Southern California

PSYCHIATRIST

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President's Column

Comfortably Numb

Erick H. Cheung, M.D.

Hello… Hello… Hello?
Is there anybody in there?
Just nod if you can hear me
Is there anyone at home?

(The Wall, Pink Floyd)
© 1979, Gilmour/Waters

Sitting in this chair, a little dazed from endless hours of video conference calls, I'm ready to pen my final presidents' column. I find myself reflecting on this moment in history, and I am searching for an emotional soundtrack that matches this feeling. It's like a feverish delirium. A detached frenzy…. this fight against an invisible enemy, the Novel Coronavirus. Panic and fear streaming through the radio and TV. Right now, there is a building intensity somewhere out there, just beyond the curtain. Most are keeping calm as we ready the stage, waiting on edge for the storm to roll in, waiting for the curtain to lift and the show to really get started, dreading the surge. What a year it has been, and much as I wish we were parting on a high note, Comfortably Numb… seems to sum it up for me right now.

This virtual reality is a necessity of life for now. I'm virtually there with my patients, my colleagues, and my relatives. I find it truly remarkable to think that in a matter of a few weeks (or less) many psychiatrists and other physicians could convert outpatient practices to a video-based enterprise. My patients have adapted surprisingly well to this change, and I am frankly surprised how much I have adapted as well. At the hospital where I work, we have rapidly revised workflows to deploy tele-psychiatry in the emergency department and consultation liaison service, which helps minimize exposures and minimize the burn rate of masks, gowns, and gloves; and deterred visitors to keep infectious vectors away. We are preparing for what seems like the inevitable wave of psychiatric illnesses that will be worsened by this public health disaster.

In This Issue...

This sheltering in place, this state of “lockdown” and social distancing, is too much isolation for some of our patients. The excess time breeds destruction. And I worry about the loss of jobs and housing that will hit like an aftershock lasting far beyond the initial crisis.

I’m looking for the silver lining… and I think I see some. The streets are filled with 6-ft-spaced-out kids on bikes, dogs on walks, babies in strollers. Never seen so many people rule the streets. There’s an inspiring atmosphere of collegiality among us, among the healthcare workers, as we pull together to get this job done. And, on the weekend, in the spaces in between zoom conference calls, I start to feel the slow life – we aren’t planning anything, we aren’t going anywhere for now, no karate practice, no waves to catch, no dinner reservations, babysitters, or barbeques. Be strong. We are here.

A Physician's Creed (in 2020)

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

In March, we had two featured articles. The first by Dr. Thomas Strouse, "Cannabinoids in Psychiatric Practice". Dr. Strouse cut through the noise and helps us to understand what the current data actually shows about using cannabinoids in our clinical practice.

The Second, by Dr. Janet Charoensook looked at hot topics regarding how marijuana is impacting our patients, specifically adolescents. I want to again thank both Dr. Strouse and Dr. Charoensook for their contributions!

This month, our featured article is a clinically useful article by Dr. Shannon Suo, "When Less is More: Psychiatric Perspectives on 90 day Prescriptions". Have you struggled with what to do when your patient's insurance company requires a 90-day script? Is it safe to comply? Is it clinically appropriate? This article covers all the important perspectives and considerations.

Another article I want to highlight in this month's newsletter is from Dr. Danielle Chang about LA County's efforts to combat Covid-19 , resources and ways for psychiatrists to get engaged.

This month, I want to share my thoughts and hopes that all of you and your families are staying safe during this unprecedented time. Many psychiatrists in private practice have gone to fully remote visits via secure video. While others, working in hospitals and clinics continue to serve on the front lines.

The following is a poem I wrote for our colleagues and our profession.

A Physician's Creed (in 2020)
A Poem by Matthew Goldenberg D.O., Psychiatrist

As students we studied and prepared for a journey,
We were tested and we sacrificed while we reached for our dreams,
We were donned with a white coat, before we had the means.

We took an oath, to do no harm,
Learning on Rotations and making our families proud,
We experienced primary care to medical specialties,
Some of us had a white and others had a black cloud.

In residency we honed our skills, and became the experts,
Nights and weekends, away from our families,
And Burdened with student debt,
So close to reaching our dream and little time for regret.

Next we found our place and established our Practice,
CME, MOC and Self-assessment, at times it felt like harassment.

We went into medicine to change lives and make a difference,
And then insurance, electronic medical records, and bureaucracy took hold,
Now nearly 50% of physicians have experienced burnout,
We endure never ending sacrifice for our patients,
And continued time away from our loved ones,
And no one but ZDogg MD has stood up for us, but at least that is someone.

