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President's Column

Is it Physician Assisted Suicide or Is it Death with Dignity?

David Fogelson, M.D.

March Hare: Then you should say what you mean.
Alice: I do; at least - at least I mean what I say — that's the same thing, you know.
Hatter: Not the same thing a bit! Why, you might just as well say that, 'I see what I eat' is the same as 'I eat what I see'!
March Hare: You might just as well say, that "I like what I get" is the same thing as "I get what I like"!
The Dormouse: You might just as well say, that "I breathe when I sleep" is the same thing as "I sleep when I breathe"!

Lewis Carroll, Alice in Wonderland.

I received an email from Tim Murphy, the president of the California Psychiatric Association (CPA), asking the Southern California Psychiatric Society to provide the CPA with feedback about proposed Senate Bill 128, "End of Life Bill". President Murphy wanted to know if the SCPS Council supported the bill, opposed the bill, or preferred to take a wait and watch approach. After every member of the SCPS council shared their analysis and opinion of the bill we polled Council. 9 were in favor of the bill, 9 supported a wait and watch approach, and one was opposed. I was initially opposed but was persuaded that a wait and watch approach was best. The discussion led me to believe that I did not understand this issue well enough. My initial opposition came from a fear that this bill would open a door that patients suffering from Major Depression might exploit to commit suicide. Over my 37 year career in psychiatry, one of the heaviest responsibilities I have carried is preventing suicide in my patients. Before opining on this bill, I wanted to better understand its potential impact on patients at risk for suicide.

What does the bill state (SB 128)? *The bill includes an "End of Life Option Act" authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal illness (an incurable and irreversible illness that has been medically confirmed and will, within reasonable medical judgment, result in death within six months) to make a request for medication prescribed pursuant to these provisions for the purpose of ending*

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In This Issue...

his or her life. The bill would provide immunity from prosecution to participating physicians. Participation by physicians will be voluntary. The bill would make it a felony to coerce an individual to make a request for medication to end their life and it would be a felony to conceal or destroy a rescission of such a request. Euthanasia will not be permitted under this act. Before a physician may prescribe life ending medication, the physician must determine that the requesting adult is competent, has a terminal illness, must discuss the medical diagnosis and prognosis, any risks associated with the "end of life" medication, feasible alternatives including hospice and palliative care, and request a second opinion from a consulting physician regarding diagnosis, prognosis, and the competency of the patient in question.

Do our professional organizations have already existing positions on this issue? The American Psychiatric Association (APA) does not have a position on an individual's right under the law to request life ending medication. The APA does have a position paper dated June 2001 on the *Core Principles for End-of-Life Care.* These core principles encompass alleviation of pain, enabling access to palliative and hospice care, respect the right to refuse treatment, respect the physician's decision to facilitate the withdrawal of medical treatment(s) consistent with the patient's wishes, and alleviate mental anguish. The American Medical Association (AMA) takes the position, that *allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life.*

After reviewing the positions of our professional organizations and after better understanding the provisions of the bill I was left with one primary concern: What provisions are made for protecting patients suffering from a terminal illness and severe Major Depression from being unduly influenced by their depression into opting for, and requesting end of life medication? Let me expand on this concern. I am often confronted in my clinical practice by patients suffering from severe Major Depression who feel an urgency to make a major life decision. The decision might pertain to employment, an investment, a relationship, a career choice, or medical care. I routinely counsel patients not to make these decisions until their depression is in substantial remission. I explain to them that they will otherwise be unduly influenced by the pessimism attendant to their depression. They might end a relationship because they can see no way to salvage the relationship. They might sell an investment because they are convinced the investment will rapidly dwindle in value. They might decline further medical treatment for their depression, deeming treatment as futile. A depressed patient viewing the last six months of their life may have an extraordinarily pessimistic view of those six months compared to a patient with the same terminal illness not suffering from depression.

I wondered if research had been conducted to examine the view of patients in hospital with medical illness, with and without depression, on preferences for life sustaining measures, physician assisted suicide, and euthanasia. I reasoned that such research might support or refute my concern that depressed patients confronted with a terminal illness might be unduly influenced by their depression into opting for end of life medication. A study by Karen Blank et al in the Journal of the American Geriatric Society, 49:153-161, 2001 examined this issue. Dr. Blank and colleagues examined 158 medically hospitalized, nondemented patients with an average age of 74. The patients were rated on severity of depression using the Center for Epidemiologic Studies-Depression score. Patients with a score of 16 or greater were placed into the depressed group (n=71) and the others into the control group. Patients were surveyed about their attitudes towards withdrawal of life sustaining treatments, physician assisted suicide (PAS), and euthanasia. Depression was found to be highly associated with acceptance of PAS and euthanasia. When asked to imagine that they were facing a hypothetical terminal illness, depressed patients were twice as likely to accept PAS. The presence of passive suicidal ideation was strongly predictive of interest in PAS. When asked to consider their current medical illness, the depressed group was 15 times more likely to choose PAS. This held true after controlling for other variables including severity of current medical illness.

