than those of other members, but they are mine, and if I hadn't shared them, members would not have been aware of them. We all have them, and I think they should be shared. And I believe that doing so helps flesh out *Southern California Psychiatrist*, and make it more enjoyable and informative.

As to coming across a journal article that seems particularly interesting, I think that happens to all of us at times. To me, most of them are not all that interesting -- either so technical and narrow that they are tedious to read and of little clinical relevance, or discovering the obvious. But when there is one that really registers with one of us, calling it to other members' attention in this way seems right.

As I do the math, if one per cent of members would do this once a year, each newsletter would have such material, which seems like a good idea.

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The first Art of Psychiatric Medicine event was held on March 8th at the home of Heather Silverman, M.D. and Michael Gales, M.D. It was a beautiful day and an epic event! Two wonderful collage panels were created by the attendees: Favored vs. Feared Experiences. The committee will hold more events, create more art, and hopefully hold an exhibit. Proceeds would be used to support the activities of our new Volunteerism Committee. The following are photos from the event and from the final pieces.

Council Highlights
March 13, 2014

Joseph Simpson, M.D., *Secretary*

Dr. Soldinger opened the meeting at 7:10 PM. The February meeting minutes were approved.

President's Report: How to survive an APA annual meeting. Dr. Soldinger has been to over 30 APA meetings. In the past he has given talks to residents and other groups about how to make the most of the meeting in terms of education. He is willing to host another meeting in advance of the upcoming meeting in May. Council approved this.

Joint meeting with SCSCAP: The child psychiatry chapter of AACAP would like to discuss marijuana at the joint meeting. Previous joint meetings have been at Dr. Arroyo's house. SCPS will provide CME. There was a discussion about whether to move the venue so that the entire SCPS membership could be invited, rather than just the San Fernando Valley region. At the last meeting, Dr. Soldinger was the only non-child psychiatrist in attendance.

Medicare issues: Dr. Samuel Miles discussed two Medicare issues. One was a proposal by HHS to remove protected status from antidepressants and antipsychotics so that insurance carriers could restrict their formularies. This proposal has already been withdrawn. The second issue is a proposal to make any doctor who prescribes medications for Medicare patients register with Medicare. This would have to be renewed every five years. In order to not receive Medicare referrals, you would to opt out every two years. APA opposed the removal of protected status, but does not have an official position on the registration issue. Dr. Schaepper and Dr. Miles will work on an action paper for the APA Assembly.

The art of psychiatric medicine: The first meeting had a dozen psychiatrists and attendance as well as a guest artist who served as facilitator. Dr. Furuta displayed the two art works that resulted from the meeting. Of note, several of the doctors who came to the meeting had not been seen at SCPS-sponsored events. It was discussed that as the meetings continue, eventually there could be an art show or possibly even a symposium at an APA meeting.

Legacy program: Dr. Lymberis discussed this initiative. The SCPS monthly newsletter will publish a series of articles about how to prepare your practice for closure due to death or disability. The first article appeared in the March issue. Ultimately, it is hoped that malpractice carriers will provide an add-on policy to help practitioners prepare.

SCPS election: the deadline is March 22. This is the first year of all electronic voting. So far about half as many people have voted as last year. Another e-mail reminder will go out.

Upcoming Events: The PER event is coming up on March 29 at UCLA. The Installation and Awards Ceremony will be on April 12th at Le Merigot. Please RSVP for it.

Screening of *My Name was Bette:* Dr. Duriez would like to have a screening of this documentary in late May or early June, with a question-and-answer period with the filmmaker. The original venue that was planned is undergoing renovations, so a second venue has been identified in downtown LA. However the cost will be $700 for this theater. Dr. Duriez will discuss with the Program Committee and PER. The movie could also be shown at the CPA meeting in 2015.

President-elect's Report: Dr. Fogelson reported that the next NAMI-SCPS joint meeting is being planned. Last year it was held at Billingsley's. This is an option again. Other possibilities would be the UCLA faculty club or

the Capital Grill. Mindi will look into these. The meeting will be held on the same night as the June Council meeting.

Membership Committee Report was given Dr. Augustines. Three resident/fellow members were approved.

Treasurer's Report was given by Dr. Silverman and was approved.