Hospital administrators making a fortune,
Ruling from their ivory towers,
Now they call us to work without PPE and other essential safety gear,
Almost as if they think we have nine lives or aren't human and do not experience fear.

We find ourselves suddenly on the front lines,
And in the fight of our lives,
A failure of leadership, delays and an ongoing series of follies,
All while we fight side by side with our PA, NP, Nurse and technician colleagues.

Where are the masks?
Where are the face shields?
Despite these great odds,
The physician never yields.

There will be many injured,
But no purple hearts will be awarded.

There will be acts of valor,
But not one of us will receive a Silver Star.

Some of us will die,
But there will be no military type funerals with honors,

We will leave behind our children and our spouses as widows,
We might even bring the illness back to our homes,
But there will be no national memorials, holidays in our honor or salutes during Superbowl pre-game shows.

We didn't go into medicine to go to war and die on the front lines,
And when return, many will have wounds,
But there will be no discounts with a medical ID,
Many of us were never even trained for a pandemic of this kind,
So how can this be?

My brother and sister physicians we are fighting the greatest fight of our lives,
Be safe and be well and take care of yourselves,
There will be no hospital administrators in the tents or even in sight,
We alone are on the frontlines, fighting this fight.

Our profession, our patients and our practice of medicine can and never will be the same,
When we return from the front lines,
Let's take back the administration of healthcare,
We have been malleable and tried to heed the advice to improve our wellness,
So we did yoga and practiced mindfulness,
But this has done little decrease our burnout or our levels of stress.

But the culture of healthcare is diseased to its core,
Our patients are dying and now so are we,
Elected officials and political leaders are either with us or against us,
and we must start keeping score,
We need our physician leaders to stand up,
Our medical associations and professional societies need to fight for us to reach this new shore,
and we all need to say enough is enough,
Our lives are on the line and we can wait no more.

Here are some resources to Support the Health and Well-Being of Clinicians During COVID-19: https://nam.edu/initiatives/clinician-resilience-and-well-being/clinician-well-being-resources-during-covid-19/

How is your practice affected by the pandemic and need to social distance?

How are you staying busy and safe during these unprecedented times?

What you are you facing on the front lines?

Please write in and we will do our best to share your thoughts in the May newsletter.

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

When Less is More: Psychiatric Perspectives on 90 day Prescriptions

by: Shannon Suo, MD, DFAPA

Author's note: this article was written prior to the major social, economic, and political changes related to the current healthcare crisis. Minor modifications were made to acknowledge our current state. I apologize if anything remaining seems anachronistic.

How many of you have received a fax from a pharmacy or a letter from an insurance company requesting/requiring that you change a prescription you wrote for a 30 day supply of medication to a 90 day quantity? In some cases, maybe you said, "okay, that seems reasonable—the patient has been stable on this medication for several years, the dose is unlikely to change, the patient is reliable, and it's not a controlled substance." But in psychiatry, the very nature of the disorders that we treat in patients often results in an unpredictable and unstable course, intermittent crises, and use of medications with narrow therapeutic indices that make the usage of medications simultaneously critical and dangerous, especially when available in large quantities. This highlights the importance of making sure that people who prescribe these medications are appropriately trained in physiology, anatomy, and pathology, in addition to psychiatric wellness and illness, and pharmacology and specifically psychopharmacology. And as experts in medicine and psychiatry, we need the right to make the clinical decision for our individual patients about whether a 90 day supply of medication is appropriate! The 2012 APA Position Statement on Banning of Pharmacy Benefit Management Policies that Require the Provision of Dangerous Quantities of Medications supports that right, stating, "Pharmacy Benefit Management companies should offer prescribing physicians flexibility in determining when dispensing of an entire 90-day supply of a medication is clinically dangerous, and should offer alternatives that would enable dispensing a 90-day supply in multiple shipments without financial penalty."