The results of the study by Dr. Blank and colleagues confirm my concern that patients suffering from depression and a terminal illness will be influenced by their depression when considering PAS. Should not a physician writing an order for "end of life" medication be required to assess the severity of depression in the patient requesting the prescription? Should this be any physician or a psychiatrist? What impact should the severity of the depression have in determining the physician's decision to grant the request? Should not there be safeguards in this bill to protect patients suffering from depression? Until these questions are answered, I believe it is premature to support the "End of Life Option Act."

Let me pose a hypothetical, loosely based on the study by Blank and colleagues. What if 100 patients all have the same terminal illness that will likely end their lives within six months and ten of those meet criteria for clinical depression? What if the 90 who do not have depression make the decision to forgo PAS but 5 of the 10 depressed patients opt for PAS? What then? Should the severity of the depression in any way mediate a patient's right to request PAS?

Dr. Ira Byock, professor of medicine at Dartmouth University, is an expert in palliative and hospice care and writes in the Los Angeles Times that we should be skeptical that SB 128 is good social policy. He warns us not to conflate women's rights, voting rights, and gay marriage with the right to PAS. He warns us that arguments for this bill are Orwellian. In place of the term, PAS, proponents of this bill use terms such as "physician aid-in dying" and "death with dignity." Physician aid-in dying makes PAS sound like an extension of hospice care. They are not the same thing. Hospice care is aimed at relieving symptoms and supporting patients in completing their lives. It does not include providing the means to a patient to kill themselves. Dr. Byock reminds us that "death with dignity" implies that patients with a terminal illness are not dignified. He argues that a dying patient can be aided in feeling respected, worthy, and valued; dignified if you will without resorting to PAS. Dr. Byock argues for at least two amendments to SB 128: one would require that medical schools allocate equal time in their curriculum for palliative care and pain relief along with other clinical coursework and two, physicians must demonstrate competency in pain management and shared decision-making skills, before receiving a medical license. I would add a third amendment, one that addresses the needs of those afflicted with depression.

I invite members of SCPS who share my belief that SB 128 is a touchstone for a much needed discussion of this policy to contribute their own opinion pieces on this issue. I understand that I am not in the majority on this issue amongst Council members. I believe dialogue on this issue is important. I look forward to reading your opinions. I look forward to a better understanding of the reasons to support or oppose this legislation.

Please join us for SCPS' annual

Installation and Awards Ceremony

Le Merigot Hotel and Spa
1740 Ocean Ave
Santa Monica, CA 90401

Saturday, May 2, 2015
3:00 p.m. - 7:00 p.m.

Buffet Lunch - Cash Bar
RSVP: scps2999@earthlink.net
Guest Speaker: Marvin Southard, D.S.W.

Letter from the Editor

First Steps

Colleen Copelan, M.D.

This week my granddaughter took her first steps. I got the news in a video clip sent to my cell phone. She lives with her parents in faraway San Diego, where her dad—my son-in-law--is career U S Navy.

Why can’t they live next door like normal people?

What a world she’s stepping into! She’ll take for granted what we only imagined. Who knows where that will take her?

And who knows where the Navy will take her!? San Diego is close compared to worldwide Navy deployment options. My daughter is happily (!!!) talking about a 3-year adventure in Italy!

Why can’t they stay put, like normal people? I could babysit if she stayed anywhere in the United States.

Thank goodness we imagined cellphones and facetime! cocopelan@aol.com

ADHD: Assessment, Interventions and Management

Unwrapping the Gifts: A Strength-Based Approach to Treating Adult ADHD - **Edward (Ned) Hallowell, M.D.**, *Adult and Child Psychiatrist; Founder of the Hallowell Centers; Learning Differences Expert; Co-author of 'Driven to Distraction' and 'Answers to Distraction.’*

Child & Adolescent ADHD - **Michael Enenbach, M.D.**, *Assistant Clinical Professor, UCLA Psychiatry.*

Saturday, April 18, 2015. West Los Angeles

Find all details here:
http://www.socalpsych.org/events.html

The Art of Dying

Top 10 Reasons Why Psychiatrists Should Support SB-128

By Michelle Furuta, MD and Arsalan Malik, MD

"But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it the good we do can be breathtaking."

-Atul Gawande, *Being Mortal*

Science and Medicine have come to the point where we can keep the dead alive. Technological medicine can now maximize longevity but it still cannot adequately alleviate some cases of extreme suffering at the end of life, and when not used thoughtfully can create more suffering than it prevents. It is very different from any other point in medical history, and raises new issues for our profession to consider. It demands that Psychiatrists actively engage in the conversation about how we die in America. It calls on us as uniquely positioned experts at the intersection of medicine and mental health to weigh in on what we think about this issue, and to illuminate some of the nuances that only we may see.

On January 20, 2015, Senate Bill 128 (SB-128) End of Life[1] was introduced into the California Legislature by Senators Wolk and Monning, amidst a nationwide resurgence in support of legalizing aid in dying. The movement was precipitated by Brittany Maynard's widely publicized use of Oregon's Death with Dignity Act to end her life on November 1, 2014. There are currently 5 states in the U.S. with similar laws – Oregon, Washington, Montana, New Mexico, and Vermont. Twenty seven other states currently have bills under consideration in their legislature.[2] If it passes into law in California, psychiatrists may be called upon to evaluate a patient making a request for life ending medication who may have a mental illness interfering with their capacity to make that decision.

