Over the last year, under the leadership of Dr. Ijeoma Ijeaku and through the efforts of a number of very dedicated members, SCPS tackled several significant issues. We made great strides in creating a more coherent legislative framework for our advocacy efforts; created pathways to addressing the stigma and bias that hampers our work; and developed some creative solutions to our financial and work force needs. But, there is always more to be done. In this initial report to our membership, I’d like to highlight some of these recent activities and discuss the opportunities and challenges ahead for our organization. These areas can be broadly categorized under the headings of Advocacy, Committees, and Programs.

**Advocacy**

To provide our members with effective advocacy, we joined the California State Association of Psychiatrists (CSAP). This decision was made after a careful and extensive review of the options available to us. In brief, joining CSAP provides a path toward integrating the advocacy efforts of all California’s District Branches within a framework that is consistent with the bylaws of the APA and the Procedural Code of the APA Assembly. Furthermore, CSAP meets other demands of a membership-driven organization like SCPS by providing guarantees of fully transparent governance and by having an exclusive duty to serve the needs of the physician members of California’s APA District Branches, thereby avoiding the potential conflicts of interest inherent in receiving funding from non-physician groups. Additionally, CSAP provides SCPS a means to meet its fiduciary responsibility to our members by providing a determinative role in the use by CSAP of our member’s advocacy funds. In addition to our work with CSAP, we intend to engage other groups and organizations in the exchange of ideas as well as the development of collaborations and joint advocacy projects that will benefit our members, our patients, and our profession.

As a member-supported organization, SCPS seeks to advance the interests of its members and the patients they serve. One way we do this is by support of and input to CSAP which engages in legislative advocacy. To this end, SCPS has supported initiatives to expand access to quality care (AB 32, AB 858, SB 221), create alternatives to law enforcement as de facto responders to mental health crisis calls (AB 988), and address long-overdue changes to LPS law (SB 340, AB 1443, SB 1416).

Perhaps in the vein of “the big one that got away”, we have also seen AB 35, a bill developed to reform MICRA, move through the California legislature at lightening speed. The lack of opportunity for physicians and other interested parties to contribute to this bill serves as a warning of the perils of disorganized and unfocused legislative advocacy. While it is unclear whether or not a more robust and coherent legislative effort would have changed the outcome, it is certainly easy in hindsight to see missed op-
opportunities for physician-aligned groups to take the lead on MICRA reform.

To this point, one issue that will need SCPS’ ongoing attention is the effort to tie homelessness and mental health treatment together through SB 1338, the euphemistically named Community Assistance, Recovery and Empowerment (CARE) Court. The need to address these disparate but interrelated issues is obvious, but the solution certainly is not. It is imperative that SCPS members as well as their patients and families be involved in this process and continue to voice their perspective on potential harms, blindspots, and opportunities to improve these efforts going forward.

Committees

Closely aligned with SCPS advocacy efforts is the work of our diverse and energetic Committees. While regular readers of this newsletter may already be aware of the activities of these groups, there are a few notable additions and developments to highlight.

In the last year, we have launched two important additions to our committee roster: the Diversity and Culture Committee and the Access To Care Committee. The Diversity and Culture Committee will assist SCPS in developing a more representative organization by bringing our attention to the needs and experiences of under-represented and marginalized groups within our community. The Access To Care Committee was started out of a need to bring specialized and focused attention to the difficulties and unique needs of disenfranchised groups that would benefit from mental health care. My hope is both committees through active discourse with our Government Affairs Committee and other stakeholders will become a rich source of legislative initiatives and programs that will help SCPS be a more representative and effective partner to these communities.

We are also working to revitalize the Managed Care Committee, the Private Practice Committee, and the Academic Liaison Committee. One area of focus will be developing better engagement with these groups to encourage membership in SCPS and foster collaborative projects.

Finally, we are sad to say goodbye to the LGBTQI Committee Chair Dr. Madeleine Lipshie-Williams. We owe them a debt of gratitude for their efforts championing the needs and experiences of our gender diverse community. We are especially grateful for their sponsorship of the important SCPS Program: Transgender Issues: Thinking of Gender Without Pathology.

Programs

SCPS is dedicated to professional development and creating value for its members by sponsoring educational programs and curating resources relevant to our members. One of our long running programs is the highly regarded Advances in Psychiatry Series. We also sponsor the Managed Care Update, SCPS Career Fair, and NAMI Walk each year. Additionally, the Disaster Mental Health Relief Committee has begun hosting multiple Red Cross training forums and Psychological First Aid meetings each year. We will expand on these offerings by promoting a series of Town Hall meetings between our members and the members of allied organizations to foster the exchange of ideas, promote familiarity with their needs and our resources, and improve awareness and opportunities to address structural problems affecting these communities.

Given the effects of the pandemic on social gatherings and the increasing costs of sponsoring programs, the way SCPS carries out its mission of supporting our members’ professional development through educational programs deserves attention as does the role of our organization in providing a re-
source to our members for CME credits. We will be working on ways to improve our meetings to allow socially responsible in-person attendance while the pandemic continues, and further develop our catalogue of online videos available for CME credit on our website. The cost of delivering CME accredited programs and how to best return value to our members through the choice of programming will be another area for careful consideration.

