If you are reading these words, it is very likely that you are a member of SCPS and of our state and national organizations. And that means that you need little if any convincing that membership in organized psychiatry is valuable and worth the expense. But what about all of your colleagues and friends who have never joined, or who have let their membership lapse? Just imagine, if every member of SCPS brought one non-member into our ranks, our membership would double. Even if only half of us succeeded, we would increase by 50%.

Psychiatrists, like other physicians, tend to have a lot of positive attributes, including creativity, enthusiasm and a strong work ethic. It may seem tired and clichéd to say it, but the truth is, we need to tap into the creative ideas of all of our colleagues in these exciting but challenging times for our field. There is strength in numbers, and the more perspectives we can incorporate into our activities, the better. Right now we are missing out on a lot of good ideas, and at the same time all of those non-members in our midst are missing out on much of what organized psychiatry has to offer them.

For me, a major challenge has always been: what is the most effective way to communicate the value of membership? As it turns out, in recent years the APA has built a set of presentations that provide an excellent starting point. I encourage every member to view them at: www.psychiatry.org/mybenefits/membership-outreach-toolkit. (It is in the “members only” section of the APA site.) There are four presentations, one tailored for residents, another for early career psychiatrists, and a third for prospective general members, as well as one for potential international members. There are also corresponding flyers and “talking points” in PDF format to go along with each slide presentation.

Speaking of residents, the number of graduating medical students matching in psychiatry reached an all-time high this year at 923 (Psychiatric News, April 21, 2017). That’s up from 850 in 2016 and a significant increase from 2012, when it was only 616. The APA has been quite successful in reaching out to residents recently. Last year, according to SCPS’ own Dr. Bill Arroyo (who serves on the APA Membership Committee), the number of residency programs in the “100% Club,” i.e., all residents being members of APA, reached 104 – nearly 50% of the 211 programs in the U.S. The number of 100% programs has been rising steadily, as it was 71 in 2014 and 87 in 2015. Unfortunately, none of the programs in the SCPS area are “hundred percenters,” yet. Wouldn’t it be great if all our train-
ing programs were, and if they could achieve Platinum status, by sustaining it for five years?

Before you click away from this Newsletter to check out the APA outreach site, please allow me to mention just a few items that stood out for me when I attended an orientation session for district branch presidents at the APA Annual Meeting in San Diego in May.

The APA is a powerful lobbying group in Washington D.C. This is especially the case when they join with other organizations such as the AMA, other medical organizations, NAMI, the American Psychological Association, and so on.

One of the membership’s biggest concerns is the confusing maze of Maintenance of Certification. The APA has heard this message, and is working hard to address that issue.

Incoming APA President Dr. Everett pointed out that getting out of your own practice setting and engaging in another activity (for example, a District Branch committee or Council) can be very generative.

APA CEO Dr. Levin related a story of going to Balboa Naval Hospital, where he discovered that the psychiatry department chair was no longer an APA member. Dr. Levin asked him about it. The chairperson said that he had let his membership lapse, but because Dr. Levin had taken the time to visit their program and speak to him personally, he was going to renew his membership.

With so many competing demands on our attention these days, personal, one-on-one interaction is the most effective means to spread our message. I encourage everyone reading this to identify at least one colleague who is not an APA member, and talk to them about joining.

Here at SCPS we also welcome your creative ideas on ways we can continue to build and strengthen our organization. We look forward to hearing from you!

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**Founded in 1993, the SCPS Lesbian, Gay, Bi and Trans Issues Committee serves to:**

1. Support lesbian, gay, bi and trans members.
2. Educate SCPS members, Committee members and members-in-training.
3. Enhance education in Southern California training programs.
4. Serve as an SCPS resource for clinical consultation and referral.
5. Address local lgbt public mental health issues.

We share, review and discuss relevant current events and literature—online and at Committee Sunday brunch meetings.
Please consider joining and actively participating in setting our Committee’s agenda and meeting its goals.