There are many factors motivating patients, pharmacies, and insurance companies to move towards 90 day prescriptions that may be obvious: fewer trips to the pharmacy, fewer/lower co-pays, fewer dispensing episodes (and risk of error). In the current pandemic, you may have to weigh the risks of your elderly patient with underlying lung disease going to the pharmacy more often vs. the risk of overuse/overdose. (Note that many pharmacies have drive-thru and delivery options at no extra cost.) A retrospective study of nearly 53,000 Medi-Cal patients obtaining prescriptions for statins/antihypertensives/SSRIs/oral hypoglycemic medications at Walgreens in 2010 found that adherence was 20% higher in the 90 day group than the 30 day group and the 90 day group resulted in a minor savings in "wastage" (medication left over due to changes in prescribing, discontinuation/poor adherence, repeat/auto fills before actually out, etc.). Persistency (staying on the medication for the intended length of time prescribed) was 23% higher in the 90 day group as well, and the difference was greatest for SSRIs. (Taitel, M., Fensterheim, L., Kirkham, H., Sekula, R., & Duncan, I. (2012). Medication days' supply, adherence, wastage, and cost among chronic patients in Medicaid. Medicare & medicaid research review, 2(3).) So there is evidence that 90 day prescriptions are better! But that's on the aggregate, and they only studied SSRIs. What about tricyclic antidepressants? Antipsychotics? Mood stabilizers? Benzodiazepines?? And what about patients with intermittent suicidal ideation and/or impulsivity, experiencing homelessness (higher risk for loss/theft), or cognitive problems? Those patients are often deliberately excluded from studies, so we may never have evidence on those groups.

In researching this issue, I came across some even more alarming information: "How Chaos at Chain Pharmacies Is Putting Patients at Risk," published in the NY Times on Jan 31 of this year shines a spotlight on a dark underbelly of insurance and pharmacy practices. I recommend everyone read it, but the high (low?) points are: pharmacies are understaffed and making more mistakes now than in the past (patients receiving the wrong medication), pay/bonus pay for pharmacists is contingent on how many prescriptions they convert to 90 day supplies, and pharmacies are sending refill requests to physicians' offices that are not initiated by patients so they can bill for another prescription! The result is not only putting patients at risk for overdose, both intentional and unintentional, but inundating physicians' offices with unnecessary refill requests, taking up cognitive space and time to consider and respond, taking away from patient care.

The WSJ commentary, “The 90 Day Prescription Isn’t for Everyone,” published Feb. 6, documents Brian Barnett’s (an inpatient psychiatrist) experience with taking care of patients who have been admitted after intentional overdose. He describes the 3-fold increase of intentional OD in 10-15 year olds from 2010 to 2018. (Spiller, H. A., Ackerman, J. P., Spiller, N. E., & Casavant, M. J. (2019). Sex-and age-specific increases in suicide attempts by self-poisoning in the United States among youth and young adults from 2000 to 2018. The Journal of Pediatrics, 210, 201-208.) He reiterates the problem of psychiatrists fighting the 90 day request as taking away from patient care and the frustrating result of sometimes being denied anyway. According to Dr. Barnett, in West Virginia and Ohio, pharmacists can convert a 30 day prescription to a 90 day at their own discretion. Rest assured, the CPA would fight any such law proposed in California!

On the other hand, blister/”bubble” packaging in limited quantities, a tool which many psychiatrists use to limit patient access to large quantities of medication, simplify medication administration in complicated medication regimens or patients with cognitive impairment, and improve adherence, was shown in a VA population to not increase costs to the overall health system compared with dispensing as usual in 30 or 90 day comparator groups. (Lavigne, J. E., Falbo, K., & Gutierrez, P. M. (2019). Cost–utility analysis of blister packaging all outpatient medications for veterans with bipolar disorder, major affective disorder, post□traumatic stress disorder or schizophrenia. Journal of Pharmaceutical Health Services Research, 10(4), 401-406.) Curiously, costs associated with medications was not significantly different between the two groups, either. The study was not powered to detect changes to rates of suicide attempt. What this means, however, is that the practice of prescribing blister packs does not increase costs to the overall healthcare system as may be assumed! Futhermore, in the UK, studies limiting the quantity in packages of paracetamol (acetaminophen) have suggested reductions in suicide attempts. (Hawton K, Bergen H, Simkin S, Dodd S, Pocock P, Bernal W, et al. Long term effect of reduced pack sizes of paracetamol on poisoning deaths and liver transplant activity in England and Wales: interrupted time series analyses. BMJ. 2013;346:f403.) The increased effort and time associated with having to punch pills out of the blisters has also been hypothesized as a deterrent and potential interruption to impulsive suicide attempts. In Sacramento we have pharmacies that deliver blister packages *weekly* at a physician’s direction at no extra charge to insurer or patient.

