Southern California

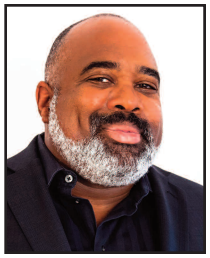
# PSYCHIATRIST

Volume 65, Number 7 March 2017 Newsletter of the Southern California Psychiatric Society

*President's Column*

# Transformations

## Curley Bonds, M.D.



This month's newsletter goes to press on the heels of the stunning and unexpectedly drama filled victory of the film *Moonlight* for Best Picture at this year's Academy Awards. After the dust cleared and the two septuagenarian presenters (Fay Dunnaway and Warren Beaty) were deemed to not be suffering from encroaching dementia but rather victims of a cruel envelope mix-up, we were able to appreciate this historic win. The film's victory highlighted a cultural shift towards acknowledgement and recognition of the untold stories about a marginalized group in our society. This is a very healing development during what can best be described as interesting and often turbulent political times. I don't want to spoil the film if you have not seen it, but suffice it to say that it portrays a subset of the LGBTQ community and their intersection with African American values that are often misaligned. We see the protagonist of the story, Chiron; go through various stages of development that include bullying, loss, love and much emotional pain. But throughout the film, the humanness of his survival through adversity is what catches our attention. It is an exquisite depiction of what we often refer to clinically as *resilience.*

Jeffrey Tambor who stars in the Amazon series *Transparent* has won several awards as Best Actor for his portrayal of a father who decides late in life to transition to being a woman. Through his skillful acting, Tambor dispels many of the myths about transgendered individuals – including the misconception they are a threat to the public when they use bathrooms that conform to their gender identity. Legislation aimed at "protecting" children and women from predators in the restroom is ill-informed and wrong. There have been no cases of harassment in states and cities that ban bathroom discrimination. In fact, the people most likely to be hurt by so-called "bathroom bills" are transgender individuals themselves. In one study, 70 percent of trans-respondents had been harassed, assaulted or denied access when attempting to use a public bathroom. More than half reported suffering physical ailments, such as dehydration or kidney problems, because they were afraid to use the restroom while out. Fortunately California is ahead of much of the rest of the nation on this issue. In 2013 Gov. Jerry Brown signed the first law of its kind in the nation protecting the rights of trans-youth to use bathrooms and participate on sports

(Continued on page 2)

In This Issue...

teams with the gender they identify with.

As psychiatrists we have long known that access to care is crucial for all individuals regardless of their gender identity or sexual orientation. So it has been disheartening to see others who are less enlightened threaten to take away gains towards acceptance that were hard fought by advocates and activists. In 2012 the American Psychiatric Association approved a position statement on “Transgender and Gender Variant Individuals.” The statement is brief, but it supports the removal of barriers to care and supports the coverage for gender transition treatment by both public and private insurers. In this regard California is again ahead of the curve when it comes to funding for gender conforming surgery. Most medical professional organizations including the American Medical Association have approved guidelines that can be used to determine the medical necessity of treatments ranging from hormone replacement to surgical intervention. Most psychiatrists are not aware that they may be approached and asked to write a letter of medical approval for someone seeking gender conforming surgery. It is concerning that most  who are approached don’t have the skills or knowledge base to write such a letter and have no clue what it should contain. Many transgendered individuals have had negative experiences with mental health providers, so it is important that we educate ourselves about their needs. Fortunately this content is available through the APA in the form of CME courses and other instructional formats. Also, groups like the WPATH (The World Professional Association for Transgender Health) provides conference and information resources on their website.

As psychiatrists we are charged with the task of being neutral, non-partisan and above political rhetoric. Most of us by training and nature want to avoid participating in contentious debates about controversial topics. But it also behooves us to stand up for our beliefs when we see conflicts between the law and our professional ethics. This terain may be challenging to navigate in the current environment but it is important that we continue to be advocates for the vulnerable populations that we treat.

*Editors Note: SCPS recently hosted a 2 hour CME meeting on Transgender Issues.  Please let us know if you would be interested in attending future CME meetings on this topic.*

You and a Guest
are Cordially Invited

SCPS Installation and Awards Ceremony
Saturday, April 22, 2017
Le Merigot Beach Hotel
1740 Ocean Ave, Santa Monica, CA
3 pm - 7 pm

Joseph Simpson, M.D. - Incoming President

To RSVP: scps2999@earthlink.net

# Letter from the Editor

## The Goldwater Rule: What you need to know

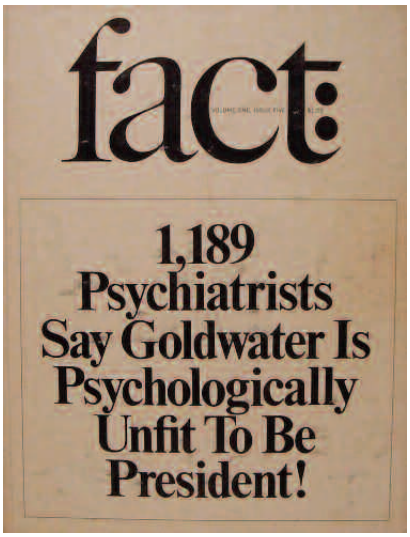
Matthew Goldenberg, D.O.

Much has been made in the media of late about the "Goldwater Rule" and how this pertains to Psychiatrists speaking about public figures, including President Donald Trump. As an example, I was watching the evening news in the past week and a clinical psychologist and a psychiatrist were taking the position that we as mental health experts "have the ethical duty to speak out using our expertise and training and by not doing so we are being complacent."

The exchange actually gave me the sinking pit in my stomach feeling. That is a heavy burden for our field. A similar, but separate consideration, when to disclose personal beliefs to patients, made the front page of the *Los Angeles Times* on February 24th, 2017.