In closing, I would like to extend an exuberant Thank You to all SCPS members for their ongoing support of the organization. Without you, SCPS wouldn’t exist. We welcome your ideas, observations, and participation. I’d also like to thank Dr. Ijeaku, the SCPS Executive Committee, and all the Committee Chairs for their exceptional work, diligent effort, and for being exemplary role models within our organization and our profession. I look forward to working with you to help SCPS become a more effective, inclusive, and vibrant organization.
Happy June!

After writing a long and concerned article last month, I wanted to write something more upbeat this go round.

Starting off, I would like to thank William Arroyo MD, for guest editing this month's newsletter. Dr. Arroyo is the current SCPS Ethics committee chair and a longtime leader in our field. I am very appreciative of him helping to solicit, write and edit articles that have been published this month.

I also want to thank all of the authors who submitted such timely and clinically applicable articles. Special thanks to Dan Willick, SCPS’s legal counsel, for submitting two articles this month. Dan has been a longtime confidant and supporter of SCPS and I thank him for his ongoing support!

Lastly, I wanted to bring to your collective attention a change coming to the SCPS newsletter. After six years of service, as your Newsletter Editor, as of this publication, I have officially stepped down as SCPS Newsletter Editor.

Serving as the SCPS newsletter editor has been a true privilege. I have served 6 presidents including Curley Bonds MD (who first appointed me to the role), Joseph Simpson MD, Anita Red MD, Erick Cheung MD, George Fouras MD and Ijeoma Ijeaku, MD.

Some of the highlights from my time SCPS newsletter editor include that newsletter becoming the 2nd largest source of income during the Covid-19 pandemic, starting the “get to know your board” series of interviews, themed newsletters with guest editors, being your sources of information during the CPA dissolution process and the processes of joining CSAP and, my personal favorite, the addition of “throw-back photos”.

I owe a great deal of thanks to Mindi for putting it together every month. I also want to thank everyone who contributed an article the past six years. Without you, there would have been no newsletter.

My motivation for stepping down is that I will serve this year as SCPS president-elect and then will be elevated to SCPS president next year. It felt most appropriate to give another member, with a separate voice, the ability to spearhead the newsletter. However, after an exhaustive search, we were unable to find a replacement newsletter editor.
Therefore, the SCPS council in April, voted to make the President-Elect the acting newsletter editor, during times when there is not a current/active newsletter editor in place. Accordingly, as president-elect, I will serve as acting newsletter editor this year (starting in July 2022 and ending in May 2023).

An additional change to be aware of, which was also approved by SCPS council in April 2022, is that the SCPS council will now be more directly engaged in the newsletter preparation each month. Specifically, a minimum of two council members and a minimum of one committee will write or solicit articles for the newsletter each month.

So, look forward to hearing and reading much more directly from SCPS council members in the coming months or from authors they have solicited an article from.

My hope is that the SCPS newsletter will continue to be vibrant, well read and something all SCPS members can be proud of.

If you have interest in serving as the SCPS Newsletter Editor, please let Mindi know!

Otherwise, please continue to submit articles, continue to read the newsletter and share it widely on social media!

Stay safe,

Matthew Goldenberg D.O.
SCPS Newsletter Editor
President Elect
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APA and Review of Ethical Misconduct by Its Members

By William Arroyo, M.D., APADLF

The American Psychiatric Association (APA) has adopted the principles of medical ethics as developed by the American Medical Association (AMA). However, the APA has elaborated on these principles to make them more directly applicable to the practice of psychiatry. The publication, APA's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (hereafter APA’s Principles) (2013), has been periodically revised following a revision of the principles by the AMA. The APA is the only national medical organization that routinely reviews allegations of ethical misconduct and that may issue disciplinary action of a member or impose a stipulation of education related to the allegation of misconduct. Most medical organizations reserve the option to expel a member due to medical board disciplinary action, for example, a revocation of medical licensure.

Each District Branch (DB) of the APA is given the responsibility by the APA to review any allegation of ethical misconduct brought to the attention of the APA or the DB to which the accused member belongs. SCPS Council in turn assigns this task to the SCPS Ethics Committee (SCPS-EC); every DB of the APA is required to have an Ethics Committee. Each DB Council determines the final recommendation for disciplinary action and findings based on the review by the SCPS-EC which at the conclusion of such review is forwarded to the APA. All members of the APA/DB agree to abide by the APA’s Principles upon joining the APA.

There are certain jurisdictional standards or criteria that must be met for a preliminary review of an allegation to proceed. The individual who submits the complaint must submit the complaint in writing and have first-hand knowledge of the conduct; this may be a patient or other physician, for example. The accused psychiatrist must be a member of the APA/DB; the APA does not have authority to review any allegation regarding a psychiatrist who is not a member of APA/DB. The conduct must have occurred during the past ten years except in the case of a minor in which the ten-year period begins at age eighteen. All information gathering activities do not proceed when a separate review by another body is ongoing. SCPS-EC will resume its activities related to this case at the conclusion of any such external review; any documents related to these reviews must be submitted to SCPS-EC upon request. In addition, any identifying information of the accused psychiatrist is shared on a very limited basis, e.g., the small number of psychiatrists who are assigned to review the allegations in the actual review process.

On occasion, the SCPS-EC may process a review based on “external evidence” which may consist of formal judicial or administrative reports, medical or hospital records and other similar reliable documents. In this instance, there is not a formal complainant. If the jurisdictional standards are met, then a preliminary review proceeds in which it is determined whether the allegation aligns with a violation of the APA’s principles assuming the allegation is true. At this point the complainant must agree not to share any of the information with another administrative body and consent for release of complainant’s medical records. If there is not an apparent violation, then the case is closed with an option given to the complainant to appeal to the APA Ethics Committee which may or may not agree to grant such an appeal.

