Southern California

PSYCHIATRIST

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President's Column

The Election Issue

George A. Fouras, M.D.

At the time of this writing, we are 1 week away from the election. By the time you are reading this, some of the questions I raise will have been answered, some will not.

An analogy occurred to me that we are living in a scene from the 1982 movie, The Dark Crystal. In it, the evil Skeksis have shattered the Crystal and are on the brink of ruling the land of Thra forever, unless the Crystal can be healed by the efforts of the Gelfling. However, time is running short, the Great Conjunction, where three suns come into alignment, is upon us! Will we be saved? Or are we doomed to eternal misery.

Metaphorically, our three "suns" can be interpreted to be:

1) The Presidential election. The contrasts between the two contestants could not be starker. If you believe the forecast as predicted by Nate Silver's FiveThirtyEight.com site, Joe Biden is favored to win in 88 out of 100 scenarios, Donald Trump in 12 out of 100. However, while that may be comforting to most and upsetting to some, it by no means implies that the election is a "done deal". The Electoral College is where the final shoe drops, and surprises may happen, as occurred in 2016, when Ms. Clinton won the popular vote but lost at the EC. My personal opinion is that healthcare will be devastated should Mr. Trump win re-election. We have already seen how he has side-lined science and mis-managed the COVID pandemic. There is no reason to believe that this will improve in the future. Nor do I have confidence that he would be any better prepared for the next adversity that befell his administration. When Mr. Biden was in office with President Obama, they had prepared a plan to address just such an adverse event. A plan that Mr. Trump deleted, to our detriment. And this does not even begin to address the potential for increasing gun violence and racial discrimination that his policies might inflict on our nation.

2) Amy Coney Barrett. With the now confirmation of Justice Barrett, Mr. Trump has had the incredible fortune of shifting the philosophical make up of the Supreme Court to the right for decades. This not only has implications for his own election, should there be any court action as to the results on election day, but to other issues that affect the lives of every American directly. Perhaps most concerning is that Justice Barrett has been sworn into office just in time to hear oral arguments regarding the law suit against the ACA, that has been brought by 20 states, which will begin on November 10th. Judge Barrett has expressed opinions suggesting that the ACA ought not be upheld and Trump appears to have selected her as the torpedo to sink it. The ACA mandates inclusion of mental health and sub-

In This Issue...

stance abuse services, as well as the more famous mandate for pre-existing conditions. Furthermore, it is expected that a challenge to abortion rights in general, and Roe v Wade specifically, will also soon be heard. One could also expect cases that would expand gun rights and limit voting rights.

3) MICRA and Scope of Practice. Many psychiatrists may be unfamiliar with the Medical Injury Compensation Reform Act (MICRA) passed in 1975 and signed by, then, Governor Jerry Brown. This act was needed to save the state from losing medical practices secondary to the high cost of malpractice suits due in large part to large jury awards for non-economic losses ("pain and suffering"). As a result of these suits, many practices were driven out of business, with several counties having absolutely no access to services, such as Ob/ Gyn. The trial attorneys have been trying to gut this law ever since, most recently with Proposition 46 in 2014 which failed by 67%. It is already known that another attempt to change the law will occur in 2022. In addition, we can anticipate that psychologists will introduce legislation in 2021 to increase their scope of practice.

We are lucky to live in CA, a state large enough and strong enough to withstand some of the national assaults even under a worst case scenario outcome of the national election. But even in CA, we must be vigilant to protect our patients, our practices and ourselves. For these reasons, ongoing, strong support of statewide advocacy is crucial. I have heard some say that unless an issue directly affects mental health care or policy, it is not within our purview. I would counter that to say that we are part of the House of Medicine. What affects one affects all. Therefore, if you are a CMA member as well, I applaud you. If you are not, this is the time to become one. Advocacy can't wait; it must be a 24/7/365 undertaking for us all. Our decision to support the Psychiatric Physician Alliance of California (PPAC) and to revive our GA committee are strong signs of commitment to advocacy for our patients and the public health.

