Southern California

PSYCHIATRIST

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President's Column

I've Got Guns in My Head

Erick Cheung, M.D.

In 1999, I was nearing the end of college when Columbine happened. Much of that time may be fuzzy now, but I still remember days of numbing disbelief, which later turned to anger and desperation for something to be done. 20 years later as a psychiatrist… I didn't know that I would be thinking and talking about guns every day. There's Goleta, and El Paso, and Dayton. Just in the last 30 days. Add Odessa. Not long ago, I had that same numbed disbelief while staring out of my office window during lockdown, watching hundreds of SWAT and FBI flood Westwood Boulevard in search of an active shooter on the UCLA campus.

Since the 2014 Santa Barbara shooting, we have included education for our psychiatry trainees about Mass Murder, Violence, and Mental Illness - or to be more precise clarifying the distortions around public rhetoric and misattributions of mental illness as the cause of mass murder. The authors of CPA's policy platform on gun violence sum up the problem nicely: "The wrath and remedies that follow a mass shooting, whether committed by someone with mental illness or not, are nearly always deflected toward people with mental illness, not toward gun safety."

The American Psychiatric Association condemned the recent loss of life from gun violence, and thankfully is speaking up to dispute the link to mental illness. Our APA joined six other medical organizations (American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American College of Surgeons, American Medical Association, and the American Public Health Association), in the release of a "Call to Action on Firearm-Related Injury and Death in the United States". Together, as six of the nation's largest physician professional societies, (representing 731,000 U.S. physicians), we are advocating for solutions and calling for policies to reduce firearm injuries and deaths

I have guns in my head, but that mental space is divided between all the guns used for homicides and mass shooting, and all the guns used for suicide. It's the job. As an emergency psychiatrist where the vast majority of patients we see have some element of suicidal ideation or behavior, we must ask about possession or access to firearms. When it comes to suicide prevention, there is potentially no single more important question to ask, considering that more than half of suicide deaths in this country will occur by firearm. A suicide attempt by firearms is fatal 92% of the time.

Needless to say, psychiatrists have many reasons to be concerned about gun violence and safety. It is critical that organized psychiatry advocate for gun violence policy. The California Psychiatric Association, our voice on state legislative affairs, has recently updated a comprehensive policy platform that includes

In This Issue...

support for legislation that includes, but is not limited to, the following key elements:

1. Address gun violence as a legitimate public health problem, study and develop strategies to reduce disease, injury and death.
* Highly prioritize funding for research on gun injuries and deaths.

2. Establish reasonable safety measures that can reduce accidents and impulsive gun related injury and death.
* Mandate that guns be equipped with a trigger lock and other effective safety measures approved by state and/or federal regulators and be subject to standard product liability.
* Mandate that guns be stored in a lock-safe approved by state and/or federal regulators and subject to standard product liability.
* Mandate that all gun owners pass a state or federally approved examination certifying basic knowledge of gun safety.
* Mandate that gun owners be legally accountable for access, loss and use of their guns.
* Mandate that age for gun possession be twenty-one.
* Mandate universal background checks for all gun purchases and transfers.
* Assure that guns be banned in K-12 schools except for those carried by duly authorized security officers.
* Ban the sale of rapid-fire weapons, conversion of weapons to rapid-fire function, large-capacity ammunition clips, and armor-piercing ammunition.

3. Ensure that gun restriction is reasonable and non-discriminatory (Gun restriction is reasonable when there is probable cause to believe an individual poses a threat to self or others, but restrictions based solely on mental illness is not).
* Assure that gun restriction is based on probable cause related to a threat to self or others.
* Mandate that probable cause for gun restriction be based on an individualized assessment of risk of violence and never solely on the presence of mental illness.
* Mandate that individuals whose gun-related rights have been restricted have a legal recourse for restoration of those rights.

4. Ensure confidentiality in the physician-patient relationship.
* Assure that gun violence, threat management, and gun safety issues be included in curricula for medical school and residency.
* Mandate that physicians be free to inquire about access and use of guns with their patients.
* Mandate that reporting requirements be clear and limited to specific, identifiable, imminent risk to self or others.

20 years after Columbine, looking for a way forward in a world of mass shootings and suicides, I am appreciative of the courage for CPA to stand strong on gun violence prevention advocacy.