If the alleged conduct appears to be a violation, then a few members of the SCPS-EC are convened to conduct a “merit” review; this review will often include documents directly pertinent to the allegation and may include additional information through a written request of the complainant or an interview. If the SCPS-EC believes there is a potential violation, then the accused member psychiatrist is notified; if there does not appear to be a violation, the SCPS-EC has the option not to notify the Accused member psychiatrist.

A hearing with the accused member and the member’s witnesses is often the next step in the review process when the SCPS-EC believes there is a potential violation. Such a hearing would be comprised of SCSP-EC members who have not participated in any of the aforementioned review processes related to the complaint. The Complainant may appear at the request of the members of the SCPS-EC Committee. This process is conducted sim-
ilarly to a judicial hearing.

At any time before a final determination by the SCPS-EC hearing panel that there is a violation, the panel may recommend an “Educational Option” wherein the panel identifies areas within psychiatry for which education is deemed to be a reasonable alternative to the “Enforcement Option” wherein a disciplinary recommendation due to an ethics violation could be the outcome. In the Educational Option, there is no ethics violation found and thus no recommended discipline.

Any “judicial hearing” conducted by SCPS pursuant to APA ethics review procedures must comply with the provisions of CA Business & Professions Code (BPC) sections 809-809.9. Under certain circumstances, after the hearing, reports will be required to be made to the National Data Practitioners Bank and, pursuant to BPC section 805, to the CA Department of Consumer Affairs data bank. Under other circumstances, pursuant to BPC sections 805-805.01 reports will be required to be made to the CA data bank before the hearing. A disciplinary measure of suspension from the APA also triggers the publication of the psychiatrist in APA’s Psychiatric News and in DB newsletter. An expulsion triggers similar notices issued as that of a suspension. The final determination of the suspension is made by the APA EC and the decision to expel is determined by the APA Board of Trustees. The Accused member has the option to appeal any decision to the APA-EC. These procedures are published by the APA (2013).

One final note on reviews of alleged ethical misconduct is that there are many shades of gray in such reviews. It is not uncommon for more than one ethics principle to apply to each situation; this conflict of principles must be examined as well as is possible by a group of psychiatric colleagues, members of the SCPS-EC. Furthermore, one of the principles states that a psychiatrist must “follow the law” thereby introducing legal issues into any such review. At times a legal consultation may be appropriate. It is always advisable to consult another psychiatrist about a particular situation which may have ethical implications. I and other members of the SCPS-EC are available for consultation to SCPS membership. As chair of the SCPS-EC, I can be reached at 818-231-9684 or wmarroyo@pacbell.net.

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**Difficult Discussions – What to Do When Our Patients Disclose**

A Sexual Relationship with A Prior Provider

By Michael MacIntyre, M.D.

As psychiatrists, we are all aware of the uniquely intimate nature of treatment with our patients. We learn early in training the importance of monitoring for boundary crossings and to avoid boundary violations that may harm our patients. However, most psychiatrists have far less training in navigating treatment when a patient who discloses an obvious boundary violation with a past treating provider.

As a clear example, the APA states that sexual activity with a current or former patient is unethical in all circumstances. While this may be well known, it can be challenging to respond to a patient who discloses a sexual relationship with her psychotherapist or explains she switched to your care because of an affair with the prior psychiatrist. Conflicts naturally arise for the psychiatrist when a patient discloses such an upsetting incident. We want to care for the patient and help process any psy-
ological distress from the event. We may also feel the urge to do something to report the ethical violation and to protect future patients from potential harm (One study showed about one-third of psychiatrists who had a sexual relationship with a patient had a sexual relationship with multiple patients). However, we also want to protect our patient from potentially unwanted intrusions into the patient’s personal life, honor confidentiality (a key component of all medical treatment) and enhance the autonomy of our patient in choosing how to handle the sexual exploitation.

Some reading this may believe sexual exploitation by providers to be a problem from a different era in psychiatry. However, recent articles by the Los Angeles Times and the Atlanta Journal Constitution suggest physician sexual exploitation remains an often missed and mishandled problem. Additionally, almost two-thirds of psychiatrists have had a patient disclose a prior sexual relationship with a previous provider at some point in their career.

When dealing with sensitive disclosures from patients, confidentiality has never been considered absolute. However, there remains constant debate about when it is okay to disclose information from a confidential treatment session. It feels more comfortable to report imminent harm (such as that required by Tarasoff) or when we know information is factual (such as when a patient admits to planning to harm someone). Breaking confidentiality becomes complicated when we may not know the whole story or can’t be sure if the offending behavior will be repeated (and therefore there is less risk of future harm). Reporting laws don’t always make things easier as they often use poorly defined terms such as “reasonable belief.”

Surveys have shown that the vast majority (over 90%) of physicians don’t report prior sexual exploitation disclosed by a patient. Does this mean as a profession we are failing to protect patients from exploitative providers? It would appear so. Most outcomes for a patient who had sex with a provider are negative and include increase rates of psychiatric hospitalization, suicide attempts, and completed suicide. Failing to protect our patients and future patients by declining to report potential sexual misconduct does a disservice not only to our patients but to public trust in the field of psychiatry. The APA seems to agree, stating that ethical physicians should “strive to report physicians deficient in character or competence.” Surely a sexual relationship with a patient meets this definition.

