Southern California

PSYCHIATRIST

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President's Column

Hello Members,

Yesterday, we all had an "extra" day, February 29th, a leap which brings our clocks, and calendars into alignment. Many of my peers spoke of the opportunity to take a leap of faith about a personal goal or career goal. I found myself in our University's Wellbeing Committee with five other physicians meeting with 5 student/faculty colleagues who have voluntarily taken their "leap" of trust/responsibility/faith into recovery. From DUI's, AWOL's from work due to anxiety, narcotic abuse and all the personal chaos that comes with such behaviors, to meeting regularly with AA/NA, individual therapy / group / family therapy, AND being accountable to a peer who is part of the Wellbeing Committee is an amazing transformation. This transformation comes for these five at a time in our state when there is no formal statewide physician health program to support their efforts. On July 1, 2008, the Medical Board of California (MBC) closed its Physician Diversion Program which had been operating since 1980 and which had monitored and supported approximately 1800 physicians in recovery. The program was funded from physician licensure fees. At the Diversion Program Summit Meeting on January 24, 2008 Dr. Richard Fantozzi, the then President of the Medical Board maintained that the Diversion Program had failed despite 27 years of efforts to improve it. The audit found inadequate monitoring of participants, chronic understaffing and poor oversight by the Medical Board. Despite these serious problems, the closure of the Diversion program was abrupt, and questionable.

What is the background of the Diversion Program?

To give a bit of history, the Diversion Program was created in 1980 to provide public protection by including monitoring controls on impaired physicians to prevent them from working while under the influence as well as to assist them into treatment and support them in their recover. Participants were required to sign contracts which required them to comply with conditions which included, but were not limited to, an evaluation by an evaluation committee, abstinence from use of alcohol or drugs other that prescribed medications, random drug testing, regular attendance at group meetings, psychiatric care, therapy, and worksite monitors, etc… Physicians entered the program by self-referral or in lieu of discipline during a Board investigation, or as a probationary order. The identity of participants remained confidential (approximately 83%) except for those who enrolled in Diversion as a condition of probation. This was to encourage physicians to seek help. Physicians had to remain in the program for at least five years, with at least three years of unbroken compliance with the terms and conditions of their Diversion agreement before they would be considered for completion.

What is happening to physicians in the absence of a statewide program?

When the MBC Physician Diversion Program closed its doors in 2008, each institution was faced with the decision of how to handle physicians who would have been referred to that program. Different institutions have taken different paths. Some have established their own structured programs that

In This Issue...

are carried out by the institution and the well-being committee; many times, those programs were a continuation of the elements of the Diversion Program. Many counselors and therapists who served as group facilitators for the Diversion Program have private practices where impaired physicians can be referred to for treatment. Other providers of care and monitoring for health care professionals have stepped forward. Guidelines are being developed now to assist physician health committees that must make a selection for whose services to use and where to refer physicians. For a review copy, contact California Public Protection and Public Health, Inc. at CPPPHinc@gmail.com.

According to the Medical Board, physicians on probation now are required to have an evaluation and recommendations for on-going treatment and monitoring. Compliance is monitored by the probation unit, and failure to comply is considered a violation of probation and grounds for further disciplinary action.

What new organization is actively working toward a physician health program for California?

A new organization was established in 2009 by the California Medical Association, the California Psychiatric Association, the California Hospital Association and the California Society of Addiction Medicine to develop a statewide physician health program. The new organization is called California Public Protection and Public Health, Inc. (CPPPH). It is a collaborative effort funded by many medical organizations – specialty societies, county medical societies, liability carriers and medical groups. Its mission is:

To collaborate with physicians, physician groups and entities responsible for quality patient care in defining an optimum program for California
To provide consultation, education and assistance to strengthen the network of services
To develop guidelines and standards for physician health service providers
To create a full-scale statewide program that coordinates all the services needed to address the spectrum of physician health issues

CPPPH has organized regional networks in three parts of the state, with workshops given every 4 months, and information sharing among those serving on physician health committees of hospital medical staffs, medical groups and medical societies. More detail is available from its website, www.CPPPH.org, about the three regions: Los Angeles, Sierra Sacramento Valley, and San Francisco. Dates of the workshops are given on the website. USC will host a Workshop on March 3, 2012. Gail Jara, the coordinator of CPPPH's regional network, who graciously discussed this topic with me, assured me that networks are expanding to include more counties.

Where are we with the Medical Board of California?