As experts in the field of mental health, management of risk of self-harm, and the parties who prescribe medication to patients, psychiatrists should retain the right to determine what is safest for our individual patients, be it blister packs, 30 day bottles, or 90 day bottles. The APA and CPA support that right. Continue to consider your patients’ best interests and act as an agent for them. Let the CPA know if your PARs are being denied by particular insurance companies consistently without justification. In some cases 90 days may be a good choice, but when it’s not, refuse the request. And if it’s denied, ask to talk to the decision-maker at the insurance to argue your case. Sometimes this is a pharmacist, sometimes it’s a physician (fodder for another article). Maybe you’ll have time to do it in the opening created in your schedule by the patient who was hospitalized after an overdose on a 90 day prescription…

What a Difference a Week Makes

By: Vivian Tang, MD on 3/22/20

As a fourth-year psychiatry resident at Harbor-UCLA, I can't really recall a week during my training when so many changes occurred in such a short amount of time.

During my overnight shift in the county Psych ER last Sunday, not much seemed to be different besides having to don a surgical mask to screen patients who were coming in via ambulance and the police. However, when I interacted with my medical ER colleagues, there was a sense of dread and anxiety in the air. One told me she would get to my consult once she "figured out this patient who might be a COVID-19 train-wreck." Another was donning a purple mask that he seemed to have brought in from home as he screened "patient's under investigation." The realization that COVID-19 wasn't just some other country's problem but at our hospital's doorstep resonated with me. Post-call, I tried to sleep but could only manage to get a few hours. I woke up the news that the Bay Area was to "shelter in place" and that most schools in Los Angeles had closed. I turned on my phone and looked at various "telehealth" trainings I had to complete before going into the VA the next day. Before I started doing that, I called my dad, a 68-year-old family practice physician in Riverside and expressed my concerns that he was still seeing patients. Given his age and that my mom has multiple medical conditions, I asked if there was any way he could turn his appointments into phone or video appointments. He was resistant at first but we finally came up with some easy changes he could make. I urged him to protect himself, his employees, and the community at large.

On Tuesday, I parked at the Long Beach VA campus at 7:30 am prior to the suboxone clinic opening at 8:00 am where I am doing a year-long elective. It took me 20-30 minutes to find the one entrance that was allowing both employees and patients enter where I was screened for COVID-19 symptoms and given a special bracelet. In addition to seeing patients in the clinic, I worked that morning to configure a webcam on my desktop and finish my telehealth training so that patient appointments could be moved to video chat. When I got home, I went to the grocery store with my boyfriend where the only meats available were packages of bacon and whole turkeys.

On Wednesday, I was unable to call into a conference call remotely so I did my best to text my co-chief resident who was able to be part of the meeting. At the same time, my roommate was on another conference call and found out she would be laid off. My boyfriend and I tried to calm her nerves as she worried about health insurance, paying the rent, and affording basic necessities.

On Thursday, I was surprised to get a voicemail from a long-time patient of mine asking me how I was doing and wishing me well. I sat in my office with the door closed trying to socially distance myself as I ate the bacon sandwich my boyfriend packed me due to his/my concern that I may get sick from the cafeteria. I then participated in a department-wide conference call with our chair, program director, and residents who brought up concerns about screening in the psychiatric emergency room, having enough PPE, and isolating vulnerable psychiatric inpatients. When I went home that night, the governor of California issued a "shelter in place" order and all non-essential businesses in our state were closed.

On Friday morning, I drove to work on an almost empty 405 freeway. I had always wished for no traffic on the 405 but not like this. When I got to my office, I started doing telephone visits with my patients. I stayed on the line while one patient who is currently homeless made his way through a ransacked 99 cent store to only find a package of sugar-free cookies. As he attempted to eat a cookie (due to being hungry), he started choking/coughing and was promptly asked to leave the store by personnel. He reassured me he was okay before I hung up but I couldn't help but be concerned about how he would fair in the coming weeks without a place to stay. Thereafter, I received several texts and an email about the medical students who had matched to our program. To be honest, I had forgotten it was Match Day.

On Saturday, I Facetimed my brother who is a pediatrics ED fellow in Massachusetts. He shared how a colleague of his put a plastic bag over his head and cinched it closed with a tube inside, before intubating a patient because they were so short on PPE. My brother has an autoimmune disease for which he takes medication daily. We talked about the risks, and indirectly our fears, around him intubating patients during this pandemic. My brother,

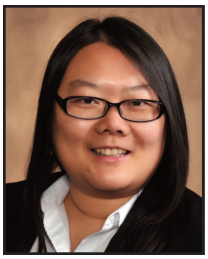
who normally doesn't talk to me or my family for weeks at a time, is sending us texts daily.