So why don’t psychiatrists report? Some may misunderstand the limits of confidentiality. Others might fear their own reputation being tarnished for “betraying” colleagues. Likely, many providers do not know when to report, what to report or where to report (the relevant specialty board is usually a good place to start).

California makes things easier for the clinician thanks to clear law. In our state, sex with a patient is a crime and is unprofessional conduct which should result in the loss of licensure. Additionally, if a patient ever discloses a prior sexual relationship with a treating therapist (by definition this includes all physicians, psychiatrists, psychologists, clinical social workers, and many more), the psychiatrist must inform the patient that this is considered abusive behavior. The psychiatrist MUST review a patient advocacy pamphlet titled “Professional Therapy Never Includes Sex,” prepared by the state (found online at Therapy Never Includes Sexual Behavior - California Department of Consumer Affairs). The pamphlet ultimately encourages the patient to report behavior to the appropriate board but leaves the decision to the individual, attempting to balance autonomy and future patient protection. Under certain circumstances, such a revelation must be reported by the health facility to the relevant licensing agency within fifteen days.

As psychiatrists, we are in a unique position to address sexually inappropriate behavior of health providers. If patients disclose sexual exploitation, we should educate them on the seriousness, provide
support, and assist them in reporting or report on their behalf, if they consent. While autonomy and confidentiality will always be important, we should consider our duty to protect – our patients, future victims, and the reputation of the field – from sexually exploitative providers.

Sources:

Legal and Ethics Considerations in Reporting Sexual Exploitation by Previous Providers | Journal of the American Academy of Psychiatry and the Law (jaapl.org) http://jaapl.org/content/early/2020/02/12/JAAPL.003911-20/tab-article-info


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Can Treating Psychiatrists Ever Ethically Assess a Patient’s Disability?

William Connor Darby M.D. and Robert Weinstock M.D.

Ethical dilemmas arise in psychiatric practice when duties conflict and it is not possible to meet one ethics obligation without violating another. In most of our work, ethical guidelines suffice in informing psychiatrists how to act. But there are situations in which no guidelines exist to prescribe what to do, and other situations when guidelines or other ethical obligations conflict with one another.

We developed Dialectical Principlism to deal with these situations in which ethics guidelines alone are not enough. Dialectical principlism is a method for psychiatrists to analyze dilemmas that arise in their practice such as situations in which psychiatrists are asked to become involved in multiple roles. One example of conflicting dual roles occurs when treating psychiatrists are asked to take on the pseudo-forensic role of opining on psychiatric social security disability issues. For treating psychiatrists, advancing patient welfare is the primary goal of care. Whereas forensic psychiatrists have the primary obligation of answering the legal question honestly and as objectively as possible. This situation creates an ethical dilemma for the treating psychiatrist asked to answer a psycholegal question when doing so could harm the patient by destroying the therapeutic relationship. Additionally, treating psychiatrists will have biases to favor their patients that impair their ability to be as objective as possible.

This situation raises two questions. The first, is whether it is ever ethically permissible for treatment psychiatrists to opine on disability issues for their patients. The second, is if it is permissible, then how can treatment psychiatrists ethically opine on these issues. To address the first question, it is important to emphasize that disability evaluations are very different than other types of psycholegal questions that forensic psychiatrists address. It is not a criminal or civil judicial matter, and thus disability evaluations do not carry the same legal justice significance and societal consequences. That is, for criminal and civil legal matters a treating psychiatrist should almost never, save for the rarest exceptions (e.g., when a dual role is required or unavoidable), act as the forensic expert because bias in favor of the patient would prevent their ability to be adequately objective to foster justice. Disability evaluations do not necessarily require the more intensive method employed for forensic evaluations in criminal or civil matters (e.g., interviewing corroborative sources, exposing information to public scrutiny, or subjecting evaluatees and the treatment itself to potentially damaging cross-examination).
Treating psychiatrists could refuse doing disability evaluations, but that could result in harm to patients not receiving disability benefits that they are legitimately entitled to receive. That is, the government does not fund independent forensic psychiatrists to perform these disability evaluations and there could be significant deleterious effects on the patient’s course of illness by delaying such an evaluation. Most of the time, the only psychiatrist realistically available for these disability evaluations is the treating psychiatrist. Therefore, we believe that these disability evaluations are such an exception to the rule of not acting in dual-roles because it is logistically unavoidable and the nature of the evaluation is less stringent than other forensic evaluations for judicial matters.

So, how can psychiatrists ethically perform disability evaluations on their patients? Answering a legal question like disability as objectively as possible would entail exploring facets that often do not arise in the treatment role such as questioning the veracity of a patients’ subjective accounts, confronting inconsistencies in their narrative, and seeking out corroborating evidence. This approach, while maximizing the psychiatrist's ability to objectively answer the disability question, can potentially interfere with the therapeutic alliance and undermine treatment. We would favor an approach to evaluating the disability question that prioritizes maintaining the treatment relationship, even at the expense of limiting access to relevant data for answering the question. Although treatment psychiatrists have bioethical duties to the patient to promote good (i.e., beneficence) and prevent harm (i.e., non-maleficence), they cannot lie or distort the truth on disability evaluations to do so. Treatment psychiatrists should not have ethical qualms, however, in trying to be as helpful as honestly possible to the patient when opining on these questions of disability. For example, predicting the duration of disability can be incredibly difficult as it is largely uncertain. It would, thus, be ethically permissible to honestly interpret this ambiguity in ways that promote the patient’s ongoing treatment and wellbeing.