Call to Action on Firearm-Related Injury and Death in the United States:
https://annals.org/aim/fullarticle/2748085/firearm-related-injury-death-united-states-call-action-from-nation

APA Condemns Loss of Life from Gun Violence, Disputes link to mental illness:

https://www.psychiatry.org/newsroom/news-releases/apa-condemns-loss-of-life-from-gun-violence-disputes-link-to-mental-illness

CPA Policy Platform:

https://docs.wixstatic.com/ugd/86eb1f_51bf26445011482e92a908f12a5ffd0f.pdf

Mann et al., (2016) “Prevention of Firearm Suicide in the United States: What Works and What is Possible”, American Journal of Psychiatry, 969-979, 173:10

Welcome Back. The work has just begun.

By: Matthew Goldenberg D.O.

SCPS Newsletter Editor

Welcome back. Many of you took summer vacations and now find the kids getting back into the swing of a new school year. Those without young children at home, you are simply enjoying the increased traffic, as schools around LA get back into session. The SCPS Council is also getting back into session after taking two months off for summer.

In July, I wrote an article on my experience and reflection after watching the new film miniseries *When They See Us.* I am so appreciative, that Dr. Curley Bonds, our former SCPS President, took up my request to expand the conversation around race and psychiatry. His very personal and very timely article is included in this month's newsletter. I hope you find it illuminating and take some time to reflect how race impacts your work and our field as a whole.

Additionally, you will find my interview with current SCPS President, Dr. Erick Cheung. This is the first of this year's series of interviews to help you better get to know your SCPS Executive Council.

So welcome back!

For the SCPS, this year is just beginning. I am excited for what lays in store for the SCPS and the SCPS Newsletter for the 2019 to 2020 year!

Best,

Matthew Goldenberg D.O.
SCPS Newsletter Editor
Secretary (2019 – 2020)
Email: docgoldenberg@gmail.com

Important Notice About Your Dues

We hope this message finds you well, and we want to thank you for your support of the Southern California Psychiatric Association (SCPS) and the California Psychiatric Association (CPA). This pair of organizations serves as your voice on important matters at the local and state level, and they work together with the American Psychiatric Association (APA) at the national level.

We write to inform you of a change in billing format. You will notice that your 2020 dues statement from the APA no longer reflects the dues collected to support the California Psychiatric Association (CPA). The CPA has received a portion of your District Branch (SCPS) dues that has been specifically earmarked for state-level activities, including advocacy, education, and judicial and policy action in California.

The dues for the CPA will now be billed directly *. Therefore, you will be receiving three separate statements for dues, one each for support of SCPS, CPA, and APA. We apologize for the inconvenience that multiple billings and payments causes our members, and we are actively exploring ways to reduce this in the future.

*Residents are not assessed any fee for CPA.

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Get to Know Your SCPS Board

By Newsletter Editor
Matthew Goldenberg D.O.

This part of an ongoing series of interviews with members of the SCPS Executive Council Leadership. My hope is that this will allow our members to get to know their leaders. May a better understanding of the history of SCPS and how our leadership got involved, inspire a new generation of future leaders to join and become active on the council.

For the September 2019 edition of our newsletter, I have the pleasure of presenting my brief interview with President, Erick Cheung M.D. We hope you enjoy getting to know a little more about your SCPS Council.

President, Erick Cheung M.D.

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

Well, I hope this isn't too cliché. In college, I was majoring in the fields of neuroscience and psychology. That itself didn't really dictate that I was going to be a psychiatrist, I thought about being a teacher, *maybe* a neurologist or a neurosurgeon (just to be cool), but honestly med school sounded like a pretty awful idea. Then I went to Paris for a half year, where I was studying Surrealistic Art and Poetry. Turns out this is what really ignited my fundamental interest in the human condition… what is free will? What is truth? What is mind and what is body? Where, how, and what is human consciousness? In my senior year at UCSD, I went on a goose chase writing a full-blown undergrad thesis on human consciousness… and the rest is history.

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

Before going to medical school, I worked for some psychiatrists in an outpatient office, doing the dirty work like prior auths, calling med refills, hounding insurance companies for payment. I remember one of the docs working 10-hour days, doing 15 minute med management visits, never taking a lunch, maybe just stopping here and there to eat a spoonful of peanut butter and some red vines that one of the drug reps had dropped off. I thought that was entertaining and pretty wild, but it was really my first impression of psychiatry. By the way, I still despise doing prior auths.

