Southern California

PSYCHIATRIST

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President's Column

The End of the Year Is Here

Steve Soldinger, M.D.

It is hard to believe that the end of the year is here. We must prepare for next year as Obama Care is eminent. We really don't know what this will mean yet. It could be better or worse for our patients. There are some hidden things about the new healthcare plans. Let's pay close attention when reviewing these plans. I am sure that some of these changes will be quickly tested in court. Overall, I think the law has most patients' best interest at heart. It will be interesting to see what they have in store for doctors. If these plans don't work with the medical community, what will happen to access to care and affordability? We will just have to wait and see.

On a lighter note, the psychopharmacology program for January looks very good. As always, our committee has tirelessly worked to provide us with the best academic program. I hope all of you will take advantage of this opportunity to join with your colleagues in this worthwhile event.

The season for elections will be coming up quite soon. Do you have untapped talent that we are missing on Council? If so, let us know and we will help you become the candidate of your choice. We always need fresh faces and perspective to spark us on to do the best we can for each other. Even if you don't run for office, talk to your officers and let your voice be heard; this way we can represent your ideas and positions. Remember elections are for CPA and APA as well, so please be informed and please vote.

As we enter the holiday season, I hope that we are able to spend as much time as possible with our families. Our families are our hidden strength and we should strive to support them as they support us. If you have children, grandchildren and pets, pay special attention to the joy they bring to you and vice versa. To me this is what the holiday season is all about. As practicing psychiatrists we often forget about our own mental health. Our families are the ones that love us and always tell us the truth. We must be aware of the gifts involved in this wonderful process.

The APA convention will be held in New York in May 2014. If you have never attended an APA convention before, this is a special treat. New York is a great destination, and the chance to learn and share with colleagues is un-

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In This Issue...

paralleled. I have attended the APA conventions since my intern year at USC in 1977, missing not more than three or four conventions. I have loved the education and the chance to stay ahead in our field. The poster sessions from around the world let you put your finger on the pulse of our profession. I suggest that if you are interested in attending you sign up now as the hotels and courses offered fill quickly. You can just go online to sign up for everything. I look forward to seeing you in New York. Remember "if we can make it there we can make it anywhere, it's up to you New York, New York." I guess this means I win for the joke of the month.

The new location for our Council meetings is a smashing success. Caffe Roma in Beverly Hills has been very gracious and amazing to our group. Wonderful food and great support create a meeting that I look forward to attending. A big thank you goes to Mindi and Sophie for making this work for us.

Our President-Elect, Dr. David Fogelson, is hard at work getting together our next slate of officers. If anyone has suggestions please contact him directly. We are all grateful for input into this process. We are the life blood of our organization, so let's keep the heart pumping!

To the members of my Council I want to say, "Thank you." I know we are only mid-year, but I truly appreciate the effort that has been put forth. Our meeting room is full and our voting is conscientious. You are all to be commended for the job you are doing and the example that is being set. I am humbled and grateful. I also want to express my gratitude to our amazing staff, Mindi and Tim.

Respectfully submitted,

Steve Soldinger, M.D,
PRESIDENT

Letter from the Editor

NAMI Does USA

Colleen Copelan, M.D.

The National Alliance on Mental Illness, "the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness" has just published a wonderful survey of progress in our 50 united states.

It's clear, colorful, interesting and very informative. Have a look at this link.

NAMI has fought for access and parity and against stigma, the enemy of both. Their fight is our fight. Many of us are members of NAMI and I recommend you join while you're checking out their website.

As you know, parity has been a long time coming and still not here. But it's closer. The Final Rule on the federal Mental Health Parity and Addiction Equity Act was published one month ago and applies to all Affordable Care Act Exchange plans issued after July 1 next year. Check out this message: APA President Jeffrey Lieberman, MD.

Any questions? cocopelan@aol.com

A Tale of Three Colleagues

By Walter T. Haessler, M.D.

We start with Dr. Charles Krauthammer. Yes, *that* Charles Krauthammer. Long before I knew that he is a retired psychiatrist, he was my favorite political analyst. Since I rarely disagree with him, he must be getting it right.

There was a very nice one-hour special program on Dr. Krauthammer on Fox News recently. He talked about his interest in psychiatry — as being the medical specialty closest to philosophy. Fortuitously, after the diving accident that left him quadriplegic, it turned out to be the medical specialty he could best do in a wheelchair. He must have done it well, as he went on to serve as Chief Resident in the Mass General program.