To join, please contact Stanley Harris, MD DLFAPA, Chair, at seh52@yahoo.com or phone/text to 323-646-7524.
Is [Mental] Health a Right? You tell me.
By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

Memorial Day has just passed and it is a good reminder to be thankful to those who have served in our armed forces and fought for the freedoms we enjoy today. Like many of you, much of my psychiatry residency training (and addiction psychiatry fellowship training) took place at Veterans Administration Hospitals. Treating our veterans, as part of medical school and/or residency training, has become both an honor and a rite of passage for the majority of today’s physician workforce.

My experience working with veterans with opioid addictions at the Phoenix VA was one of the seminal reasons I chose to continue my education and training with an addiction psychiatry fellowship. It was extremely gratifying and rewarding to help veterans regain control of their lives, knowing they had already given so much to our country. Sadly, the wait times were often long and we heard stories that some veterans were lost as they waited for their appointment day to arrive.

It was around this time that Time magazine ran the cover story “One A Day”. This was the summer of 2012 when nearly one veteran per day was being lost to suicide. The causes were multifactorial. However, the solution was clear. There was a need for immediate increased access to quality mental health services for veterans, including early screening and interventions for high risk groups. Suicide hotlines were formed, new clinics were opened and additional treatment providers were recruited and hired. Veterans are without question a group that has earned the right to have access to healthcare, especially those whose [mental] health was negatively impacted by their service to our country.

This Memorial Day, I had recently returned from the APA annual meeting in San Diego. There I attended the first APA town hall on Physician Burnout. It was an extremely well attended event and ended up being a standing room only event. Psychiatrist after psychiatrist from across the country took turns sharing their personal story of burnout and the lack of resources they had experienced in dealing with this national epidemic. One resident physician shared the tragic, but all too common, story of a classmate who had taken his life a few years before. The emotion and pain in the room was matched by passion and drive to reshape our field and the way we care for our colleagues who are suffering.

Earlier, I wrote that Veterans are a group that should have earned the right to access quality healthcare. Their service and sacrifice sets them apart in some ways from those who have not served in the military in this way. They may be the only group that almost everyone would agree has the right to healthcare. However, that made me reflect on if Physicians and other healthcare providers also should have the right to healthcare. For the sake of patient care, it seems obvious that the healthcare workforce should be at its most optimal state of physical and mental health. Healthcare providers, like military service members, can develop mental and physical health conditions as a result of their service. The emotional and physical suffering healthcare providers experience in the hospitals and clinics in communities across America is a known risk factor for burnout. Should healthcare providers have the right to treatment if their service leads to health problems? If you get into an automobile accident, do you want the team that is going to try to save your life to be physically healthy and mentally well? If you do, then you may believe healthcare providers have also earned the right to access quality healthcare.

From a public health perspective, as a society, we individually benefit from mentally and physically healthy neighbors. For example, your health is only as good as the person driving next to you at 80 miles per hour on the highway or stopping for you when you cross the street.

Whether or not healthcare should be a right for all Americans is a debatable issue. However, that is not the point
I want to focus on here. I want to discuss an issue I think we all coalesce around. That is how we can best improve [mental] healthcare for our patients?

It has been the recent debate over Obamacare vs. Trumpcare that has helped me to realize how fragile our current healthcare system is. Just when we thought pre-existing conditions were a thing of the past… they may again become an issue for us and our patients. Have we taken it for granted that we could accurately diagnose our patients without fear that they would lose their coverage or be unable to obtain future coverage?

While the future of healthcare is unclear, the present state of our healthcare system is bleak. A large number of Americans with health insurance currently struggle to access quality healthcare. Some Americans have health insurance and cannot find treatment providers that take their plan. Other Americans have insurance but cannot afford to go to the doctor, or pay for the medications they need, due to high deductibles and large out of pocket expenses. A healthcare system does not do anyone any good if you cannot access it. Just ask the Veterans and Physicians I referenced above.