Below are the top 10 reasons why we support SB-128:

1. There is a massive difference between suicide and taking aid in dying medication. The word "suicide" is currently defined as the act of intentionally taking one's life. It is typically associated with mental illness or an acutely distressing circumstance, where a person is suffering from a mental disorder or an altered state with distortions of reality, causing them to wish to die. This is very different from a person who is dying of a terminal illness and wants desperately to live, but is going to die, is enduring intractable pain and suffering in the death process, and makes a thoughtful, rational choice to take a lethal dose of prescribed medication after weighing the risks and benefits of all available alternatives and having had in depth conversations about what matters to them with friends, family, and their healthcare providers. So we now have two situations which are very different, but are being defined by the same word. This is a problem. The chart below highlights some of the differences between suicide and aid in dying:

Suicide	**Aid In Dying**
1. Can have a devastating impact on individuals, families, schools, and communities	Can provide peace and closure for individuals, families, and communities
2. Often done in secret and isolation	Two physicians and 2 witnesses (most often family and/or close friends) must sign off on the request. Patients often have the support of their broader family and friends, and are often present when the person passes.
3. 1 out of 25 success rate	100% success rate, and may reduce the incidence of suicide and suicide attempts in this population
4. Is often violent	Is non-violent.
5. Results from a dynamic mood state which is theoretically treatable	Results from a rational choice independent of mood.
6. Approximately 40,000 Americans die from suicide every year.[3]	Last year in Oregon, 155 prescriptions for life-ending medication were filled, and 120 were used.[4]
7. Access to lethal means increases the likelihood of death	Access to lethal dose of medication can reduce the likelihood of suicide
8. 51% of Americans support “assisted suicide”[5]	70% of Americans support “ending a patient’s life by some painless means”[5]

SB-128 proposes that the terminal illness be listed as the cause of death, not the life ending medication. We agree. To list the medication as the cause of death (or worse, “suicide”) misses the bigger picture. If a 3-story building were engulfed in flames, and just before it collapsed from the fire you threw a rock at the last standing support beam, causing it to crumble to the ground, would you say the fire destroyed the building or the rock? When other palliative measures are used to hasten death, they are not listed as the cause of death. This should be no different.

2. Patients should have the right to choose (and doctors should not be criminalized for honoring and supporting their choices). We are not advocating that people use the law; we are advocating that they have the CHOICE. Nobody is forced to participate. The principle of liberty in this country supports patient autonomy – the right to make decisions about your life and your health as long as you are competent and don’t hurt anybody else. What matters in the end, and the choices surrounding the end of one's life are among the most personal and important decisions one can make. What right do we have to categorically deny someone who is in a constant state of unimaginable suffering this option? It is *their* decision to make, even if we as individuals may make a different choice. It is our role and our responsibility to support individuals in this process, treat mental disorders that may be interfering with their decision-making ability, compassionately facilitate end of life discussions, and to respect, uphold, and advocate for their decisions.

We understand that the principle of patient autonomy must be balanced against the public good and what is good public policy. The bill has numerous safeguards built into it to prevent abuse and coercion. Based on data from Oregon and the Netherlands, there is no evidence for the claim that legalization would have a disproportionate effect on patients in vulnerable groups (e.g. people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations).[6]

3. We took an oath to do no harm. Regardless of which side of the debate you are on, it is clear that "harm" means different things to different people. We have moved beyond the outdated, I-keep-you-alive-therefore-I-do-no-harm interpretation of the Hippocratic Oath. In certain cases, forcing someone to live in a torturous state of prolonged suffering before death when it is incongruent with their personal end of life wishes is doing incredible harm. The dying who meet criteria to use this law are a small minority of the population. We advocate for them as being among society's most marginalized and vulnerable, and understand the depth of suffering, desperation, and fear that comes with having no options to maintain a reasonable quality of life. There is sufficient evidence of harm being done because of the absence of this law. Few will use this option, but many will have peace and tremendous relief of anxiety knowing it exists.

While many psychiatrists already support legislation like SB-128, there still remains the potential challenge of feeling confident to do these evaluations well. Reconciling how to assess patient competency with or without the presence of depression, what to do in cases where a patient goes from competent to incompetent after the medication is prescribed, being able to distinguish a plea for reassurance from a rational request, and management of the physician's own countertransference to a dying patient are among those challenges which warrant the development of comprehensive guidelines in this area.[7]

4. The religious beliefs of one group should not dictate the medical care options for another. For some people, religious beliefs may preclude them from using this option or engaging in the process as a physician. But not everybody shares those beliefs, and participation is voluntary. A 2013 Gallup poll found that 70% of the population supported the legalization of this practice.[5] We are highly trained as Psychiatrists to be aware of the appropriate distinction between our beliefs and those of our patients. To convince a patient of a particular course of treatment based on your personal religious beliefs as a physician is unethical and an abuse of power.