***To speak out or not to speak out… that is the question.***

It is one thing to advocate for our patients, for things like: increased access to quality mental healthcare; for parity; for increased training for first responders to identify mental illness; for decreased stigma etc. If you have been following my articles in this newsletter and elsewhere you will know I am in full support of using our positions as mental health experts to advocate for our patients and our field. However, it is completely different to use our expertise and training to influence the political process. Section 7.3 of the American Psychiatric Association's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* actually makes this distinction.




Fact Magazine, Sep-Oct 1968

From my understanding and recollection, avoiding such a scenario was the purpose of the Goldwater rule. So I decided to look it up and share the highlights:

The Goldwater Rule has been in effect since 1973.

It was put in place in response to the 1964 presidential election. In short, there was a survey of psychiatrists in a magazine regarding then candidate Barry Goldwater. Close to 50% of the responding psychiatrists reported that he was unfit to assume the presidency. Some psychiatrists responded with specific diagnoses (without having formally evaluated him). The ethics came into concern.

The key aspect of the Goldwater Rule is that it prohibits psychiatrists from offering opinions on someone they have not personally evaluated.

The ethics are that diagnostic terminology and theory should not be used for speculative or ad hominem attacks which could promote the interests of an individual or group (for either political and ideological causes).

The consequences of breaking the rule include: Further stigmatizing mental illness and marginalizing the field of Psychiatry (by using them as a political or media tool) and an ethics violation.

The APA's concern is to safeguard the public perception of psychiatry as a scientific and credible profession.

It has since been noted there are problems with the Goldwater Rule. Chief among them is Psychiatrists' 1st amendment right to free speech. As Psychiatrists, we have dual roles as both professional figures and private citizens and often these roles overlap. With the advent of social media, it is harder and harder to define the boundaries of those roles. Second, I reviewed an article from the Journal of American Academic Psychiatry and The Law (published last year) while preparing this article that noted third-party reviewers, expert witnesses and historical psychobiographers often make a diagnosis, or give an opinion thereof, without conducting formal diagnostic interviews. These authors concluded that the Goldwater Rule was an overreaching response to an embarrassing moment for our field.

***Conclusions***

I have a better understanding of the history and reasons for the Goldwater Rule. Searching for a picture helped me to realize the power of our voice. The cover of a major magazine declaring "1189 Psychiatrists Say Goldwater is Psychologically Unfit to be President!". That is powerful stuff. Though I wonder if some of those individual Psychiatrists felt their opinion was being used out of context or in a forum for which they had not intended?

My goal in writing this article was to share those facts with you. An additional goal was to kindle a conversation among our members. I am eager to hear your thoughts on the Goldwater Rule. Do you agree we have a duty to speak out or conversely do you feel doing so could be detrimental to our field? At the least your thoughts will be shared at our next SCPS Board meeting. If you include data and peer-reviewed citations in your response, I will make an effort to publish your thoughts here, if you indicate that is of interest.

> The "Goldwater Rule:"
>
> On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement."

**References (also cited within text via hyperlink):**

https://www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/08/the-goldwater-rule
https://www.ncbi.nlm.nih.gov/pubmed/27236179
http://jaapl.org/content/44/2/226

# The Psychiatrist's Role Treating Patients Living with Cancer: Beyond Depression, and Anxiety to Quality of Life and Living with Dignity

By: Monika Chaudhry, M.D.
Consultation-Liaison Psychiatrist at Cedars Sinai Medical Center

Whether it is the first moment a patient hears the news of cancer, the loss of their hair, or end of life care, we as psychiatrists play a vital role in their journey. Shock, grief, anxiety, depression, and adjustment disorders all relate to the type of cancer, the age it is diagnosed, potential prognosis, and social support.

In 2013, the *Lancet*, published articles based on UK studies showing the increased prevalence rate of depression in cancer patients, which is about two to three times the rate in the general population; the highest with lung cancer (13%) and the lowest with genitourinary cancer (6%). Depression was more common in females, younger patients, and those with lower socioeconomic status and social support. The SMaRT Oncology-2 study demonstrated that among patients who received intervention for their depression as part of a collaborative care model, at 24 weeks, 62% had a positive response compared to 17% who had care as usual. At 12 months, these patients reported additional symptomatic improvements including: less anxiety, pain, fatigue and improved functioning and overall quality of life.

Only about 25% of cancer patients with depression or anxiety seek out treatment, often seeking help for overcoming fears, finding meaning in life, finding hope, finding spiritual resources; and, some want to talk to about finding peace of mind, the meaning of life, and death and dying. Taking a page from Erik Erikson and using breast cancer as a model, different conflicts arise in different stages of life. For example, a young woman worries about access to health insurance, fears less about dying, and is concerned about reproduction and re-occurrence. A middle-aged woman worries about kids adjusting or potentially losing a parent, body image and loss of sense of being a woman, marital issues-distress with relationship in terms of support and sex life. Finally, an elderly woman feels a loss of independence, like a burden, and may feel that it is "their time to go".

The goal for psychiatrists, is to help the patient adjust to a new normal by addressing past conflicts, shoring up coping mechanisms, and guiding them through the arduous medical process while preserving a sense of self. Often overlapping models of therapy are engaged including group-for generalization/coping, cognitive behavioral-for reframing, ITP-for role change, psychodynamics to help with family relationships as often illness can bring families closer or break them apart. As the clinician works with the patient to guide them through this interpersonal and intrapsychic journey, they prepare the patient to constantly adapt to unpredictable and unknown complications addressing negative emotions, defense mechanisms, social supports, and existential crisis.

Fatigue, poor appetite, poor sleep, and poor concentration are all neurovegetative symptoms that overlap with major depression. These are inherent to both the cancer and chemotherapy and severely impact the patient's quality of life. Additionally, nausea is often linked with anxiety, which may lead to a cycle of panic and anticipatory anxiety.

When considering medication options, bear in mind the patient's symptoms caused both by the cancer and also the adverse effects of the cancer treatment. For example, depressed patients with prominent symptoms of loss of appetite, nausea, pain and sleep Remeron or Zyprexa could be utilized depending on the severity of symptoms. Both of these medications target 5HT-3 receptor that mitigates nausea and downstream opioid receptors to assist with pain control. In some instances, patients will use Dronabinol (purely THC) or medical marijuana for similar symptoms (currently data is limited and efficacy is variable).