We talk a lot about Parity, in that mental health and addictions should be treated the same as physical health problems. It saddens me that in 2017 that even needs to be a point of contention. However, considering how poorly our current healthcare system (and proposed replacement) addresses the physical health problems of large numbers of our fellow Americans, Parity cannot be good enough. Parity is better than stigma. Parity is better than shame. But Parity does not mean access to quality mental healthcare if that, for which you seek Parity to, is the stripping of funding, the return of exclusions for preexisting conditions and so on.

Therefore, I encourage us (me, you, our colleagues and our profession) to join with our colleagues who treat physical illness and fight not just for Parity, to lobby, advocate and educate for improved Healthcare as a whole, both physical and mental health. By remaining in silos, I see two major issues.

First, we tether the quality of mental healthcare to that of physical healthcare. If congress destroys healthcare for physical illnesses, what good is parity? Second, by fighting only for mental health parity, I think we continue to stigmatize mental health. As mental health providers, we know full well that you cannot have optimum physical health without being mentally well and vice versa. They are one and the same. We are mental health experts and we should use that expertise to form a coalition of those who share the common goal of improving Healthcare. I believe this is how we can best improve mental healthcare.

So, let’s come together with our colleagues from across other medical specialties and advocate for health, both mental and physical. There is power in numbers and with a shared interest and collective lobbying we can pool our resources for greater effects.

I am not going to make the argument for healthcare as a right for all Americans. That is a highly debatable topic, with a diversity of opinion. However, I hope to start a productive discussion.

Write in.

Share your story or your patients’ stories [while being HIPAA compliant].

Share your ideas.

Tell us about the projects, leaders and missions that have made a difference in your backyard.

Let’s use our positions as leaders in the community and experts in mental health, to advocate for our patients, our field and for healthcare reform that improves access to care and outcomes.

This is your newsletter. I hope to hear from you soon.

You can send your articles to SCPS Executive Director Mindi Thelen. Email: mindi@socalpsych.org
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Monitoring labs is not the most glamorous part of practicing psychiatry. Nevertheless, it remains an important clinical duty for all prescribers to ensure that our treatments are both safe and effective for our patients. While the average toxicity of psychotropic medications has decreased significantly from the age when Miltown and Parnate reigned supreme, a few of the drugs we prescribe still have the potential to cause significant damage. In particular, mood stabilizers such as lithium and valproate require regular lab monitoring to ensure safe serum levels and to watch out for potential side effects (such as thyroid or kidney problems with lithium and liver or blood problems with valproate). In addition, the metabolic effects of newer antipsychotics have also spurred calls for more regular monitoring of labs.

The responsibility for checking labs ultimately falls upon the ordering provider. However, while we like to assume that every physician will stay on top of this, reality shows this not to be the case. It’s easy to forget to order labs or to follow-up on labs that were already ordered, especially when the time allotted for each patient seems to be decreasing all the time.

To help this process be more user-friendly for psychiatrists in the UCLA healthcare system, we developed a clinical decision support system that automatically provides laboratory data to the clinician at the time that the medication is ordered. Previously, prescribers would need to check a different part of the electronic health record to see if appropriate labs had been done and to monitor their status. Under the new system, relevant labs are programmed to appear directly within the order screen for the medication (see a screenshot from the order screen for valproate below). It is our hope that this change will bring necessary information to the ordering provider at the time it is most needed.

While this was a seemingly simple change, the process of bringing it about was very complicated. For one, the
change had to be approved by various boards and regulatory committee, including hospital staff, pharmacy, and medical records. In addition, implementing the change and fine tuning it to be as helpful as possible involved a lot of back-and-forth dialogue with the programming staff at CareConnect (the Epic-based electronic medical record software used in the UCLA healthcare system).

