Southern California

# PSYCHIATRIST

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*President's Column*

# Real Mental Health *Access* to Anyone, Anywhere, Anytime...

Ijeoma Ijeaku, M.D.

I was working late one evening January 2019 when I heard sobbing sounds coming from the reception area in my clinic. I had assumed that I was alone in the office with just the security outside, but I found one of my office assistants choking up in her tears. It took me several minutes to get her to share why she was overwhelmed by so much grief at the end of her workday. She shared that just a few days before Christmas she had found her father, a known schizophrenic who lives alone about few minutes away from her, acting in a very erratic manner during her visit. He refused to reason with her, take his medications, or get in her car to go for an emergent visit for mental health services. As an American living in the developed world with access to emergency services, she placed a 911 call for help. Her father was dead within the hour, killed by bullets dumped into him by the police officer sent her way in response to her call for help while she watched helplessly. She shared that not only was she dealing with the loss of her father under such traumatic circumstances, but she was also dealing with the guilt of her involvement in his death as well as judgement from her family for her role in her father's death.

According to the 911.gov website, the establishment of the 911 program was undertaken following a landmark publication in 1966 by the National Academy of Sciences titled 'Accidental Death and Disability: The Neglected Disease of Modern Society'. The report had highlighted the epidemic of accidental death and injury in the US and explored the 'feasibility of designating a single, nationwide, telephone number to summon an ambulance.' By 1968, the first 911 call was made, and the 911 system was subsequently established to replace the need for individuals to dial local 10-digit phone numbers when calling for help. Indeed, it appears that the system has achieved the original goal for which it was established and much more. However just like with other systems in society, the 911 system has expanded beyond the scope for which it was created, and it now serves every emergency. And as with other systems which are being stretched thin, we start having issues and poor outcomes…

In the current 911 response system to emergency, the police respond to emergency calls of every nature. According to the Institute for Criminal Justice Training Reform, a non-profit research and advocacy organization dedicated to making the streets safer by increasing, improving, and regulating training for US police, law enforcement and criminal justice employees, police officers across the country receive less than 6 months of basic training. Out of 80 countries analyzed by this organization, only Iraq and Afghanistan have lower police training requirements than the US. According to a report from LA Times from July 2020, '*Of the nearly 18 million calls logged by the LAPD since 2010, about 1.4 million of them, or less than 8%, were reports of violent crimes…'* Another important comment in the same article states *'Although armed with weapons and the unique authority to use*

*force, cops often are sent to resolve problems that should not require their coercive powers. Family fights, episodes of mental illness, complaints of loud parties, and dogs running loose are all part of the job*.'

A psychiatric evaluation is incomplete without adequate safety assessment and safety planning as needed. When we encounter a patient with potential safety issues, we review a safety plan with the patient and their family that ultimately includes planning for a possible call for help. As a physician who took the Hippocratic Oath to first do no harm, I like to think that my plans are airtight and will not harm my patient. Therefore, I bear some of the burden when my safety plans fail to keep my patient safe. I take some of the blame when my patient (or family)'s cry for help goes awry and we have a fatal outcome...

The Federal Communications Commission (FCC) has adopted 988 as a new 3-digit number to be used nationwide to reach the National Suicide Prevention and Mental Health Crisis Lifeline, starting July 16, 2022. The idea would be to grant ***access* to anyone anywhere anytime** to much needed emergent care in the middle of a mental health crisis. California's Miles Hall Lifeline Act AB 988 was introduced by Assemblywoman Rebecca Bauer-Kahan in February 2021 *calling for a new three-digit phone line, 9-8-8, for suicide prevention and immediate, localized emergency response for individuals in mental health crisis by trained mental health professionals*. The intent is great, but the devil is in the details. As various stakeholders analyze, reimagine, and amend that bill, its parts continue to change. If AB 988 is carefully and comprehensively crafted, it might be the game changer for California's mental health crisis. And if we throw in the fact that California is making history with its $100 billion surplus. I believe that real sweeping reform is possible and would include well trained call dispatchers, timely mental health crisis response by unarmed community members who are adequately trained in crisis management and who will continue ongoing mandatory up to date training, adequately staffed acute crisis centers where emergent mental health services are administered and expansion of the inpatient psychiatric services to allow for inpatient care if needed. California must ensure that any citizen within the state has real access to emergent mental health care not just those individuals who live within zip codes that can afford to pay for the service as is being suggested by some. All Californians and visitors should have real access to a comprehensive 9-8-8 system when a mental health crisis arises to ensure an outcome that is aligned with the safety plans, we Psychiatrists make with our patients and families.

PS:
Have you considered joining an SCPS committee (check out current committees through our website https://www.socalpsych.org/)? You can join a committee by reaching out to our most devoted executive director Mindi Thelen @ socalpsychiatric@gmail.com or you can contribute your ideas so that SCPS continues to grow and serve all of us.

## In This Issue...

# This is Us:
# Physician Suicide and Burnout Edition

By Newsletter Editor
Matthew Goldenberg D.O.

As many of you know, much of my professional career has been dedicated to evaluating and treating safety sensitive workers, including pilots and healthcare providers with suspected and diagnosed mental health and/or substance abuse diagnoses. Caring for a colleague is both a challenge and motivating.

It is a challenge because healthcare providers often make for difficult patients, it is true. However, more importantly fear makes it difficult for healthcare providers to come forward and get the help they need. Fear of losing their license, their hospital privileges, their malpractice coverage, their colleagues respect, their livelihood and the list goes on. I do believe this is a major reason why a healthcare provider often delays getting the help that they need and presents with more advanced addiction and mental health symptoms than the general population. It may be partially to blame for the high rates of burnout and suicide that you will read about in this month's newsletter.

Working with healthcare providers is motivating because you are helping not only the physician, pharmacist, dentist, nurse etc. that you are treating but you are helping the thousands of patients that they may be able to help themselves if you can help them to stabilize and return safely to their medical practice. The military believes that a unit is only as strong as its weakest link. It is gratifying to help strengthen the hospital systems, medical practices and communities that these healthcare providers in recovery will return to.

Through my clinical experiences and from the research I have engaged in, over the past few years, I have written articles for this newsletter related to Physician Health, including articles on Healthcare Provider Suicide and Burnout. I always enjoy writing articles and giving talks on these topics, primarily because it is a nice reprieve from talking about our patients, to take the time to talk about us, the care providers.

That is what this newsletter is about, this is us.

I want to thank this month's Guest Editor, Kavita Khajuria, MD., who has helped shape this very robust and high-quality contribution to our field. Dr. Khajuria has been an ongoing contributor to the newsletter and was recently awarded an appreciation award by SCPS, in part for these significant efforts.

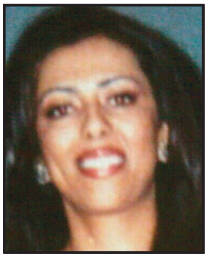
Please also join me in thanking all of the contributors this month and Mindi Thelen our dedicated Executive Director for putting this all together!

Continue to stay safe,

Matthew Goldenberg D.O.
SCPS Newsletter Editor
Treasurer (2020 – 2022)

# Physician Suicide and Burnout Edition: Letter from the Guest Editor

Kavita Khajuria, M.D.



On behalf of the Southern California Psychiatric Society, I'd like welcome all the readers to this Issue themed "Physician Suicide and Burnout".

A couple of years ago I received books from the APA for reviews - one was 'Physician Suicide'. I refrained from reading it - and it sat on my bookshelf for a long time. Perhaps the hesitation stemmed from resistance to a topic that was perceived to be dark or tragic. I eventually came around and contemplated on this topic and its associations. The first thing I did was recollect memories:

I was a first year resident in Michigan, and had recently moved into the residency apartment building on the hospital grounds - which would be my home for the next couple of years. One day after work, I returned to the apartment building. I entered the lobby and after a few seconds, the elevator door opened, and I stepped in. I pressed my floor button, but before the doors could close, a flustered bellman thrust himself into the elevator. He was perspiring, tense and appeared visibly flustered. After a brief greeting, all I could gather was that an emergency had occurred, and he was in a hurry to get to the top floor. I disembarked on my floor, and proceeded to my apartment. I then did what I usually did after a days work - drink a glass of water and stand and relax on the balcony for a few minutes to decompress. After gazing out at the city view, I peered over the patio rail. The sight from below confused and stunned me. The limp body of a young man lay flat on the sidewalk, directly below my line of view, in a small pool of blood. He wore a lab coat. He was dead.

I came to learn that he was a first year Internal Medicine Resident from the Middle East. He had jumped off his balcony a few minutes before I stepped onto mine. Nobody knew the reason for his suicide, or perhaps they would not choose to divulge this. I was stunned at the visual memory and thought about this for some time. I wondered what he had gone through that was so terrible that he would take his precious life, especially after all the extra hurdles a foreign medical graduate needs to overcome to start a U.S residency program at a respected medical establishment. And what was it like for the family to receive the death notification phone call from the Program Director? I shuddered at the thought. I wondered about his parents and family. It seemed unspeakably tragic. I recall speaking to the chief resident about it at some point thereafter - but only because he was a friend. He came back the next day indicating the Program Director expressed that she was open to any of us coming in to discuss this matter with her. I never did. That was 20 years ago.

Fast forward a few months. I then came to hear of another suicide. My classmate from medical school committed suicide within a year of graduation. An honors graduate. There were no details except reference to 'personal' problems. Once again, I was shocked and wondered - what happened? What could compel this after all the sweat and toil of medical school? What was so awful and unbearable that a young doctor would take her life? What prevented access to support? Or would that have made a difference? And how did she compartmentalize so well? These incidents seemed devastating and have always caused me to wonder about the untold lives and experiences of physicians.

When submitting the book review on Physician Suicide, I was invited to be the Guest Editor for the June Issue. At the time, no one else knew of the experiences I described above, but I share them for many reasons. It has always baffled me that psychiatric professional energy is spent on taking care of others, but I've often wondered about the doctors themselves, including their conflicts and challenges. And much has been written or discussed about Physician Suicide, Burnout and Wellbeing over the past few years, but how much do we really know about the lives of physicians and their reasons for suicide, including supports (or lack thereof) or impediments to resilience? And where are we now?