For patients with depression fatigue and neuropathic pain from chemotherapy often Effexor or Cymbalta is coupled with gabapentin or Lyrica. Subsequently patient's fatigue and "chemo brain" –a brain fog with difficulties in attention, memory, and new learning is caused by inflammation, increased oxidative stress, anemia, or presence of epsilon 4 version of Apolipoprotein E gene- can be targeted with Modafinil, Ritalin, Wellbutrin, Abilify, or antioxidants. Studies are equivocal regarding the chemoprotective role of Memantine during chemotherapy, but

there is some promising data with Lithium. Currently, the best evidence is engaging the brain in cognitive activities. Given patients often have a multitude of symptoms there are often synergistic effects while combining Effexor and Remeron, and earlier action of onset by using stimulants as SSRIs/SNRI's take effect in a few weeks.

A patient's quality of life is often determined by their experiences with providers, adequate control of symptoms, and social support. The benefit of collaborative care and having psychiatrists imbedded within oncology clinics or part of palliative care teams, is improved communication and streamlined care. Spiritual care can help guide the patient through their faith, provide community support and for some address existential questions. Palliative care teams can target symptoms of pain, fatigue, and nausea as well as assisting the patient to guide their treatment based on their goals for how they want to live.

One last consideration is that, over the last year, there has been resurgence in the discussion regarding death with dignity. As of June 2016, California has enacted the *Right to Die* law, where a terminal patient can petition their primary provider for medications to end their life. This often allows the patient to retain control with a disease process that afflicts every person in different ways and there is no certainty how their treatment course or adverse effects will unfold. We as psychiatrists have the unique position of impacting a patient's experience of living with cancer through therapy, medication, and support. By collaborating and being imbedded within the treatment team, we can help both the providers and the patients improve outcomes with mental health and quality of life, despite the decrements in physical health that patients with cancer often experience.

CEDARS-SINAI

# Harnessing Stress Management and Emotional Intelligence to Enhance Performance and Fulfillment: A Skills-Lab for Healthcare Professionals

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**Saturday, March 18, 2017**
Cedars-Sinai Medical Center
Harvey Morse Auditorium
8701 Gracie Allen Drive
Los Angeles, CA 90048

**Registration Fees**

**Received by March 10, 2017**

| | |
|---|---|
| Physician | $140.00 |
| Non-Physician | $95.00 |

**Received after March 10, 2017**

| | |
|---|---|
| Physician | $170.00 |
| Non-Physician | $120.00 |

## Course Description

There is a growing body of literature on the need to improve well-being of healthcare professionals over the past five years. In the U.S., healthcare professionals suffer more burnout than other workers, with prevalence rates as high as 50% in physicians. Extensive research over the past decade illustrates that this issue could have a profound effect on the quality of patient care and there is concern that it might lead to early departure from the practice of medicine.

This unique course will examine the importance of wellness and provide recommendations, tools, and resources that healthcare professionals could utilize to develop resiliency, work/life balance, and self-care. By using a skills lab approach, attendees are expected to learn and practice stress management methods, and emotional intelligence techniques with the opportunity to meet in small groups with fellow healthcare professionals to acquire and practice wellness skills.

To learn more about this course, visit our website:
http://www.cedars-sinai.edu/Education/Continuing-Medical-Education/Psychiactric-Stress-Management-and-Emotional-Intelligence-2017.aspx

# Pharmacogenomics: Not ready for Prime Time

by: David Fogelson, M.D.

I coordinate a journal club for the UCLA faculty. At a recent meeting we reviewed the clinical utility of pharmacogenomics testing. The discussion was led by Drs. Erika Nurmi and Thomas Strouse. The lead off provocative questions were, "Should we perform pharmacogenomics testing for SNP's (single nucleotide polymorphisms) that predict treatment response due to a medication's pharmacodynamic effects and/or should we perform pharmacogenomics testing for P450 SNP's that predict treatment response due to a medication's pharmacokinetic effects? Is this so important to patient care that we should perform these genetic tests on every patient admitted to the UCLA Resnick Neuropsychiatric Hospital? The answer was, "It depends upon the use for which the results will be applied." If the results are to be applied to optimize current clinical care, the answer is no. If the results are to be applied to research efforts to use "data mining" of large electronic databases to further the possibility that pharmacogenomics can one day be clinically relevant, the answer is yes.

The answer to the clinical care question surprised me. I decided to ask a provocative question of my own related to pharmacogenomic testing for breast cancer patients treated with Tamoxifen. Tamoxifen is metabolized by the P450 isoenzyme 2D6. Tamoxifen is metabolized to an active metabolite that produces anti-estrogneic effects. One might predict that a patient who is a poor 2D6 metabolizer, either due to inherent genetics or treatment with a 2D6 inhibitor such a fluoxetine, might receive poorer protection from cancer recurrence than someone with normal 2D6 metabolism. Given this prediction you might advise your patient to avoid or discontinue treatment with medications such as fluoxetine. Surprisingly, you would be incorrect in giving such advice. Clinical phamacogenomic studies using data mining of big data have shown that women who are poor 2D6 metabolizers receive the same benefits from Tamoxifen treatment as do women who are normal 2D6 metabolizers!

In turns out that the same is true for predicting response to psychoactive medications. SNP's that are putative markers for predicting response to one class of antidepressant over another have been dismal failures in predicting response. SNP's that characterize P450 metabolism in patients have been unhelpful in predicting effective dose ranges for patients. There are simply too many other variables to account for: absorption from the gastrointestinal tract, serum protein concentrations, brain metabolism different from liver metabolism and wide ranges of therapeutic efficacy and safety.