The good news is that Senator Darrell Steinberg, Senate President pro Tem and a powerful politician in California, notified the Coalition that he will be the author of the Physician Health Program bill that has been planned since the Medical Board of California ended the diversion program in 2008. Our lobbyist Randall Hagar wrote, "This is very good news and it represents many long hard hours by members of all of the coalition organizations and their lobbyists. It brings the prospect of a bill landing on the Governor's desk in 2012 into sharp focus."

How can SCPS members make a difference?

Each member's support and more importantly expertise in clinical care of impaired patients, including physicians, is vital to the establishment of a state of the art, evidence-based Physicians Health Program. SCPS is committed to excellence in psychiatric care for all, and at this time for our own impaired physicians. Our calls of support to our local legislators make the difference between "what was and is no longer" and what an accountable and healing Physician Health Program can be.

Respectfully,
MaryAnn Schaepper, M.D., M.Ed., DFAPA

Letter from the Editor

Smaller Beds - Why Didn't I Think of That!

Colleen Copelan, M.D.

Emergency rooms are often crowded and it's the mentally ill who wait the longest for treatment. For the mentally ill, disposition is the immediate cause of crowding and delay--there are fewer places to send patients for hospital care. And of course there's the dearth of funds, the revolving doors, the co-morbid substance abuse, and the absence of sustainable outpatient treatment.

There are about 6,500 psychiatric beds in California, down from 8,500 in 1996. State funding for the most seriously mentally ill was down 16% in the two years 2009 to 2011, and headed further down for 2012.

When emergency rooms are full, crowds spill into hallways, people sleep on floors in decidedly unpleasant and often unsafe conditions.

That's why I was astounded to read in the LA Times about over-crowded Olive View Hospital. Since the rooms at Olive View cannot accommodate more full-sized beds--because of fire safety rules--LA County officials have ordered smaller beds! Why has no one thought of this sooner? And why not small-size bunk beds?

It's either that or more money for treatment. And it's a good time too for the Board of Supervisors to serious think about implementing Laura's Law for a sustainable, assisted outpatient treatment program. cocopelan@aol.com

Please join us at our annual
Installation and Awards Ceremony
Le Merigot, Santa Monica
Saturday, April 21, 2012
3 p.m.-7 p.m.
Light meal will be served. Cash bar.
More details to follow.

A History of Treatment Resistant Schizophrenia
by: David Fogelson, M.D.

A version of this case will also appeared in E Focus in the spring of 2011, a publication of the American Psychiatric Association.

A colleague asks you to consult on a patient who is a 23 year old single white male junior college student and college athlete who was forced to drop out of a major university his freshman year because of poly-substance abuse, including cocaine, ecstasy, psilocybin, alcohol, and marihuana. He describes increasing isolation from family and friends culminating in extreme paranoia at age 21. He was so fearful that he left his dormitory and began living on the street. It was two months before his parents located him and brought him to the hospital. On admission to hospital he complained of visual hallucinations of bright lights, auditory hallucinations of voices telling him all his problems are a result of a stressful home environment and that he should not go back to college, and delusions of being controlled by someone else's thoughts. The most disturbing delusion was that his thoughts were being broadcast out to others. This caused a feeling of extreme humiliation. He explained that this feeling of humiliation led to drug and alcohol usage. You are being asked to provide a second opinion because despite current treatment with Valproate 1000 mg, Quetiapine 800 mg, Escitalopram 20 mg, and Risperidone 4 mg he continues to suffer from hallucinations, delusions, and alcohol abuse.

You determine that he does not suffer from a mood disorder and make a presumptive diagnosis of schizophrenia. A toxic screen demonstrates no recent exposure to drugs or alcohol. The patient says he has only occasionally used alcohol in the past 90 days which is corroborated by his parents. Blood tests, including a comprehensive metabolic panel, CBC, thyroid function tests, RPR, Lyme's titer, HIV titer, RF level, ANA, copper level, ceruloplasmin level, and porphobilinogen levels all come back normal. A brain MRI is normal. These results corroborate the diagnosis of schizophrenia.

You recommend that he switch from Risperidone to Olanzapine. You cross titrate his medications to a dosage of Olanzapine 20 mg per day. There is no clinical improvement. You taper him off Valproate and Escitalopram and there is no worsening of his clinical condition. To his cocktail of Quetiapine and Olanzapine you add memantine 10 mg BID with no improvement of symptoms.

1. What is the next treatment option you would recommend?

A. ECT.
B. Switch from Quetiapine to a first generation "neuroleptic" such as Thiothixene or Haloperidol.
C. Switch from Quetiapine and Olanzapine to Clozapine.
D. Would not change pharmacotherapy, but rather add cognitive behavioral therapy.