5. It is happening anyway. Hello gorilla in the room. The absence of this option increases the risk of patients using painful, dangerous, and violent methods to end their lives, including firearms and online 'suicide kits'. They will be forced from an aid-in-dying situation to a suicide situation. Some of these patients will stop eating and drinking to hasten death, but it can take weeks. Hospice care is permitted to dose escalate opiates to control pain which may also hasten death, but can also cause severe nausea, vomiting, and delirium. Some patients will attempt to overdose on the medications at their disposal, but others fear it would not work and they would only feel worse. Palliative sedation can put someone in a coma if pain cannot be controlled. But it is not known how long they will stay in this state before they pass, and they must be in a hospital - not the comfort of their home. This law offers a safe, humane, and dignified means to pass in peace, at home, with loved ones present, is painless, and 100% effective.

6. To advocate for all possibilities of achieving a “good death”. The legalization of this bill does not negate the highly needed development and expansion of other support options available to the terminally ill at the end of their life – particularly in the psychiatric and psychological domains. We hope that discussion of this issue will help to redirect our attention to development of more thoughtful conversations about what matters to individuals in the end, and a more sophisticated understanding of how to help people achieve a good death. There are reports of this cultural shift transpiring in other places where aid in dying is legal[8]. Access to high quality palliative and hospice care is desperately needed so it can become available to all who need it in a timely fashion, and this issue should not be relegated to the back burner, regardless of the fate of SB-128. A recent study of patients with hematologic malignancies showed that patients are referred to hospice far too late (or never) – with an average length of stay less than 10 days before death.[9] The truth of modern death in our society is that getting a ‘good death’ is rare. Because Psychiatrists are poised at the intersection of the mental health and the medical communities, we have a responsibility to educate ourselves and the public about how to have these important conversations, and to advocate for better death experiences.

7. Psychiatrists are experts in understanding how people move through transitions. As psychiatrists we are charged with the responsibility of helping people move through the full spectrum of psychological challenges that life presents us – from the common to the rare and everything in between. The transition to death is universal, and affects us all. Death is a part of life. It is an influential presence in our everyday lives on the most basic emotional levels. How we understand, manage, and respond to the complexities of our feelings about death has massive implications for our lives and the lives of those we touch. We are charged to explore the uncomfortable, and ask the difficult questions in ways that facilitate compassion, safety, and understanding.

8. Psychiatrists should be active on the frontlines of progressive change in the country. The destigmatization of homosexuality by removing it as a mental disorder from DSM in 1973 is a good precedent in this regard. That decision could not have been more fraught, controversial or “political” back then. Thankfully, common sense and the grass roots efforts of thousands of gay psychiatrists and citizens meant that we ended up on the right side of history.

9. We do it for our pets out of love and compassion for their suffering. While the technicalities are obviously completely different with an animal, there is a relevant parallel. Supporting the decision of a loved one to be released from the throes of pain and suffering at their request is a courageous and altruistic act.

10. The ends of stories matter. Studies have shown that perceptions of an experience are shaped by 2 things- the peak emotion and the end emotion. The end of a life's story is not just important to the dying, it is crucial to the emotional transition of the living. Psychiatrists have heard countless traumatic stories from patients of how they have had to watch their love one die – in pain, prolonged suffering, helpless, and out of control. Sometimes patients cannot even remember the positive stories of their loved one after a traumatic death. One patient recently recounted "…all I can see when I think of her are those last days…her screaming, confused, in pain, and nobody could help her...hospice wasn't helping…we couldn't help her…". It is common to hear people say "please don't EVER let that happen to me" after going through the traumatic death experience of a loved one.

Death and fear are close friends. All too often fear takes over and leads to a denial of the inevitability of death. At face value, the issue of aid in dying elicits fear and hesitation. Concerns for protective measures and responsible use are valid. The state has a responsibility to provide those measures and physicians have a responsibility to implement the law appropriately. As with all complex issues, when we look closer to examine the data, learn the history, and hear the stories, we can see beyond our individual fears and new truths emerge. Remaining 'neutral' as Psychiatrists on this issue does not serve our profession, and more importantly, it does not serve our patients or society at large. Please read the bill. Do your research. Listen carefully to both sides. If you support the bill as we do, you can send a stock or a customized letter to your senator through Compassion and Choices' site:

https://www.compassionandchoices.org/what-you-can-do/get-involved/ask-your-state-senators-to-support-end-of-life-options-bill/

We invite your thoughts, feedback, and stories. Please join the discussion at:

https://endoflifeoption.wordpress.com/

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Advertisement

Horseback Writing

By: Walter T. Haessler, M.D.

As I understand mindfulness, the basic idea is that you can't think about two things at once —-at least you can't give them both the attention they are due. So attending fully to one situation kind of sweeps other situations away. At least for awhile.

This is hardly a novel concept, and hardly limited in its usefulness to formal psychotherapy. Churchill wrote about how oil painting helped clear his mind during World War II. Although I'm no particular fan of our President, I disagree with those who say he plays too much golf. It's a tough job.

I have read a few books over the years, just a few, that have made a difference in how I see the world, the way I understand things. One of them is *Golf in the Kingdom* by Esalen Institute founder Michael Murphy. Besides being a fine mystical adventure, and a lot of fun, it is all about this kind of thing.