One of the primary sources for our discussion was a review by Steven Dubovsky in the 2016 volume of Psychotherapy and Psychosomatics. He explains that even though dozens of markers have been identified and associated with psychiatric disorders none has shown to be useful for prospectively identifying a psychiatric diagnosis. Because thousands of loci in the genes each contribute a small effect to psychiatric diagnosis, and because many of the loci contribute to multiple disorders, studies have not been able to predict diagnosis by genotype. And this is the least of the problems. Once a genotype has been completely characterized it still does not predict diagnosis. Genotype expression is mediated by epigenetic factors and environmental factors, affecting final psychiatric outcome/disorder.

Dubovsky provides additional reasons why P450 genotyping does not predict dosage range for therapeutic response. Some patients may have multiple copies of a poor metabolizing gene that results in normal metabolic rates for the gene in question, e.g. 2D6. Complex interactions with other medications and food and supplements (e.g. St. John's Wort) make prediction even more difficult. Dubovsky further explains that even if we could pre-

dict drug level by P450 isoenzyme typing we would not be able to predict clinical response by blood level obtained. Blood level is poorly correlated to clinical response for most medications.

Dubovsky reviews four studies that report that genotyping improves outcome in patients treated for depression. He criticizes these studies because they are non-randomized, supported by the manufacturer of the genetic kits used to test the patients, and confounded by comorbid factors, concomitant medications, treatment adherence, substance use, adjunctive psychotherapy, and non-blind nature of the studies.

The consensus of the UCLA journal club participants was that we should not advocate that clinicians in practice adopt genotyping routinely for all patients. We caution that it is easy to succumb to the wish to appear more scientific to our patients in our treatment approach and choices by applying genetic testing that has little clinical utility. We hope that we see the day when further research will make genetic testing clinically viable. That time is not now.

Register Now!

*SCPS Presents*

## Internal Medicine for Psychiatrists

Endocrinology/Gastroenterology/Cardiology

Saturday, April 1, 2017 8:30am - 12:15pm

Cedars-Sinai Medical Center - South Tower
Harvey Morse Auditorium
8700 Beverly Blvd., Los Angeles, CA 90048

CLICK HERE FOR COMPLETE DETAILS AND REGISTRATION

**Endocrinology** - Michael A. Bush M.D. - *President, CA-AACE Clinical Chief, Division of Endocrinology, Cedars-Sinai Medical Center Associate Clinical Professor, Geffen School of Medicine, UCLA*
Dr. Bush will discuss the effects that commonly used psychiatric medications have on the endocrine system. Problems often seen in clinical practice include changes in glucose and lipid metabolism, alterations in pituitary hormones, and effects on thyroid function in susceptible patients. The role of the psychiatrist in diagnosing and even treating some of these medical problems will be discussed.

**Gastroenterology** - Caroline Hwang, M.D., - *Assistant Professor of Clinical Medicine in the Division of Gastroenterology at the Keck School of Medicine of USC*
Dr. Hwang will provide an overview of the most common gastrointestinal disorders encountered in the medical setting, including basics of their diagnosis and treatment and the signs and symptoms which should prompt the non-internist to refer for urgent medical evaluation. We will also discuss functional gastrointestinal disorders (irritable bowel syndrome, functional dyspepsia) and how multidisciplinary care which includes mental health and nutrition may be beneficial to the patient.

**Cardiology** - Mark K. Urman, M.D., *Clinical Professor of Medicine, Cedars-Sinai Heart Institute and David Geffen School of Medicine at UCLA*
Learn what every psychiatrist should be familiar with regarding the latest in state-of-the-art cardiac care and how psychiatrists can be an integral part of caring for cardiologists' patients.

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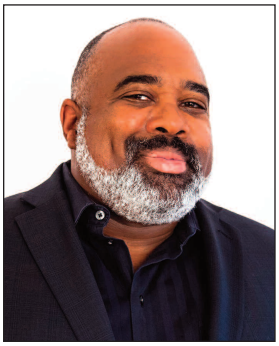
# Get to Know Your 2016-2017 SCPS Board Members: A Brief Q+A with SCPS President, Curley Bonds M.D.



This is the fourth in a series of conversations with 2016-2017 board members. We hope you enjoy getting to know a little more about President, Curley Bonds M.D. We thank our Board Members for their time and participation!

**1) What initially sparked your interest in the field of Psychiatry?**

My first exposure to psychiatry was up close and personal when a family member experienced symptoms of a serious mental illness. I watched while she received appropriate and compassionate care and fortunately she recovered. The team of medical professionals that cared for her was led by a psychiatrist. I admired his ability to use science and humanistic inquiry to treat her illness successfully.

Later during medical school I learned that psychiatry was a misunderstood and often stigmatized profession. While others thought that those with mental illness were frightening or difficult to interact with, I knew that there were people behind the illnesses who really needed help.

Of all of my clinical rotations psychiatry was the most rewarding since I saw that I could make a meaningful impact and save lives. The specialty tapped into my talents of being able to understand and communicate with people and to help them through very challenging times. I felt good about being a source of hope for people who society often avoided or neglected.

**2) How has field changed or been different than you initially imagined?**

There has been a true movement towards recognizing that mental illnesses occur in a cultural context and that affects how they present in people from diverse backgrounds. Biological psychiatry has finally evolved to the place were we can look at personalized markers that tell us how genes are expressed so that we can make more educated guesses about what will or won't work for different patients.

I've also seen a positive change in the ability for us to understand psychiatric illnesses as being just as serious and debilitating as other medical illnesses. I'm encouraged by the trend of reintegrating psychiatry and general medicine to treat the whole person. Collaborative care is becoming the standard so that psychiatrists are practicing less in isolation and more as members of broader healthcare teams. This is resulting in a greater recognition of the important work that we do and shedding light on the fact that behavioral health is essential to overall wellbeing.