There is no one best answer. I slightly prefer C, then B, then A, then D. The Texas Medication Algorithm Project, published in 2007, recommends this order. My experience has been that this produces positive results so the patient is able to attend college full time and receive acceptable grades with relative extended remission.

2. What would you do if his white blood cell count fell below 3,500?

The package insert guidelines recommend continuing medication, but increasing blood draws to twice weekly. The expectation is that the patient's white blood cell count will slowly return to an acceptable level such as 4,500. At that point he may go back to once weekly blood draws and so long as he is doing well.

3. If you switched to Clozapine and he responded, but began to gain weight would you recommend:

A. Topiramate
B. Metformin
C. Consultation with a nutritionist

If he had gained weight, I would have initiated B and C. Both Metformin and Topiramate have been used as adjuncts to manage weight gain in patients on psychotropic medications. I prefer Metformin because of its relative safety and tolerability. The key safety issue with Metformin is kidney function. A patient must have a creatinine that is normal and must not be suffering from medical/surgical problems, sepsis, dehydration, excess alcohol intake, hepatic insufficiency, be >80 years of age, or suffer from acute/unstable heart failure. Topiramate confers a risk for kidney stones, acute glaucoma, acidosis, and severe cognitive dulling. In practice, Metformin is usually well tolerated. Nutritional counseling has proven to be an effective strategy and should not be ignored in favor of a strictly medical approach.

If you switched to Clozapine but his eosinophil count rose to greater than 8% would you

A. Consult a cardiologist
B. Measure C-reactive protein level
C. Measure a troponin level
D. Obtain an EKG
E. Discontinue the Clozapine

I would do A, B, C, and D before discontinuing his clozapine. If his troponin levels were twice normal or his EKG showed new abnormalities I would discontinue the clozapine. If he showed heart failure on a chest x-ray or had an elevated CK-MB fraction, I would discontinue the clozapine. These are all signs of impending heart failure related to clozapine induced myocarditis.

Editor's Note: Information included in this article has been changed to protect confidentiality. Hence, the situations presented are constructs provided for educational purposes.

Psychopharmacology Update 23

Audio CD Order Form

_____ **Bipolar Spectrum Disorders: Underdiagnosed? Over-diagnosed? Strategies for Treatment - Mark Rapaport, M.D.**

_____ **Hormone Replacement Therapy: Helping Your Patient Decide - Deborah Yeager, M.D.**

_____ **Consequences of Long Term Treatment With SSRI's: What do we know about safety and side effects? - Thomas Strouse, M.D.**

_____ **Treating Resistant OCD, Compulsive Buying and Skin Picking - Lorrin Koran, M.D.**

_____ **Borderline Personality Disorder: New Findings and Current Controversies - John Oldham, M.D.**

_____ **Complete Set + Syllabus** ____ **Syllabus Only**

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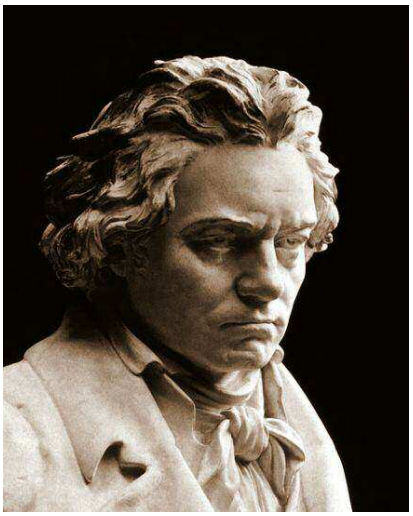

Saturday April 14th 2012

The PER Board is honored to feature for its second fundraiser a highly unusual and exceptional presentation at the Zipper Hall of the Colburn School of Music in downtown Los Angeles:

The PER Foundation invites you to a special benefit performance and presentation

Beethoven
Creative Genius and Psychiatric Illness
April 14th 2012 7:00PM - 10:00PM

Performance and presentation by **Richard Kogan, MD**
&
PER ADVOCATE AWARD presentation to **Sharon Dunas,** NAMI West LA

Richard Kogan, MD, is a concert pianist and practicing New York City psychiatrist, Artistic Director of the Weill Cornell Music & Medicine Program. Dr. Kogan is a graduate of Harvard Medical School which he attended after he graduated from Juilliard School of Music. For over 10 years Dr. Kogan has been performing nationally and internationally his highly unusual blend of live piano playing while masterfully detailing the life and psychic suffering of famous musicians. His presentations humanize mental illness and deepen our appreciation of the creative role of music in human life.