This morning, I woke up to a flurry of text messages from residents in our department about the lack of PPE and what we were going to do about it. After reading the numerous messages and emails, I summarized concerns and sent a message to our program director and chair. I sat at my desk thinking what could be done. I looked up "homemade masks" and the former occupational therapist in me started to contemplate how to use t-shirts, towels, coffee filters, etc. as protective gear.

It's hard to believe that only one week ago, things were almost normal. After what has happened the past few days, I am preparing myself for the many changes that will come in the next couple of weeks. I try my best to read what seems like hundreds of forwarded emails on COVID-19 and synthesize the information the best I can. In time, I hope things become clearer and we return to normal again.

Important COVID-19 Information from SCPS' Disaster Relief Committee

by: Danielle Chang, M.D., Chair



Over the past few weeks the world has changed quickly and dramatically in ways we may never have imagined it would. Our current reality is one that requires physical distancing, which has been isolating for some. We have less direct contact with our communities, and are being forced to devote time, energy, and resources to finding new ways to live out our usual daily activities with caution. Many of us have experienced financial losses, and have potentially lost homes, businesses, jobs, or even loved ones. Though we have hope and believe that our society will overcome COVID-19 as a whole, it can be difficult to adapt to the uncertainty and instability we are faced with on a personal level throughout the process of attaining that goal.

As psychiatrists we have been asked to serve our patients in new and creative ways, often under difficult and dangerous circumstances, and putting ourselves and families at risk. We are lacking in resources to protect ourselves physically as we work, and support for the vicarious trauma and burnout that some are experiencing. We are witnessing the stress of our current situation exacerbate the conditions of our patients, and anxiety and depressive symptoms arise in members of the general population.

Now is the time for us to stand together as a community, to help one another to continue to serve and thrive during this time of great need. The Southern California Psychiatric Society will be sending regular email updates and launching a resource page for psychiatrists and the general public, with up-to-date information about COVID-19, relevant trainings, and opportunities to offer services as a volunteer or through paid deployment as a physician/psychiatrist. We also want to emphasize physician wellness as a priority and will be posting information about wellness resources for physicians at https://www.socalpsych.org/. As we navigate this time together, may we stay connected and continue to support one another in caring for ourselves and others.

For those who are looking for ways to volunteer or participate in paid deployment, the following are two ways that psychiatrists may get involved in the work that is being done to care for those patients, healthcare providers, and disaster response workers affected by COVID-19:

1) The Los Angeles County Department of Mental Health will be recruiting volunteers (psychiatrists, other mental health professionals, and students across mental health disciplines) to help provide support to a) healthcare providers, employees, and other disaster service workers who are experiencing stress, vicarious trauma, or burnout from their work providing services during the COVID-19 pandemic, and b)

members of the general public experiencing stress regarding COVID-19 via a telephone support line.

We will be posting details about the application process for volunteering, and about how to access the support line for services, once it has been established. Volunteers will be sworn in by Los Angeles County as Disaster Service Workers and LA County has stated that volunteers will be covered in regard to liability.

At this time, please contact Mindi Thelen, Executive Director of the Southern California Psychiatric Society, at scps2999@earthlink.net if you are interested in applying to volunteer.

2) California is preparing for an increase in the number of people who urgently need health care due to COVID-19 by opening additional health care sites to provide medical services for people who have symptoms of, or test positive for COVID-19 and to relieve the pressure on our health care system by providing care for non-COVID cases. There is a call for help to ensure adequate staffing for these sites throughout the state from healthcare providers, behavioral health professionals, and health care administrators including:

- Behavioral health professionals (psychiatrist, psychologist, psychiatric nurse practitioner, LCSW, LMFT, LPCC)
- Other physicians (MD, DO), including medical students
- Pharmacists
- Dentists
- Nurse practitioners
- Physician assistants
- Nurses (RN, LPN, LVN, CNA), including nursing students
- Respiratory therapists
- Paramedics
- Medical assistants
- Certified nurse assistants
- Emergency medical technicians

The State of California has stated that participants will be paid and given malpractice insurance coverage. Locations will vary, but geographical preferences will be considered. Once you have signed up and your application is accepted through the California Health Corps system, you will be contacted with information about serving at one of the health sites.