**3) Tell us about the area of psychiatry in which you practice or your practice setting?**

My professional life is very rich and diversified. I identify as a community psychiatrist with academic roots. I work for a large community mental health center with 11 locations throughout Los Angeles. As the medical director for Didi Hirsch I oversee a group of about 30 doctors, nurses, and nurse practitioners. My role is to ensure that we deliver quality care that takes into account the special needs of patients from many cultures and social environments. All of our patients live at or below the poverty line and usually come from communities where trauma, incarceration and violence are commonplace.

I continue to maintain academic appointments at UCLA and Charles R. Drew School of Medicine, where I serve as department chair. In that capacity, I work with faculty members who do research with health disparities in ethnic minorities among other areas. I'm also involved with teaching medical students from both Drew and UCLA and mentor residents and fellows who are interested in community mental health.

Lastly, I have a small private practice based in Westwood where I provide long-term psychotherapy and psy-

chopharmacological management for patients who are well resourced with good social support.

So my professional lens is a wide angled one!

**4) What motivated you to become more active with SCPS?**

Academic physicians are expected to demonstrate community involvement as a part of their basket of contributions to society on behalf of the University. Several years ago I was approached by a colleague who asked me if I'd be willing to sit on the SCPS Council to fill a vacancy as Councillor for West LA.

After my first few meetings, I realized that there were only a few voices representing the life and career path that I've had and that people were interested in hearing my views. I also recognized how important it was to connect with colleagues from other practice types and other educational institutions. I discovered that how we practice psychiatry is not only about neurotransmitters and psychodynamic theory, but also about how the public perceives us and how laws are made that govern what we can and cannot do. I was drawn to the educational opportunities our district branch offered and also the chance to work with advocacy groups and legislators to make the practice of psychiatry better.

**5) Where do you hope to see the field of Psychiatry go in the next 20 years?**

Psychiatrists are too few in number to treat the huge volume of individuals who suffer from mental illness. Because of the time and expense of medical education there will never be enough of us to meet all of society's needs. We will need to partner more closely with our colleagues from primary care and the behavioral health professions to provide appropriate treatment. Because of the intensity of our training, I see psychiatrists as being well poised to lead treatment teams and provide consultation in addition to direct one on one care.

As technology advances we will have more tools like registries to help us oversee the health of populations. There will always be plenty of work for us, but our roles will shift more towards treating only the most severely disabled patients while those who are on a stable course will be treated by colleagues with narrower scopes of practice like nurse practitioners, physician assistants and advanced practice nurses.

**6) If you could go back in time, with what you know now, what advice would you give yourself related to your career as a Psychiatrist?**

As I become more seasoned, I have a much greater appreciation for the impact of social justice and political forces on how medicine and especially psychiatry are practiced. I'm catching up now, but I would encourage any early career psychiatrist not to shy away from getting involved with opportunities to learn more about how health policy is created and how our health care delivery system is financed.

We are currently experiencing a great deal of uncertainty in this country not because we don't know how to treat psychiatric diseases, but because our hands are frequently tied by the restrictions placed on us by the legal system and the insurance industry. Politics and advocacy are not always given much attention in medical education, but they are vital to our survival. It is important for us to understand and participate in the political process effectively or we risk being marginalized by it.

In order to protect our right to practice medicine as we are trained we need to have more than a superficial knowledge of the business, legal and social forces that have a tremendous influence on our work.

# Why giving to our PACs is Vital to Psychiatrists and Our Patients

By: Peolia Fonsworth, M.D.

Given our current political climate, many SCPS members are worried about if our patients will continue to receive mental health care, and our patients are worried too. As Congress considers significant changes to health insurance coverage following the repeal of the ACA, it is vital that those changes don't undo the gains that have been made over the past several decades for individuals suffering with mental illness. For this reason, both the American Psychiatric Association and the California Psychiatric Association have political action committees that pool campaign contributions from members and donate those funds to campaigns, ballot initiatives, and legislation. As SCPS members supporting these efforts is one way we can directly help to protect mental health care.

The American Psychiatric Association is our voice in Washington, D.C. The American Psychiatric Association Political Action Committee (APAPAC) is a non-partisan political action committee. This is the political arm of APA and is a tool to get "more friends of psychiatry" elected to Congress. Notably, the APAPAC contributes to both Democrats and Republicans because legislation cannot pass without support from both political parties. APAPAC fights to help ensure psychiatry is included in determining policies that impact mental health parity, network adequacy, federal scope of practice standards, Medicare funding, physician payment levels, mental health research, and psychiatry residency education.

The California Psychiatric Association is our voice in Sacramento. The California Psychiatric Association Political Action Committee (CPAPAC) has helped elect representatives from local districts knowledgeable on issues involving mental health parity, scope of practice issues, and the potential expansion of assisted outpatient commitment. As CPAPAC makes connections with local legislators, doors can open for relationships in which psychiatrists can become experts on both local and state issues that arise.

One goal of our PACs is to create a strong grassroots network and serve as a direct link between our membership and our legislators' who impact on key issues to psychiatry. As a chief resident physician and constituent of SCPS, I encourage you to contribute to a PAC today if you haven't already done so. By working within the political process, and supporting candidates committed to the wellbeing of individuals suffering from mental illness and substance use disorders, we can help advance the interests of psychiatry at the federal, state, and local government levels. Giving any amount is important — it all helps to add numbers to the collective voice of these PACs. Monetary support for "friends of psychiatry" in government requires a contribution from every SCPS member to be effective. Take your pick!

https://www.psychiatry.org/psychiatrists/advocacy/apapac

http://www.calpsych.org/cppac-fund

Also, if you are attending the APA Annual Meeting in San Diego, there will be an APAPAC reception on Monday, May 22nd, 2017 at the Ultimate Skybox at Diamond View - 350 Tenth Ave. (corner of Tenth and J Street) from 8:00pm-11:00pm. All APAPAC members who have made contributions of over $250 are welcome to join for free. All others are asked to purchase tickets for $100 ($50 for Early Career Psychiatrists and $25 for Residents).

# Working on Commission
## By Walter T. Haessler, M.D.

Serving on the Riverside County Behavioral Health Commission, as I have done for the past four years, has been a very nice involvement for me.

