Southern California
PSYCHIATRIST
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President's Column

Towards a Position on Medical Marijuana

Larry Lawrence, M.D.

Welcome back from your summer vacation. We look forward to seeing you at the CPA Annual Meeting in Dana Point. Meeting dates are Friday, Sept. 28th through Sunday, Sept. 30th. The program offers 14 CME credits. The courses will include legal updates in mental health law and policy, development and implementation of DSM 5, and a guide to the subtleties of Maintenance of Certification. There will be multiple courses, a dinner on Friday followed by a movie, "Mahler on the Couch" and a discussion graciously led by Dr. Maria Lymberis. Dr. Steve Koh has also obtained special funding for a reception for Members in Training and Early Career Psychiatrists scheduled after the Saturday dinner.

I look forward to these conferences for their timeliness and camaraderie, as well as opportunities to share information with members statewide, and visitors from other states. There is always much to learn and much to share. I hope to see you there!

We have been asked to provide input to the CPA regarding a position on marijuana. As most of you are aware, the position staked out by the CMA earlier this year was to support legalization of marijuana. They did this after much discussion and a white paper reviewing the options. Several of our district branches put forward strong positions. The CPA has started a committee to address this issue. If you have an interest in participating, please contact me or Dr. Tim Murphy who will chair the committee.

Marijuana became available in California following Prop. 215, titled the Compassionate Care Act. It appeared that the people spoke on this issue for California. The ensuing expansion of medical marijuana clinics took off, perhaps surprising those who supported the act as a means to provide relief to profoundly and terminally ill individuals. The federal government has never accepted this law, continues to enforce federal law and policy, and has intermittently raided the marijuana co-ops. The feds continue to keep marijuana on Schedule 1 of the controlled drug schedule.

When this discussion came to SCPS last year, I quoted the old aphorism, "If you can remember the sixties you probably were not there." For those not there, this refers to the drug revolution which was part of the sixties. Interestingly, we continue to hear of clinicians prescribing drugs such as ketamine and mescaline to treat depression and PTSD. It is not a sur-

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prise that psychoactive drugs may be effective. Issues of safety, efficacy and evidenced based medicine continue to require our attention. There is a significant political change a foot, with many municipalities closing down the marijuana clinics.

As federal and state laws take conflicting stances, the people who step in find themselves in a strange land. When I read about the Reverend Pat Robertson supporting the decriminalization of marijuana and treating it like alcohol, I suspected he was joining others who have suggested that conviction under these laws can be more damaging than the effect of drug use. These are complicated issues - legal issues working through the courts and informed by the voters. Where do physicians fit in this landscape?

There is a very nice article in the June American Journal of Psychiatry, 'A Commentary on Physicians and Medical Marijuana.' I encourage you to read it as it summarizes the issues involved for us as physicians and psychiatrists.

The issues for medical consideration include questions of evidence based care, smoking to administer medication, and the hundreds of cannabinoids released in smoking marijuana. The use of "spice" and its psychosis inducing effects come to mind.

This marijuana clinic approach also leapfrogs the FDA and their process of evaluating specific products and predictable dosages looking at safety and efficacy. The other issue raised is the increasing potency of marijuana,, with most estimates suggesting an increase of potency by a factor of at least 10 since the 1970s.

As a psychiatrist who works in a very busy psychiatric emergency service, I see a skewed population - but clearly alcohol, methamphetamine, and marijuana contribute strongly to the decompensation in thinking, mood instability and aggression we see in our population. Our child and adolescent psychiatric colleagues also have clear concerns about marijuana availability and abuse as they apply to the developing brain; affecting memory, attention, moods and personal growth.

In working with addicted teens, we have all seen arrests in development when drugs are introduced. Do we need a position on medical marijuana? Does the current marijuana distribution system rise to the level of a "medical clinic"? Some states have begun to not only decriminalize marijuana, but also pass bills specifying what conditions can be treated by marijuana. So, the legislature is not only changing the law, but also moving into the sphere of diagnosis and treatment recommendation. I believe we can help to inform these discussions and address these issues. I welcome your observations, input and suggestions.

Dr. Itai Danovitch will present at the CPA conference in Dana Point, the subject Psychiatric Perspectives on Cannabis Use-Practice to Policy. This will be a nice opportunity to review this subject. See you at Dana Point,
Regards, Larry Lawrence, M.D.