The Annual APA Conference last month conducted a number of sessions related to these topics. 'The Suicidal Physician' was presented by a physician who survived suicide and the physician widow of one who did not. Personal anguish, non-disclosure, shame and denial - these were common themes, regardless of marital status.

'Navigating Potential Pitfalls' was another presentation hosted by a panel of forensic psychiatrists, who shared individual stories about personal and professional dilemmas, including health consequences and their efforts and struggles to overcome these challenges. The session on 'Physician Wellbeing' provided considerable information about the UC-Davis Clinician Health and Wellbeing Training Program – the impact of a patient's suicide on a psychiatrist was noted to be something relatively unaddressed in psychiatry. Attendees were reminded that physicians are resilient people - they need to take up prior activities and look at what helped their resiliency in the past.

This issue contains a variety of thoughtful contributions, including articles that outline the scope of the problem, contributory factors, actions for suicide risk reduction and advice for medical educators and individual health professionals. Thoughtful and candid reflections are shared from a psychiatrist with 30 years of experience as the Chair of a Well-Being Committee. Information and advice on Medical Student Burnout and Wellbeing are shared from a Professor in the U.K. Forensic psychiatry perspectives call attention to the increased risk to those involved in criminal work. Other experts emphasize the crucial need for self-care and focus on family, given the toll of COVID on the public, especially healthcare workers. Contemplative and compassionate reflections are shared by a Pastor. Challenges and secondary effects of the pandemic on the LGTBQ community are shared, including the strain on identity. The Founder of the Physician Support Line shares consequences from the medical culture that propelled this entity into action – and lessons learned. A thought-provoking poem may compel us to reflect on this theme from other perspectives. And last, but not least - The President-Elect of APA shares timely reflections on bioethical dilemmas of life and death, further complicated by the pandemic.

I'd like to express my sincere thanks to all the contributors for their thoughtful articles, time and energy.

Wishing each and every one of you good health, peace and happiness,

With Best Wishes,

Kavita

Kavita Khajuria, MD is a forensic psychiatrist at Twin Towers Correctional Facility, Los Angeles; a Forensic Evaluator for Physicians for Human Rights Organization, an Educator with the Psychology Internship Didactic Correctional Program, and the Book Review Editor for Serotonin Poetry Journal on Mental Illness and Suicide Prevention.

Message from your colleague: John Raiss, M.D.

Medical Associations Claim $15 Check Scheme Is A Trap For Physicians – Dr. John Raiss has alerted SCPS members to a possible trap for unwary physicians which the California Medical Association (https://www.cmadocs.org/newsroom/news/view/ArticleId/49240/CMA-demands-TRPN-immediately-cease-illegal-15-check-scheme) calls "illegal" and "a deceptive business practice." According to CMA, a company called TRPN DirectPay sends a physician a $15 check which may be mistaken for a payment for services. If the physician endorses the check for payment, TRPN DirectPay may, in the words of CMA, contend the physician "has signed a unilateral provider participation contract of adhesion for consideration of a one-time $15 'license fee.'" CMA states that the purported contract "includes onerous and burdensome terms.'

# Physician Suicide and Burnout

By: Rahn Kennedy Bailey M.D., ACP, DFAPA
Timilehin Oluseye M.D.

Each year more than 400 physicians take their lives likely related to increasing depression and burnout. Burnout is a psychological syndrome featuring emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. It is a disturbingly and increasingly prevalent phenomenon in healthcare as a whole (1).

As self-care based solutions have proven unsuccessful more system-based causes beyond the control of the individual physicians have been identified. These include limitations of the electronic health record, long work hours and substantial educational debt, all in a culture of “no mistakes allowed.” Blame and isolation in the face of medical errors and poor outcomes may lead to physician emotional injury, the so-called “second victim” syndrome which is a contributor to burnout and a consequence of it as well. In addition, other factors such as risks of litigation, chronic fatigue of circadian rhythm disruption have been identified (2).

Stressors and health risks in the medical profession are well documented but seldom openly discussed. Very often, a “conspiracy of silence” about these stressors exist and this conspiracy is allowed to continue because of denial and defensiveness. The most important stressors in the medical system result from the treatment and care for patients. Others include team conflicts, insecurity, lack of autonomy, large workload and increasing criticisms, expectations and demands from the public. In addition, female doctors suffer from the role-strain between job stressors and family responsibilities. Signs of these double-stressors can already be seen early in the medical course and mark the whole career of female doctors. We must keep in mind that despite being “gods in white,” a medical degree does not infer immunity to mental illness, drug addiction, alcoholism, or other self-destructive behaviours (2).

The society is shocked when a physician commits suicide. It is estimated that 400 physicians in the U.S. die by suicide each year. Compared to the general population, the overall mortality rate of doctors decreased during the last decade, but is still worse than that of other professionals of comparable education (1). In particular, the suicide rates are high for males (2-3 times) that of the general population and for females as much as (5-6 times). This is due to a high proportion of psychiatric diseases, particularly addiction and depression (1).

In conclusion, Burnout doesn’t directly cause suicide but can develop into depression and then lead to suicide (3). The burnout rate for practicing physicians in the United States was already high before the COVID-19 pandemic which has exacerbated the factors underlying burnout by increasing isolation, workload and uncertainty as well as a potential clash of organizational decisions with personal safety. Achieving effective strategies to combat burnout and protecting physicians and health care workers from depression and suicide should be a priority for all systems (4). Early detection and referral to treatment as well as de-stigmatization of treatment are crucial (4).

Additionally, expanding the conversation about the role of structural and organizational changes in promoting wellness is essential. Effective and consistent leadership can help tremendously when combined with individual efforts toward work-life balance (3).

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# Honor and Grief: The American Family is Essential to our Recovery from COVID-19

By: Richard F. Mollica, M.D.
Laurie Charles, Ph.D.

Families across America have been devastated by the COVID-19 pandemic (1). In the U.S., where we are both based, one in three persons have lost a loved one. Virus deaths have hit the elderly especially hard: 80% of those who died in the U.S. were 65 years of age or older (2). In some states, including Idaho (94%), New Hampshire (92%), and Massachusetts and Rhode Island (90%), the percentages are even higher (3). Health disparities research reveals that many were persons of color. The loss of grandparents and other close family members is painful and overwhelming. This grief is complicated by the reality that many families could not be with their family members while they were sick and dying. For public health reasons, funeral arrangements did not allow traditional ceremonies to grieve the loss (4).

The family is the most significant social group in every society. Families speak to the legacy of history and to the hopes for future; they are the first and foremost natural group for all of us, wherever we are on the globe. Although the values associated with it are often up for political debate, in our work as public health clinicians, "family" is not simply an ideal or an abstraction. Research clearly shows how critical family relationships are to promoting and maintaining resilience (5). Yet in typical health care in one of the wealthiest countries on earth, attention to "family" is given a polite nod, without the health care infrastructure to back it up. Sensitivity to family systems, in which we are all embedded, adds value to health outcomes. These outcomes have ripple effects on the community and society as a whole. The COVID-19 pandemic has shined a light on many issues that had previously been sidelined in modern medical practice. A response to this public health emergency must be family-focused. Families must emerge as a centerpiece of medical and mental health care (6).

A major additional area of concern is the impact of the pandemic on health care workers and their family members (7,8). The CDC estimates that hundreds of thousands of health workers were infected by the virus. A recent study based on CDC data revealed that more than 3,600 U.S. health workers died during the first year of the pandemic, including doctors, nurses, support staff, and nursing home employees (9). Again, health workers of color were disproportionately affected (10). Infection, death, long hours of caring for extremely sick patients, isolation from family members, and fears of infecting family have led to increased rates of burnout. It is the families of the health workers that pay the highest price for this burnout.

The impact of the COVID-19 pandemic on our American families, including the families of health care workers, must be urgently addressed with robust action. We strongly recommend four levels of family support be implemented as soon as possible.

First, we propose that a national day of mourning take place each year to honor those who have died from the COVID-19 pandemic. Families need a collective date to memorialize their loved ones, a time of grieving and remembrance across all levels of our society. In Massachusetts, for example, March 10, 2020 was the date a state of emergency was called. WHO did so on March 11.

Second, families need useful information from public health officials on how the pandemic has changed the family unit. This would include health and mental health resources on dealing with grief, coping with loved ones dying alone, and the cumulative impact over time of the loss of grandparents on relatives and grandchildren.

Third, health care institutions need to actively reach out to their staff in order to guarantee the safety and security of their families, and provide counseling and financial resources if necessary.

Fourth, President Biden in his new American Families Plan can address these issues by offering a national initiative to train America's primary health care providers in grief counseling that addresses family systems. Every

primary care patient, including health care workers, needs to be asked:

Did you lose a loved one from COVID-19?
If so, how is this affecting you and your family?
What physical and emotional support do you need in order to cope with this loss?

Health care workers and their families are not immune to the impact of COVID-19. In fact, in their intense devotion to the COVID patients, health care workers may be hardening their basic resilience style: "The patient comes first" and "Never show weakness." (11). A confidential chat with their trusted primary care practitioner may be therapeutic for them as well as their families.

This simple screen can lead to the offer of culturally effective counseling and psychosocial support, case management, and, most critically, the prevention of serious chronic diseases due to traumatic losses.

Families must emerge as the centerpiece of medical and mental health care and the self-care of our health care workers. Self-care must begin with the top priority: "Take care of your family and loved ones first." (12)

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Dr. Mollica is a Professor of Psychiatry and Director of Harvard Program in Refugee Trauma. Dr. Charles is a Licensed Marriage and Family Therapist in Boston, Massachusetts.

Message from Randall Hagar, Legislative Advocate, Psychiatric Physicians Alliance of CA, to SCPS Members:

$100 billion Lightning Round.

Lightning has struck.

California has discovered it has $100 billion in disposable income, the sum of a projected $77 billion state budget surplus, and $23 billion in federal stimulus funds coming to California. Psychiatrists send your spending priorities and suggestions to us. Don't be afraid to suggest big lump sum projects. The Governor has. The budget is due to be finalized in the near future, tell us, what would benefit psychiatric patients the most? What would benefit California the most? The $100 billion in surplus funds is the largest in California history, the largest of any state, ever! PPAC is already working with budget committee staff on some ideas (hint: acute inpatient bed stimulus). Let's see what you got! Do it soon!!