In the film, the Gelfling, Jen and Kira, heal the Crystal and the world of Thra is saved. I am optimistic as well that we will also be able to experience a time of healing and growth. And even though we sometimes take a step back, it is often followed by two steps forward.

Physician Safety

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

A survey of emergency physicians revealed that nearly half of emergency physicians have been physically assaulted at work. Of those, more than half were assaulted in the past year. While 7 in 10 said their hospital reported the incident, only 3% pressed charges.

Whether the abuse suffered by healthcare employees may be verbal or physical, every single day employees in the healthcare field are assaulted in the United States.

Doctors who have been exposed to violence at work (verbal and psychological), especially psychological violence, experience increased rates of burnout.

Psychiatrists reported a significantly higher rate of patient aggression than any other group of mental health professionals. For instance, 97% reported verbal aggression, 74% reported verbal threats, 97% reported patient aggression involving objects, and 62% reported physical patient aggression.

Unfortunately, these statistics hit home with me when a patient threated to come to my home and shoot and kill me because I would not agree to prescribe the medications they wanted, for as long as they wanted them. It has been a long time since I made rounds on a psychiatric unit. It has been several years since I did psychiatric consultations in an emergency department. I never would have guessed the most significant threat against my life would come while I was working fully remotely due to Covid-19.

I have taken every step that I am aware of to protect myself and my family. This experience has made me realize that violence or threats of violence against a healthcare provider can happen at anytime and anywhere. Yet when it happens to you during a pandemic, when you are working remotely from home, it feels particularly isolating.

It made me wonder how many colleagues have had a similar experience? How many of my fellow psychiatrists had a patient harm them or threaten to harm or kill them? It made me wonder what more can be done to protect physicians and other healthcare providers. Are there laws and tools that could be used to better inform healthcare providers if their new patient has a history of violence or threating a past care provider?

One of the most difficult aspects of this experience has been that law enforcement is not experienced in dealing with healthcare providers who are threatened by patients. As we know, psychiatrists and other physicians form doctor patient relationships. Ethically the moment we become the doctor, we cannot ethically or morally have other types of relationships with a patient because of the power of the physician and patient relationship. It is so strong that psychiatrists can never have a sexual relationship with a patient no matter how long it has been since we have last treated them. Obviously, our doctor patient relationship is immediately intimate and powerful. Physicians also have specific legal requirements when terminating care with a patient, that a non-physician/patient relationship does not have.

We know this. Sadly, law enforcement does not. It was hard for police to understand how to navigate a system that generally deals with domestic violence between two or more individuals with long and often domesticated relationships. They seemed to not understand that you cannot just block a patient's phone number or why some-

one you had only spoken to via video less than a dozen times would be so angry that they would actually follow through with the threats they made. Despite having nearly, a dozen threatening emails and voicemails it took repeated 911 calls and perseverance to have action taken.

I know I am not alone. If this has happened to me, I know it has happened to others and I wanted to take the time to speak about it to both raise awareness and also offer a platform for my colleagues to share their experiences. I think that the more that we talk about the violence we have experienced the more power we will have to impact change.

It is my hope that SCPS and other organizations can use their influence and infrastructure to help develop resources and laws that better support healthcare providers who have been victims of workplace violence. Additionally, it is my hope that a database can be developed, much like the CURES database, that identifies individuals who have documented criminal charges for threatening or harming healthcare providers to better protect healthcare providers from future incidents of violence.

Please share your stories, if you are comfortable and/or your thoughts on what needs to be done to decrease violence against healthcare providers.

You can write directly to Mindi (scps2999@earthlink.net) or to myself.

Stay safe,

Matthew Goldenberg D.O.
SCPS Newsletter Editor
Treasurer (2020 – 2022)
Email: docgoldenberg@gmail.com

Letter to the Editor

Mindi, I want to join Dr. Goldenberg in celebrating your outstanding service to the SCPS for all these years. I have always been a great fan of yours and have admired your unrelenting dedication and commitment to the organization. I can also proudly acknowledge knowing you for the whole time (all 29 years) you have graced us with your focused and superb presence. Without your amazing organizational skills, constant quick responses to problems and issues and your gracious presence at all events, we would not be the top notch organization we are.