SCPS' Annual Psychopharmacology Update will be held on Saturday, January 26, 2013.

Save the Date!
Watch for more information soon!

Letter from the Editor

Candidates

Colleen Copelan, M.D.

Last week, I and six fellow physicians from the Ventura and Santa Barbara Medical Associations interviewed the candidates for Assembly District 37 and Senate District 19. CALPAC provided the questionnaires, the candidates provided the answers and we provided a more personal conversation, all with the view of recommending endorsement.

It was a job interview for public service. The candidates reflected a wide range of life experience, policy expertise, pragmatism and political ideology. We talked about health care reform, payment models, quality of care, scope of practice, physician autonomy—and our eagerness to participate in a building a better world.

The evening was both invigorating and frightening. I recommend all of you to take a personal interest in selecting and hiring the best public servants.

Every two years Californians refresh all 80 State Assembly seats and half the 40 State Senate seats—the other half of the Senate is on the ballot in the alternate 2-year cycle. Terms are 2 years and 4 years respectively.

Term limits were approved in 1990: 3 terms for Assembly and 2 for Senate. Last June, voters changed that to 12 years maximum per legislator, regardless of chamber.

Term limits have kept the Legislature very fresh—at the cost of seasoned leadership and institutional memory which, critics complain, defaults to staff, party bosses and lobbyists. The near elimination of party-dominated ”safe” districts due to redistricting and the advent of voter-approved open primaries this year means less “polarization paralysis” in the Legislature but adds new—but certainly better—uncertainties.

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cocopelan@aol.com

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The Ethics of Soliciting Patient Feedback for Maintenance of Certification

by David L Scasta, MD, DFAPA
Reprinted with permission from NJ Psychiatrist, Summer 2012 issue.

> He placed his hands lightly on her shoulders and pulled her close to him, kissing her delicately on the lips. Their tongues touched.
>
> She then responded, *"Same time next week, Doctor?"*

Context is everything. The scene described in the first paragraph could be seen as touching and appropriate between a romantically connected couple. Change the context, and the same behavior leaves one with a knot in the stomach and anger over the violation of boundaries and ethical standards by a mental health clinician.

And then there is cultural perspective.

> *"Allowing your sons to be exposed to sodomites will pollute your sons and turn them into sodomites themselves…The sodomites betray themselves by not marrying."* (From the sermons of St. Bernardino of Siena, Italy 1425 AD) Local officials in Tuscany responded by encouraging heterosexual prostitution and appointing a special court called, "Officers of the Night," to prosecute homosexuals with the hope of preventing the youth from being turned forever into sodomites.

Fast forward nearly 600 years later, the same exposure provokes increasingly less frequent condemnation with the advent of civil unions in New Jersey, opening of the military to gay and lesbian soldiers, and removal of criminal statutes for homosexual behavior. Official prostitution however is proscribed and viewed as abusive of women. Ultimately, it is cultural perspective that decides whether the context of behavior is considered ethical or not.

Although social conservatives and others long for absolute ethical standards that are immutable over time, the reality is that even the most rigid religious ethical dogmas are affected by changes in perspective over time. (cf. the rejection of the Levitical dietary laws by St. Peter, a Jew, in the context of Gentile converts, forever changing Christian theology despite Christ's admonition that he did not come to change the law). At one time, no one questioned a representative of a pharmaceutical company bringing lunch to the office of a medical staff to market a new drug. Within the last few years, the same behavior has acquired such disrepute that it is now considered unethical to even use a pen or Post-it notes with a pharmaceutical company's logo on them, little alone accept a free hoagie. Time changes ethics.

And Time is changing the ethics of Psychiatry. Residents coming out of training are finely honed in the art of biological treatment of psychiatric patients. As more and more psychiatrists are lured away from treating patients with psychotherapy – to address a shortage of clinicians with true expertise in behavioral medicines and facing a plethora of clinicians in a variety of other specialties only too happy to take over the psychotherapy treatment – fewer and fewer faculty in training programs maintain skills in psychotherapy to pass on to their protégés. I find that many residents lack basic skills in psychodynamic therapy, which was the underpinning of psychiatric training when I was a resident some 30 years ago. No matter what school of psychotherapy one practices, it is psychodynamic psychotherapy that bests trains for the pitfalls of doing psychotherapy, so that the scenario described at the beginning of this article does not occur. For many current residents, the issue is moot because a social worker, or a psychologist, or a nurse practitioner does the psychotherapy: the resident prescribes medications in cursory meetings with the patient; the psychodynamic issues are issues for the other clinicians who spend more time with the patients.