If you have ideas or suggestions please email them to SCPS Executive Director Mindi Thelen at socalpsychiatric@gmail.com.

# Life, Death, and Resilience: Ethics in the Era of COVID-19

Rebecca Weintraub Brendel M.D., J.D., DFAPA

Perhaps it's redundant to say that the last 15+ months have been like no others in our lifetimes. Without warning — or at least without an appreciation of the potential global magnitude of what was to come — COVID-19's grip on our lives from the day to day ways we lived to the ways we practiced in our professional lives has been unrelenting. Now, as more than half of eligible Americans have received at least one dose of vaccine, as the incidence of COVID-19 is decreasing and deaths are on the wane, how can we reflect and understand this moment in time to chart the future of our profession and our lives? As a psychiatrist who focuses on ethics, I'm drawn to reflect on where the field of medical ethics was concentrating its efforts pre-pandemic, where it has found itself now, and where we must go into the future as we chart a course for our 'new normal' with cautious optimism. We must be deliberate, humble, and tireless in our responses: individually and collectively.

Where can we start? One way of looking at the legacy of COVID-19 is to look at how ethics engaged life and death pre-pandemic and where we are now. Back in the spring of 2019 at a time we can hardly remember, our bioethics center at Harvard filled an auditorium for a multi-day conference entitled 'Controlling Death,' which focused on the ethical dimensions of care at the end of life with a particular focus on medical aid-in-dying (physician assisted death). In the conference, we queried the parameters of individual autonomy of persons to make decisions about accepting or refusing care at every stage of life —a tenet now deeply embedded in US law and medical ethics for more than three decades. Based in this deep appreciation of autonomy, the conversation progressed to where we found ourselves at our annual bioethics conference. Specifically, what are and ought to be the parameters of individual liberty in controlling the timing and manner of one's death, including the right to access medical assistance in ending one's life, either indirectly through legally-sanctioned receipt of a prescription for a lethal dose of medication to be taken in the future (now legally permissible in a growing minority of U.S. jurisdictions including California) or directly via physician-administered euthanasia — which remains illegal in the US but is now lawful in Canada and several other countries.

Abruptly, COVID-19 changed the landscape and brought urgency to what previously seemed hypothetical: the looming crisis of more patients in need of critical care than the resources to provide that care. As physicians and front-line workers faced the risk of COVID themselves, who would determine the patients to place on ventilators, who would decide which patients would not receive resources, and how would those decisions be made? In every attempt to sidestep the implementation of crisis standards of care, the scientific and medical communities implored the public to flatten the curve and come together against this devastating new pathogen. By the time of the surge in Boston, where I live, crisis standards of care were not invoked. But the shadow of death lingered. If a single virus could grind society to a halt globally and tax our healthcare resources to the limit, our preoccupation with being the autonomous, individual authors of our own destiny seemed —at least on some level— foolish hubris.

Even more, the endings of the COVID-19 surge in the spring of 2020 laid bare the many problems our ethical inquiry about controlling death had sidelined. We should not, it turns out, have been relieved to learn that data from Oregon, the first state to legally authorize physician-assisted-death, showed that those who availed themselves of the option were not disempowered or marginalized for the most part: they were white, educated, and insured. Granted, Oregon's population is demographically different from other parts of the U.S. But what we weren't asking about or addressing was the larger societal issue of access to and availability of high-quality palliative and hospice care for all persons. Our focus on a 'good death' for some eclipsed focus on the full arc of life — and death — for others. And in its stress-test to our broken system of care, COVID-19 spared no time in bringing these glaring disparities in our society into stark focus. Just one manifestation of these inequities was the disproportionate COVID-19 death rates in Black communities, in particular, last spring and the ushering in of a flood of long overdue reckoning with systemic racial injustice and violence generations in the making.

So, where do we go from here? First, we must continue to respect each other as persons — as embodied by individual autonomy — yet not retreat to the fallacy that we live as individual beings disconnected from those around

us. We must embrace relationships and community in capturing our full humanity rather than to continue conceptualizing medical decision-making as an individualistic rational act. In death, and in life, we must as psychiatrists hold front and center the narrative arc of lives of care lived in spheres of community and care and embedded in the lives of others. We must take on this project both for individuals and for the collective good. In addition, if we as physicians want to be serious about health, we need to get serious about not just the individual decisions of patients and doctors, but also about the systemic factors that prevent the advancement of health, and life, for all.

In the only 24 hours we have each day, in order to do this work towards a brighter future post COVID-19, we must take care of and nurture ourselves and our medical profession and communities to support the important work ahead. Caring for ourselves as caregivers must be as deliberate as caring for others. After 15+ months of telemedicine and zoom meetings, cancelled conferences and social media as connection, let us be considered and focused on rekindling relationships and constructing collegiality and community within our profession to create environments supportive of change, growth, and progress. Let us approach our efforts in the care of persons and humankind with humility and heart, beginning from within. And let us never forget to enlist humor, joy, and celebration in building our resilient profession in anxious anticipation and realization of the possible. With these renewed commitments to each other, our relationships, our profession, and those we serve, the future is bright and all may flourish. And, even more, the next time we face a formidable foe — infectious or otherwise — we can hope to find ourselves beginning from our commitments to advancing equity and prepared for any challenge.

Rebecca Weintraub Brendel is the director of the Master's Degree Program at and Associate Director of the Harvard Medical School Center for Bioethics. She bases her clinical work in psychiatry at Massachusetts General Hospital (MGH) where she is the director of Law and Ethics at the Center for Law, Brain, and Behavior, provides medical oversight for the hospital's inpatient guardianship team, and practices clinical and forensic psychiatry.


*SCPS Presents*
**E-Prescribing: Mandatory in California 2022**

An Online Meeting
**Saturday, September 11th, 2021 9:00 A.M.**

Registration Open Soon!

Hear from our colleagues already using E-prescribing:
Matthew Goldenberg, D.O., Heather Silverman, M.D., Steve Soldinger, M.D.

**Also**
**Reducing Risks When E-Prescribing and Using Electronic Health Records**

Allison M. Funicelli, MPA, CCLA, ARM, CPHRM, FASHRM

Assistant Vice President, Risk Management Group

**Description of Presentation**
This presentation will focus on the benefits, potential risks and best practices associated with e-prescribing. The webinar will cover topics including e-prescribing systems and vendor functionality and compliance with CA regulations related to e-prescribing. At the conclusion of the presentation, the attendees will obtain strategies to reduce the potential liability when e-prescribing and using electronic health records.

Allison has over 30 years of experience in medical professional insurance industry. She assisted in the ground up build-out of two successful medical professional insurance carriers. Allison is an active member of the Connecticut Society for Healthcare Risk Management (CSHRM) and has served on their board in positions of Director, Treasurer and President. Allison is a member of the American Society of Healthcare Risk Management (ASHRM), the Massachusetts Society for Healthcare Risk Management (MSHRM) and the Professional Liability Underwriting Society (PLUS). Allison frequently speaks on national, regional and local levels on topics related to claim and risk management

A Vendor Fair will also be featured.

Please note that e-prescribing will be mandatory for ALL prescriptions in California:

California State Mandate: All Prescribers: In 2018, the legislature of the state of California passed Assembly Bill 2789, mandating electronic prescribing for California prescribers beginning on January 1, 2022. The bill specifically requires prescribers to employ electronic prescribing for all prescriptions, and requires pharmacies to be equipped to receive said electronic prescriptions.
See full text here: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2789

# Commentary on Physician Suicide and Burnout

By: Ira Lesser, M.D.

Over the last decade or so, there has been an explosion of interest in and writings about burnout, work/life balance, depression, suicide, and substance abuse in physicians, with psychiatrists included in these concerns. When asked to contribute a piece to the SCPS Newsletter's edition devoted to this crucially important topic, I wondered what could be said that was not already written about and discussed more eloquently than I could do here.

I decided to share some thoughts about two aspects of well-being, one related to the challenging times we all have experienced over the last year and the other an issue for those of us who have colleagues referred to us for assessment and/or treatment. Both of these issues, though not apparently related, coalesce when one considers the role that we, as psychiatrists, play in providing these necessary services.

We do this work for many reasons, both internal and external. At the core is the notion of wanting to provide a service to reduce another's pain and anguish, to be a helper, to honor the derivation of the word psychiatrist as a "healer of the mind (or soul)". This is what we strive to do and what is expected by those who seek our care. But what happens when, for whatever reason, we are thwarted in our ability to do this? How do we process those situations where our efforts to help are unwanted, unwelcome, or even denigrated?

In my work in a public/academic hospital, I have chaired our Well-Being Committee for over three decades, and during the last year I worked closely with wonderful colleagues in setting up multiple programs for all staff to process their emotions and get support in the face of dealing with the COVID pandemic. Like all hospitals, we were overwhelmed with the numbers of COVID patients, the numbers of deaths, and the witnessing of families unable to take part in the necessary rituals of dying and death. Add to this the very real fear (particularly in the early days) of healthcare workers getting ill and infecting their families, the unrelenting workload and fatigue, the changing roles, and the unknown future. We were able to provide a considerable number of individual and group sessions for support, for discussing anxiety and depression, fears, post-traumatic symptoms, etc.

Remarkable to us were the relatively low numbers of physicians who sought our services, despite setting up dedicated confidential phone and email services and sending out notices to physician staff and to physician administrators encouraging staff to utilize these services. We all witnessed the struggle of our colleagues and heard them talk about the difficulty of watching patients suffer and die and about their own exhaustion; but most of this discussion was about how hard it was for them to see their staff (e.g. trainees, nurses, respiratory therapists) suffer and remarkably little about how it affected them. Trying to engage them to discuss their own reactions was, for the most part, unsuccessful.

We all can hypothesize reasons for this reticence to seek help. This reluctance has been written about quite extensively in the physician well-being literature. Issues of shame, stigma, concerns about confidentiality, concerns about being perceived as "weak" or "complaining", fears of being ostracized if colleagues or administration knew how they felt or if they sought help, time constraints, and not wanting to be asked to discuss the traumatic memories, hoping they will go away on their own. During the pandemic, physicians who often were leaders of their teams, diligently worked to provide the services to patients and support to their team members. It is entirely possible that in this process, they felt the need to be strong and to be seen as strong, denying their own emotions, and eschewing any offers of help. Whatever the reason, it appeared that we, who so strongly wished to be of help, were unable to do so. A sense of helplessness pervaded our efforts. What did we do wrong in our approach to providing services? How could we have been more sensitive? What did we miss? Although we discussed this and were told by other colleagues, that "we did all that was possible", somehow, that felt hollow and unsatisfying.