Yet, he came to see himself as temperamentally unsuited for psychiatry — not "touchy-feely" enough, as he put it. As a resident, he had declined to attend the mandatory group therapy sessions for residents. Reminded by the program director that his choice was between attending the sessions or seeking training elsewhere, he did attend — but did not participate. Putting this together with the remarkable serenity with which he seemed to accept his disability, even as a young man, perhaps his personal philosophy involved stoicism.

He completed the Mass General program in 1978, and *Wikipedia* tells us he became board certified in 1984, but meanwhile had worked for Jimmy Carter and then Walter Mondale, and had become a successful political writer. He now is a Pulitzer Prize-winning syndicated columnist for *The Washington Post,* and has been an important contributor to PBS and Fox News. I'm glad he found his niche.

Are psychiatrists close to philosophers? Yes, we are — or at least we were. I believe philosophers — and novelists, and dramatists, and poets, and artists, and theologians, and lots of loving and thoughtful people with no particular credentials — know people as well as we psychiatrists do, although perhaps in a different way. There is a comment I have heard attributed to Dr. Freud, although I don't really know, but it is a jewel: "Whenever I 'discover' something new (about human nature), I realize that a poet has been there before me."

Enter our second colleague, Dr. Alik Widge. His article appeared in the Residents' Forum of *Psychiatric News,* August 17, 2012, and he was at that time the member-in-training trustee on the APA Board. He also was serving on the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee for psychiatry. Thus, he was well-placed to know which way the wind was blowing for our profession.

I read his article more than once — in part, because the first time through I didn't entirely grasp what he was saying; in part, out of a heavy sense of loss for our patients and ourselves; and in part, out of a kind of morbid curiosity, like reading about a train wreck. It affected me enough that I saved it, without knowing exactly why. I'm glad I did, as I can now share it. I recommend reading the whole piece, but here are two excerpts:

> The expectation is that we will come out of residency prepared to be managers and leaders, trained to direct and coordinate an integrated mental health team. Many of us experience this on inpatient rotations, where we learn to coordinate the actions of nurses, therapists, social workers, and others. Tomorrow's psychiatrists will do this across care settings, and our program directors are trying to figure out how to prepare us for that role.
>
> ...a set of ACGME initiatives focuses on improving skills in "systems-based practice" — that is, working in a large medical-financial-legal network, allocating resources, and advocating for patients.

So, the thoroughly modern psychiatrist is to be a manager/coordinator of an integrated treatment team within a large medical-financial-legal network. I suppose there will also be the opportunity to consult on psychopharmacology. That doesn't seem to leave much time to be a healer, let alone a philosopher.

Then we have this little matter. I recently saw, on Fox News, tapes of heavyweights Barack Obama, Kathleen Sebelius, Harry Reid, and Nancy Pelosi. On different occasions, and in response to direct questions, each affirmed that their real preference was for a single-payer type of health care system — the mother of all "large medical-financial-legal networks." Call it socialized medicine or call it social justice, but whatever you call it, it may be something we will have to deal with in time.

Enter our third colleague, Dr. Michelle Furuta. Her riveting article in the October *Southern California Psychiatrist* speaks for itself. She doesn't just lament this drift of psychiatrists from healers and philosophers to managers and coordinators, but is doing something about it by setting up The Art of Psychiatric Medicine Committee. "Art," for her, seems to have multiple meanings. As she put it:

> The curiosity which enticed me to create artwork of my own and to study that of others, eventually propelled me to want to know more about people in general, and then the person in particular.

An interesting route to our profession, which involves the "art" of healing and what she refers to as "the art of compassion." It makes sense, though, when you keep in mind that artists are closer to healers and philosophers than they are to managers and coordinators.

I imagine that, if the "large medical-financial-legal network" is able to keep advancing, the 50-minute psychiatric hour will become even scarcer than it is at present — will be placed squarely in the luxury category. I also imagine, however, that even with the "large medical-financial-legal network" holding all the cards, and making all the rules, there will be patients to keep the 50-minute psychiatric hour and the art of psychiatric medicine alive: sufficiently sophisticated to appreciate its value, and sufficiently affluent to pay for it. Not just the one per cent, but perhaps the five or ten per cent.

This brings to mind the days when the arts were supported by wealthy patrons (or the church, which also had a lot of money). As I think of it, that's how it was when the 50-minute hour got started. We know that Dr. Freud always demanded a fee, believing that therapy works better that way. Maybe it does.

Best wishes to Dr. Furuta.

Call me for a quote.