The cleanest approach in situations of multiple roles is for the psychiatrist not to wear the two hats of being the treatment provider and forensic expert. But often there are logistical constraints and financial burdens to consider. When the forensic role of opining on social security disability is thrust on treatment psychiatrists, psychiatrists can resolve the dilemma of conflicting obligations by answering the question honestly and prioritizing treatment considerations (e.g., not jeopardizing therapeutic relationship) over performing the most thorough and objective forensic evaluation.

Business Ethics, Bioethics and the Solo Private Practice
By: Aryeh Goldberg, M.D.

Despite robust bioethics curricula in medical schools and residency programs, private practice ethics are rarely discussed. This may be because the private practice is thought to be free of bioethical quandary and devoid of any unique bioethical interest. I strongly disagree. There are matters of ethics pertaining distinctively to private practice that a standard training program would be ill-equipped to anticipate. Private practice (especially for the solo practitioner) offers a unique arena in medicine in which business ethics and bioethics collide. Consider that most academic physician-bioethicists within large academic institutions have never had the experience of engaging a patient directly in both a treatment and a contractual business relationship. It should therefore be no wonder that the multi-layered ethical questions of a private practice might go overlooked despite both their importance and their regularity.
I will present two common scenarios to illustrate this point, both of which arise in the first moments of a clinical encounter.

#1. Capacity to Contract

QB* called my practice requesting an intake. He asked for my fees and willingly offered his credit card information to be kept on file (as per my practice policy). He did not express any hesitation with the price that I quoted. In fact, he requested weekly one-hour sessions at full cost. He spoke loudly, was somewhat abrasive, and referred to himself as “a genius,” who was “worth millions.” I wondered if he might be in the throes of a manic episode.

In accordance with my policies, QB will have signed my intake paperwork ahead of the first session. This paperwork involves treatment and financial policy consent forms and a credit-card on file agreement, contractually obligating him to pay my fees at the time of service via a charge directly to his card on file. If JB is indeed experiencing mania, might this impact his capacity to engage in such a contract? If so, how must I then proceed? Must I refuse to accept him into my practice in his questionable state of mind? Must I refrain from charging for services until his capacity is confirmed? Or might I simply proceed with business (or treatment) as usual?

Legally, the standard for capacity to contract requires that one understand and appreciate the consequences of the contract at issue. The California Probate Code (Section 810) clearly states that someone diagnosed with a mental disorder may maintain their capacity to contract unless “based on evidence of a deficit in one or more of the person’s mental functions rather than on a diagnosis of a person’s mental or physical disorder.” This wording suggests, like the standard for medical decision-making capacity, that these criteria are strictly cognitive. By this I mean that little attention is given to whether the decision is consistent with the individual’s known values, or whether the decision might have been made but for their manic state. However, there is a New York case that alludes to a broader standard for contractual capacity. In the case of Faber v. Sweet Style Manufacturing Corporation (40 Misc. 2d 212, 242 NYS2d 763 – Sup. Ct. 1963), the New York Supreme Court voided a real estate contract enacted by Faber just prior to a hospitalization for mania. The Court found him to be, “under the compulsion of a mental disease or disorder but for which the contract could not have been made.” This introduces some legal grounds to nullify a contractual agreement if it’s execution was under the compulsion of a mental disease (and irrelevant of whether he understood or appreciated the contract).

Ethically, the principles of non-maleficence and patient autonomy feature prominently here. Primum non nocere is not limited to physical or medical harm. Financial harm ought to be equally included in that doctrine. Further, to engage a patient in a contractual business relationship at a time in which her capacity is in question would be an arguable breach of patient autonomy as it disrespects the patient’s agency over his financial and treatment decisions.

The American Psychiatric Association’s Principles of Medical Ethics states, “Psychiatric services… are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement… should be explicitly established.” One can argue that this requisite informed consent regarding the contractual elements of treatment presume and require the patient’s capacity to understand and appreciate it’s provisions, and to agree to them wholeheartedly and without compulsion.

#2. Advantage-Taking

RG* called my practice requesting a diagnostic intake. He spoke slowly and quietly. He had been suf-
fering with Depression for many years and had significant trouble accessing care. He made a minimum-wage salary and could barely afford food and rent. When I shared the cost of an intake, and the projected costs of regular follow-up appointments, RG paused. He ultimately responded that he would pay “anything”, even if it meant accruing debt, because he was so desperate for mental healthcare. He felt that adequate care would be his only path toward financial success and security.

This case is quite different from the first. RG’s capacity was fully intact. He understood his financial circumstances and appreciated the financial toll of treatment of this kind. And yet, he was willing to initiate care for one reason common to so many who seek our services: he was suffering immensely and was desperate for relief. Does the severity of his suffering suggest duress? Am I taking advantage of his vulnerable state by accepting him into my practice? Am I ethically obliged to consider this issue as we execute a contractual relationship?