Even deciding on the exact labs to be ordered was not without controversy. There are no definitive guidelines on which labs should be ordered for each medication or how often. Various guidelines exist, but they would sometimes disagree with each other. Most psychiatrists would agree, for example, that you should monitor kidney function in a patient taking lithium, but how often? Every 6 months or every year? And is creatinine sufficient, or would urine specific gravity values be preferable? These points resulted in significant discussion. Ultimately, however, we decided upon the following labs for each medication:

Lithium: Most recent level, TSH, creatinine, and urine pregnancy
Valproate / Divalproex: Most recent level, AST, ALT, WBC, Plt, and urine pregnancy
Carbamazepine: Most recent level, AST, ALT, WBC, RBC, Na
Typical Antipsychotics: Prolactin
Atypical Antipsychotics (excluding clozapine): Glucose, A1c, LDL, BMI, and prolactin
Clozapine: ANC, glucose, A1c, LDL, BMI, prolactin, clozapine/norclozapine level

This change went live in early March, and we are planning to monitor clinical outcomes after this change to see if there were appreciable differences in rates of compliance with lab monitoring guidelines or a reduction in adverse events related to these medications.

Support for this change came from the UCLA Resident Informaticist Program which encourages trainees to become more involved in clinical informatics. Clinical informatics is a relatively young field that focuses on the effect that healthcare technology, like the electronic medical record, has on patient care. Informatics research has shown that even tiny changes can have drastic effects. For example, one study showed that the changing the default frequency for Zofran orders from QID to TID dosing resulted in an increase in TID dosing of Zofran from 6% to 75% in just 4 weeks and cost savings of nearly $250,000 over one year.

Our department has been active in the realm of informatics, including this project and others, and we hope to stay on the forefront of bridging healthcare technology with our daily clinical practice. We don’t want these changes to result in less physician autonomy, and we have been vigilant about structuring our changes around this idea (for example, we do not tell providers how often they should be ordering the labs). Our goal is to build a better “cockpit” for psychiatrists that will allow them make clinician decisions with the necessary information already at their fingertips. We hope that this will result in a better experience for physicians and, more than that, in better care for our patients.

**Art of Storytelling: The Human Experience of Being a Psychiatrist** was screened for the Senior Psychiatrists at the APA annual meeting. Our panel included: Drs. Furuta, Lymberis, Soldinger, Schaeppe, and Gales and Tim and Mindi Thelen.
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It's been almost exactly 36 years since I first met Marcia Goin. In July 1981, I was a 4th year resident coming to California from West Virginia for an elective to gain more supervised experience in psychodynamic psychotherapy at, of all places, the LA County/USC Medical Center. Sitting in her office in Graduate Hall at “The County,” I, like dozens of residents before me and hundreds since, was captivated by her warmth, her knowledge, and her skill – a psychoanalyst teaching residents and supervising the care of severely ill patients in a public psychiatry clinic, not on Rodeo Drive. How did she get there, and where was she going?

Marcia Kraft was born in the base hospital at the Portsmouth, New Hampshire, Naval Ship Yard. The daughter of a career naval officer, she was the youngest of three children, and the family moved every two years (mostly on the East coast) while she was growing up. The seeds for becoming a physician were planted early – she recalls being given a stethoscope by the surgeon who performed her appendectomy at age 9, and she also related spending six months in bed with rheumatic fever during the seventh grade. “When I was a kid I wanted to be a doctor, but I didn’t think about being a woman doctor.” After graduating from Middlebury College, she went on to medical school at Yale, one of 4 women in her class of 80. Following graduation, she headed west for an internship at UCSF, where, “on Day 1,” she met her future husband, John Goin. He was planning to train in plastic surgery in Los Angeles, so she came to LA after her internship, joining the psychiatry residency at LAC/USC. Without specific job plans at the end of her residency, Joe Yamamoto, MD, then the LAC/USC Adult Outpatient Psychiatric Clinic (AOPC) Director, told her “We’ll find a place for you here.”