Medical professional liability policies can vary widely from one company to the next. It is important for psychiatrists to know the full – and accurate – story on a policy. Whether it is reviewing the difference between occurrence and claims-made policies or explaining how another policy might leave the doctor with an uninsured risk, I have done my job when I help psychiatrists evaluate their options to make the right choice.

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Malpractice Litigation Prevention

Renee Binder, M.D.

As a forensic psychiatrist, I have reviewed multiple malpractice cases. I have identified five common areas that arise in malpractice cases which have informed my own clinical practice. I am writing this article in the hope that these pointers will help my colleagues, young and experienced, avoid malpractice lawsuits.

Excellent documentation is crucial.

Most of us give excellent care to our patients, but because of our busy schedules, we often do not document very well. When we are sued, experts on both sides look at the documentation. It is usually assumed by the fact finders (arbitrators, juries or judges), that when physicians testify in court or at depositions, they may say that they did something even if they did not, and therefore the best defense to malpractice is good contemporaneous documentation. It is especially important to document our thinking process when we are dealing with a high-risk situation, e.g. prescribing off label, discharging a suicidal patient or prescribing/not prescribing medications to a pregnant or lactating patient.

It is especially important to document risk assessments for suicide or violence risk.

For example, in one case that went to trial, a patient committed suicide one day after discharge from an inpatient unit. The patient had been on a voluntary status with suicidal ideation. In the medical records, there was excellent documentation by the psychiatrist about suicide risk during the hospitalization and on the day of discharge. The documentation included the risk factors for suicide as well as mitigating factors.The documentation included the risk factors for suicide as well as mitigating factors and that there was a reasonable after care plan. The documentation also included the rationale for discharge including the fact that the patient insisted on discharge and did not meet the criteria for an involuntary commitment. Since the patient was on a voluntary status, he could leave if he wanted. The jury agreed unanimously that there had not been a breach in the standard of care and that the subsequent suicide was unforeseeable at the time of discharge.

In another case, a developmentally disabled clientstabbed his roommate in a Board and Care home one week after discharge from a hospital. In this case also, there was excellent documentation about violence risk factors and the thinking process behind the decision to discharge the patient back to his Board and Care Home with supervision. The documentation included the rationale that the two clients had lived together for over ten years without any prior incidents of violence. The case against the psychiatrist was dismissed.

When following outpatients on a long-term basis who have shown minimal evidence of suicidality or violence potential, psychiatrists understandably do not assess for suicide or violence risk on every visit. It can be argued that the standard of care does not necessitate such assessments. However, when the patient's situation changes, e.g. the loss of a job or relationship, or there is report of an increase in depressive symptoms, it is important to assess and document the risk of suicide. In cases where this was not done, the argument which has prevailed at times is that the situation of the patient had changed and the psychiatrist should have done a more detailed assessment of violence or suicide risk.

It is important to only treat patients within our areas of expertise.

If we have any questions about how to use a specific medication, it is important to refer the patient to or to get consultation from a clinician with more experience with that medication.

In one case, a patient died after she was treated in an emergency room with a combination of medications that were contraindicated in her situation. When in doubt, it is useful to check a website like "drugs.com","Lexi-Comp"or another

reference about interactions and contraindications. In another case, a patient developed severe complications from neuroleptic malignant syndrome after being given high doses of antipsychotics with a rapid upward dose titration. The actual dosage and the rate of titration were significantly higher than what was recommended in the peer-reviewed literature. In another case, a patient died of fulminant liver disease secondary tovalproic acid. The patient had had a prior history of hepatitis, but this was not recorded in the review of systems or past medical history. In addition, liver function tests were not obtained before or after starting valproic acid, until the patient developed jaundice. The implication was the clinicians in these cases did not know how to use these medications and were unaware of the potential risks.

It can be argued that psychiatrists have the skills and knowledge to use medications above recommended doses and for off-label indications. However, if doing so, psychiatrists need to obtain written and informed patient consent and document their thought process and their rationale for their prescribing practices. Otherwise, it may appear that the psychiatrist did not know the risks of their treatment plan.