Although legal terms like “duress” and “undue influence” may naturally come to mind, both are likely too harsh for the circumstance described. Both are examples of active advantage-taking, whereby one party to a contract plays an active role in making the other party vulnerable. There is a subtler term in the legal literature that aptly captures this scenario. Pure advantage-taking refers to when one party happens upon an already vulnerable person (made vulnerable by unrelated circumstances) and takes advantage of that vulnerability by engaging them in a contract. RG is made vulnerable by the severity of his illness. And it is precisely this vulnerability that facilitated his potential engagement with a business contract he couldn’t afford. The recognition of this undeniable fact ought to give any private practitioner considerable pause. But to categorically prohibit engagement with cases of this kind would create immense confusion. The vast majority of our patients initiate care while suffering! In fact, they engage with treatment because of that suffering and precisely when they are most vulnerable. Is there any way to treat the ill without advantage-taking? Is it not inherent in our work that suffering, per se, sustains us?

The law is often mum on cases of pure advantage-taking (contrary to its approach to duress and undue influence), which forces us to look to time-honored ethical principles for guidance. These basic principles offer a meaningful red line between the standard patient who seeks us out in suffering and the case of RG which smacks of pure advantage-taking. Here, we are guided by the balance between beneficence and non-maleficence, the weighing of risk and benefit. When the financial risk outweighs the medical benefit, the intervention (i.e the treatment relationship) should be withheld. When the benefit outweighs the financial risk, it should be pursued. Often, this risk-benefit calculus should be left for the patient to consider autonomously, but there are unique circumstances in which the financial risk is so great (or the benefit so slight) that the physician would be taking advantage of the patient should he execute the contract without more. So what additional steps, if any, should be considered in the case of RG? I would simply point to two competing principles from the APA’s Principles of Medical Ethics that ought to be duly balanced. On the one hand, a physician shall be free to choose whom to serve and the environment in which to provide medical services. On the other, a physician must support access to medical care for all people, and shall not be party to any policy that excludes on the basis of socioeconomic status. These considerations may be balanced by offering RG a sliding scale or pro bono treatment or, alternately, by providing RG with meaningful referrals to low-income clinics.

In this brief essay, I intentionally refrain from authoritative guidance on these matters. Space, time and inexperience would preclude me from doing so. But I hope to have demonstrated that ethical dilemmas exist in private practice psychiatry, and they emerge from the very start of a new patient interaction. They are complex and multi-layered, engaging legal precedent and classic ethical principles. And importantly, they emanate from the distinct interplay between business ethics and biomedical ethics. As long as business remains a part of healthcare (for better or for worse), we would do well to consider business ethics within the realm of bioethics, and to prepare future psychiatrists for the many ways they co-
exist.

References:
1 California Probate Code. Section 811.4.b
5 Ibid. Section 9.
6 Ibid. Section 1, Part 2.

* Editor’s Note: Patient details have been altered for patient privacy.

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Psychiatric Ethics And The Law
By Daniel H. Willick, J.D., Ph.D.

A. Introduction.
In the United States psychiatric ethics bear an uneasy and fluid relationship with the law. The law and psychiatric ethics each evolve and often interact with dramatic consequences. This is because the right to practice psychiatry and the rights of psychiatric patients rest on the law. A psychiatrist’s right to practice and a patient’s right to receive psychiatric treatment each require permission of the law. Try to practice psychiatry without a license required by the law and you risk legal punishment, including imprisonment. Try knowingly to receive psychiatric care from someone who lacks a required license and you run a similar risk.

B. The Relationship Of Psychiatric Ethics And The Law.
The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2013 Edition) recognize the intimate relationship of ethics to the law.

Section 3 states – “A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.” Annotation 1 – “It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession.”

Section 4 states – “A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.” Annotation 2 – “A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion.”

As a result of the political process, the law has come to incorporate psychiatry’s central tenet of the obligation to “safeguard patients’ confidences and privacy” (e.g., HIPAA, protecting confidentiality of psychotherapy, and the psychotherapist-patient privilege). Yet the psychiatrist’s obligation to “safeguard patient confidences and privacy” must be “within the constraints of the law.” This raises the problem of what to do if the constraints of the law violate psychiatric ethics.

C. Instances Where The Law May Conflict With Psychiatric Ethics.
As an attorney I may not and I do not advocate or advise violation of the law. However, I have gone to court to protect psychiatrists who are at risk of being legally compelled to violate psychiatric ethics.
Also, I have advised psychiatric organizations on seeking changes to make the law comply with psychiatric ethics.

Unfortunately, there are current situations where it can be argued that psychiatric ethics conflict with the law. A partial list follows:

1. CURES is a California data bank established as a federally supported prescription drug monitoring program. It requires reports of all prescriptions of controlled substances and identifies the prescribing physician, the patient and the prescriptions. The California Medical Board in its discretion may data mine the CURES databank without the knowledge or consent of either the prescribing physician or the patient (Lewis v. Superior Court (2017) 3 Cal. 5th 561). A psychiatrist is legally required to consult CURES as part of prescribing certain controlled substances and must record all such prescriptions in the CURES database on a timely basis. Does this violate psychiatric ethics by disclosing the names of psychiatric patients and their diagnosis as revealed by the prescribed scheduled psychotropic medications?

2. Therapists, potentially including psychiatrists, who treat certain classes of convicted sex offenders as a condition of probation, are required to share therapy information with probation officers and to assist polygraph examiners in the administration of lie detector tests of the patient (People v. Ignacio Garcia (2017) 2 Cal. 5th 792; California Penal Code section 1203.067, subd. (b)). This arguably violates psychiatric ethics by breaching treatment confidentiality.

When faced with situations, such as those described above, a psychiatrist must follow the law or risk career ending or career restricting outcomes.