"Thank you Mindi“ does not begin to express what we all owe you.

With great fondness and affection,

April Mayer, MD

Save the Date!
Advances in Psychiatry
Saturday, January 30, 2021
Online via Zoom
More details SOON!

YOUR SPECIALIZED PRACTICE IS SAFE WITH US

WE PROTECT YOU

PRMS understands that each psychiatric specialty possesses its own unique set of challenges, which is why we have tailored our policy to meet your needs.

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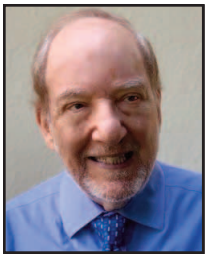
Using Psychological Insight to Understand the "Fatal Denial" That Is Allowing the Coronavirus Epidemic to Continue to Spread on a Deadly Path & How to Use Psychological Insight to Breakdown This Denial and Save Lives. An Analysis and a Plan.

by: Michael Blumenfield, M.D.
The Sidney E. Frank Distinguished Professor Emeritus of Psychiatry at New York Medical College, Private Practice in Los Angeles and Author.



The deadly Coronavirus epidemic continues to spread in my state of California and throughout the country. Medical experts have clearly identified the reason that the epidemic is getting out of control is that a significant number of people are not listening to the medical experts and are not using facial masks, keeping social distancing nor are they following other precautions concerning opening businesses, restaurants, beaches, sporting and political events etc. Of course, these people do not want to get sick or spread this illness to their loved ones. Such individuals are using a very common unconscious psychological defense mechanism of "denial" to keep out of their consciousness that their behavior could be fatal to themselves and their loved ones. They support this denial with another well-known psychological defense mechanism known as "rationalizations." Examples are, "I am healthy and won't get sick," "These precautions by the experts are political in nature," "You are only young once" and many other rationalizations. Because these are psychological defense mechanisms and they won't protect anyone from this fatal virus, I have coined a new term for this denial and am calling it "FATAL DENIAL."

In order to overcome this "fatal denial" we must communicate the message to the deniers as coming from people with whom they have a strong positive identification. There are well known scientific approaches to determine who such people would be. This is the technique of running focus groups with a wide cross section of deniers. (The advertising industry is quite skilled at utilizing this method). During such meetings it would not necessarily be important to determine the rationalization that are used but rather the scientific inquiry would be to identify who are their role models and heroes among movie, tv, music, sports and even political stars. Once these names were identified, they would be approached and be invited to participate in a massive public service announcement campaign which would speak to the Fatal Deniers. There should be TV and radio ads as well as billboards and posters as well as a concerted campaign on social media which could be made available throughout the country. In addition to the "heroes" being the face and voice of these announcements, there also should be series of such announcements done by young and older regular people who have lost loved ones to the virus.

While I would hope that celebrities might donate their time and perhaps networks would also donate free time for these pieces, there still would be costs in making them and distributing them. I would hope that Governor or California and the state legislature as well as their counterparts in other states would be interested in supporting such a program. I know TV producers who would be skilled and capable of carrying out such a program and I would be willing to help in any way that I can. Perhaps such people as Bill Gates, Jeff Bezos and others might get behind such a life saving program and provide the financial support needed. In view of President's actions, even after getting the virus, make this issue of prime importance.

Every year, SCPS takes an opportunity to thank our dues exempt Life Members for their donations to SCPS—and every year our gratitude is genuine. But this year, our grattude is even deeper because we are living under uncertian times—so your generosity means even more—and we sincerely **Thank You!**

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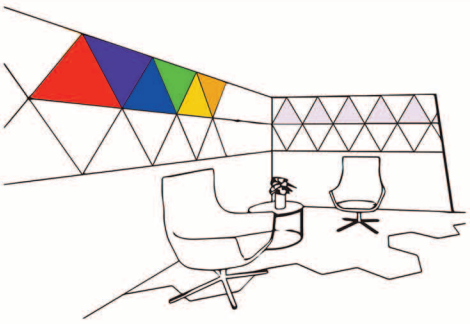

SCPS CAREER DAY 2020

Online: Saturday, December 5th

Speakers | Exhibitors | Strategies

SAVE THE DATE!