It is important to be aware of the institutional policies in the setting where we work

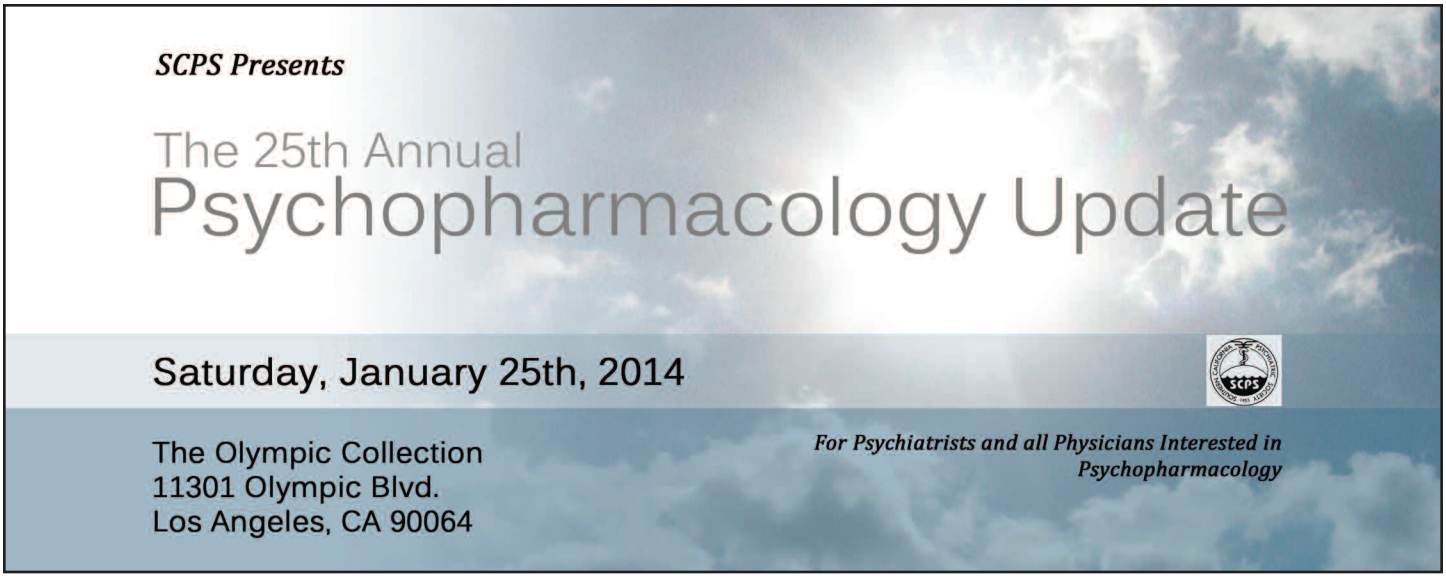
In one case, a psychiatrist admitted a depressed, suicidal patient to the hospital. The psychiatrist wrote for level 1 observations, which meant 30-minute checks in that hospital. The psychiatrist seemed unaware of what level 1 meant. Hospital policies said that if patients are admitted with a complaint of depression or suicidal ideation, they should never be put on level 1. The policies stated that such individuals should either be put on level 2 (15 minute checks) or 1:1 observation. The patient committed suicide on the unit in between the 30 minute checks. It was very difficult to defend the actions of the psychiatrist.

It is important to consider the family's wishes in important and risky decisions(with the patient's consent).

When there is a bad outcome, such as a suicide, the family will bring the lawsuit. There have been cases where the family was consulted and agreed with the treatment plan to discharge a patient from a hospital or release them from an emergency room. In these cases, if a suicide subsequently occurs, family members can still claim that they did not know any better because they are not professionals and were swayed by the opinions of the psychiatrist. Nevertheless, psychiatrists are in a more advantageous position concerning why they made the decision if the family agreed with this action. There have been cases where the psychiatrist discharged a patient against the wishes of the family. The family members then said that the doctor should have listened to them. If psychiatrists disagree with the recommendations of family members, psychiatrists need to document their thinking process and the basis of their decision to go against the family's wishes.

In summary, I have described some of the lessons that I have learned in consulting about malpractice cases. Although anyone can be sued, and we all may be sued, it is helpful to be aware of what we can do as busy clinicians to minimize the likelihood of lawsuits being successful.

Renee Binder, M.D. is the Forensic Fellowship Director at the University of California, San Francisco. She is both a Past President of the American Academy of Psychiatry and the Law and a Past Chair of the APA Council on Psychiatry and the Law.



Psychopharmacology Update 25

Saturday, January 25, 2014
Olympic Collection, 11301 Olympic Blvd., LA 90064

Mood Disorders as Metabolic Inflammatory Disorders: Implications for Disease Modelling Clinical Care and Future Treatment Discovery ***Roger McIntyre, M.D.***

Treatment Strategies for Patients with Dementia
Gary Small, M.D.