The American Board of Psychiatry and Neurology (ABPN), under mandate from its parent board, the American Board of Medical Specialties (ABMS), modified the process of board certification to require multiple modules of assessments that must be met over a 10-year cycle to maintain psychiatric board certification. The manifest goal is to ensure that psychiatric skills and knowledge are continuously maintained and upgraded. One of the modules is the Performance In Practice (PIP) module, which requires solicitation of patient feedback from five patients

in the third year of the cycle, followed by an action plan to address problems revealed by the feedback, and then solicitation of feedback from five more patients in the sixth year to ascertain if the corrective action was effective. That requirement provoked protest among American Psychiatric Association (APA) members – particularly the psychodynamically trained members – which led to the unusual step of compelling a referendum directing the Board of Trustees of the APA to oppose the PIP requirement as unethical. Although the referendum failed on technical grounds, 80% of voters were opposed to PIP. The Assembly (legislature) of the APA reaffirmed that opposition in its last Plenary.

Interestingly, the younger members (as well as the APA Committee on Ethics) see no problem with soliciting patient feedback. Patient feedback is, in fact, a requirement of the Accreditation Council for Graduate Medical Education (ACGME). Residents routinely obtain such feedback, which is then viewed by their supervisors for training purposes.

Some view the opposition to patient feedback as a thinly disguised effort by older psychiatrists to avoid scrutiny. No one on either side of the PIP debate, however, believes that patient feedback is not a critical component of psychiatric treatment. It is the context under which feedback is obtained and its effect on the psychotherapeutic process and therapeutic alliance that raises the question of ethics.

A patient who is treated by a resident knows (or should know) that his or her therapist is in training. In that context, when the resident gives the patient a form asking for feedback, the patient expects that the feedback will go to a supervisor to help with the training. The patient is aligned with the resident to help the resident be a better clinician. The therapy, however is being controlled by a senior therapist whose supervisory skills are never assessed. It is the supervisor who ultimately has responsibility for the patient's treatment – both legally and ethically.

The context is quite different for a fully trained clinician in private practice engaged in psychotherapy with a patient. Traditionally, a psychodynamically trained clinician might ask such questions as, *"How did that work for you?"* to elicit feedback on therapeutic interventions. The focus is not on how the therapist did, but on how the patient is doing. The psychodynamically trained therapist uses that information to modify therapy and guide future interventions. It is quite a different matter for the psychiatrist to come to the patient, hat-in-hand, asking for feedback for his or her own benefit – *i.e.,* to maintain certification – rather than solely for the patient's benefit. In that context of using the patient for the therapist's needs, the therapeutic alliance is contaminated and the patient gains power – to his or her detriment. It is not much of a stretch to contemplate a psychiatrist who has been working towards getting a patient off benzodiazepines to decide to keep the patient on them. A happier patient means a happier assessment – but not necessarily a healthier patient.

The ABPN has backed down on its PIP requirements under a blizzard of criticism. The ABPN is downplaying its warning, that 10% of all PIP assessments will be collected to monitor for compliance, to decree that the PIP only requires that psychiatrists attest that they have taken feedback information from their patients and used that information to make changes in clinical practice. That requirement is hardly controversial and is consistent with the standard practice of psychodynamic psychotherapy – particularly if the psychiatrist keeps the focus on the patient and the patient's benefit rather than the psychiatrist's benefit. The board certification issue should not be on the table when feedback is taken.

Having said such, the feedback approach suggested by the ABPN actually provides little true guidance for the practice of psychotherapy. The feedback questions are not designed to answer important psychodynamic questions.

> The patient reminds me of my Aunt Zelda whom I never could stand. Perhaps my decision to take the patient off benzodiazepines and let her wrestle with anxiety is more my unconscious desire to punish Aunt Zelda than a desire to prevent addiction to a mild tranquilizer.
>
> Maybe the reason that the patient never completes his homework for his cognitive behavioral therapy is because I remind him of his bossy mother with whom he always locked horns. I need to do something to change the construct so that he sees CBT as something that he has chosen rather than imposed on him by an authority figure.