D. Conclusion.
In light of the above discussion, I have three bits of advice for psychiatrists.

1. Have a good malpractice insurance policy which provides robust coverage for attorney’s fees associated with responding to peer review and Medical Board investigations. The risk of such peer review and investigations will not be diminishing in the foreseeable future.

2. Join and support psychiatric associations, such as SCPS, which support efforts to bring the law into conformity with psychiatric ethics.

3. Educate yourself about the moral and legal risks at the intersection of psychiatric ethics and the law. Unfortunately, medical education often ignores this subject.
Disclosure of Psychiatrist’s Personal Opinion Regarding

_Roe v. Wade_ Among Others

By William Arroyo, M.D., APADLF

A draft opinion suggesting the Supreme Court of the U.S. will overturn _Roe vs. Wade_ was shared with _POLITICO_ on May 2, 2022, and to the public almost immediately. Few political issues have caused such a reflexive turbulence throughout the nation in the recent past. And seemingly everyone is sharing and requesting their opinion about this very controversial proposal. Psychiatrists are no exception to this social phenomenon and patients are inquiring about their psychiatrist’s opinion about the likely reversal of the law which has been in place since 1973; they may have already asked about prior headlining political issues. The disclosure of personal information by a psychiatrist to one’s patients is a dilemma with which virtually all psychiatrists have had to contend since the first days of their residency. The standard guidance during my residency decades ago was, in general, not to self-disclose. The underpinnings of this thinking have been attributed to psychoanalytic theory in which the predominant standard is to not self-disclose as it likely compromises the boundaries between a patient and doctor. Current guidance is for a psychiatrist to weigh the risks and benefits of self-disclosure, always keeping the treatment plan and the needs of the individual patient as the decisional framework.

The self-disclosure practice falls in ethics commonly known as boundaries. Boundaries, in general, refers to the structure of the patient-doctor relationship in which the role and behaviors of both the patient and doctor are well-defined and separate and distinct. The question of whether these boundaries are being transgressed or violated arises when psychiatrists engage in self-disclosure. At times following a self-disclosure by a psychiatrist, patients reportedly have felt more trust in the psychiatrist and subsequently believe they can reveal more to the psychiatrist. Other patients, however, have reported feeling less trustful and that the psychiatrist may be getting too involved. The school of thought in which self-disclosure is deemed useful to maximizing treatment according to Howe includes such reasons as: (1) instilling hope after a psychiatrist self-discloses having had the same problem; (2) reduction of shame due to admission of the same problem; (3) reduction of feelings of isolation knowing that the patient’s psychiatrist has had the same problem. Each contributes to a better therapeutic alliance. The prevailing reasons for those against self-disclosure include: (1) the patient’s conclusion that the doctor is too impaired to help the patient especially if the disclosure relates directly to having a mental disorder; or (2) the patient believes that the doctor does not want to listen to the patient and won’t stop talking about the doctor’s issues. Sometimes the type of information to be disclosed is key, such as a political issue, in the determination to disclose. Another variable is likely to be the level of “emotional stability” that may sway the psychiatrist to disclose or not. Many believe that stable patients are less likely to misinterpret the information than, for example, patients with a psychotic disorder. However, some patients may view self-disclosure as intimacy which may make them uncomfortable. Previous relationships with psychiatrists and cultural factors may also come into play. Complete non-self-disclosure by psychiatrists is impossible according to some authors.

Self-disclosure dilemmas are long standing for psychiatrists; these inquiries and discussions by patients are also dilemmas for other specialties. While I generally don’t make inquiries related to current “hot button” issues to my treating physicians, they have shared a fair amount of personal information about themselves, their families, their marital challenges, and those of their children among an array of other issues. There are times when I must structure the interaction because it veers, in my opinion, beyond what I consider to be patient care, namely, my own care. At times, I wonder if it’s because I am a psychiatrist that self-disclosures flow so readily. Nonetheless, I value their medical expertise and have not pursued other options for my medical care. Non-psychiatric physicians reportedly may self-disclose to:
improve support of their patient; to develop a mutually trusting relationship; to create a greater sense of closeness among other reasons. Disadvantages for non-psychiatric physicians reportedly include: possible fostering of intimacy; creates risk of having to deal with demands that are not treatment related among others.

Recent changes in society have set a new context of doctor-patient relationships including psychiatry. These include media exposure of doctors, new modalities of treatment, e.g., psychopharmacology, self-help groups, Cognitive Behavioral Therapy, which are not constrained by a need for anonymity. In addition, some community-based treatment settings are not office-based and conducted “in the field”. The recent “consumer and provider” context has nearly replaced doctor-patient paradigm in some settings. Market forces have also influenced the doctor-patient relationship while social media and other newer technologies make doctor’s personal information much more accessible to patients than had been the case previously. In rural areas it may be virtually impossible to remain anonymous. Cognitively impaired patients may require a less rigid self-disclosure approach. The Group for the Advancement of Psychiatry condones the “therapeutic use of deliberate” self-disclosure in which the broad context of treatment is the framework for deciding of self-disclosure.

In conclusion, factors to consider in self-disclosure by a psychiatrist should include: the patient’s treatment plan and the degree to which self-disclosure may veer from that plan; the psychiatrist’s perceived benefit to the patient; absence of benefit to the psychiatrist; the psychiatrist’s level of comfort in self-disclosing the information; modality of treatment; and treatment setting. In the matter of Roe v. Wade, a psychiatrist who knows the patient well may reliably predict how the patient may react to the doctor’s opinion on the impending decision by the U.S. Supreme Court. Self-disclosure is not necessarily harmful to a patient nor to the therapeutic alliance.