I'm writing to provide information about what Commission membership involves, with the idea in mind that other members, especially those who are retired, or at least not wedded to a full-time practice, may want to consider this activity.

In 2012, I had not worked in psychiatry for two years, and wanted to be involved again in some way. (As to why I won't likely be returning to work in psychiatry, see, "Maybe Surgery Would Have Been Easier" in the July, 2015 newsletter.)

But as I filled out the application at my Supervisor's office, I actually had little idea what this involvement would entail. I assumed that the Commission would be made up of mental health professionals who would advise and oversee the Department in some way. I assumed that the meetings would be in the evening, to make it easier for working people to attend. I assumed that clinical issues would come up fairly often.

So much for assumptions.

During all my four years of service, I have been the only mental health professional, and the only physician. When I saw there was a PhD on the roster, I assumed he was a psychologist. Actually, he is an entrepreneur with a PhD in mechanical engineering. (Gotta watch that assuming.) And clinical issues don't come up all that often.

But there is something about that that I like — the chance to contribute, to inform, in a way that would be otherwise lacking.

It's not, as they say, rocket science; rather, it is generally on matters that are to us rather basic. Here is an example from the January, 2017 meeting (the most recent, as of this writing).

Riverside County is very large, in both respects — soon to be the second most populous county in the nation's largest state, and extending from the Los Angeles suburbs to the Colorado River. There has been an ongoing inability to hire a permanent psychiatrist to work in Blythe, which is on the Arizona border, and the Director was telling us about using locum tenens psychiatrists, as they have been doing, and perhaps telepsychiatry.

At that point the Commission Vice Chair asked me to discuss telepsychiatry. I don't know a lot about telepsychiatry, but was able to discuss outcome studies a bit, based my reading about it. I also took the opportunity to define and discuss locum tenens practice (which I *do* know a lot about) for the benefit of the Commissioners and others in attendance (which averages about fifty interested parties from the Community and the Department).

In discussing what locum tenens practice can do, and possible drawbacks as well, I found myself talking about the psychological concept of transference, and especially a positive transference that can get lost in a succession of locum tenens psychiatrists.

Another recent example came up at a meeting, when there was evident confusion over different diagnostic categories in substance use issues. I used Venn diagrams to illustrate the categories of use, abuse, and dependence; and then discussed *ICD-10* and the changes from *DSM-IV* to *DSM-V*.

Again, not rocket science, but I think it was helpful to some of those present.

And, as all teachers know, it's not that the teaching goes in only one direction. These are smart, civic-minded people from various backgrounds, who want good results (some of them Consumers or Family Members) and there can be lively discussions. Specifically, I had known nothing about evidence-based psychotherapy programs, In-

novation programs and the MHSA funding that makes them possible, and the great range of comprehensive services now available to outpatients.

What the Commission does, for the record, is stated in the bylaws. Here's the short version. We advise the Board of Supervisors and the Behavioral Health Director as to any aspect of the County's behavioral health programs, ensuring citizen and professional involvement at all stages of the planning process. We also submit annual reports to the Board of Supervisors and to the California Mental Health Planning Council, and review and make recommendations on applicants for the position of Behavioral Health Director. We also conduct site reviews on each of the County's behavioral health facilities, on a three-year cycle.

The meetings are from noon to 2PM on first Wednesdays, dark in August and December. This is obviously not ideal for many working types and, I believe, keeps some very qualified people from applying. Commissioners are appointed by their Supervisors, and approved by the Board of Supervisors. They are not paid, but are reimbursed for travel expenses. A nice buffet lunch is served. (On that, I can speak for only Riverside County.)

Commission meetings follow Roberts Rules of Order in a standard format. There is ample time for announcements from the Commissioners and from the public, and ample time to discuss them. There is a "Celebrate Recovery" presentation by a patient or former patient or a family member, that gives us a look at the Department's operations from the perspective of patients or their families.

Meetings are always open to the public, as required under the Brown Act, to assure openness and an opportunity for public participation. I suggest that any interested SCPS member attend at least one meeting to get the feel of it, before applying either through their County Supervisor or through the Commission Liaison, who will be at the meeting.

I welcome calls or emails from members who would like to know more. (951-693-0639; wthaessler@hotmail.com)

You should be receiving your SCPS ballot on or around March 3, 2017.

Please be sure to review the candidate statements in the February issue of this newsletter.

http://www.socalpsych.org/february17.pdf

Deadline to vote is March 31, 2017

Please review abbreviated CVs at:

http://www.socalpsych.org/CV-Election-2017-2018.pdf

Officers will be installed on April 22, 2017

**PLEASE BE SURE TO VOTE!**

**HELLENIC AMERICAN PSYCHIATRIC ASSOCIATION**

# HAPA 18th ANNUAL MEETING

## Tuesday May 23d 2017

## San Diego, California

**Time: 6:00PM- 8:00PM**
**Location to be announced after February 2017**
**Attend the 18th ANNUAL HAPA MEETING on 5/23/17**
**IN CONNECTION WITH THE APA 2017 ANNUAL MEETING**

This year HAPA features a very special, timely and fascinating presentation by our HAPA President Elect

# "Its our turn now:"

## Refugees, Relief Workers, and Resilience

## Philip J. Candilis, MD, DFAPA

**1) Director, Forensic Psychiatry Fellowship Saint Elizabeth's Hospital Dept. of Behavioral Health, Washington DC**
**2) Clinical Professor of Psychiatry**
**George Washington University School of Medicine &**
**Howard University College of Medicine**
**3) Adjunct Professor of Psychiatry**
**Uniformed Services University of Health Sciences**

Attend both the meeting and the Dutch Treat Dinner at 8:30PM.

**YOU MUST pre-register** by paying your HAPA 2017 dues at our website; www.hellenic-psy.org thru the HAPA Paypal or by credit card

Or mail in your dues to HAPA Treasurer: Katina Matthews-Ferrari, MD 19022 Midway Blvd, Port Charlotte, FL

Learn more about HAPA & join by filling out the HAPA Membership Application on the website. Email: maria@lymberis.com for further information.