I liken this to the pre-pandemic experience when a physician was referred to a well-being committee, usually because of colleague's or supervisors' concerns for a behavior change and/or concerns about depression or sub-

stance abuse. These meetings can be difficult in two ways: Hearing the stories of colleagues, at least to the extent that they are willing to share, is often heart-wrenching. I have often wished that I was not the one with who they were discussing personal and family issues. Or, difficult in another way is hearing that the issues for which they were referred, regardless of their seriousness, were totally someone else's fault, or the result of a non-responsive system, and that there was no need for them to be discussing this with me in the first place. As if I was part of the problem.

We all know about countertransference and its ramifications (both positive and negative) in assessment and treatment. What I am writing about here are the set of feelings experienced when we cannot, or are not "allowed" to, fulfill our mission as "healer of the soul". I have felt the uncomfortable combination of helplessness and powerlessness when faced with a physician colleague so obviously in need of help but who adamantly refuses it, and with being unable to help colleagues who have suffered so much during this last year because of the myriad obstacles to their availing themselves of the services offered mentioned above.

What can be done about this? On the macro level, we can continue our efforts in educating our colleagues about the value of seeking support, counseling, therapy or however we frame the therapeutic situation. We can continue our work to reduce the stigma of seeking help, even when, as with COVID, the "reasons" for the dysphoria are apparent. Intellectually, we know that this unprecedented stress has serious emotional consequences; for our physician colleagues, this explanation may serve to "inoculate" them against seeking help. But the suffering continues.

For those of us in positions to provide these services, who wish to help but find ourselves unable to do so, seeking support of colleagues who may have similar experiences may help to mitigate the discomfort. We need to recognize that it is likely not the case that if we were (choose one or more) "smarter", "more empathic", "more sensitive", "more charismatic", "more approachable", or whatever we may say to ourselves, we would be more successful. More likely the salient feature preventing our providing help are the broader cultural reasons and barriers inherent in the practice of medicine. We must be vigilant in monitoring ourselves, as sitting too long with the feelings of helplessness and powerlessness to do what we so fervently wish (and need to do) and not having an outlet to discuss these frustrations, runs the risk of us experiencing the very same burnout issues and emotional dysphoria as those we seek to help.

**FEATURED ARTICLE**

# Working Together to Prevent Clinician Suicide During the Covid-19 Pandemic and Beyond

Christine Yu Moutier, M.D., Chief Medical Officer, American Foundation for Suicide Prevention

*The following article is a modified version of "Preventing Clinician Suicide: A Call to Action during the Covid-19 Pandemic and Beyond" which originally appeared in the May 2021 issue of Academic Medicine, Journal of the Association of the American Medical Colleges. That piece, found here, was co-authored by: Christine Yu Moutier, MD; Michael F. Myers, MD; Jennifer Breen Feist, JD; J. Corey Feist, JD, MBA; Sidney Zisook, MD*

In April 2020, Dr. Lorna Breen, a talented NYC emergency physician working on the frontlines of the Covid-19 pandemic, took her life. Dr. Breen was one among a number of clinicians who have tragically taken their lives over the past year.

Sadly, the problem of physician suicide is by no means a new phenomenon related to the pandemic. The risk of burnout, depression, suicidal thoughts and suicide amongst physicians are higher than the general population. The stigma of seeking help is pervasive and reinforced by licensing boards in many states inquiring inappropriately and intrusively about mental health conditions or treatment.[1] The pandemic is presenting a new layer of risk to population suicide,[2] which certainly includes health workers on the front line and all members of the work force.

In response, Dr. Breen's family launched the Dr. Lorna Breen Heroes' Foundation, a lightning rod for advocacy in the ongoing fight to reduce physician suicide. The current centerpiece of their work is federal legislation championed by Senator Tim Kaine entitled the Dr. Lorna Breen Health Care Provider Protection Act[3] aimed at supporting the well-being of healthcare professionals and reducing burnout and suicide. Dr. Breen's story has helped raise awareness of the problem of physician suicide. Yet there are things those of us in the medical community must do to help save lives.

Long hours, heavy workload, onerous health care system changes, lack of autonomy, and increased time spent on computers instead of with patients are obvious set-ups for burnout and cynicism. Added to these workplace factors are a stoic culture of self-sufficiency and real and/or perceived barriers to help-seeking which allow deterioration in well-being to go unaddressed and to potentially spiral into more severe, entrenched mental health problems.[4] One well-established effective method to prevent suicide is treatment of depression, yet the majority of physicians and nurses with depression do not seek professional care.[5]

Fortunately, even before the pandemic, several national initiatives have emerged to address the issues of physician and nurse well-being, burnout, and suicide.[4] What these many programs have in common is attention to evidence-based practices, safe and accessible avenues for physicians and nurses to address mental health concerns, confidential and timely follow-up and stigma reduction.

Since suicide is a complex health outcome with many drivers of risk, preventing suicide requires a strategic, multipronged, evidence-based attack that can be sustained over time. Despite numerous organizations making suicide prevention a priority, change has been slow to start, but perhaps now reaching a tipping point. Reducing the suicide risk of health professionals requires changes in regulatory policies, curricula and role modeling in medical education, increased access to mental healthcare, and transformation of entrenched culture.

Despite these challenges, we are seeing a readiness to act like never before among various parts of the healthcare infrastructure. Below are the top actions that have the most evidence for suicide risk reduction, organized by role and type of organization within the healthcare industry.

<u>Regulatory Agencies, Licensing Boards & Hospital Privileging Boards</u>

Follow the recommendations of the FSMB,[6] AMA,[7] APA,[8] ACEP[9] and others to refrain from asking questions about health professionals' mental health. This practice of asking intrusive questions about diagnoses and treatment history has been shown to be an ineffective way to detect impairment and protect public safety; it is also at odds with the American with Disabilities Act in many instances.[1] Moreover, it has driven treatable health issues underground and prevented scores of health professionals from accessing effective treatment that *can*, in fact, protect both patient safety and the health and careers of the providers themselves.[4] This change may be the most important "lynch pin" to dismantling a toxic infrastructure that has perpetuated fear of getting help for too long.

Launch communication strategies that allow health professionals in each jurisdiction to be aware of the protections afforded to therapy, psychiatric treatment and addiction recovery. Policies and procedures related to matters of health must be transparent and effectively communicated.

Develop initiatives for HCPs that safely address barriers to addressing one's own suicide risk factors and health concerns; e.g., the Interactive Screening Program of the American Foundation of Suicide Prevention, now implemented by academic institutions, health systems and even state associations.[5]

Pass the Dr. Lorna Breen Provider Protection Act[3] as it encompasses many of our recommendations.

Specialty Boards, Professional Associations, Continuing Education Organizations

Within each health discipline, specific barriers must be identified and addressed. To accomplish this, workgroups with members at all levels of seniority and settings can optimally accomplish these goals.

Board certification and continuing education bodies could incorporate questions related to self-care that help drive the point that alongside medical knowledge, technical skills, and empathy for others, the ability to optimize one's own mental health, including availing oneself of mental healthcare, is an essential component of professional responsibility.

Medical Educators

Ensure policies at the UME and GME levels provide the greatest access to mentors, support, and mental healthcare without punitive consequences, e.g., build in debriefs following critical incidents, encourage therapy as a way to optimize resilience, allow for access to treatment within and outside of the home institution when feasible.

Be transparent; communicate clearly about how trainee challenges are handled.

Prioritize and promote a growth mindset: e.g., "*Every HCP struggles at times. It's a sign of strength to address challenges. It's commendable not to wait until the point of crisis to get help*."

Continuously provide information about how trainees can access support, guidance and mental health treatment. Resources can be listed on the back of i.d. cards, on program websites, etc.

Introduce self-care early in the curriculum as a practice linked to professionalism that can be cultivated throughout one's career.

Model mental health literacy by disclosing human struggles when appropriate, and by mentioning that we as leaders regularly lean on others for support or treatment.

Provide opportunities for storytelling to set new norms with hopeful narratives for addressing struggles.

Enhance peer support by teaching trainees how to reach out and respond to distressed peers, cultivate active listening skills, and utilize available resources for support.

Individual Health Professionals

Cultivate daily habits of self-care by being curious about "how you tick;" i.e, take note of and practice the activities that lead to positive outcomes.

Realize that mental health is a dynamic part of human health for each of us, which means we can have

some influence over our own mental health outcomes; e.g., staying on effective treatment for a recurrent pattern of depression or anxiety is an obvious way to positively impact mental health.

Look out for your colleagues; realize that subtle changes in behavior can be the “tip of the iceberg” indicating more significant struggles.

Don’t fall prey to assuming that accomplished peers have it together and don’t ever struggle; i.e., check in on your strong friends.

Learn how to have caring conversations, colleague to colleague, that invite deeper disclosure.

When dialoguing with a distressed colleague, remember with distress comes negative cognitive distortions, so it’s critically important to state the obvious: that you respect them, think well of them for getting help, are willing to help them connect with treatment; and will continue to be there for them. If you have struggled previously, you may have special empathy that can be marshalled to help them understand they are not alone.

It is too early to know whether clinician suicide rates have changed since the beginning of the pandemic. However, this challenging time in our history has increased the realization that the mental health of health professionals must be protected, and placed the problem of physician suicide been front and center. This collective momentum has been further energized by the tragic loss of Dr. Lorna Breen. Medical educators, professional associations, insurers, state medical boards, suicide loss survivors and clinicians with lived experience have all come to the table. It will take all of us. It is time to reject the myths and stigma so many discriminatory policies were based on and allow mental health challenges to be addressed as the health issues they truly are.

**Read the full article here.**

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# Medical Student Burnout and Well-Being

By Dinesh Bhugra, M.D.
Department of Mental Health and Cultural Diversity, Institute of Psychiatry, Kings College, London, U.K.