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

I am a full time faculty member at UCLA Department of Psychiatry in Westwood. I was lucky to inherit the role of Medical Director of Psychiatric Emergency Services pretty much straight out of residency. Two years ago, I began transitioning to do more work for the Resnick Neuropsychiatric Hospital, taking on the role as Chief Quality Officer, then later Associate Medical Director. I'm fortunate to work with a tremendous group of people who are all extraordinarily talented and dedicated to patients, clinical excellence, and teaching. I have a roughly 40% outpatient practice, and by far, my most enjoyable clinical work is the individual psychotherapy that I do weekly, mostly in a transference-focused framework.

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

I joined the board of SCPS when I was a resident, and have been in various positions ever since then. My engagement with organized medicine goes back to medical school, when I experienced the birth of my social conscience. Our country was at war in Iraq, Howard Dean was running for President, and pretty much in the second week of med school a fire was lit in me. I started leading grassroots activism and medical student campaigns for universal healthcare. The point was to do something to address the crisis and plight of the uninsured. We marched on the capital of New York with a 70-foot long banner (went to school right down the street at Albany Medical College), and I remember almost getting arrested by some NYPD mounties (horse mounted police officers) for unlawful assembly.

So, I grew up a bit, and got elected to serve as the medical student chair to the Association of American Medical Colleges, on a platform of access to care, and later working on issues of conflicts of interest, criminal background checks, medical school indebtedness, NRMP data, and other issues. Ever since then, I have had a deep understanding and appreciation for organized medicine and the critical role that it plays in advocating for our profession and our patients.

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

We (American society) just spent the last 60 years de-institutionalizing patients and shutting down psychiatric hospitals. There were legitimate wrongs to right, back then. But now we are bearing the consequences, with an utter lack of sufficient acute care resources to address patients in mental health crisis and emergencies. Patients languish in emergency rooms for days, vying for an ever-shrinking number of hospital beds. Worse, for those beds that do exist, my personal impression is that the average standard of care leaves much room for improvement. In the next 20 years I hope that we will have hit the low point, such that we will see a re-building of acute care and long term care services that deliver high quality / high value care, within a mental health and legal system that truly supports it.

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?

You can't save time, you can only spend it. Spend it wisely. (B. Hoff , The Tao of Pooh,)

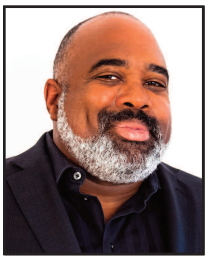
7) Surprise me. What is something we didn't know about Dr. Erick Cheung?

I'm addicted to surfing. You're an addiction psychiatrist, what do you have for me?

Featured Article

Race and American Psychiatry

By Curley Bonds, MD, DFAPA



Now that I am working fulltime as a public sector psychiatric administrator with a daunting array of duties and responsibilities, I'm frequently asked "Why do you still do private practice?" The question usually comes from friends and colleagues who worry about my mental wellbeing and fear that I'm overworking. When Dr. Goldenberg asked me to write a companion piece to his article about the Central Park Five [*Southern California Psychiatrist,* July issue 2019] , I readily agreed. While collecting my thoughts I realized that the primary reason I still travel to Westwood every other Saturday to do med checks and psychotherapy is that it *helps* me to maintain my sanity. I spend my work week trying to help restructure and create a new level of responsibility and accountability in the largest public mental health system in the country. This is a Sisyphean task - so it helps to spend time providing care that also allows me to do advocacy at a grassroots level. The words that follow are my attempt to explain how this works.

At least once a month I receive a request from a distressed family seeking something very specific - an African American psychiatrist to help them intervene with their young son or daughter in the throes of what they perceive to be a mental health crisis. The stories that they tell are strangely predictable. The common denominator is that they have witnessed themselves or been told by an instructor/coach/neighbor that their child is exhibiting unacceptable behaviors that put them at risk for everything from school expulsion to incarceration. In the worst of these scenarios their loved one has already had an encounter with law enforcement that invariably did not go well. Their worst nightmare is to have their child become the next opening story on the evening news, another young Black suicide/homicide-by-cop statistic. (One need only watch or read the press regularly to realize that their fears are not delusional). In many cases they have already attempted to access mental health treatment, but the outcomes have been disappointing. They are sent on an endless goose chase by their insurance company as they attempt to find providers who are 'in network' who accept their coverage. Those who have the financial resources to afford a private psychiatrist quickly learn that the number of African American psychiatrists even in a booming metropolis like Los Angeles is very small. The most recent statistics available suggest that only about 2 percent of American Psychiatrists self-identify as being of African descent. If you apply this statistic to the roughly 1000 active SCPC members, one could estimate that about 20 would are Black. When you subtract those of us who have positions that are mostly administrative, academic or institutional – the number of APA affiliated African American psychiatrists available to see private patients can practically be counted on one hand.