So, when we're at the race track, as we are today, there isn't room for everyday hassles, nor even for weightier concerns. That means it's doing its job. What there is room for, somehow, is writing. So between races, as the mood strikes me, I put pen to paper and let it happen. Ellaine asked if this is "horseback writing," hence the title of this piece.

So, what to write about? I'd like to write about two doctor visits in the past few weeks, and how they give me a first-hand look at changes in medical care. The doctors are in the same medical group.

I saw the urologist on March 4. My December 26 appointment with him had been cancelled by his office and postponed until February 24, for the stated reason that OR time had become available, and he had to make use of it. The February 24 appointment was then cancelled, for the same stated reason.

When I saw him on March 4, we discussed the cancellations. It was just a routine follow-up appointment, and I told him that I was not so much complaining as wanting to be sure that if I ever *needed* to see him sometime, he would be available. And that I wanted to keep him as my doctor.

He was apologetic, but I told him not to be — that had I thought it a pressing matter, I would have pressed to see him sooner. He explained that there were at least two economic and political forces leading to his being overextended and OR time being scarce.

It seems that his medical group may become heavily involved with a university medical center; and the board does not want to hire the additional urologist they need until that situation is clarified.

As to OR time, it seems that the uninsured are treated at the county hospital. Under the ACA, many of the newly-insured are now electing to be treated at the hospital where he operates. Thus, OR time is at at premium; he has to scramble for OR time; and sometimes his clinic patients get cancelled as he makes use of this now-scarce resource as it becomes available.

I saw my primary care physician on March 13. As with the urologist, it was a routine follow-up appointment. The medical group recently went to electronic records, and toward the end of the visit he handed me a print-out. That reminded me of another print-out last year, which I had not reviewed until I got home.

There is a problem/condition list which is quite a piece of work, involving current problems, and also problems that are now resolved. When I had looked over the last one, though, I noticed a problem that never was — something that further testing had ruled out. (Actually, in looking at this more recent print-out, I see three problems that never were — just diagnostic entities that were considered at one time but were never active problems.)

During the visit I asked him about removing the rule-out that had been ruled out. He replied that it was not an easy matter to do so, and he did not have time that day to undertake it.

During our visit he spent most of his time across the room from me, looking at the computer screen. He asked a couple of questions that had nothing to do with the situation at hand but seemed to be in response to missing information, or perhaps prompts from the computer screen. (I don't really know how all this works.) He did respond to my needs, though. He's a nice man. I like him.

As we walked from the examining room at the end, he looked me in the eye, paused, and said, "Be glad, Dr. Haessler, that you are not in this profession anymore."

Somehow, I'm reminded of my youngest daughter's college graduation. The commencement speaker's theme, which was repeated often during her speech, was: "Change is good!" Ellaine and I had the same reaction: Really?...Always?...Are you sure?

The Southern California
Psychiatric Society presents

ADHD Assessment, Interventions & Management

Saturday, April 18th, 2015
8:30am - 12:15pm

The Olympic Collection
11301 Olympic Blvd.
Los Angeles, CA 90064

Ned Hallowell, M.D.
Adult ADHD

Michael Enenbach, M.D.
Child & Adolescent ADHD

Unwrapping the Gifts: A Strength-Based Approach to Treating Adult ADHD - **Edward (Ned) Hallowell, M.D.**, *Adult and Child Psychiatrist; Founder of the Hallowell Centers; Learning Differences Expert; Co-author of 'Driven to Distraction' and 'Answers to Distraction.'*

Child & Adolescent ADHD - **Michael Enenbach, M.D.**, *Assistant Clinical Professor, UCLA Psychiatry.*

Find all details here:
http://www.socalpsych.org/events.html

OCD Genetics: What to know and What to explain to your patients

Michele T. Pato, MD- Keck School of Medicine of USC

The field of psychiatric genetics has exploded in the past 5 years. Yet, there is still a need for caution to not over-interpret results. While genetic profiles have made it easier to identify risk for diseases, in some cases, like prostate cancer, breast cancer, and even Alzheimer's disease, one must always remember that most genomic analysis is simply a matter of risk to develop these particular illnesses and not destiny. This is particularly true of psychiatric disorders like OCD. Psychiatric genetics has made us aware of more than 200 variants that may be contributing to psychiatric illnesses. Yet, even monozygotic, identical, twins (MZ), that share almost all of their DNA, can be discordant, rather than concordant, for developing a mental illness like schizophrenia or OCD. What we mean by discordant is that one of the identical twins has the illness and the other does not. Almost all studies to date, use DSM designations prior to DSM-5, and have reported MZ concordance rates around .50 (50%) and DZ (dizygotic twins or fraternal twins) rates around .20 (20%), no different from non-twin siblings. (Browne et al., 2014). This speaks to the role of environment, as well as, genes in developing an illness like schizophrenia, bipolar disorder, or OCD!