Career Day Speakers – 9:00 a.m. – 11:45 a.m.
Managed Care/Kaiser – Galya Rees, M.D. – 9:00 a.m.
Private Practice – Katherine Unverferth, M.D. – 9:15 a.m.
Public Psychiatry – Kelly Jones, M.D. – 9:30 a.m.
Group Practice – Victoria Huang, M.D. – 9:45 a.m.
Academic Psychiatry – Charles Manchee, M.D. – 10:00 a.m.
Clinical Trials – Haig Goenjian, M.D. – 10:15 a.m.

5-Minute Break – 10:30 a.m.

Financial & Investment Strategies – George Fouras, M.D., Zeb Little, M.D. – 10:35 a.m. – 11:45 a.m.

15-Minute Break – 11:45 a.m.

Employer Exhibits – 12:00 Noon – Exhibitors include:

Community Psychiatry
Department of State Hospitals
Kaiser/Permanente
PRMS - the psychiatrists' program
Sites Professionals
Telecare Corp.
Traditions Behavioral Health

This will be an online event. More details and exhibitors to be announced soon! Save the Date!

The Problem with Calling Physician Burnout a Human Rights Violation or a Moral Injury

by: Torie Sepah, M.D.

Our profession is in crisis, but “human rights violations” and “moral injury” are inaccurate terms to use.

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 2000 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.

Of late, there have been two new terms used to describe the current physician experience which I find difficult to wrap my head around: “human rights violations” along with “moral injury” being the what is truly occurring instead of physician burnout syndrome. While these terms are catchy, they lack a grounded foundation and, thus, risk undermining our cause altogether.

For example, it is bold to claim “human rights violations” when most physicians, myself included, weren’t exactly forced into medical school or residency. I begged and pleaded for my position as an MS1 and thanked every deity known when I matched as a PGY1. I freely chose to have two children during training knowing that it would be nothing like what another woman in a different profession would experience. It was hard as hell, but I did not suffer human rights violations. And it was my choice.

I am sure I did not experience human rights violations because I have lived through actual human rights violations having fled a country undergoing a violent revolution at the age of six. Seeing the fingers and toes of those scarred with cigarette burns after the revolutionary guards tortured them in Iran’s notori-

ous Evin prison is a memory I can't erase nor reconcile as being congruent with my experience as a physician.

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.

This article previously appeared on KevinMD
https://www.kevinmd.com/blog/2019/06/the-problem-with-calling-physician-burnout-a-human-rights-violation-or-a-moral-injury.html

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Abolition, Antiracism, and Psychiatry

Online: Sunday, November 22nd 11:00am – 12:30pm

with our speaker:
Rupinder Legha, MD

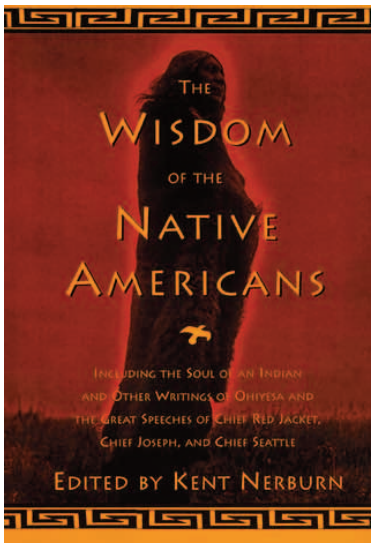
1.5 Hours Category 1 CME will be provided.

The highly publicized murders of Ahmaud Arbery, George Floyd, and Breonna Taylor; the worldwide collective activism generated by the Black Lives Matter movement; and the disproportionate COVID-19 deaths of tens of thousands of Black Americans have forced a racial reckoning in our country and in our profession. Amidst racism’s heightened recognition as a global public health crisis, individual practitioners, academic medical centers, journals, and organized professional groups are contemplating strategies and solutions to dismantle it. This 90-minute presentation imagines what antiracism and abolition in the field of psychiatry might look like and posits core components to inform these efforts.