Medical students are the future work force and the key to patient care and wellbeing. Yet they exist in a vulnerable age group wherein 75% of psychiatric disorders start - and for a variety of reasons: the stress of medical education, financial responsibilities, and rapid changes in learning and practice are likely contributors to burnout. To address medical student well-being is an investment in the mitigation of future illnesses, and a key to optimize community health.

It's been recognized for over 50 years that doctors and medical students are prone to higher risks of psychiatric disorders and burnout. Burnout has been defined as a pervasive and debilitating state resulting from a period of overwhelming stress, but has classically been defined as an experience of physical, emotional and mental exhaustion. Burnout has three major components: emotional exhaustion, depersonalization and an absent sense of personal accomplishment. Emotional exhaustion is the feeling of being emotionally overextended by one's work with a detrimental effect on functioning. Depersonalization includes an unfeeling, unempathetic impersonal response. A lack of personal accomplishment in a highly competitive group may further compound a sense of despair. This differs from stress, which involves over-engagement, urgency, and anxiety with physical symptoms - unlike burnout wherein one is additionally prone to despair and depression.

Causes of Burnout:

A lack of workload control is a precipitating factor, given the relation of burnout to work performance. Monotonous, chaotic and/or mundane routine work interspersed with complex urgent tasks add to the likelihood of burnout, especially with inadequate breaks or lack of access to reasonable working conditions. Select personality types may compound the problem, particularly those with a tendency to perfectionism, competitiveness, or traits of control.

Stages of Burnout:

The first stage of burnout pertains to stress arousal, poor concentration, memory lapses, irritability and anxiety. This may be followed by stage of energy conservation and maladaptive strategies - such as avoidance, tardiness or social withdrawal. The third stage is that of exhaustion - which can be associated with anxiety, depression, apathy and suicidal ideations. This results in disappearing acts, low work rates, rage, or difficulties with examinations.

Burnout may be seen as a result of working conditions and the stress that occurs as a result. Most doctors tend to work long hours and worry about the welfare of their patients, which can be further burdened by a fear of things going wrong and 'blame culture' - but being fastidious bordering on obsessional comes with the territory. So why do medical students experience burn out?

A series of studies encompassing 12 countries revealed 66-69% burnout rates, although these were online surveys and may not have been entirely representative. Similar findings emerged from more recent surveys from 25 countries.

A qualitative study from the UK identified five key factors:

Systemic factors: Medical students were not always considered as part of the team. In some situations they were seen as an additional burden.
Occupational factors: Clinical responsibilities and the availability of staff support were relevant factors. Simulation training rotations were found to be unhelpful and not as genuine.
Interpersonal factors: Not feeling as included in the team.
Environmental factors: Practical issues i.e work space, place to rest, access to a nutritious diet.
Sociocultural: Cultural and structural factors impacted a sense of support.

International surveys have identified 4 types of stressors including relationships with peers and parents, financial pressures, accommodations and studies. These vary according to cultures - which additionally impact cannabis or alcohol use. 79% of medical students have reported cannabis use in Portugal and higher rates of alcohol have

been reported in Wales and Paraguay.

Stressors in the academic field include increased scholastic workload, high stake examinations, excessive tests and expectations, and competitiveness with consequent influence on career choices. Stressors in the clinical years tend to include unfamiliar environments, variable types and degrees of supervision, poor role models and poor quality of teaching. Personal stressors include leaving home for the first time, loss of contact with parents and friends, difficulties in forming new friendships and loneliness. Unrealistic expectations of the self and by others can be stressful. Familial pressures and expectations can also add to the vulnerability of burnout.

What is needed?

An important solution is the development of resilience. Resilience is defined as an individual's ability to adapt and manage stress, having a grounded moral compass, good role models or mentors, physical and brain fitness, cognitive and emotional flexibility, and having meaning, purpose and growth in life - with realistic optimism.

Prioritization of activities and Self-care: This is important as mental health is critical to one's functioning. Physical activity, yoga, meditation, mindfulness and other activities can facilitate relaxation in order to maintain a healthy and balanced lifestyle

Peer support: Recognition of peer pressure and provision of mutual support strengthens social networks.

Access to and utilization of confidential services from primary care physicians - without feeling stigmatized. Support organizations must be publicized and easy access made available. Medical students need be clear about boundaries and seek help early and feel able to share problems.

Organizations including medical schools and universities must offer spaces in which to rest and relax, wellness programs, confidential support, and resources for the prevention of bullying and harassment.

Maintainence of good relationships, a sense of humor, and taking regular breaks.

These are some of the broad principles. Some solutions may need to be modified according to cultural variations. It is important that medical students are taught to look after themselves so that they can look after their patients. Recognition of one's own vulnerability will make an individual a better and more empathic doctor.

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# The Physician Support Line

By: Mona Masood, D.O.

"Hey, any of you guys writing your will? Where do you start?"

I saw this social media post in a large physician forum created specifically and urgently for exchanging clinically relevant information on Covid19 in March of 2020 - I felt sick.

Did any of the thousands of physicians in this forum know what this meant? What was really behind their seemingly casual words? This colleague, an ICU doctor in New York, was talking about dying almost as though it was imminent, but could not, or would not dare admit to having emotions about this. It was much more acceptable to be pragmatic and almost clinical about death, even your own. That was the implicit expectation of the culture of medicine.

But the doctor and human in me couldn't let it go. I thought about that post, and the ones that followed. Doctors talked about anxiety, depression, insomnia, escape fantasies, and poor coping. And they all hid it behind the façade of objective language, rationalization, intellectualization, and the defense mechanisms primed and ready for physicians.

Finally, I did the opposite. I acted impulsively.

*"CALLING ALL PSYCHIATRISTS! Who would be interested in joining an American group of psychiatrists to provide an on-call hotline for our physician colleagues…who really need to talk...during the course of this pandemic?"*

I was relieved when my psychiatrist colleagues saw the same risk factors for an impending physician mental health crisis, the same worrisome writing on the wall.

Physician Support Line started off as 50 volunteer psychiatrists who answered my post, then 100, 200, 400, now at over 800 who volunteered to center and support their peers, colleagues, friends, and mentors navigating the many intersections of their professional and personal lives. As our numbers built, so did the feedback from physicians and physician organizations. The carefully crafted defenses started to reveal cracks. People commented with messages and testimonials of thankfulness, hope, vulnerability and desire for this kind of service to outlast the pandemic.

It was over a year ago that Physician Support Line was formed and this incredible serendipitous group of sincere, intelligent and empathic physicians joined together in this mission of normalization and validation of physician mental health. We are humbled and in awe to have supported thousands of colleagues since.

## ***LESSONS LEARNED***

There was no doubt, in those early days, that we were building this plane as we flew it - a natural outcome of most crisis situations. Besides having to learn how to logistically operate a support line, including legal and ethical considerations of malpractice and medical licensing, anonymity, and suicidality - we became immersed in the many individual and systemic barriers that led to the mental health struggles we were addressing on the Line.

In our weekly debriefing session with the volunteer community, we would discuss our own emotional processing of the calls, at times joy and connection with our peers over the shared experience of being physicians, the validation and normalization that can be so grounding when you receive it from someone who "just gets it". And at times, the topic would be projective identification and internalization of their helplessness, frustration and cynicism of a broken medical system that valued the bottom line and not the physicians that served and the patients they served.

We became very familiar with one statistic. 300-400 American physicians die by suicide yearly. That averages out to one physician death per day. This was true even prior to the pandemic but now we had permission to speak about it. The media, community, and our government called us “heroes” which was damaging and isolating in the way it felt like we were sacrificial lambs for this pandemic, but it inadvertently gave us the outlet to take back our narrative.

We quickly learned that there were two important aspects to sustainable change: individual reform and systemic reform. Physician Support Line focused initially on the individual aspect, similar to other movements such racial and gender justice and reform. We first focused on individual stories, and looked at patterns of discontent and roadblocks for our physician and medical student callers. We validated and normalized these narratives, in hopes of creating a ripple effect of similar conversations amongst peers that would lead to motivation for change, and hope for the future.

Though we theorized the inception of this support line that the need and utilization for an anonymous, unaffiliated, peer to peer support line was born of a punitive medical culture and healthcare system - thousands of conversations confirmed it. We understood that the physician mental health crisis we were witnessing was vilified as the ultimate fault of a doctor. Furthermore, it was a fault that delegitimized years of intellectual, financial and emotional investment in a career that was not just a job, but an identity. It is at this intersection of fractured identity that suicide presents itself as a viable option. We needed systemic change.

We are now partnering with multiple physician-led and focused organizations to reframe mental health questions on medical state licensing applications, and hospital credentialing forms to encourage rather than penalize mental health seeking behaviors. We have also encouraged our volunteer group to reach out to their local medical schools and graduate medical education programs to speak openly about systemic changes - outside of sporadic wellness didactics on burnout.

We are simultaneously proud and humbled by our work, mostly because it has brought us back to the roots of our commitment to medicine: service, community and health for all. And this time, we unapologetically include ourselves in those goals.

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*Dr. Mona Masood, DO is the founder and chief organizer of Physician Support Line, a peer-to-peer support line run by volunteer psychiatrists to help our medical student and physician colleagues navigate the many intersections of our personal and professional lives. You can learn more or sign up to volunteer by visiting www.physiciansupportline.com, following us on Twitter at @PhysicianLine and Dr. Masood @ShrinkRapping and our Facebook page.*

*If you would like to debrief yourself about any subject, not just crisis, with an anonymous colleague who understands the joys and difficulties of medicine, please call us at 1-888-409-0141 8am ET to 1am ET 7 days a week.*

# Vicarious Trauma in Forensic Psychiatry

Joe Simpson, M.D., Ph.D.

Trauma and its sequelae are ubiquitous topics in the mental health profession. Less well-known is the potential impact that working with patients who have experienced trauma can have on mental health professionals. Such exposure is particularly common for practitioners in certain areas of the field, including forensic and correctional psychiatry, as well as the treatment of patients impacted by natural or man-made disasters.