Legislative Report by Dr. Thurston: There are few bills moving through the Legislature currently. MICRA is the biggest issue. All psychiatrists are encouraged to write a check to California Alliance to Protect Patients (CAPP), and send it to the CPA who will forward it on to CAPP. CAPP is an umbrella organization of approximately 900 groups, including the CPA. Approximately 140 members of CMA went to the California State Democratic convention to discuss MICRA. The state Democratic Party had been considering adopting a platform plank in favor of raising the MICRA damage cap.

CPA election results: President-elect is Dr. William Arroyo. Treasurer is Catherine Moore from San Diego.

Program Committee Report: Dr. Gales was not present. Dr. Silverman reported that the Program Committee has not met since the Psychopharmacology meeting in January. Survey results from that meeting indicate that all speakers were very well-received.

New business: There is an action paper for the APA assembly meeting about bringing pharmaceutical companies back to the annual meeting. They would sponsor non-CME symposia. Discussion followed. The majority favored exploring the option to bring an industry role back to the annual meeting.

Old business: none

The meeting was adjourned at 8:50 PM.

Congress Delays ICD-10 Implementation and Huge Medicare Fee Cut

A bill passed by the Senate Monday night and the House last week includes two critical changes affecting physician practices—one involving ICD-10-CM implementation and one concerning physician reimbursement in Medicare.

A provision in the bill that affects physicians and other clinicians nationwide delays implementation of ICD-10-CM coding until October 1, 2015. The Centers for Medicare and Medicaid Services had previously set October 1, 2014, as the date by which clinicians had to be in compliance with ICD-10-CM coding. APA has emphasized that DSM-5, released last May, already includes the ICD-10-CM codes, as well as the ICD-9-CM codes currently being used. APA has posted a guide on its website to help psychiatrists and other mental health clinicians understand the relationship between DSM-5 and ICD-10-CM.

The other key part of the bill, which focuses on multiple Medicare-related policies, postpones for the 17th time a scheduled cut in Medicare's physician reimbursement. The cut was scheduled to go into effect yesterday and would have resulted in physicians' fees being cut an average of 24%. The substantial size of the fee cut—a result of a complex formula involving practice costs and other factors known as the Sustainable Growth Rate (SGR)—reflects multiple postponements since 2003 that have caused the cut to keep growing. The House agreed to a one-year delay last week in a voice vote, and the Senate did so Monday night by a vote of 64 to 35. The legislation is now awaiting President Obama's expected signature. APA, the AMA, and almost every other physician organization have been vociferous in calling for the SGR formula to be replaced. While the need to scrap the formula and replace it with a new funding system that focuses on the quality of care provided is widely acknowledged on the Hill, proposals to do so have been introduced but have not yet been voted on by either chamber.

To read more about efforts to replace the SGR formula, see the Psychiatric News articles, "Law to Repeal SGR Clears Key Congressional Committee," and "Physician Medicare Payment Rule Needs Several Changes, APA Says."

This is from a Psychiatric News Alert.

"I'll do it for you if you'll do it for me." The Partnership Approach to Professional Wills, Wonts and Won'ts.

Steven Frankel, Ph.D., J.D.[i]

Welcome to the second article on ways to address the problem of how to prepare for unanticipated disruptions or terminations of practice due to death or disability. In this article, I address a way of approaching the problem that has been around the longest in our fields – the professional partnership model.

Where to start:

The partnership approach requires that two colleagues make an agreement to "be there" in the event of a disruption in one of their practices.[ii] The modal strategy is to form a relationship with a colleague who practices in your geographic area, with the specific agenda of assisting each other with a practice transition in the even of an "event." The typical approach is to work with a fellow senior colleague, as practice seniority is associated with a good working knowledge of how practices work, the ways in which records are kept and managed, a familiarity with other psychiatrists who practice in the community, their specialties and other indicia of relevance to being good choices for referrals of one's patients, etc.

Informed consent:

The standards of care for psychiatric practice require that patients be provided with informed consent to treatment, which typically includes: 1) diagnosis, 2) proposed treatment plan (with nature, purpose, risks/benefits), 3) alternative treatment plans (with nature, purpose, risks/benefits), and 4) likely consequences of no treatment.[iii] In addition, informed consent includes information about how the practice operates – limits to confidentiality, fees and payments (including insurance), accessibility, emergency procedures and access to records.

When a partnership between colleagues is created, the informed consent discussion and documentation should include an identification of who the partner is ("if I do not respond to phone calls, letters, etc., please call ……."), that the partner has agreed to manage the transition of the practice, and that, by signing the informed consent document, patients authorize the partner to view charts and make direct contact with the patients for the purpose of practice transition. The only foreseeable problem with this part of the plan is that, especially in "small" communities, there may be a patient who, at one time, has received services from the colleague, and refuses to sign a release for that reason. For such patients, an alternative means of providing a referral and transmitting records must be found.