One might question the necessity of having culturally congruent psychiatric treatment. Arguably any psychiatrist can treat any patient provided that they share a common language and possess basic diagnostic and treatment competencies. But another perspective is that we all harbor unconscious biases that may cause us to prejudge individuals with backgrounds different than our own resulting in suboptimal care. A clear example is the research (replicated multiple times) that African Americans are over diagnosed with schizophrenia and other psychotic disorders than other ethnic groups presenting with the same constellation of symptoms. African Americans also tend to receive higher doses of antipsychotic medications than whites despite the fact that they may be at greater risk for untoward side effects like tardive dyskinesia. It is hard to pin these findings on blatant racism, but they do point to institutions that have allowed systemic discrimination to persist.

There are multiple unmeasurable or difficult to measure aspects of care that contribute to treatment adherence and outcomes like countertransference, comfort with disclosing private or embarrassing secrets and the ability to efficiently communicate using culturally specific language without having to provide subtitles. As an example, if a patient tells me that they grew up in Baldwin Hills, belong to an AME Church, pledged Delta Sigma Theta at Spellman and that they participated in Jack and Jill social clubs as a child – I instantly know volumes about their

values, socioeconomic status and robustness of their social network. These things are impossible to learn by completing a mandatory 2 hour CME course on so-called cultural competence or unconscious bias. My treatment plan, crafted with the patient's input, will incorporate culturally relevant elements that others might overlook. By these statements I do not mean to imply that only Black psychiatrists can be effective providers for Black patients. But I would strongly argue that for some, they are much more likely to seek care, remain in care and benefit more from care if their doctor or therapist share a similar cultural and ethnic background.

In 1999, Surgeon General Dr. David Satcher produced a groundbreaking report on Mental Health in our country. His report highlighted the fact that despite many efforts to reduce disparities, the ability for African Americans to access mental health treatment is far below their non-Black peers. Sadly, twenty years later, this situation remains unchanged. A primary reason for the inequity is the failure of American medical schools and psychiatry residency programs to train a sufficient number of psychiatrists and other mental health professionals to meet community demands of underserved minority communities. Evidence has shown that institutions like Charles R. Drew, Morehouse and Howard that have missions dedicating them to train minority physicians do indeed produce more doctors who practice within the safety net. Since 1969 the Black Psychiatrists of America (BPA) has created a space for political activism and provided a platform supporting academics who have dedicated their careers to teaching and research focused on Black patients. The founders of this organization saw a need for a group focused on the priorities of the African American community in a way that the APA did not. The election of Dr. Altha Stewart as the first African American president of the APA coincided with the 50th Anniversary of the BPA and was a shining moment of optimism for our field. While attending the annual meeting in San Francisco I appreciated the increased volume of sessions dedicated to the notion that the APA can and should do more to highlight and address health disparities among underrepresented populations.

While we have advanced in many ways towards parity and equality in access to care and training, the number of African Americans entering our specialty still lags behind where it should be. Programs like the APA Minority Fellows Program and The APA Black Men in Early Psychiatry Mentorship Program (BMEPP) encouraging African American male undergraduate students to consider careers in psychiatry. These programs help to reduce some of the barriers that contribute to the low percentages of African American psychiatrists. They are much needed, especially as senior psychiatrists retire or pass away. A notable recent loss to our field was Dr. Carl Bell who devoted his career to issues relevant to the African American community like the impact of interpersonal violence, trauma and fetal alcohol syndrome. Dr. Bell was well known for raising the alarm bell through his insightful lectures about how risk factors that impact Black Americans were tempered by protective factors like strong families, spirituality and appropriate mental health care.

The challenges facing African American patients cannot be addressed solely by minority providers. If we are to move forward towards the ultimate goal of closing the health disparity gap, we need all hands-on deck. The first step in this direction is awareness and education for all of us so that we can come together as a profession to take a stand that racial discrimination in any form is unacceptable. Advocacy is an important but underutilized tool that may at times require us to navigate territory outside of our comfort zone. One key question that we should all ask ourselves is "What am I doing to create access and safe spaces for patients of all backgrounds?"