The deleterious effects of exposure to traumatic information in mental health providers have been conceptualized as 'vicarious trauma.' (1) Vicarious trauma can lead to depression and to symptoms similar to those of post-traumatic stress disorder. 'Compassion fatigue,' a term that has some overlap with vicarious trauma, has been defined as 'deep feelings of suffering, sorrow, or sympathy (to the point of exhaustion) that are associated with a desire to alleviate the suffering of another person. It reduces therapists' capacity or their interest in bearing the suffering of others.' (Ref. 2, p. 303) 'Burnout,' i.e., '[f]eelings of emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment that leads to decreased effectiveness at work' (3) is also linked to the experience of vicarious trauma.

Frequent and repetitive exposure to traumatic material increases the risk that a psychiatrist will be negatively affected. The extreme stimuli that forensic psychiatrists can be exposed to, especially when working on criminal cases, elevates the danger of vicarious trauma. For example, in the course of their work, forensic experts may be required to review photographs or audio or video recordings of terrible acts of criminality such as rape, torture and murder.

Prominent Canadian forensic psychiatrist John Bradford has written and spoken about his experience of vicarious trauma resulting from his work on a notorious case in which a husband-and-wife pair of serial killers made video recordings of their crimes. In keeping with the adage that doctors make the most difficult patients, Dr. Bradford did not seek help until after his condition had become so severe that he made a serious suicide attempt (4).

In forensic psychiatry, there is often an attitude that forensic practitioners are or should be 'tough' enough not to be fazed by exposure to the details of horrible events, or by interviewing those alleged to have perpetrated such crimes. Dr. Bradford has acknowledged that this self-conception caused a significant delay in his seeking care, almost ending his life. In the past few years, it has become clear that this conceptualization of the imperturbable forensic psychiatrist is more myth than reality, and that vicarious trauma is a real danger for mental health professionals in the forensic field no less than in other areas. As Dr. Bradford and a co-author wrote in a 2020 editorial, '[e]xperts in the forensic psychiatry field have often viewed reading about and viewing crime scenes as an interesting and expected part of their work. However, the insidious creep of more images and more details allowed progression of the effects of vicarious trauma to go unreported for so long.' (Ref. 1, p. 1)

Ultimately, Dr. Bradford realized that forensic psychiatrists are by no means immune to the effects of repetitive exposure to traumatic material, and received treatment that led to his recovery. He also learned that it is essential to take steps to protect oneself against this risk. '[W]e in forensic psychiatry should firstly acknowledge that vicarious trauma is an occupational hazard in the forensic psychiatry domain. We can and should develop guidelines for the management of forensic psychiatry material. We should also put in place accessible supports for those experiencing vicarious trauma.' (Ref. 1, p. 2)

In one of the few published studies of vicarious trauma in forensic psychiatrists and psychologists, Barros et al. reported that the experience of undergoing one's own personal psychotherapy had a protective effect, reducing rates of vicarious trauma (2). The authors pointed out: 'It is challenging for experts to be able to recognize their own state of mind and emotions and to manage these aspects. This process requires constant self-observation. Personal psychotherapeutic treatment can provide the opportunity for experts to face their feelings and find relief, thus enabling the proper continuation of their duties.' (Ref. 2, p. 312).

The value of psychotherapy as a protective activity is important in the context of the broader subject of 'physician

wellness.' Interest in this concept saw a massive surge after the COVID-19 pandemic began. While various structural factors in society and in the culture of medicine can lead to job dissatisfaction, psychiatric manifestations, and suicidality among all physicians, psychiatrists face additional challenges due to the nature of the work. At some point, most mental health practitioners are exposed to stimuli and situations that create a risk for syndromes like burnout, compassion fatigue, and/or vicarious trauma. By recognizing this, we can take steps to protect ourselves. These may include diversifying practice to lessen the amount of time spent with particularly difficult material, seeking peer support or formal mental health treatment, or making other changes to reduce overall stress levels and improve work-life balance.

As the field moves toward a better understanding of the importance of wellness, opportunities to become educated about and promote one's own wellness and resilience have increased. The culture at academic centers and other work venues is gradually changing to recognize the importance of physician wellness. The APA has resources available on its website (3), and a recent article in their monthly publication Psychiatric News is another source for information about tools we can use to promote the wellness of ourselves and our colleagues (5). Now that psychiatry is aware of the danger of vicarious trauma, we can hope that its incidence will start to go down, and more clinical and forensic practitioners will be able to maintain their wellness and continue doing effective and compassionate work.

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**Caring under capitalism**

by: Nisha Sajnani, Ph.D.

Before the Covid-19 pandemic
There was an epidemic slowly spreading
Each day, another headline
About the crisis of physician burnout

*The signs are visible*

In the absence of what used to be present
Joy, time, integrity, optimism, motivation, compassion
And the presence of absence itself

*This is a dilemma of course*

For providers
Become detached and cynical
For patients
Don't feel truly cared for
For organizations
Who lose good people, everyday

*Some blame it on the physician*

It's an individual problem!
Just adapt!

Exercise more! Eat better!
Manage your time!
Get with the program or leave!
And many do.

*Some point to the culture*

You do not have human needs.
Never display vulnerability.
Humiliation is part of the job.
You are a machine.
Sleep when you're dead.

The shame and stigma
Of needing help
Is often felt most acutely
By those who offer help

*Some ask questions*

What if electronic health records
And performance metrics
Measured meaning and care
Instead of maximizing
Efficiency and profit?

What if
What I did
Actually aligned
With what patients need
And who I am?

*Some point to possible answers*

Minimize documentation
Train future physicians to identify
And develop strategies to manage stress
Surround yourself with beauty

Rest

Take refuge in loving relationships
Recall your higher purpose
And organize for change

*What about the money?*

It wasn't mentioned until now
But we know it is always there
In the background
Humming like the Uber driver who
Works his own body to exhaustion
Without a safety net

*What of other economies of care?*

Exchanges that do not abbreviate dignity
But acknowledge our interdependence
Our efforts to balance care

For ourselves and our families
As we care with and for others

Economies that recognize impermanence
As the only constant
The necessity of kindness
In this present moment
And the inheritance of future generations
Our primary responsibility

Dr. Sajnani is Associate Professor and Director of the Drama Therapy Program at NYU, Chair of the NYU Creative Arts Therapies Consortium, and President of the Foundation for the Arts and Trauma.

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# LGBTQ Sadness and Suicide: Reflections on the Concept of Burnout

By: Madeleine Lipshie-Williams, M.D.

Different people, and different groups of people, have experienced this pandemic differently. One of the consequences to communities that have long been marginalized, disempowered and oppressed has consistently been premature death. Our recent pandemic has been no exception. Thinking here specifically about LGBTQ communities, pre-existing factors including reduced access to and discrimination in medical care, over-representation in jobs with both high-exposure and high-layoff risk, and barriers to social benefits all contribute to a greater risk of harm during this time. The secondary effects of COVID on mental health are also borne differently and unequally. We know that social isolation and stay-at-home bring particular burdens to LGBTQ people. Queer and trans people, and especially youth, are already at elevated risk of depression, self-harm and suicide, all things worsened when disconnected from community or required to stay in homes with potentially unsupportive or threatening family.

Doctors have also had a particular, and particularly difficult, experience of the pandemic. Doctors aren't, as a class, disempowered in our society. Rather, we are recognized as a group with authority, and given the power to control that comes with that recognition. So what does that mean for doctors who are also members of marginalized communities? Specifically during this pandemic, where have those allegiances brought us?

This past year I certainly noticed strain from this broken allegiance in my identification. I work in a psychiatric ER, where we have experienced what feels like an onslaught of queer and trans kids thinking about suicide. One day not so long ago, I realized that over that week, I had talked to 7 different trans teenagers who wanted to die. I approached those encounters as a psychiatrist, but I also approached them as another transperson, who had also been a teenager and who had felt very lonely. I started thinking about how exhausting it was to still feel that I don't know how to fully bring these identities together. I also thought about pressures I have felt not to do so.

I have experienced a personal challenge with the categorical separation of patients and providers, them and us, since I started medical school. Some of my earliest introduction to this hard separation was the way we were taught about disease as if none of us could ever have experienced it. I remember once being asked a simple question about diabetes management, the type of question anyone who had themselves managed diabetes would have known, and no other medical students offering an answer. I later asked the group if no one had a family member with diabetes, and about half of them said they did, but they thought the response may be something

they didn't know about. This scenario underscored something about the separation of us, even as medical students, from patients: even if we did share something with our patients, it was not to be used as a source of knowledge. Thinking about our similarities with patients would have no benefit.

My own experiences with conversations about burnout have felt parallel to this medical school teaching scenario. As physicians, we openly discuss feeling burnout, but rarely do we hear about physicians with depression. Even discussing physician suicide, perhaps the most concrete expression of depression and hopelessness, we don't say that one of our own had mental illness. I think of how often I have written the phrase "depressive symptoms in the context of psychosocial stressors" to describe a patient. Particularly after this past year of intense psychosocial stress faced by doctors, why does that phrase not apply? Why do we still create another term, burnout, for ourselves?

This brings me back to thinking about what happens when we see ourselves or our loved ones in our patients. What do we do with that identification, and can it be of use to us therapeutically? Will it endanger our professional identity to admit it publicly? Imagine if when we felt sadness, fatigue, hopelessness and helplessness it wasn't just because of burnout from our jobs, but instead because we are human and experiencing something hard. Imagine if when these feelings reached a certain strength or persistence, it wasn't burnout but depression. We both gain and lose by distinguishing our distressing emotions from those of others, and more specifically those of our patients. I think there is a lot of possibility open to us if we begin to more consciously consider our similarities with our patients, including our similar experiences of distress. These possibilities are particularly notable for LGBTQ physicians who are, like our LGTBQ patients, susceptible to the harms of isolation and rejection, and who may have important knowledge to share.

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# Suffering, Spirituality & Self-Care: Living and Practicing Faithfully in Uncertain Times

By Reverend Dr. Frederick J. Streets

**Introduction**

Conditions over the past year have been challenging, to say the least. A sense of vulnerability and mortality has profoundly impacted people worldwide. The COVID-19 pandemic, social and civil unrest, and inadequate socialization have additionally compounded the stress for many. It seems as though we, as a society, have stood at a dividing line with death on one side and life on the other. Although many sacred texts tell us to 'choose life,' we have witnessed life marred by considerable destruction.