Step 1 - Are you eligible?
To be eligible for COVID-19 emergency medical staffing roles, you must:

- Be 18 years of age or over
- Be eligible to work in the United States
- Have a valid driver's license and either a social security card or valid US passport to provide to EMSA HR at time of hire
- Have a valid California License for clinical practice (if you are a MD, DO, etc.) OR are a medical student or nursing student
- Have no negative licensure/certification actions (for licensed/certified professionals)

Step 2 - Register in the California Health Corps System
If you are already registered in the Disaster Healthcare Volunteers System, please email dhv@emsa.ca.gov so we can move you in the appropriate COVID-19 group.

Step 3 - Wait to See Your Skill Matches

- Your skills, experience, location preferences and interests will be reviewed to see where they match deployment needs
- When a match is found you will be contacted with detailed instructions on the next

steps including necessary paperwork and arriving at your deployment location

For more information and to apply for the California Health Corps, please visit:
https://healthcarevolunteers.ca.gov/

Here is a compilation of COVID Resources and Information—some we have already sent to you via email. Please watch your email for ongoing COVID resources and infomration.

THE FDA WILL NOT REQUIRE THE USUAL FREQUENCY OF BLOOD TESTING FOR CLOZAPINE IF THE PHYSICIAN PRESCRIBING CLOZAPINE DEEMS THE RISK OF GETTING A BLOOD TEST EITHER TOO RISKY FOR THE PATIENT OR TOO RISKY FOR OTHERS EXPOSED TO THE PATIENT. WE SHOULD LET ALL OUR PATIENTS KNOW AND INFORM PHARMACIES ON A CASE BY CASE BASIS.

This message is to notify you to please **be aware of scams** as consumers and healthcare facilities have been targeted by scammers pretending to be representatives of CDC, DEA, or WHO and asking for personal information, donations, etc.

For example, it was recently brought to the attention of the Massachusetts Board of Medicine that Massachusetts licensees have been receiving scam calls from individuals posing as investigators of the Massachusetts Board of Medicine of the DEA. The caller will falsely state that the license is in jeopardy or has been suspended. The caller might ask for additional information including, NPI, DEA registration number, financial information and may state that the call was being recorded on a secure line. Please note that the scam calls may show up as the Board of Medicine's main number. Physicians from other states received similar scam calls from individuals purporting to be FBI and DEA. Please see link to DEA webpage which includes information on reporting the online threat:
https://www.deadiversion.usdoj.gov/pubs/pressreleases/extortion_scam.htm

Additionally, the FTC has provided some tips to avoid coronavirus scams including recorded scam calls on "fake tests for medicare recipients" and "free test kit scam." Please take a moment to review this information at https://www.consumer.ftc.gov/features/coronavirus-scams-what-ftc-doing

From PRMS - https://www.socalpsych.org/wp-content/uploads/2020/04/PRMS-coronavirus-alert_4_3.27.20.pdf

This link may be helpful to those of you who do not have contracts with HIPPA compliant TeleHealth Platforms:
https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html

Here is more information about telehealth and telepsychiatry during this crisis:
https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19

LA County General Updates on COVID-19 (LA County Dept of Public Health)
http://publichealth.lacounty.gov/media/Coronavirus/

http://www.publichealth.lacounty.gov/media/Coronavirus/CommunicableDisease-StrategiesForCoping.pdf

Additional Resources may be found at CPA's site:
https://www.calpsych.org/

Volunteering in the Time of Covid-19

By Daniel H. Willick, Ph.D., J.D.

Introduction

The Covid-19 pandemic has created an increased need for psychiatric services. (Please see the article by Dr. Danielle Chang elsewhere in this Newsletter.) There are developments which lower the risk of malpractice claims against physicians who provide care to alleviate Covid-19 suffering. That suffering includes patients with the disease, their family members and healthcare providers.

Three Sources of Possible Legal Protection

Three potential legal protections exist for physicians providing Covid-19 care to new patients assigned by local governments or the State of California in response to the pandemic emergency.

1. Government Code Section 8659 California Government Code Section 8659 provides that any physician who 'renders services' during a state of emergency 'at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of those services, regardless of how or under what circumstances or by what cause those injuries are sustained; provided however, that this immunity herein granted shall not apply to the event of a willful act or omission.' This law has been triggered by California Governor Gavin Newsom's March 4, 2020 Declaration of a State of Emergency due to Covid-19. Hence, emergency aid rendered in response to an appropriately documented request from a responsible state or local official to render care due to the emergency should trigger application of Government Code Section 8659. It is important that a physician answering such a call to duty be provided with a written request from the government to provide emergency aid and receive a written commitment to defend, indemnify and hold the physician harmless from any claim arising from such care other than a claim adjudicated to be malpractice due to 'a willful act or omission' of the physician. Alternatively, the government should provide insurance which defends, indemnifies and holds the physician harmless from such claim.