The Psychopharmacology of Personality Disorders
Michael Gitlin, M.D.

Off-Label Use of Atypical Antipsychotics: An Update
David L. Fogelson, M.D.

Can We Develop New Antidepressants?
Alan Schatzberg, M.D.

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Council Highlights
November 14, 2013

Joseph Simpson, M.D., *Secretary*

The meeting was called to order at 7:05 PM. The minutes from the October meeting were approved.

Worker's Compensation: SCPS members Drs. Tom Preston and David Friedman gave a report to the council regarding Senate Bill 863, which was passed approximately 1 ½ years ago after a deal was reached between labor and employer groups. The bill was in part a response to increasing rates of fraud in psychiatric Worker's Compensation claims in the 1980's. Although the last 20 years had been much better in this regard, the new law makes drastic changes to psychiatric claims. First, it only allows a psychiatric disorder arising out of a physical injury to be compensable if the injury was catastrophic, which is not defined in the statute. There is also a very draconian method for reviewing the treatments recommended by the patient's doctor.

The California Society of Industrial Medicine created a task force, which pointed out that the outcome of a workplace injury could be catastrophic even if the injury itself was not. (Loss of job, home, family, etc.) The insurance companies thought this was too liberal a standard. In general, the new law goes against parity between mental health and physical health diagnoses and treatments. Another change in the law is that psychiatric claims arising from repetitive injuries that cause only temporary disability are barred. Worker's comp lawyers will not go through the work of filing a claim if there's no permanent disability, due to the reduced fees they will earn. Psychiatry is being treated differently from all other specialties. The result is that injured workers are being shut out of receiving treatment for their psychiatric conditions. A number of members of the California Medical Association resigned in protest of the CMA's lack of opposition to the bill.

Under the new law treatment must be authorized ahead of time. This is done by an anonymous reviewer of the records. There are no state-sanctioned guidelines to assist them. One important change which CPA could work for is adoption of APA guidelines in this area. Under the previous scheme, treatment was reviewed by a QME or AME. However since January 1st, 2013, they can only opine regarding the disability and the general need for treatment, not the specifics of the treatment. There is no medical treatment utilization schedule. Treatment has to be approved before it is done, and usually will only be authorized at a very low level, such as four or six psychotherapy sessions, or two medication management visits in six months. If the treating doctor wants to appeal, this is done to an independent medical reviewer who is also anonymous. The treater does not know which records are provided. And the independent medical review cannot be appealed. In all specialties, there are 50,000 requests for treatment pending since July 2013. There is no time limit for the state reviewers to approve or deny these requests. Therefore, Worker's Compensation treatment, except for catastrophic injuries, has essentially stopped. Even patients who have been undergoing treatment for years can have their approval terminated by utilization reviewers.

Mr. Willick suggested that a federal lawsuit against the state for violating the Americans with Disabilities Act might be evaluated as one way for this to change. Another would be if an injured worker had private medical insurance; the insurer could pay for treatment and then try to go after the Workers' Comp carrier for the denied coverage.

Dr. Thurston moved that the CPA should set up a Worker's Comp task force to begin addressing these issues, which was seconded and approved unanimously.

2014 dues: The billing has gone out via electronic mail only. This was the first time this was done. Collections are behind schedule, so a bill will be sent via regular mail to members who not already paid their dues.

The Women's Brunch was very successful. It was very well attended, including by residents and fellows who reviewed sections from the book entitled *Lean In.* Dr. Lissy Jarvik, the oldest female psychiatrist in SCPS, also spoke.

SCPS Office: The lease is up in August 2014. The building was sold in the last month and now has new management. Mindi suggested that a smaller office would be feasible given that many functions are now paperless. The current office is 895 sq. ft., including a meeting space that is only used several times a year because only the Program Committee meets in person. All other committees meet via phone conferences. Approximately 600 sq. ft. would probably be sufficient. However, moving would cost money, and given the commercial real estate market, it may be possible to negotiate a lower rate on the current office space and avoid the moving costs.

The PER report was given by Dr. Lymberis. Their board met in September. Plans going forward include an annual resident's excellence in psychiatric education award for each residency program. The next major event is March 29 at the NPI Auditorium. Dr. Kogan will be the speaker. He will be donating $2000 out of his $5000 fee to PER. They are also planning to have a small dinner for people who want to join PER and contribute donations to research at UCLA. Dr. Lymberis also requested that the SCPS president sign a letter to be sent out to dues-exempt members inviting them to the dinner, which will be held at a PER member's home. Note that the March event is not being billed as a fundraiser because if it were then UCLA would have to sell the tickets. A motion to sign the letter was approved unanimously.