This awareness may cause us to feel overwhelmed, fearful, angry or hopeless. Voices of humiliation, ignorance, and power-mongering are heard on a daily basis, and a sense of personal limitation may be additionally paralyzing or depressing. It may be difficult for some people to hope or imagine a better future. Loving ourselves, our fellows and engaging in self-care practices can feel like trivial pursuits. Pain and suffering may create room for pause - as to options and choices. Those attending to the healthcare needs of others are additionally faced with stresses unimaginable just over a year ago. Stress is experienced physically, emotionally, psychologically and can influence our behavior.

**Burn-Out**

Feeling stressed and burned-out is a normal response to working under stressful conditions without the proper support and resources to do the work expected of us. *Jerry Edelich and Archie Brodsky (1980) in their Burn-Out: Stages of Disillusionment in the Helping Professions. Human Sciences (Press. NY), offers a description of burn-out that has, in my experience, stood the test of time: 'Burn-out is a progressive loss of idealism, energy, and purpose we experienced as a result of the conditions of our work.'* Such conditions may exacerbate pre-existing or underlying medical, emotional, psychological and or spiritual challenges. The process of burning-out can be a repeatable cycle of feeling *enthusiasm, stagnation, frustration* and *apathy*. Each phase requires an intervention to break the pattern or reframing of the work experience in such a way as to reduce feeling burned-out. People who are burned-out need time to recover from the emotional and physical exhaustion caused by the stressful conditions and environment under which they work.

**Suicide**

It is a terrible feeling to think that we have no other options but to be miserable or worse. A report for example, given at the American Psychiatric Association's Annual Meeting, May 5, 2018, 2018 WebMD, LLC. All rights reserved) indicated that:

The rate of suicide among physicians is the highest suicide rate of any profession.

Doctors who die by suicide often have untreated or undertreated 'depression' or other mental ill nesses, a fact that underscores the need for early diagnosis and treatment.

Female doctors attempt suicide far less often than women in the general population, their completion rate exceeds that of the general population by 2.5 to 4 times. It also equals the completion rate of male doctors.

The most common diagnoses are mood disorders, alcoholism, and substance abuse.

Depression is more common in medical students and residents. About 15% to 30% have symptoms of de pression.

Stigma is a major obstacle to seeking medical treatment.

Of all medical specialties, psychiatry is near the top in terms of suicide rates.

Stress, high demands, competitiveness, long hours and lack of sleep are contributing risk factors to sub stance abuse and physician suicide.

**Grief and Self-esteem**

The sense of self as a healer has been challenging for many. Some may grieve the loss of who they thought they were, but this sense of having lost oneself is a subterfuge, a diversion, a distraction from the authentic persons

and healers that they are.

In this current environment we have seen a heightened awareness of our mortality, an increased vulnerability and a greater sense of interdependence. We are all experiencing losses. Grief is a natural response to having lost someone who was and will remain meaningful to us. We can also grieve losing what was once our perspective on life. We can grieve a change in our relationship with someone, resulting in feeling less close to them. Grief can be the felt distance between what once was and what is now. Grief is global, local and personal. Global grief wraps around the world as though it were a new equator - but this grief is a not an imaginary line separating the earth's Northern and Southern Hemispheres or a marker dividing those suffering from the non-sufferers. We can see the grief in the eyes and faces of people around the world. We grieve people being humiliated by bullying and domestic, ethnic and gender violence to name just a few examples.

The painful stories we know or hear about can impact us as vicarious suffering. We take into our minds and bodies the pain of others - as though they are our own. This can result in our becoming emotionally and physically ill. The general use of the word 'trauma' by people is their attempt to give language and voice to the pain of their experiences - but the wide use of the word trauma goes beyond its clinical definition and application, leading to a variety of diagnoses and treatments. One must therefore be cautious when relegating the use and meaning of the word trauma to *pathologies* when some people are just speaking of their encounter with debilitating and stressful situations. Those caring for other's suffering may develop symptoms of compassionate fatigue. They may give of themselves to the point of becoming emotionally, physically, and spiritually exhausted. Vicarious suffering *taking in* and compassion fatigue *giving out* can aggravate and intensify any other mental or physical limitations we may be enduring. These add to the weight of grief.

**Self-Care**

The situations of burn-out, suicide and grief points to the importance of self-care. Self-care is not selfishness. The popular use of the term self-care does not diminish the importance of what it implies. It is our ability to recognize our physical, emotional, and spiritual needs, to accept our limitations and treat ourselves with compassion. Self-care is a planned and intentional daily practice to nourish our physical, emotional, and spiritual needs. Each person decides what these practices will be. It may include spending time with other people - as well as solitude, a mindful diet, hobbies and exercise.

Self-care and self-compassion create a safe emotional space, which allows us to examine our conceptions and perceptions of how we see ourselves and the way things appear. Sometimes feeling depressed and or chronically anxious are medical conditions that need clinical evaluation and care. We may also suffer because we care and love what we do. We may hide that we are struggling and feeling regret or shame. Professionals across the medical and mental health fields are human beings who may be afraid of being stigmatized by their need for care. It is important to our well-being to ask for help and to realize that we are not alone with feeling the way we do. We may need assistance with withdrawing from or identifying with those aspects of our identity that contributes to our suffering.

All of us undergo stress at some points in our lives. Negative stress strains us physically and emotionally, and manifests itself in worry and can cause us to engage in actions that may evoke deep regret and guilt, and corrode self-confidence and self-esteem. We then perpetuate a cycle of suffering unless we get help or change.

**Self-Care Practices**

A daily routine with deep breathing exercises, meditation, prayer, expression of gratitude, commitment to the present moment, and being fully present whether alone or with others - are some of the behaviors that can enhance our well-being. Meditation, breath work, and visualization and physical exercises can also facilitate exploration and identification of emotions and thought patterns associated with the incidents by which we experienced suffering and from which we can heal. Breath work, silence, stillness, prayer, image making and the use of all our senses can be elements of meditation. Meditation helps increase our ways of seeing ourselves, other people, and the world. It is a process that can help to expand and give meaning to our experiences.

Close attention to the impact of our thoughts on feelings and actions is a must for self-care. This means atten-

tion to what we take into our hearts and minds. Toxic images, relationships and negative thoughts poison our spirits and can lead to deterioration. The idea of healthy mindfulness - the joining of head and heart - was expressed by Greek philosophers and is taught by contemporary teachers of spirituality and mindfulness. This kind of healthy thinking, mindfulness and orientation to life doesn't ignore reality, nor the good and bad about life. It can nurture in us a sense of peace as we deal with life's challenges.

**Conclusion**

Empathy, compassion, and self-compassion are essential attributes that enable us to deal with what life brings us. Equally important is how these qualities evoke a sense of love and hope which can encourage us to live and work each day with gratitude, humility and service - and live a loving life - with the hope that was generated in us when we pursued the healing profession we joined. In a chaotic and beautiful world - hope is a powerful contributor to our overall health and sense of meaning in life.

Frederick J. Streets, Yale University former Chaplain, is a licensed clinical social worker and a founding Faculty Member of the Harvard Program in Refugee Trauma, Senior Pastor of Dixwell Avenue Congregational Church in New Haven and Faculty Member of Yale University Divinity School.

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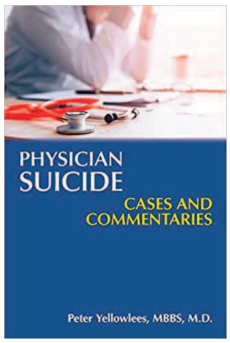
Physician Suicide: Cases and Commentaries
By Peter Yellowlees, MBBS, MD.
America Psychiatric Association Publishing
2019
251 pages
$52 Paperback
ISBN: 9781615371693

Book reviewed by Kavita Khajuria, MD




Approximately 300-400 physicians die by suicide each year in the United States - an underestimated number. Many are preventable. Ten fictional cases bring this topic to life - a collection of unidentifiable composites of patients, situations, media clippings and legal documents from medical boards. With individual foci, each chapter builds sequentially - with commentaries and a case-based curriculum on physician health and suicidal behaviors. The first two thirds encompasses professional lifestyles, expectations and burnout - with an emphasis on interactions between suicide and suicidal behavior. The last third of the book contains more foci on solutions: prevention and treatment.

Chapter 1 'Personal Stress Therapy' begins with a case of completed physician suicide set in the funeral of a popular physician who struggled with depression and alcohol use. The commentary focuses on core beliefs, clinical issues, preventive efforts, and the comprehensive impact on treating providers. Major defenses outline factors that caused avoidance of treatment. The quintessential question remains - "wonder if I could've done anything different" - with guilt and self-doubt. The more uncommon emotional reactions and responses to a patient suicide are noted. The defenses are important to hear - as denial, shame and stigma tend to be some of the biggest obstacles to seeking treatment.

Regulated monitoring and treatment programs are discussed, including success rates at the 5 year mark, as well as the unknowns. The utility of random or routine physician testing is questioned, including the futility of late testing. And not to forget the self-employed or private practitioners (over 50% of practitioners) - who have far fewer checks unless reported by individual patients via self-referral – and elevated risk in residents. Reasons for the higher suicide risks are discussed, including drivers of burnout and barriers to care. Yellowlees notes medical subculture behaviors to encourage denial, self-reliance and the potential for mixed feelings in loved ones i.e "no one really expects (the) healer to destroy himself or herself." An underlying message prevails - physicians are ele-

vated to a higher level, which can make it much harder for them to seek self-help, compounded by the startling fact that half of all U.S physicians aren't registered with a primary care physician. Important questions are raised - should all doctors be routinely and randomly tested, and for which drugs and for how long? Which substances should restrain medical practice? Should the Hippocratic Oath include a component indicative of self responsibility in order to be fit to look after others?

Chapter 2 'Trapped at Work' explores the link with burnout - a concept all too common yet poorly understood. Acknowledging the need for more research, Yellowlees notes burnout to be the likely stressor in the vulnerable. The concept and subclasses are discussed, as well as highly effective strategies, and preventive and corrective resilience.

Chapter 3 'The Second Victim' portrays the downplay of an employee's death by senior management to minimize the possibility of suicide contagion or copycat suicides. A few years ago, a colleague committed suicide and I pondered on the silence – to be a dishonor to the deceased. This chapter portrays physician responses and the reader comes to appreciate the importance of an institution's Wellbeing Committee, especially those that allow for anonymous participation - which caused me to ponder on the shame and stigma of it all - including issues related to lack of confidentiality, and impact on work capacity and medical board reporting.