Committee Corner
Newsletter Committee

The SCPS Newsletter has long been a monthly tradition of the SCPS. Originally in print form, the newsletter has become fully digital in the past few years. Members receive a monthly email with a link to the Newsletter. Articles range from psycho-pharm updates, case reports, book and film reviews to articles on varying topics across the field of psychiatry. The newsletter is not only a source of original content and a way for the SCPS Council to disseminate information, paid advertisements also generate income for the SCPS. Matthew Goldenberg D.O. is the current newsletter committee chair and serves as Newsletter Editor. While the Newsletter Committee is a relatively inactive committee at this time, the SCPS Newsletter is always looking for article contributions from members and non-members alike. If you are interested in contributing an article, which can have been previously published (with permission to reprint), please contact Mindi or Dr. Goldenberg directly.

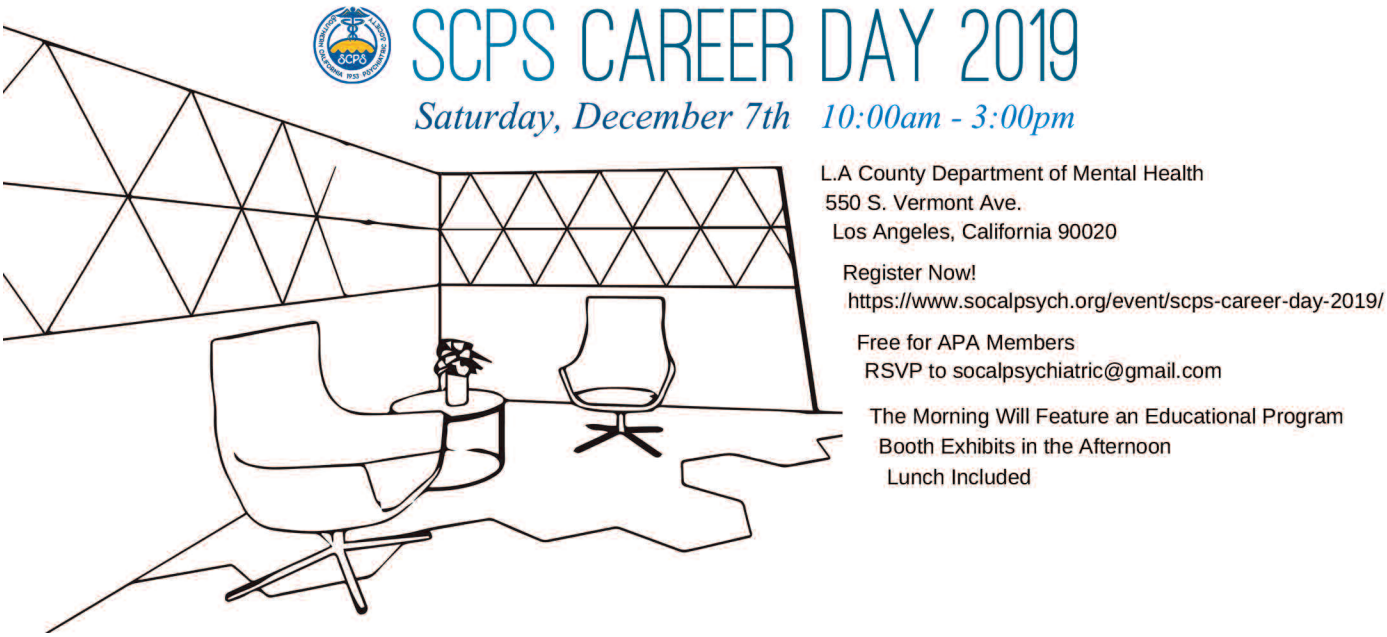
Community Medical Events in Southern California

By Kavita Khajuria, MD

Medical Camps were recently held in Riverside and Los Angeles counties in March and July respectively, facilitated by a volunteer medical group and the respective cities - intended to serve the Norco-Corona and Huntington Park communities.

Inauguration ceremonies initiated the events, including words from leaders of various faiths; the latest one in July followed by an appreciation speech by the Mayor. Numerous community members of all ages arrived early, and were registered by well organized groups of student volunteers. Medical doctors from different parts of southern California volunteered their various services, including primary care, internal medicine, endocrinology, cardiology, pediatrics, and psychiatry; other specialties included dental services, ophthalmology, women's care, and adult & child nutrition. Community volunteers included high school and college students, general members, and retirees. These events were well organized - volunteers and runners actively engaged to assist throughout the day. Breakfast and lunch specialty buffets were donated and served by volunteers, some of who had spent up to 2 hours to commute to the event.