# Chester Middlebrook Pierce, M.D.: A Life That Mattered

By Ezra E. H. Griffith, M.D.

Originally published in Psychiatric News
Published online: October 28, 2016

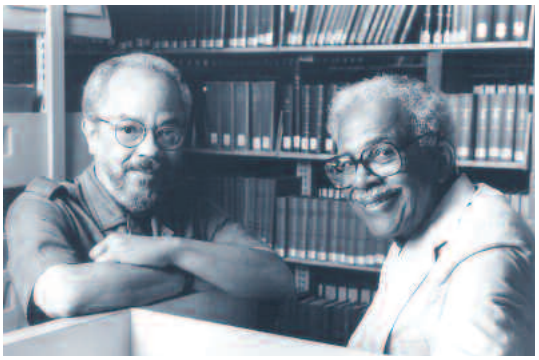



Photo: Chester Pierce, M.D., and Ezra Griffith, M.D.

Ezra Griffith, M.D. (left), is photographed with Chester Pierce, M.D., at Harvard University in 1998. Pierce was a pioneer in studying the effects of racism and health disparities, among many other areas, and was the first to propose the concept of microagressions, in 1970. After a long and distinguished career in which he broke a number of racial barriers, he died on September 23 at the age of 89. Those who knew him well describe him as a man of quiet courage, grace, and humility.
Jon Chase, Harvard News Office

He always referred to himself as “Chet” even in conversations with people he hardly knew. He took his humility to heart, even though he was a full professor on three Harvard faculties (medicine, education, and public health) and had been honored in myriad ways by organizations here and abroad. He was also serious about his commitments, as I learned over many months when I engaged in extended conversations with him on Fridays in his office located in Harvard’s School of Education. He was never late for our meetings. We must have cut a puzzling sight, strolling around Cambridge during our breaks, my diminutive stature next to his 6 feet 4 inches of erect carriage.

He was an assiduous observer of the interactions between blacks and whites in the United States. Chester Pierce tutored me about the imperative of studying how these two groups engaged with each other. Their rituals were a model for understanding oppression in all its forms. He had developed an immutable interest in grasping how the dominant white group sought to control the time, space, mobility, and energy of the nondominant black group. He was intuitively brilliant in his formulations, making it clear that on the one hand, the black-white interaction could be toxic because of the predictable mundane causticity it evoked. On the other hand, however, he knew well that those interactions had an effect at the broader community level. That’s why he talked persistently of racism as a public health pollutant.

It took time for me to recognize that Pierce was, in Hazel Carby’s terms, a 20th century “race man” (See H.V. Carby, Race Men, Harvard University Press, 1998). That is to say, like W.E.B. Du Bois and others, Chester Pierce engaged in racialized thinking, constantly focused on the black-white dichotomy and centered on an ideology that was directly related to race matters in this country. He told me of his participation in the 1968 struggle within APA to make clear the black constituency’s dissatisfaction with the white leadership’s modest interest in blacks and their concerns. But he never wanted to turn the psychiatric association into a flaming cauldron. He sought no distancing of blacks from whites. He wanted to confront whites frankly and plainly, without excessive drama, framing his thoughts about black bodies and minds and how they should be treated. It is he who discussed dignity and autonomy with me, emphasizing the salience of blacks’ controlling the development of their own identities. He had come to that paradigm from the intimate examination of the black-white interaction in behavioral studies of large organizations. He had also examined that interaction through engagement with films and extreme environments.

He helped me understand how many blacks, in repeated traumatic interactions with the dominant group, are battered into conservative and apologetic thinking. Others are simply battered into submission. Despite these observations, he still turned to cultural geography and anthropology to expand his conceptual strategies of coping with extreme environments characterized by inequity and chronic humiliation. He did not give up. He insisted that there had to be ways to create more therapeutic landscapes for all of us to inhabit.

By 1998, when I published our discussions in Race and Excellence: My Dialogue With Chester Pierce (University of Iowa Press), I had become familiar with his family history, academic life, and intellectual approach to problem solving. I had come to understand his fundamental generativity toward young people in our profession, from both dominant and nondominant groups. I had also grasped his antipathy toward selfish theatrics. As our periodic dialogue slowed in recent months, I realized his health was failing, and the time to bid farewell was coming. His absence will be a difficult burden for us in psychiatry who owe him so much.

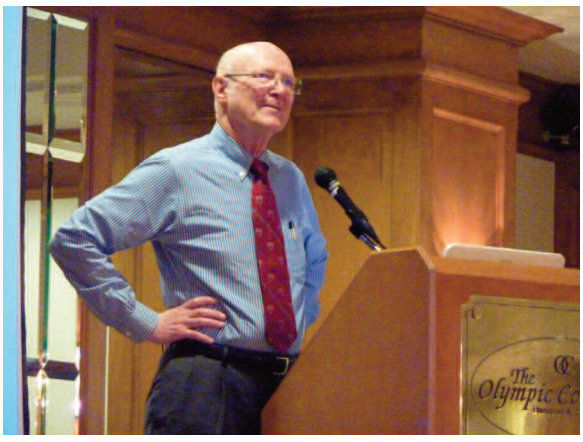
Ezra E.H. Griffith, M.D., is professor emeritus of and senior research scientist in psychiatry and deputy chair for Diversity and Organizational Ethics in the Department of Psychiatry at Yale University School of Medicine. He is also emeritus professor of African and African-American Studies at Yale University.

Thank you to Drs. Phillip Resnick, David Fogelson, Grayson Norquist and Lorrin Koran for speaking at SCPS' 28th Annual Psychopharmacology Update

Phillip Resnick, M.D.


David Fogelson, M.D.

Grayson Norquist, M.D.



Lorrin Koran, M.D.