This is why we describe OCDR (Obsessive Compulsive Disorder and Related disorders) as genetically complex, multifactorial disorders. What we mean by 'Complex' is that it is unlikely that a single gene directly causes the disorder but rather, many genes can make minor contributions to disease risk. In addition, OCDR is 'Multifactorial' to emphasize that genes alone do not cause disease, but rather a combination of genes and environmental factors usually contribute to causation.

To date there have not been any specific genes consistently identified in OCDR. However, abnormalities in serotonin (5-HT), dopamine (DA), and glutamate neurotransmission have been identified in some studies (Goodman et al., 2014; Bokor and Anderson, 2014; Stryjer et al., 2014; Taylor, 2013; Pittenger et al., 2011; Hoffman, 2011). In other studies, some genes seem to be associated with the chemistry of OCD including: catechol-O-methyltransferase (COMT), monoamine oxidase-A (MAO-A), brain-derived neurotrophic factor (BDNF), myelin oligodendrocyte glycoprotein (MOG), GABA-type B-receptor 1, and the mu opioid receptor. (Pauls, 2010),

In the same way that the development of a psychiatric illness can occur through a combination of genes and environment so too can effective treatment occur from both medications and psychotherapies. Most recently functional imaging, allows us to watch the brain as it works (like angiography allow us to watch the heart pump). We can see the changes in the brain function occur with both medications and psychotherapy, in the case of OCD with CBT-exposure and response prevention. (Baxter 1992, Chamberlain 2008)

The complexity of OCDR disorders have now been formally recognized in the DSM-V; however, this makes for even more heterogeneity/variety within and between the OCDR disorders. Thus, in analyzing OCDR it may be particularly important to look at specific symptoms, symptom severity, co-morbidities, onset, population variation like sex, race/ethnicity, and combinations of environmental factors. With this in mind even bigger samples of OCDR subjects are needed. So we are happy to announce, at the Keck School of Medicine at USC have received NIMH funding to collect 5,000 individuals with primary OCD, HD, BDD, or other OCDR. We are using a modern research design in which participants can join the research via secure Internet connection, and follow up thru face-to-face contact with research clinicians to participate in the research. By doing this we hope to reach affected individuals who may and may not come to academic research centers for care. A website for patients and clinicians has been established for USC-OCD research (keck.usc.edu/gpc-ocd). As clinicians, as well as researchers ourselves, we encourage patients, family members, and clinicians to stay involved in OCDR research efforts through our website and organizations such as the IOCDF (IOCDF: iocdf.org/). (Sobell, Pato, Pato, Knowles, in press)

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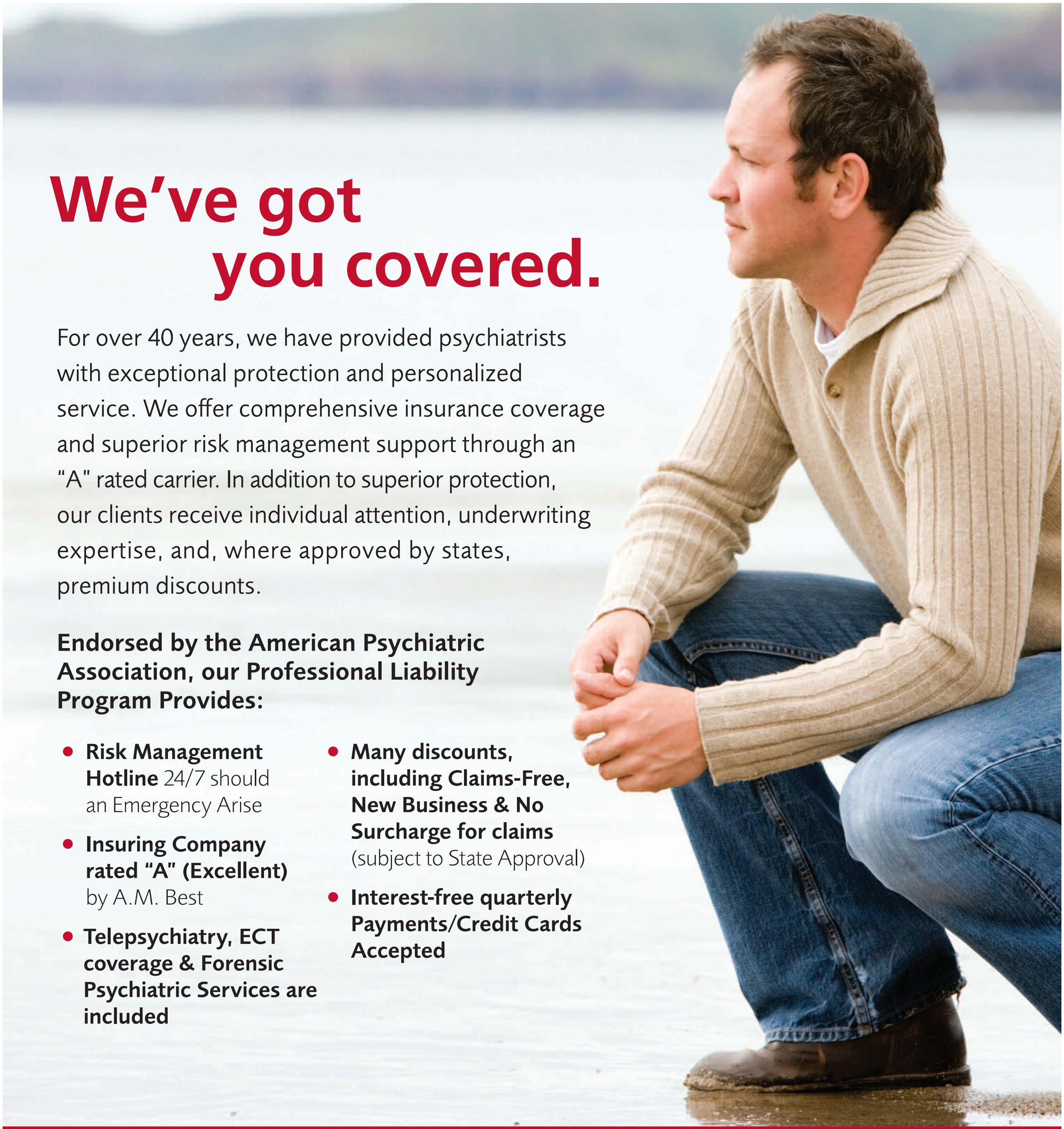
The San Diego Psychiatric Society planning committee cordially invites you to attend the San Diego Psychiatric Society's Annual Conference, Advances In Addiction on June 6th and 7th, 2015. Please visit www.sdpscme.org for the full agenda, speaker bios, and registration information. If you would like additional information, please contact SDPS Executive Director, Victoria Pak at info@sandiegopsychiatricsociety.org.