Spanish translators were readily available on hand (mostly college students), and mental health lectures were provided by a psychiatrist - topics included depression, anxiety disorders, suicide, stress resilience, and emotional resilience. These were well received and triggered interest, causing some to engage in discussion, or inquire for assistance, additional information and resources. Local mental health resource information was provided, as well as referrals, national hotlines, and APA brochures on mental illnesses, substance use and teen suicide. Notably, topics of interest from the community primarily included anxiety, depression, PTSD, suicide and resilience. These events were well organized opportunities to serve the needs of the communities.



The Problem With Calling Our Experience “Moral Injury” and “Human Rights” Violations

by: Torie Sepah, M.D.

previously published on Kevin MD and MedPage Today

It may be surprising to some that I am writing this piece as I am viewed as a staunch physician advocate. In 2017, I was stunned after a beloved classmate from medical school took his life. I felt I had let him down by missing signs of distress — dismissing them because he was a “doctor” and not one of my psychiatric patients. The void he left behind felt greater somehow than the loss of one person — there was a multiplier effect. He was a classmate, a veteran, an exceptional human being, and an ER physician.

While we will miss Jason, how many patients will miss the opportunity of having this wonderful physician? It is estimated to be 3,000 patient contacts per year. Wow. Just wow. Somehow a plaque to honor Jason in the halls of our medical school didn’t seem like enough given the implications of this loss and the sense that it was preventable.

I decided to honor Jason by providing what I should have for him — a sense of community. I started a Facebook group, “Physician to Physician: Healing the Practice of Medicine,” for physicians to have a safe, private place to share their experiences — peer-to-peer — as a way of trying to reduce the isolation and, along the way, address physician burnout syndrome from our perspective — not from what is prescribed to us as our malady.

And two and a half years and 2400+ members later, we have indeed built a community. I believe we have learned more about our condition — we have learned how to define the words used to describe our experiences, including “burnout” and “wellness” as language is powerful in what it ultimately reinforces, minimizes and to whom it assigns blame.

Maybe I am unusual in that I have heard the stories of hundreds of individuals who have experienced human rights violations. My one year working at the medical center at an ICE detention center brought with it a daily dose of meeting people who had escaped atrocities I had only read about — and some I never had. From female genital mutilation and the sequela (severe scarring, pain) to being trafficked as a sex worker (being moved from country to country and forced to have sex with up to 20 men a day) — these are human rights violations.

I have heard the argument that our suicide rate — 2.2 times that of the general population — is the basis for the human rights violation claim.

Suicide is a serious problem that needs to be addressed in our profession. Suicide has also peaked at a 50-year high in the U.S. contributing to the lowering of the life expectancy for Americans in 2017 for the first time since World War II. It is the second leading cause of death for teens and the fourth leading cause of death for women between the ages of 35-55. Do we declare those populations as undergoing human rights violations because enforcement of the mental health parity law of 2010 is lackadaisical, therefore, limiting access? Where does one draw the line? I have a difficult time assigning “human rights” violations to my own demographic because of our suicide rate but ignoring other demographics — including inmates who are literally captive.

And why is the term “moral injury” problematic? Besides being amorphous, it is used in conjunction with, “there is no physician burnout, it is moral injury.” The old adage, “don’t throw the baby out with the bathwater,” comes to mind. It is undeniable that our profession is suffering, yet that does not mean physician burnout syndrome doesn’t exist.

In fact, if it weren’t for those of us who have contributed to compiling data to legitimize physician burnout, the term

wouldn't be part of the vocabulary as it is now.

When I did a study on physician burnout as a resident in 2012, I had to explain what I was studying and why multiple times. This topic was new and quite controversial.

Since then, a great deal of effort has gone into building a foundation for understanding what physician burnout is (it is not "stress," nor it is the opposite of "wellness" — it is a syndrome defined as having three characteristics: emotional exhaustion, negative feelings about patients and a sense of low personal accomplishment).

This syndrome is measured using a validated tool — the MBI. Physician burnout even has identifiable causes, the most notable being loss of autonomy and EMR. We even have identified evidence-based interventions with peer-to-peer support in the form of groups — ideally one hour during the work week being the one with the most evidence supporting it. Recently, new studies show an impact with the use of scribes as well as leadership style.