The Southern California Psychiatric Society (SCPS) is accredited by the Institute of Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. SCPS takes responsibility for the content, quality and scientific integrity of this CME activity.
SCPS designates this educational activity for a maximum of 1.5 AMA PRA Category 1 Credit (s)TM. Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

Wisdom of the Native Americans
Edited by Kent Nerburn Ph.D.
New World Library Publishing
272 pages
$17.95 Hardcover
ISBN 13:978-1-57731-07902

Book reviewed by Kavita Khajuria, MD.



"It does not require many words to speak the truth"

- Chief Joseph

This collection includes writings, orations and thoughts by Native Indians, their Chiefs, and Ohiyesa - a member of the Dakota or Sioux Nation and a medical doctor by profession, well known for decades of attempts to bridge understanding, and who became an advisor to Presidents.

The book starts with an introduction into history and culture - Native Americans described themselves as naturalists who revered the earth. The world and nature were considered a library and it was believed that closeness to nature cultivated respect and softness. Language and speech were important, but praise and flattery had no place - there are no swear words in the Indian language. Love was considered an ingredient crucial for self-esteem, courage and creativity. They noted the ridiculous of selling a country as akin to that of selling the air or sea. The hypocrisy of being called a savage was noted, and the disrespect of 'civilization'. Dogma indicated a lack of understanding. Documents were not required to pass down memories or values from one generation to the next, as they were imbibed in upbringing, culture and oration. They mused over others quest for money, belongings and possessions -the Native version of the bank was gift giving and sharing, which was returned with great non-monetary interest.

Religion was considered an attitude of the mind, described as simple and exalted - worship as silent and solitary. Silence was considered the powerful equilibrium - the balance of mind, body and spirit. Life was a prayer - a daily devotion. Nature was the temple, and humans were considered its children. The sun and the earth were considered the parents of all organic life with the hidden embryos in plants and humanity. Nature was considered the measure of consummate beauty, and its destruction a sacrilege. The belief was that science could not explain everything, and the origin and principle of life was the ultimate miracle. Virtue and happiness were thought to be independent of luxury and possessions.

Divinity was considered to be present in all creation. Lessons were taught by example and development of personality. Education began in the mothers womb, with her attitude, meditation, mindful interaction, and the study of the habits of animals, especially birds, known for their patience and devotion. Despite a notably patriarchal society, the moral strength of a woman was considered to be the silent power behind all of life's activities, and women were expected to be superior in spiritual insight and moral salvation. Silence, love and reverence were considered to be the trinity of primary lessons in life. Elders were respected, and considered the true teachers of the world. Honor was sacred and justice was delivered by councils - trials held by old, wise men. Societal interactions were a quiet, orderly decorum. Bravery

and courage were considered to be highly honorable, and a brave man was considered to be the master of himself.

This book conveys poetic art and classic legend. Individual monologues are clear, simple and insightful. It offers relevance to psychiatrists for multiculturalism regarding traditional aspects Native Indian culture and heritage. Some news forums have recognized Native Americans from various aspects this year, including that of 'Cultural Burning' as an indigenous tool for managing natural resources – a practice done for thousands of years. (https://www.kcet.org/shows/tending-the-wild/episodes/cultural-burning; NPR Morning Edition "Cultural Burning" 8/13/20).

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Flashback Photos

Paul Bohn, M.D. at Installation.

M. Christina Benson, M.D. and Daniel Plotkin, M.D.

Sharon Jacobson, M.D, Sidney Russak, M.D., and Maria Lymberis, M.D.

Members enjoying an Installation and Awards Ceremony

Council Highlights
September 10, 2020
Eric Wagreich M.D., *Secretary*

Outline of Notable Meeting Events and Discussion

The meeting was called to order by Dr. Fouras at 7:05PM.

Meeting Minutes
Some revisions to the minutes were recommended and the revised minutes were unanimously approved.

President's Report
Approval of New Councilors
Dr's Josic and Damerla were unanimously approved as new councilors to West Los Angeles and San Gabriel Valley/East Los Angeles, respectively.