Council Highlights
March 12, 2015

Erick Cheung, M.D., *Secretary*

The meeting was called to order with quorum by Dr. Fogelson, at 7:00PM.

Minutes from the February 2015 meeting were approved by council.

President's Report (Dr. David Fogelson):
Dr. Fogelson noted that the Advocacy Training Presentation is scheduled for next Wednesday at his home. He reminded Council that the date of the May Council meeting is now set for May 7, 2015, instead of May 14, to avoid potential schedule conflicts for Council members related to the APA Annual Conference.

Dr. Fogelson reminded Council that the Installation and Awards Program is set for Saturday, May 2, 2015, 3:00 PM - 7:00 PM, at Le Merigot Beach Hotel, and that the speaker and awardee will be Marvin J. Southard, D.S.W , Director, Los Angeles County Department of Mental Health. Dr. Fogelson, and other Councillors, noted the contributions that Dr. Southard has made to mental health services in Los Angeles and California, and the support he has provided for quality psychiatric services.

Dr. Fogelson called attention to CPA President Tim Murphy's letter requesting contributions to the CPA Advocacy and Litigation Fund to help support a response to an anticipated California psychology prescribing bill.

Dr. Fogelson asked for Council input on CPA RFM Candidate Janet Charoensook, MD, currently at UC Riverside. Dr. Schaepper stated that she was familiar with the candidate, and that the candidate would be an excellent choice. Motion to support by Dr. Horwitz. 2nd by Dr. Lawrence, motion was passed.

Dr. Lawrence Gross, SCPS Assembly Rep, requested feedback for changes in ABPN Maintenance of Certification (MOC) requirements. Specifically, suspending the Part IV PIP requirement requires colleague and patient input. Council members commented that this was a favorable development. There were no objections voiced. A motion was made, seconded, and unanimously approved to support this effort.

Dr. Fogelson, at the request of CPA, invited discussion about the "End-of-life option act" (SB 128, Wolk), also interchangeably referred to as "death with dignity" and "physician assisted suicide." APA's current position on this topic was reviewed (i.e. they have no position), and AMA's position (support for palliative care and withdrawal of life sustaining care, no active participation in intentional death of patient). The question posed was: *What position should the CPA take on the legislation described below and why?*

Council held robust discussion as itemized below based on a straw poll of support, oppose, and neutral positions:

"Support" – 9 council members
Expressed support for patient autonomy in determining the circumstances of their own death, clearly separate of suicide or suicidal intent related to mental illness.
Statements were made drawing on information from European countries and Oregon's experience that PAS is not grossly abused.
Expressed support for palliative care, hospice care, and additionally end-of-life care (PAS), that these are not necessarily mutually exclusive options
Ethical positions of AMA on this issue may be antiquated
Provision of end-of-life options is compassionate and consistent with the goals of medicine; depending on one's ethical stance it is not possible to distinguish between active euthanasia (assisting a patient to die) and passive euthanasia (letting a patient die of natural causes)
Support of end-of-life options may be similar to support for reproductive options such as abortion.

"Oppose" – 1 councilmember
Concern was voiced about negative historical and societal views of the psychiatric profession, and the potential

that psychiatry support for PAS could create the public perception that psychiatry supports harmful acts
Concern about patients suffering from a terminal illness and severe Major Depression, who may potentially be unduly influenced by their depression into opting for, and requesting, end of life medication.
Concern that hospice care is not currently widely available, and that the availability of hospice/palliative care would reduce and/or eliminate the need for PAS.