This case study underscores several other important issues - including victim impact, the second victim syndrome, responses of health systems to suicide, and methods of engagement. 5 stages of a physician's life are discussed, including the stage of increased risk. Yellowlees notes the stress of raising families and the costs to children of hardworking physicians. Acknowledging one's potential to react differently depending on age and situation, he notes common themes to include personal characteristics, community perspectives, cultural expectations and medicolegal fears. Research at the time of this publishing additionally suggests medical school and medical practice settings to be discriminatory or hostile work environments for some LGBT health professionals. Noting the importance of self-assessment tools, Yellowlees discusses UC-Davis models modified from the originals developed by the American Foundation for Suicide.

Chapter 4 'Recovery One Day at a Time'. The costs of alcoholism surface into glaring view. This case outlines family disease, denial, secrecy, and the ability to conceal full blown alcoholism in a functioning doctor. Certain aspects of Alcohol Use Disorder are discussed, including, but not limited to approaches to abstinence, frequency of consumption and medications. Noting how adept physicians can be at hiding their use, disallowing special patient status to derail the process is stressed. The professional risk factors and ethical dilemmas of treating a 'VIP' are noted to include blurred objectivity and poor decision making. Occasionally controversial treatments are acknowledged. The advantages of telemedicine are outlined to include better access to a higher standard of care and a revolutionization with modern technology.

Chapter 5 'The Conundrum of treating the Physician Addict'. The ratio of various substance use disorders amongst physicians, specialties and the genders is enumerated- noting a relation more to access than to the actual disciplines involved. Risk factors are outlined, as well as physician-related stressors, outcomes, denial and the medical profession 'conspiracy of silence' - frequently supported by healthcare institutions. He notes alcohol to be the most commonly abused substance by physicians, and higher rates of prescription drug use in doctors. On a more optimistic note, post-referral physician health programs reveal excellent outcomes.

Chapter 6 'Disruptive Behavior and Life as a Ponzi Scheme' describes the disruptive doctor - noting the disservice to patients, colleagues, and the profession. It acknowledges the behavior as a possible signal for suffering - from a condition responsive to treatment despite uncertainty about management. Four documents are outlined. It describes the more frequent physician afflictions, the psychiatric disorders likely to be associated, and general approaches, citing the Canadian Guidebook for managing Disruptive Physician Behavior. Another important chapter for many reasons.

Chapter 7 'A Sudden Disastrous Day' addresses the aging physician workforce and the national impact, illustrated by a tragic case of cognitive impairment, denial and depression. This raises several conundrums - when does one report or administer cognitive testing - and how often? He notes attempts at implementation through mandates

at identified ages - an uncommon practice - and references the California Public Protection and Physical Health Guideline as excellent, despite the lack of consensus on what age to screen physicians. Competency assessments are differentiated from fitness-for-duty assessments, noting age-based testing to be a prickly issue, and fitness-for-duty assessments as inevitable.

Chapter 8 'The Physicians Physician'. This case study speaks to denial, confusion, humiliation and cultural contexts. The case notes a specific cultural context (East Indian heritage), including expectations, stigma and higher academic expectations from women. Themes include intimidation, deviation from the standard of care, excessive identification, privacy concerns, entitlement, staff intimidation, and the cost to sense of self. Acknowledging the difficulty in treating the physician with a personality disorder, he outlines the impediments to care - including loss of respect and lack of confidentiality, while noting the gender risk paradox and the role of 'doctor mom'. A safety plan is outlined, including the need to address the loss of sense of self. This is an excellent portrayal of socio-cultural factors, the costs of ambition, and offers recognition to the challenges of physicians from other countries. The need for a specialized physicians-physician training is noted.

Chapter 9 'Caring for the Carers' refers to the response of healthcare organizations and institutions to the issue of physician well-being and the impact of these committees on individual physicians. Yellowlees cites various physician networks, professional organizations and websites that address Physician Health and multidisciplinary research groups, and the ACGME interest which mandates education about physician health. Impediments to seeking care are outlined, including shame or the reluctance to admit weakness or discuss pressures. He stresses the need for balance, strategies and lifestyle adaptations.

Chapter 10 'Physician Heal Thyself' describes expectations, assumptions and challenges from multi-generational physicians within the same family. It discusses professional cultural changes, preventive and lifestyle solutions, and the need for better organizational management - rather than administrative driven requirements or technologies, including electronic records.

This book is an excellent abbreviated representation of physician suicides, which compels one to consider the enormity of the problem. It's also a reminder as to the costs of unspoken assumptions, expectations, isolation, and pressured multitasking. Physicians are used to being independent and the treators - rather than the treated. A psychiatric disorder may be seen by many as embarrassing, humiliating or an impediment - which is why many try to handle the situation themselves, rather than seek professional help. This also opens the door to culture and gender related considerations - another tip of the iceberg. This book is intended for the physician, medical student, premedical student, and the general public, but is an important consideration for any practicing psychiatrist. Hopefully it will open the door to more publications in the future, including culture and identity considerations, and results from preventive care.

# Council Highlights
# April 8, 2021

Eric Wagreich, M.D., *Secretary*

**Minutes from the previous meeting were unanimously approved without an addendum for the January minutes.**
**Dr. Wagreich presented the amendment to the minutes for January. A vote was held with unanimous agreement.**
**President's Report**
Thank you to outgoing officers
Dr. Fouras thanked the members of the executive committee, council, and other committees for having served on council and helped to accomplish

**President-Elect's Report**
PPAC Board meeting
Dr. Ijeaku shared her experience sitting in on the PPAC board meeting and that there is discussion regarding SCPS representation within PPAC. She also provided a brief summary of the current activities underway within PPAC and their efforts. She shared that PPAC just applied for the CMA specialty delegation. She posed the future question of who SCPS would like to appoint as the liaison to PPAC board, though that she will continue to serve as the immediate liaison for the coming few months. Additional discussion was held regarding subspecialty representation within PPAC.

**Diversity and Culture Committee Report:**
Dr. Ijeaku provided an update regarding the recent meeting of the committee and the George Mallory Award and who would be presenting the award. She also shared attention focused on what one member shared during the Town Hall and how to move forward. She also shared the proposed details of the upcoming Town Hall and the strategic plan moving forward. She also discussed attention of the committee on two upcoming bills and the positions of CMA and PPAC and spending more time to focus on those bills. She also discussed the attention to the current hate crimes against Asian-American females and Ms. Thelen's distribution of a letter which received some positive attention after its distribution.

**Newsletter Committee Report:**
**Monthly themes**
Dr. Goldenberg thanked various members for contributions to the newsletter both past and current. He also shared that the upcoming theme will be "Disaster" themed. Dr. Chang provided some background regarding her plans for the upcoming edition, and requested submissions.
Dr. Red brought up the idea of including intangible disasters such as the fallout from disasters, including COVID.

**Treasurer's Report**
**February Financials and Cash on Hand Report**
Dr. Goldenberg shared the highlights of the Treasurer's Report.
Regarding income, for the month, we are under budget by about $4,166. For the year, we under budget by $37,365.
Regarding expenses, for the month, we are under budget by about $1,313. For the year, we are over budget by about $1,771.
We are about $40,000 under cash on hand as compared to this time last year taking into consideration monies earmarked for PPAC advocacy funds.
A vote was held to accept the report, which passed unanimously.
Dr. Cheung echoed the importance of the lack of significant loss in membership especially given the concerns raised in the previous year.

**Membership Report:**
Dr. Ijeaku presented the 5 new members to be approved. The new members were unanimously approved.
**GA Committee Report**
Dr. Shaner began the report with a recap of the need to ascertain compliance of PPAC, and the committee's review of PPAC's bylaws, which were shared with the committee.
**Under Contract Section B:**
Sufficient evidence supporting compliance. Administrative and communication and coordination between PPAC and SCPS is developing well.
**Under Contract section C:**
Sufficient evidence supporting compliance. PPAC has provided SCPS with contractually required PPAC operational description and associated corporate bylaws clearly specifying the way decisions regarding expenditure of PPAC advocacy funds are determined.
**Under Contract Section D:**
Sufficient evidence supporting compliance. PPAC has provided SCPS with descriptions of PPAC committee structures and proceedings sufficient to establish contractually required SCPS participation in PPAC policy making and advisory committees.
**Under Contract Section E:**
Sufficient evidence supporting timely compliance. PPAC has not indicated any changes in contractual terms planned within 120 days.
A motion was made that SCPS Council find PPAC in current compliance with Sections B-E of the SCPS/PPAC contract.
The motion passed unanimously
Dr. Shaner also shared additional items regarding several items and legislative items being followed by PPAC and the current actions and recommendations from PPAC.
**Disaster Committee Report**
Dr. Chang provided a brief update regarding the Town Hall event and plans for an upcoming panel including various individuals who have participated in disaster outreach previously.
Dr. Rees shared her positive sentiment regarding the meeting.
Ms. Thelen noted her positive impression of the meeting and its highly educational nature.
**Program Report:**
Dr. Gales provided a report regarding upcoming programming, including an upcoming meeting regarding members' experience with e-prescribing, as well as the opportunity to allow some commercial entities to participate. Ms. Thelen added that these entities would include companies that offer non-EMR-connected, standalone e-prescribing companies.
**Assembly Report**
Dr. Red introduced the Assembly Report, and the season including the upcoming Spring Assembly Meeting for the APA and attention toward action papers. The date will be April 24 and 25. She shared her experience learning of the various types of action items for the assembly to vote on - action papers and position statements. Dr. Silverman also shared an update regarding maintenance of certification committee. A robust discussion was held.
Dr. Red also shared the upcoming open RFM Dep Rep position within Area 6 of the APA
**Old Business:**
April 24 4-6pm Awards and installation ceremony

Dr. Fouras thanked all members for their participation over the year

*The meeting was adjourned by Dr. Fouras at 8:54pm.*

We look forward to our July Issue which will be an update on SCPS Council and Committee activities. We will be announcing the next SCPS General membership Meeting —(a virtual event).

No August publication.

Have a great summer.

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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