For more information, see the write up by Lloyd Sederer, MD:
http://www.huffingtonpost.com/lloyd-i-sederer-md/music-madness-and-medicin_b_852867.html or
http://www.youtube.com/watch?v=4_DmRi3HxkI

The **PER ADVOCATE AWARD** will be presented to **Sharon Dunas, MFT,** President National Alliance on Mental Illness (NAMI) LA County & Westside LA. for her exceptional work in educating family members and consumers regarding serious mental illness and its treatment.

Light refreshments will be served.

You must register to attend thru the PER website: http://www.perfoundation.org . For questions email: MGlazerPERCoord@aol.com **See you on April 14th 2012!**

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Council Highlights
February 9, 2012

Anita Red, M.D., *Secretary*

Dr. Schaepper called the meeting to order. CPA President-elect candidates, Dr. Donald M. Hilty and Dr. Timothy A. Murphy, were introduced and gave candidate statements. A motion was made to accept the January minutes. All voted in favor, and none opposed. Next there was a discussion regarding the location of Council meeting. A motion was made for the next Council meeting to be held at a new location as well as to articulate appreciation for our current location. All voted in favor, and none opposed. Dr. Cheung gave a Conflict of Interest Committee report. Dr. Gross gave an update on the DSM-V Liaison Committee. Dr. Gross reported on a potential action paper on CME for Maintenance of Certification (MOC.) The APA has proposed to include the Focus Journal as a part of membership. A motion was made for the SCPS to endorse this bill. All voted in favor, and none opposed. Dr. Gross then gave an Organized Psychiatry in California (OPIC) report. There was a discussion regarding the legalization of marijuana. Dr. Red gave a Website Committee report. Dr. Schaepper led a discussion regarding the Installation and Awards event. A motion was made to allocate $5,000 from the APA grant for this event. All voted in favor, and none opposed. There was a discussion regarding a recommendation for the Best Practices Award. A motion was made to nominate the work from the Conflict of Interest Committee as well as the Website Committee if two nominations are accepted. If one nomination is accepted, the website's membership database will be nominated. All voted in favor, and none opposed. Dr. Silverman led a discussion on the Blue Shield/Magellen Issue.

Dr. Lawrence gave the President-elect's report: The Psychiatric Education and Research Foundation will hold its second annual fundraiser April 14, 2012. Richard Kogan will perform "Beethoven: Creative Genius and Psychiatric Illness." PER will give an award for excellence in psychiatric education, and nominations are being accepted. Also, Santa Barbara Mental Health Association will have a walk May 6, 2012. Reminder: the annual APA meeting is May 5-9, 2012. Dr. Thurston gave the legislative report. Dr. Ettekal gave the Treasurer's Report. A motion was made to accept the Treasurer's Report. All voted in favor, and none opposed. Dr. Lawrence gave the Membership's Committee Report, which nominated 6 new members. All voted in favor to accept these nominations, and none opposed. Dr. Silverman gave the Program Committee's Report. Dr. Schaepper reported new business regarding the requirement for children above the age of 12 to consent for outpatient mental health services. Dr. Gross reported no old business. Dr. Schaepper adjourned the meeting.

SCPS would like to welcome the following new members and members transferred in:

Marissa Andres-Kim, M.D.
Gayane Begoyan, M.D.
Gurmanjot Bhullar, M.D.
Emily Bost-Baxter, M.D.
Amy Boudreau, M.D.
Ibrahim Busnaina, M.D.
Meredith Hannan, M.D.
Micah Hoffman, M.D.
Gregory Leong, M.D.
Cynthia Moran, M.D.
Jon Porter, D.O.
Ebonie Vasquez, M.D.
Yvonne Yang, M.D.

We would also like to thank Dr. Robert Caraway for his recent contribution.

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Santa Monica/WLA (border) – Ocean facing office in prestigious psychotherapy suite on Wilshire Blvd. Adult practices only – no groups. Available MTT 1pm-evening or TT 1pm-evening (some weekend hours for those using the space) 310-453-6556 ext 403 Dana

Position Available

The Institute for Multicultural Counseling and Education Services is an outpatient community clinic providing Mental Health Services to Children & Adults. A board certified or board eligible children's psychiatrist is needed to perform psychiatric evaluation and monitoring medication. Minimum of 5-10 hours per week at $100-$140 per hour DOE. Please submit résumé via email to davidquezada@imces.org.

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