2. Business and Professions Code Section 2395 California Business and Professions Code Section 2395 states no physician 'who in good faith renders emergency care at the scene of an emergency shall be liable for civil damages as a result of any acts or omissions by such person [physician] in rendering the emergency care.' The scene of an emergency 'shall include, but not be limited to', a hospital emergency room in the event of a medical disaster, such as the one for Covid-19 proclaimed on March 4, 2020 by Governor Newsom. The immunity granted by this law does 'not apply in the event of a willful act or omission.' To seek the protection of this law, the physician should obtain the written request, commitments and insurance suggested in the discussion above of Government Code Section 8659.

3. Existing Malpractice Insurance - Any physician considering volunteering to provide Covid-19 care should consult with his or her malpractice insurance carrier as to the best practices and whether the insurer will provide coverage for, including a defense of, possible malpractice claims arising out of such volunteer care.

Standard of Care

As of April 1, 2020, the U.S. Government had waived certain requirements under the HIPAA privacy and security rules and as to telemedicine. Similarly, on April 3, 2020, Governor Newsom eased California's requirements for telemedicine for the Covid-19 emergency. Guidance should be sought from the government agency at whose request care is to be rendered, as to the techniques approved for care (e.g., telemedicine on an unsecured phone line). Notwithstanding any protections in an emergency, it may not be medically appropriate to prescribe medication without documentation of a personal examination, CURES review for the patient, patient informed consent, medication monitoring and follow up. Hence, it is not recommended that a physician providing emergency psychiatric care in the Covid-19 crisis prescribe medication without clear protections, firm guidance and adherence to sound medical practice, such as obtaining documented informed consent along with continuing consideration of other medications and substances the patient is using.

Daniel Willick, Ph.D., JD, has been the attorney for SCPS for more than three decades and has also served as CPA's legal counsel. Dan has been practicing law since 1973 with an emphasis in healthcare law and complex civil litigation. Dan has been awarded SCPS' Special Award for 2020.

PRACTICING TELEPSYCHIATRY?

As the practice of psychiatry intersects more with technology through the use of telemedicine, you can count on PRMS® to protect your practice. Our psychiatric professional liability policy includes coverage for telepsychiatry at no additional cost, as well as many other preeminent program benefits including:

- A national program with comprehensive coverage that protects you when licensed to treat patients in other states
- A nationwide defense network comprised of attorneys experienced in psychiatric litigation throughout the country
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On Emotional Intelligence
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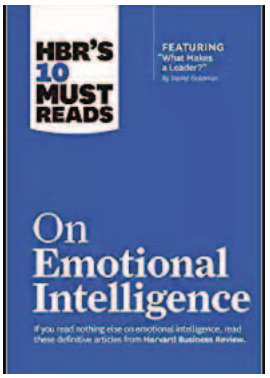

Book reviewed by Kavita Khajuria, MD

As part of the HBR Series, 10 articles review various aspects of E.I. Topics include mood assessment and management, decision making, emotional regulation, mental agility and self awareness. Following an introductory discussion on self awareness, readers are informed of the importance of mood, its contagion, and how others can 'catch the feeling'. The open loop limbic system and other neurophysiological effects partly explain the science of moods. Authors outline the five part process to rewire the brain, with an emphasis on the need for feedback and critique. Decision making is discussed - what goes into it, biases, process fairness, decision neuroscience and a reminder of unconscious origins. Other topics include incivility and solutions, with an emphasis on the power of reward and recognition.

The section on resilience is informative, inspiring and concise. Practices are offered on emotional agility enhancement in the workplace – with an emphasis on the importance of values and labelling thoughts. Fear of feedback and the costs of overidealization are interesting.

The concluding article is revealing: a man considered a genius and brilliant by some, yet perceived as aggressively ambitious by his peers - underscores the lack of self awareness and a need for appropriate feedback. Authors stress the importance of insight, peer networking, and effective social supports, as there are no substitutes for experience, reflection, and social abilities.