The rest is history, as they say, beginning an association with the AOPC spanning 55 years and including administrative and teaching roles, most notably as the clinic director of psychiatric education, coordinating lectures and clinical supervision for literally hundreds of residents over the years. She pursued psychoanalytic training, receiving her PhD in 1977, and she provided psychoanalytically-oriented psychotherapy training in innovative ways, such as one-way mirror observation of psychotherapy and a “Classic and Current Literature” seminar. Her research and publications focused on the clinic patient population as well as psychotherapy supervision and training. In addition, she collaborated with her husband to study the psychological aspects of plastic and reconstructive surgery, resulting in numerous journal articles, book chapters, and their book, Changing the Body: Psychological Effects of Plastic Surgery (1981). She and John traveled extensively, including six months providing volunteer humanitarian care in Vietnam in the 1960’s.

With all of these accomplishments, it is important to note that Marcia has always been part-time faculty in the AOPC, balancing her academic roles (25-50% time) with part-time private practice and motherhood. When her daughters were young, she started taking Mondays off, and she kept “Mondays free” even after they were grown. “I’ve always had three-day weekends.” She has put her time to good use organizationally over the years – locally with the Southern California Psychiatric and Psychoanalytic Societies and nationally with the ABPN, the American College of Psychiatrists, the Group for the Advancement of Psychiatry (GAP), and the American Psychiatric Association. A recognized leader, she served as president of the latter two organizations: APA (2003-2004) and GAP (2013-2015). She has received numerous teaching awards, a NAMI Exemplary Psychiatrist Award, and has been honored by her
alma mater, Middlebury College, with an Honorary Doctorate of Science (2005) and Lifetime Achievement Award (2014).

In recent years, Marcia wound down her office practice and gradually reduced her time in the AOPC. Timing is important in psychotherapy and in life; after 55 years, she is retiring at the end of this month. She has been a USC institution, training generations of psychiatrists and representing Southern California psychiatry on the national stage. She will now have more time to fully enjoy the success of her daughters, Suzanne and Jessica, and to spend time with them and their families, as well as her many longstanding friendships. And for me, 36 years after that initial introduction, she remains a mentor, trusted colleague, and valued friend.

*In honor of Marcia’s retirement, the USC Department of Psychiatry and the Behavioral Sciences is hosting a reception for her on Friday, June 30th from 4:30pm-7:00pm at the Edmondson Faculty Center on the USC Health Sciences Campus. It will be a chance for current and former colleagues, residents, and voluntary supervisors to celebrate her accomplished career. For more information and to register your attendance, please RSVP: (323)442-4034 or garcia8@med.usc.edu by June 19th.*

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In Memorium

Joe Schneider, M.D.

Joe was born June 17, 1945 to Russian immigrant Jewish parents in Brooklyn, NY. He was the youngest of 3 siblings.

He was precocious as a child...he wrote a letter to President Eisenhower questioning how the United States could allow racial inequality and segregation. He began to excel academically in high school, with very high scores on the NY Regent exams. In addition to his outstanding academic work, Joe’s participation on the James Madison High School track and field team earned him a “full boat” scholarship to Columbia College. Joe graduated with a B.A. in Zoology in 1967.

Joe made numerous friends while at Columbia most of whom became friends for life.

Joe’s road to his medical education had its bumps. He was diagnosed with Ulcerative Colitis, which though a cause for great worry would also become a source of empathy that influenced his work with patients. It was during this illness, Joe would discover and learn to draw upon his own ego strength never allowing himself to feel like a victim.

Joe graduated from SUNY, Buffalo Medical School, 1975, then moved out to California to do his residency in Psychiatry at L.A. County-USC. He finished his residency in 1978, and completed his Fellowship in Psychiatry and Law in 1979, passed his National Boards in Psychiatry and Neurology in 1980.

Joe met Candace at LAC-USC through a mutual friend, they were engaged 6 weeks later. They have 2 children, Daniel (34yo) and Erin (31yo).

Joe continued to play tennis, exercise almost daily, loved movies, live theatre, traveling, and swimming. He was passionate about his work and cared deeply for his patients, family and friends.

Joseph Alan Schneider, M.D. never met a stranger.

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