Understanding the unconscious processes that underlie any brand of psychotherapy may well make the difference between whether that therapy works or not. The neglect of these psychodynamic concepts in residency, and the obliviousness of the ABPN to them, is leading to a generation of unprepared psychiatrists who cannot treat their patients with anything more than medications and cookbook protocols.

Cultural perspective is driving this unfortunate trend. The public has been persuaded that physicians lose skills as they grow older and are increasingly incompetent. There is little evidence that this dynamic affects psychiatrists in the same way that it affects other medical specialties. Psychiatrists typically become more skilled in psychotherapy as they mature in their profession. Much of the evidence regarding medical incompetence comes out of research on hospitals and hospital surgical suites. The horror stories about errors in the hospital and operating room has created a cultural perspective that makes patients feel that they need to vigilantly monitor their physicians for signs of incompetence. (cf. *To Err is Human: Building a Better Healthcare System*, Institute of Medicine, 2000) The ABMS therefore has instituted patient feedback as a requirement because it has good face validity. To my knowledge, there is no quality research showing that patient feedback improves quality of care; particularly in the field of psychiatry in which psychiatrists may have to move a patient in a direction which the patient dreads going. Unfortunately, the psychiatric reservations about the advisability of patient feedback require a level of sophistication about psychiatric treatment that the general public does not have. It therefore is difficult to convince the public that patient feedback is ill-advised. The ethical standard has changed because of a cultural imperative that is being driven by perception, not by science.

We may wish for an ultimate, immutable truth to set ethical standards, but there is no such truth. Ethics are set by context that is governed by cultural perspective. Ethical standards necessarily change with changes in perspective – and not necessarily to the benefit of patients. Whether the ABPN will hold to its current position that patient feedback is done simply as a *pro forma* exercise will be governed by cultural imperative. It remains to be seen if the cultural perspective ultimately requires that psychiatrists compromise treatment in the name of certification. I worry that attrition may yet wear away the ethical wisdom of the psychodynamic psychiatrists – to the peril of our patients.

ED: Dr Scasta is a clinical associate professor of psychiatry at Temple University Medical School and a forensic psychiatrist in private practice in Princeton, NJ.

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Berkovitz, Irving H., MD

Dr. Irving H. Berkovitz, psychiatrist and psychoanalyst, died peacefully at home in Los Angeles on May 27, 2012, just short of his 88th birthday. He was a loving husband, father, and grandfather, and a friend and admired colleague to his associates in the medical, mental health and education fields.

Born in Boston on July 12, 1924, Irv earned a place at Boston Latin School and graduated from Harvard University. After serving in WWII, he attended Boston University Medical School. In 1950, Irv moved to Los Angeles to complete his psychiatric residency at the VA in Westwood.

In 58 years of marriage, Irv and Anne Berkovitz raised three children, traveled extensively and were active community participants. Irv was an avid tennis player, a passionate photographer, a lover of music and the arts. Always kind, curious and engaged in his encounters with those around him, Irv gave the gift of his time and touched the hearts of most everyone he met.

In addition to his 60-year private psychiatry and psychotherapy practice, Irv served as the Senior Psychiatric Consultant for Schools at the LA County Department of Mental Health, supervising and training teachers, counselors and school administrators.

Irv was a proud and very active member of many professional associations – among them the AMA, CMA, Southern California Psychoanalytic Institute, Southern California Psychiatric Society, American Psychiatric Association, American Society for Adolescent Psychiatry, American Group Psychotherapy Association and the American Association for Social Psychiatry. Irv taught and supervised care at the UCLA Neuropsychiatric Institute, Cedars Sinai's Thalians Mental Health, and St. John's Hospital. His professional publications include "Adolescents Grow In Groups; Experiences In Adolescent Group Psychotherapy" (1972); "Expanding Mental Health Interventions in Schools" (1985); "When Schools Care: Creative Use of Groups in Secondary Schools" (1989), as well as scores of journal studies and articles.

Irv will be missed by his wife Anne; his children, Karen, Glenn and Joel; their spouses Jane and Jeanette; his grandchildren Simone, Casey, Julia, Leila and Andrew; and many loving family members. Irv's abundant joy and deep concern for the quality of people's lives remains a sweet and lasting example to all of us.

A memorial service was held Sunday, June 3 at Temple Beth Shir Shalom, Santa Monica. If you would like to contribute in Irv's memory, the family asks that you consider giving to the programs of Vista del Mar - West Los Angeles, or to the social services charity of your choice.

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