Jury Duty: A member had asked about practice-related excuse from jury duty. Dr. Soldinger reported that LACMA has some type of arrangement with the courts such that they get members to serve only one day of jury service. This would be especially helpful for psychiatrists who do, for example, psychodynamic psychotherapy. Mindi will contact LACMA and find out how SCPS can do the same thing, or if we need to work through them, and whether they would be willing to help non-LACMA members.

The President-elect report was given by Dr. Fogelson: the Nominating Committee for the next round of elections has been selected. Offices that are open include President-elect, treasurer-elect, secretary, councilors for San Fernando Valley, Ventura, and West Los Angeles, two member-in-training positions and an assembly representative position. The members of the nominating committee are: Larry Lawrence, Rod Shaner, Larry Gross, Kathleen Moreno, Mary Anne Schaepper, Bill Arroyo and Rob Burchuk.

There was an extended discussion of the changes to the assembly representative scheme. APA has decided that assembly representatives represent the state and no longer specifically represent single district branches. However, it is up to CPA and the district branches to determine how assembly representatives are going to be chosen. Barbara Yates, a former CPA president, has generated a list of possible options and these will be reviewed further at the next council meeting.

Membership: Dr. Soldinger gave the report for Dr. Augustines. All applicants requesting new membership or reinstatement were approved. No decision was made for one member who is requesting to be placed on inactive status, pending further investigation.

The Treasurer's report was presented by Dr. Silverman and was approved unanimously.

The Assembly report was given by Dr. Thurston. On November 8th, the final rule on the Mental Health Parity and Addiction Equity Act was approved. It eliminates lifetime caps as well as practices such as requiring prior authorization every three times you see a patient. However the rule still needs to be implemented by the states. Congressman Patrick Kennedy spoke at the Assembly which was very in-

spiring. An APA position statement on medical marijuana was approved. Research on cannabis-derived substances as medicine should be encouraged and facilitated by the federal government while the adverse effects, including but not limited to addiction, should also be studied at the same time.

Dr. Thurston also gave the **legislative report**. The state legislature is currently in recess. The biggest upcoming issue is a possible ballot initiative to modify MICRA, for which signatures are currently being gathered. The proposal also includes mandatory random drug testing for doctors. However, the main purpose is to lift the quarter-million dollar cap on noneconomic damages, i.e. pain and suffering, and develop a cost-of-living adjustment retroactive back to 1975 which would change the limit to around $1.2 million. It will be essential for all medical organizations in the state to work hard to educate the public about the tremendous problems with this proposal.

The Program Committee report was given by Dr. Gales. The 25th psychopharmacology update will be held on January 25th at the Olympic Collection. The speakers will be Roger McIntyre speaking on mood disorders as metabolic inflammatory disorders, Gary Small on treatment strategies for dementia, Michael Gitlin on the psychopharmacology of personality disorders, David Fogelson on off-label use of atypical antipsychotics, and Alan Schatzberg, speaking on the development of new antidepressants.

New business: Dr. Duriez asked if the APA had any organized response to the Philippines disaster. Dr. Soldinger replied that he is unaware of any formal APA activities, however some psychiatrist from New York are already traveling to the disaster area.

There was no old business. The meeting was adjourned at 9 PM.

SCPS Council, Newsletter Committee,
and Staff
would like to wish you and your families
a happy holiday season and
best wishes for 2014!

The SCPS Women's Committee held it's fifth event on Sunday, November 4th at the beautiful home of Marcia Goin, M.D. It was the most successful women's event yet. The brunch was well attended and sparked lively participation by literally everyone there. Three psychiatry residents presented different chapters from Cheryl Sandberg's "Lean In." Thanks to the residents: Linda Do, M.D., Kimberly Brown, M.D., and Maria Theresa Mariano, M.D. Thanks to the Women's Committee for planning such a wonderful event. The Women's Committee members are: Yara Salman, M.D. (Chair), Jacquelyn Green, M.D., Lissy Jarvik, M.D., Kathleen Moreno, M.D., Mary Ann Schaepper, M.D., Barbara Silver, M.D., and Saba Syed, M.D.

A special presentation was made by Lissy Jarvik, M.D., during which she discussed the changes she has witnessed as a female psychiatrist spanning her long career.

Here is our photo gallery.

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