Conflict of Interest
Dan Willick provided an introduction to conflict of interest and defined what constitutes conflict of interest and what those with a conflict of interest may contribute to a given discussion and vote related to that conflict of interest.
Conflicts of interest were disclosed by members.

Dissolution of CPA
Dr. Fouras shared news of the dissolution of CPA, made effective by current CPA President Dr. Schaepper, as well as information regarding outstanding debts owed by CPA.
A motion was made to ratify the retention of Mr. James Goldman for the purpose of representing SCPS during the dissolution process of CPA. After a discussion, a vote was held regarding the motion, which passed with all affirmative other than 2 abstentions.

Update of AB890 (Dr. Shaner)
Dr. Shaner provided an update for the bill, including that it has passed unanimously and is currently at the governor's desk awaiting possible signature, and the current letter writing opportunities in existence, which urge the governor not to sign the bill.

Newsletter Update
Dr. Goldenberg provided an update for the newsletter and invited articles for the coming months.

Diversity and Culture Committee
Drs. Rees and Shaner provided an update on the committee's progress as well as a resolution for Council.
Dr. Shaner shared the "Anti-Racist Council Resolution" and a discussion was held regarding the resolution. A vote was held regarding the resolution, which passed with 19 for, 1 against, and one in abstention.

Vetting Committee Report
Dr Cheung provided the committee report for the vetting of PPAC, including the current planned officers and administrator.
A discussion was held amongst the council, including benefits and drawbacks toward allocating SCPS's advocacy budget to PPAC versus CAPP or to waiting and continuing the vetting process, as well as whether the vetting process was sufficient to date.
A motion was made by Dr. Goldenberg that "SCPS invite members of CAPP to a council meeting to obtain further information about the various advocacy options available in California."
A discussion was held about the motion, and the motion 9 were for, 10 in opposition, and 3 abstentions, and thus the motion failed.
A motion was then made by Dr. Red for "SCPS to support PPAC with an amount to be determined for this year." 16 were in support of the motion, two were in opposition, and 5 abstained, and the motion passed.

Treasurer's Report
August Financials and Cash On Hand Report
Dr. Goldenberg shared the Treasurer's Report, which reflected that for overall income we are under budget by about $21,955; for annual expenses we are about $16,121 under budget; and about $3,263 under cash-on-hand compared to last year. A motion was made to accept the Treasurer's Report, which was passed unanimously.

Finance Committee Report and Draft 2021 Budget
Dr. Goldenberg shared the Finance Committee's report, including keeping SCPS dues the same and to provide a thorough message to members about the dues assessment to help retain as many members as possible, and asked that two items be tabled for later discussion. Another recommendation was made to continue to pursue any available savings by subleasing our office space. Dr. Goldenberg shared his recommendation that emphasis be placed on member support and membership retention and in efforts to grow SCPS membership, and urged additional time be spent in the coming months to be spent on these efforts and additional sources of income to avoid the necessity of utilizing reserves to retain fiscal solvency. Dr. Goldenberg noted that the Finance Committee continues to support previous recommendations for balancing the budget.

Letter for Membership
A discussion was held regarding the letter to be mailed to members explaining the member dues assessments. One guest, Dr. Wood, shared that some of her colleagues have experienced confusion regarding recent emails from CPA as an update had not been received as to the most recent developments with CPA.

Budget Discussion
Executive Session
Dr. Fouras introduced the budget discussion after non-voting members and guests left the meeting.
Dr. Soldinger moved to approve the budget, and the motion was seconded
A discussion was held, including to look into the option of breaking the lease and the motion passed to accept the budget proposal.
Dr. Goldenberg made a motion to "Use the SCPS Finance Committee Summary in a letter to the members in the next week, contingent upon review from legal counsel Dan Willick, along with the dues bill, after a formal letter is crafted by the Membership and Finance Committee." The motion passed unanimously.

Membership Report:
Dr. Ijeaku provided the membership report and recommended we accept the new members, whom were accepted unanimously.

New Business:
There was no new business.

Old Business:
There was no old business.

The meeting was adjourned by Dr. Fouras at 10:37pm.

Happy Thanksgiving

Celebrate Safely and In Good Health!

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