Please review these Requirements for Distinguished Fellowship. If you feel that you might meet these requirements, or if you would like more information, please contact Mindi at scps2999@earthlink.net

## DFAPA Requirements

To be nominated for DFAPA, members must demonstrate:

- Not less than eight consecutive years as a General Member or Fellow of the APA
- Certification by the ABPN, AOA, Royal College of Physicians and Surgeons of Canada, or an equivalent certification board
- Three letters of support from current Distinguished Fellows or Distinguished Life Fellows
- A completed nomination form which demonstrates the nominees' excellence in at least five of the following categories:

| Category | Description |
|---|---|
| **Certification by the American Board of Psychiatry and Neurology, the Royal College of Physicians and Surgeons of Canada, the American Osteopathic Association or equivalent certifying board** | Once Distinguished Fellowship status is attained, maintenance of certification is encouraged but not required. If certified by another Board, details of the certification standards and process should be submitted so the Committee might evaluate the equivalence of that certification. Additional credit in this category may be earned through certification by other medical boards, sub-specialty boards, or psychoanalysis, or for a Ph.D. or Master's degree in a related field. Training without certification warrants no credit. Board certification in general psychiatry is worth category credit if the Board is current. If the Boards are expired, no points will be awarded for this category. |
| **Involvement in district branch, chapter, and state association activities** | Length and quality of service to the Chapter, District Branch or State Association are taken into consideration. Elected offices, committee work as a chair or member, newsletter work, website design/maintenance for the DB, political action committee oversight, or special projects at the district branch/chapter level are examples of activities earning credit in this category. Presentations at local meetings are usually considered under teaching activities. Substantial committee work together with elected office or membership on the Executive Council for several years will usually qualify the nominee for higher credit in this category. Membership alone does not earn credit. |
| **Involvement in other components and activities of APA** | Involvement in the work of Area Councils, the Assembly or Board of Trustees counts, as does holding elected office. Other examples of activities earning credit in this category are work on APA Councils, Committees, Task Forces, service on the editorial boards of APA publications, APA advocacy work or APA PAC leadership. Several years of activity in two or more of the above roles will usually qualify the nominee for category credit. A longer term of service or attaining elected office in one of the components mentioned will also usually qualify the nominee for category credit. Presentations at APA meetings should be listed under teaching activities. |

| | |
|---|---|
| **Involvement in other medical and professional organizations** | The role, length and quality of service, as well as the level of responsibility in the positions held, determine level of credit given. Membership alone does not earn credit. Organizations may include international organizations (e.g., World Health Organization, World Psychiatric Association), national organizations (e.g., American Academy of Child and Adolescent Psychiatry, American Medical Association), state and county medical societies, associations representing other medical specialties (e.g., pediatrics or neurology), or related professions (e.g., psychology, anthropology, sociology). |
| **Participation in non-compensated mental health and medical activities of social significance** | Voluntary activities or service demonstrating the physician's social responsibility and humanitarian concerns are included in this criterion. Voluntary service for mental health patient advocacy groups (includes service on boards or task forces, event/fundraising committees, outreach and education), free mental health clinics, educational events, mental health fairs, mental health stakeholder or advocacy groups should be included in this category. Also included is providing volunteer service to survivors of natural or man- created disasters and medical humanitarian efforts (i.e., Doctors without Borders, Give an Hour, non-compensated medical service in a foreign country, etc.). . Nominees should specify the nature of their contributions and the time commitments made. The highest weight is given to service performed over a period of time, or on a short-term but intensive basis. |
| **Participation in non-medical, non-income-producing community activities** | The Committee looks for significant contributions to the political, religious, charitable, artistic, educational, athletic or ethnic life of the community, i.e., contributions unrelated to medical income-producing activities. Mere membership in, or financial donation to, a community service organization **does not** earn credit. Supporting letters detailing the nominee's contributions from persons directly involved with these activities are very important in documenting this category. Nominees should specify the nature of their contributions and the time commitments made. The highest weight is given to service performed over a period of time, or on a short-term but intensive basis. |
| **Clinical contributions** | This category is meant to recognize excellence in direct patient care activity. Letters attesting to and detailing exemplary skill, knowledge, diagnostic ability, and therapeutic expertise are necessary. The Committee will recognize clinical distinction achieved in any of a spectrum of settings, but may take special note of work done in public service or underserved settings. Many years of respected private practice or staff work in a clinic |

| | |
|---|---|
| | or inpatient unit will usually qualify the nominee for credit in this category, especially when supported by letters detailing clinical excellence. Supervision of others who provide direct patient care should be included in this category. Service on hospital committees and other medical administrative work should be listed under Administrative Contributions (8) below. |
| **Administrative contributions** | In this category, the Committee looks for advancement in administrative positions in institutional, community/public, or private settings, as well as the level of responsibility associated with the position(s). Intraspecialty administration as well as administration within broader mental health, medical or overarching venues count towards credit in this category. Responsibilities documented should include such non-clinical activities as program development and oversight, committee work, budgeting, management of human and financial resources, strategic planning or policy formulation. Letters giving the specifics, as well as the quality of the nominee's achievements in this area are needed. |
| **Teaching contributions** | Teaching in all settings is acceptable. Teaching may include academic instruction (i.e., medical school curriculum or didactics or didactics within a residency training program), clinical instruction (i.e., supervising clinicians), non-psychiatrist instruction (i.e., teaching nurses or allied health professionals), or others. In university settings, advancement in academic rank is taken into consideration, as is the extent and quality of teaching activities in other settings. There should be letters from faculty members, heads of departments or others familiar with the nominee's work. Teaching in non-institutional, non-professional settings should be supported by letters from individuals directly involved. As indicated above, presentations at scientific meetings should be included under this category. |
| **Scientific and scholarly publications** | Articles in journals, books (other than privately published) and book chapters should be listed in this category. Higher weight will be given to articles published in peer-reviewed, refereed and/or widely circulated journals and to lead authorship. Both number and quality of publications are considered in evaluating this category. No credit is given for unpublished research. |

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