"Watch / neutral" – 9 councilmembers
Belief that "the membership" or psychiatric community are split on the issue of end-of life care.
Concern regarding the CPA being "out in front" on this issue
Concern about CPA legislative / political resources being consumed by involvement in this topic
This issue is not a "priority" topic for the organization
Concerns about the tide of "societal opinion" about end-of-life care and that it may be unknown or in transition, that it is too early to take a political stance on this charged topic
Concerns about the perception that end of life care would be viewed as a "financial solution" to costly end of life care.

Dr. Lawrence presented information about the current awards nominations, including Dr. Steve Soldinger for distinguished service award; Dr. Galya Rees was nominated for outstanding resident; Appreciation award: Dr. Sophie Duriez. Special award: Marvin Southard, Director of LA County DMH. A motion was made, seconded and approved to accept the nominations above. Awards and installation ceremony will occur 5/2/15 at Le Merigot Hotel.

PER foundation report was provided by Dr. Soldinger on behalf of Maria Lymberis, March 21, 2015 fundraising event. Ed Edelman will be honored at the event. The event will occur at Mt Olive Lutheran Church, 1343 Ocean Park Blvd, Santa Monica, CA 90405) event supporting research for children's mental health and PER Advocate award will be presented to former LA County Supervisor Edmund Edelman.

Drs. Stroman and Rees provided an update on the SCPS residents meeting, including their discussions on survey result, psychologists' prescribing bills, possible career fair, and mentorship program. Discussed past career fairs and the structuring the career fair. Discussed need for multiple aspects including presentations, "free flowing format", recruiters and booths.

Membership Report (Dr. Malik):
Current membership is 984, previous in February was 977. The following individuals were recommended for action:

New MIT: Darcy Trenkle
New GM: Jamie Feusner

A motion was made to accept the membership committee's recommendations, seconded, and approved.

Treasurer's Report (Dr. Red): A review of current financial status of the
organization was presented. A motion was made, seconded, and approved to accept the treasurer's report.

Program Committee Report (Dr. Gales): ADD/ADHD program is scheduled for Saturday April 18th.

The art of psychiatric medicine report (Dr. Furuta): Provided update on oral history-taking project, currently in filming process, 2 oral histories taken, several more scheduled.

Assembly Report (Dr. Schaepper):
Dr. Schaepper invited discussion regarding an action paper whereby the APA would establish a Work Group comprised of researchers and clinicians knowledgeable in the area of the neurodevelopmental and behavioral effects of environmental toxins, amongst other key committees, to consult with the Scientific Program Committee to help develop a long term educational plan aimed at raising awareness of this issue among the general membership of the APA. There was general agreement among council about the importance of this topic and the value of this effort. A motion was made, seconded and approved to support this action paper.

Council discussed an action paper and revised position statement on firearm access, acts of violence, and the relationship to mental disorders and mental health services. The text of the position paper and action paper were briefly reviewed. Discussion was held regarding the objections of certain APA members/areas where hunting is popular. Members of council generally agreed about the importance of limiting access to high capacity magazine, semi-automatic firearms, and high velocity ammunition. A motion was made, seconded and approved to support this action paper.

Briefly discussed action paper to support assisted outpatient treatment. Council voiced support for AOT. Finally, Dr. Schaepper is composing an updated position paper regarding mental health for the intellectually disabled.

New Business: Council discussed a request made by Dr. Lavretsky regarding the need for Farsi-speaking psychiatric services. Council discussed and recommended liaisoning with Farsi community organizations

Old Business: None

The meeting was adjourned by Dr. Fogelson at 9:40 PM.

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Positions Available

PSYCHIATRISTS COUNTY OF SAN BERNARDINO SOUTHERN CALIFORNIA

San Bernardino County Dept. of Behavioral Health is seeking Board Eligible/Certified adult and child psychiatrists. Openings are in several outpatient clinics, jail services and juvenile hall.

Full-time Adult Psychiatrist BE/BC staff positions range from $226,949 - $239,263/yr, with full benefit package including medical, vision/dental, vacation, sick time, deferred compensation and retirement package.

Contract positions for BE/BC Adult Psychiatrists starting at $121.29 - $131.01/hr, Child Psychiatrists BE/BC $136.71 - $138.71/hr. with and without medical/dental/deferred compensation and retirement.

Full-time and Contract Psychiatrists who are assigned to a Correctional Mental Health Services designated facility will receive a $5/hr. differential in addition to the base salary. **Bilingual (Spanish/English) candidates are highly desirable and receive additional compensation.**

Must possess either a valid Physician's & Surgeon's License or Osteopathic Physician's and Surgeon's License issued by the State of California Medical or Osteopathic Board.

Applicants must hold U.S. citizenship or a permanent resident Visa. Please send C.V. and copy of current License to: Teresa Frausto, MD, Medical Director, 303 E. Vanderbilt Way, San Bernardino, CA 92415-0026, (909) 388-0810, fax (909) 890-0281 or email jpringle@dbh.sbcounty.gov.

For more details, please review the announcement at www.sbcounty.gov/hr. Application can be made on-line – apply ASAP – open until a sufficient number of applications has been received. Human Resources: (909) 387-8304 - EEO/ADA

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