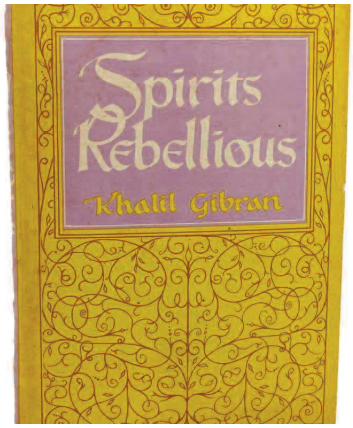
Physician burnout syndrome does not improve and is not preventable with mindfulness training (research shows that stress can be reduced, but not physician burnout). There is also no evidence that becoming more "resilient" as physicians reduces our burnout rates. Change needs to occur bi-directionally.

Yet dismissing this entire phenomenon and calling it "moral injury" removes the opportunity to generate change at the institutional level. Instead of walking into a boardroom and discussing the integration of scribes as a viable intervention, one would propose the problem of "moral injury" and "human rights violations" for the agenda?

What would be the potential interventions? Moral healing and a UN referendum?

And therein lies the dilemma — sounding alarms without identifying a clear pathway to safety. Physicians will be in a state of panic when it behooves us to be productive, sitting on boards, joining committees, applying for directorships, for example. We can't be heard unless we have a seat at the table. And if we expect to be heard, what we say needs to be clear and precise.

Spirits Rebellious
By Khalil Gibran
The Philosophical Library, Inc.
Copyright 1947. Initial publication 1908.
130 pages
$12.50 Hardcover



Book reviewed by Kavita Khajuria, MD

"..Shall we meet evil with evil and say this is the Law?.."

Upon initial publication, 'Spirits Rebellious' was burned publicly in the Beirut marketplace by enraged officials. Gibran himself was exiled, only to be welcomed back later. The three parables contained herein were an expression of his unabashed anger and calls to justice. 'Madame Rose Hanie' outlined painful complexities of love and life, and 'The Cry of the Graves' called on the rules of human society at the time. 'Khalil, the Heretic' navigated atrocities and exploitation of the common man, with a rallying appeal for social justice. Gibran challenged and rebelled against societal laws and injustices in the call for a higher universal perspective, and poetically portrayed his views on hypocrisy and corruption. A deceptively small book, 'Spirits Rebellious' reveals critical thinking with a powerful and fearless social commentary.

Kahlil Gibran (1883-1931) was born in Bsharri in the Ottoman Empire, north of modern day Lebanon. He immigrated to the U.S at the age of twelve, where he studied art and began his literary career, writing in both Arabic and English, and took part in the New York Pen League, also known as the "immigrant poets" (Al-Mahjar). Gibran is regarded as a literary and political rebel in the Arab world, and is well known as a literary hero with a romantic style.

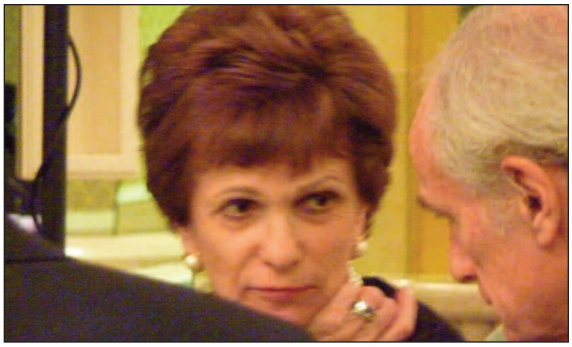
Welcome to the Next Installment of SCPS Flashback Photo Gallery

Meeting in SCPS' conference room.

Chris Benson, M.D., and Larry Gross, M.D., Installation and Awards early 2000s

More on next page

Sanford Weimer, M.D., Kimi Mann, Mayor Tom Bradley, and Maria Lymberis, M.D.



Kitty Dukakis and Ronald Thurston, M.D., 2013.

ALL EDITORIAL MATERIALS TO BE CONSIDERED FOR PUBLICATION IN THE NEWSLETTER MUST BE RECEIVED BY SCPS NO LATER THAN THE 1ST OF THE MONTH. NO AUGUST PUBLICATION. ALL PAID ADVERTISEMENTS AND PRESS RELEASES MUST BE RECEIVED NO LATER THAN THE 1ST OF THE MONTH.

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