Alcoholics Anonymous, Twelve-Step Programs May Lead To Increased Rates, Lengths Of Abstinence Compared With Other Common Treatments, Systematic Review Indicates

The New York Times (3/11, Frakt, Carroll) reports, "An updated systematic published" online March 11 in the Cochrane Database of Systematic Reviews "found that A.A. (Alcoholics Anonymous) leads to increased rates and lengths of abstinence compared with other common treatments." Additionally, "Alcoholics Anonymous not only produced higher rates of abstinence and remission, but it also did so at a lower cost, the Cochrane review found. A.A. meetings are free to attend," while treatments using the healthcare system can be expensive.

USA Today,(3/11, Rodriguez, O'Donnell) reports the review "had the opposite findings of a similar study published by Cochrane in 2006 that found 'no experimental studies unequivocally demonstrated the effectiveness of AA or TSF (Twelve-step facilitation) approaches for reducing alcohol dependence of problems.'"

Reuters, (3/11, Carroll) reports, "In an analysis of pooled data from 27 earlier studies, researchers found a 20% higher rate of abstinence for one year among people who attended AA or a 12-step program that encourages participation in AA." Included in the review were "studies that compared 12-step programs to other addiction treatments." The 27 studies "included 10,565 patients with an average age of 34."

Providing similar coverage are Newsweek, (3/11, Crowley) and Healio, (3/11, Gramigna).

Council Highlights
February 20, 2020

Eric Wagreich, M.D., *Acting Secretary*

The meeting was called to order by Dr. Cheung at 7:08PM.

Introductions: All council members and guests in attendance introduced themselves.

Minutes from the previous meeting were unanimously approved.

President's Report
CPA Action Item: Dr. Cheung reviewed the history thus far of the attempted CPA agreement between the district branches and the recent developments after 3 DBs withdrew from the attempted contract. A motion was made for SCPS to withdraw from the current attempted CPA agreement. The motion passed.
Inland Region: Dr. Cheung discussed the revival of an idea of holding regional meetings within various SCPS regions due to recent unsanctioned and non-inclusive meetings being held in the Inland Region and members' concerns that not all voices within that region are able to be voiced. Possible dates for official meetings in March are to be proposed in the near future.
Grant Update: Mindi discussed the committee's progress regarding the new items for recruitment items, which will be sent to residents and general members.
Awards Action Item: Dr. Cheung discussed the Awards Committee's recent phone meeting and recommendations for this year's awardees which were as follows: Distinguished Service Award to Dr. Red; Outstanding Resident Award to Dr. Camfield, Dr. Tang, and Dr. Wagreich; Outstanding Achievement Awards to Dr. Mark DeAntonio and Dr. Peter Whybrow; Appreciation Award to Dr. Kavita Khajuria; and Special Awardees Daniel Willick and Brian Bixler. A vote was held and passed with 10 in agreement, none opposed, and none abstained.
Award Gifts: Mindi discussed a recent recommendation by Dr. Red to discontinue gift cards for awardees. A motion was made for gift cards not to be given to outgoing officers stepping down with retention of gift cards being provided to awardees, which was seconded, and a discussion was held, the motion passed with 9 yes, 1 opposed, 1 abstained.
APMC – Movie Action Item: Mindi discussed the movie's history of distribution and the recommendation to make the video available to the public, with the Vimeo subscription ending, as well as how SCPS should proceed with the errors and omissions policy, given its expiration as of the date of the meeting. A motion was made to make the video public and to not renew the errors and omissions policy. The motion passed with 12 in support, none opposed, and none abstaining.
Newsletter: The newsletter's recent feature of residency programs was discussed, and noted to be beneficial. March will feature LAC + USC.

Treasurer's Report: Dr. Ijeaku's report was presented by Mindi. We are about $1845 under budget for income, $163 under budget for expenses, and about $28,471 over cash on hand as compared with last year.
The report was unanimously accepted.

Legislative Report: Dr. Shaner provided a state legislative report. There are only 5 new measures, 3 of which are related to MHSA allocations, and the other two are in regard to LPS laws.
Assembly Report: Dr. Soldinger noted that Dr. Red will be the next Assembly Rep, and no specific action papers are currently under way at this moment, though that there are some in the works regarding

physician-assisted suicide in Canada.

Membership Report: Mindi presented the list from Dr. Ijeaku of the members who have submitted applications.
The new members were unanimously approved.

Program Report: Self assessment CME was discussed, as well as our current CME provider's dissolution in the near future, and the fact that our CME accreditation is in flux.

New Business: There was no new business.

Old Business: There was no old business.

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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