Transition Tasks:

In the event of an "event," the following tasks must be addressed by the surviving colleague:

Notification of patients: The surviving colleague's job begins with the notification of patients that an event has occurred. This process is best done by the colleague rather than an office staff member, as psychiatrists are familiar with the grieving process and are best qualified to assist patients with the transition of care during that grieving process.

Making referrals: The surviving colleague's responsibilities include referring the patients to a new treater. Ideally, the issue of what will happen in case of an "event" has already been discussed with each patient, with an eye toward who might be the best colleague for each patient to see in the future. These discussions are typically quite beneficial to patients, who appreciate being thought of in protective ways, such that they already know who they will be seeing for future care.

Transfer of records: The surviving colleague's responsibilities include ensuring that patient records are for-

warded to the new treater, or provided to the patients who request them consistent with the laws of the jurisdiction of the practice.

Office rental: the surviving colleague's partnership arrangements should already have been explained to landlords of office buildings, such that provisions for payment of rent, disposal of equipment and furnishings and associated tasks can be completed smoothly.

Family: the families of colleagues going through life transitions will be grieving, and the partnering colleague's responsibilities include reassuring families that preparations for transitions have been made and are being implemented properly.

Estate-planning attorney (wills/trusts): the partner should be aware of the identity of the estate-planning attorney, who, in turn, should have permission to discuss the estate plan and to provide funds for handling practice transitions, as there will be expenses associated with practice transitions.

Accounts payable and receivable: an important part of the transition partnership should include information as to billing and payment processes/procedures, such that the surviving colleague is able to ensure that bills are paid and collections are received. The partners' names should be known to the banks, such that checks may be written and deposits made.

Telephone: colleagues should contact the relevant phone company and arrange to forward calls to the surviving colleague's telephone number.

Notices: the surviving colleague will place a notice in the local newspaper for two weeks, indicating that the practice is in transition and how to contact the surviving colleague. Further, notice should be provided to licensing boards, insurance companies and professional societies.

Computer access: surviving colleagues should be fully knowledgeable as to computer passwords and computer access to information.

Insurance: It is strongly recommended that partners take out term life insurance policies of $10k-$20k (which, at this time in history, are quite inexpensive), to support the partner during the transition period, as the amount of time that colleagues will be putting in to assist with the transition can be compensated in this way.

Personal "good-bye" letters: It is a matter of grace and kindness for professionals to leave letters in the charts of all patients – which can then be mailed to each patient, with a simple statement of farewell, of appreciation for having had the opportunity to provide care, and wishes for future benefits from the care provided.

Access to offices: keys, pass-codes, access to files, awareness of staff and their availability – all of these must be known to the surviving colleague.

For colleagues who utilize EMR for record-keeping, releases need to be signed by patients to provide access by the surviving colleague.

Down-sides of the "partnership" approach:

If you are still reading this article, you may be coming to realize that the partnership approach has two significant downsides. First, it is exhausting. The amount of time and the degree of detail involved can be overwhelming, and it is this degree of apprehension that has led to such a slow development of acceptance and implementation of these types of partnerships.

Second, a major downside of the partnership model is that one of the partners will most certainly predecease the other, such that the surviving partner will have to find another colleague to join with for the future.

Thus, the enormity of the tasks and the awareness that more than one of these experiences awaits colleagues who wish to be helpful, add to the general denial and avoidance that keeps us from developing needed plans.

The next article in this series will present a related model, involving a group of colleagues rather than a partnership of two colleagues. Such a model makes some of the overwhelming qualities of the partnership model less foreboding, but has problems of its own. The fourth paper in the series will discuss a quasi-insurance model that has been developed to deal with these issues and problems in ways that are far less intimidating to colleagues.

[i] [ii] If you are interested in a closer look at the issues and support systems, you're welcome to contact me via www.practice-legacy.com

[iii] Frankel, A.S. (2013). Practice continuity, Nevada Psychiatric Association Convention and Frankel, A.S., & Alban, A. (2010). Professional wills: protecting patients, families and colleagues. California Psychiatrist, February, 2010. pp.4-6.

[iv] See, e.g., Simon, R.I. (1992). *Clinical psychiatry and the law*, 2nd Ed. Washington, DC: American Psychiatric Press, p. 128.

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