APA Commentary on Ethics in Practice; Ad Hoc Work Group on Revising the Ethics Annotations, American Psychiatric Association, 2015

Opinions of Ethics Committee on the Principles of Medical Ethics; American Psychiatric Association, 2022.


In a peculiar twist of fate, a Post-Doctoral Fellow and myself recently discussed an article 'Pediatric PTSD: Clinical, Forensic and Diagnostic Understanding' which was paradoxically scheduled on the same date as the Mass shooting of children and adults in Texas. We found this bizarre and I had a hard time processing some of this as the horror was too fresh. Yet the article was informative, which caused me to think it may be helpful for other psychiatrists. It’s published by Tedeschi, MD and Billick, MD by the Journal of the American Academy of Psychiatry & the Law.

Despite exposure to trauma as a common event, Tedeschi and Billick note only a minority of youth to develop full blown PTSD, although those who do develop it tend to have an extended course of symptoms in multiple functional domains and with higher rates of psychiatric co-morbidities. Notable are increased rates with exposure to warfare and violent crime, and exponentially to 100% by witnessing the sexual assault of a mother or parental homicide. They discuss the epidemiology, clinical features, statistics, risk factors, recovery, and various models - including neurobiological, dimensional and developmental, but acknowledge a multifactorial etiology.

Perhaps what was most helpful was reviewing emotional, psychological, cognitive and behavioral responses at various age levels, including that of infants, preverbal children, toddlers, children of all ages (pre-school, school age) and adolescents. Posttraumatic play and sleep were also referenced. They emphasized the underestimation of parents of posttraumatic symptoms in adolescents, which was an important reminder of a careful of consideration of trauma in those with Oppositional Defiant Disorder. The article summarizes well and includes psychological sequelae - I found the responses and aftereffects to be particularly relevant at this time.

This article may be accessed at Pediatric PTSD: Clinical, Forensic, and Diagnostic Understanding | Journal of the American Academy of Psychiatry and the Law (jaapl.org)
Question 1: Do you recognize the following California legal definition?

A condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.

Yes, of course, it is the LPS definition of “GRAVE DISABILITY.”

Question 2: Have you ever witnessed a tragedy when a patient was deprived of life-saving psychiatric care because the LPS definition omits a fourth basic personal need: medical care?

I think that the great majority of us would sadly answer in the affirmative. We’ve spent decades trying to change this. There is now a good chance that our efforts will finally come to fruition, but it will take continued strong advocacy on our part through SCPS and CSAP.

SB 1416 (Eggman) is a bill that corrects the omission of medical care in the LPS definition. It is strongly supported by both SCPS and CSAP (CSAP is a co-sponsor). SB 1416 has survived review in the Senate and will now be heard in the Assembly. It must survive this process to get to the Governor’s desk. Simply put, the bill takes the language we grew up with and adds “medical care,” thus changing the old triad to a tetrad:

A condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter, OR MEDICAL CARE.

The opposition to the bill comes from two main sources. First are some groups that protect civil liberties. Their basis for opposition is that it expands involuntary treatment. But LPS law already establishes that in carefully limited circumstances, we must sometimes treat. SB 1416 simply recognizes that the 1968 definition of grave disability must be amended for LPS to accomplish what was intended. Of course, we must respect and strengthen protections against misuse of LPS.

The second source of opposition is from County Behavioral Health Directors. Their argument is that the current definition is perfectly adequate. Suffice to say, this flies in the face of decades of contrary experience by patients, their families, and mental health professionals. Yes, we need more mental health resources, but this is not a logical reason to oppose an accurate definition of grave disability.

By creating a more accurate LPS definition of grave disability, SB 1416 can avert future tragedies. It incentivizes the state and counties to augment resources for those who meet the new commonsense definition. Your voice through member-driven organizations like SCPS and CSAP sharpens this effort (or corrects it, if you think it misguided). Please tell your Councilor or the GAC what you think. It can be as simple as sending an email to Mindi.
Get Ready For Malpractice Reform
By Daniel H. Willick, J.D., Ph.D.

A. Introduction.

For over one quarter of a century physicians, particularly psychiatrists, have been protected from excessive malpractice claims by California’s Medical Injury Compensation Reform Act (“MICRA”). That has just changed with the enactment of A.B. 35.

MICRA is a series of legislative reforms, enacted in the mid-1970s, which protected physicians from a flourishing marketplace for malpractice lawsuits brought by contingent fee attorneys on behalf of patients. MICRA had significant features which made such lawsuits less lucrative, including a limitation on attorneys’ contingent fees, a $250,000 cap on recovery for pain and suffering and a shortened statute of limitations. That has changed as the result of the May, 2022 enactment of A.B. 35 into law. This law significantly revises MICRA to permit, among other things, much higher attorney contingent fees; increases in damages for pain and suffering beginning with an initial increase of the cap to $350,000 with subsequent yearly increases of $40,000 over 10 years to $750,000 followed by annual 2% increases; and a longer statute of limitations. These “reforms” of the original MICRA reforms have the potential to significantly change the practice of medicine, including psychiatry.

B. Consequences Of MICRA Revision.

In my opinion, the revisions to MICRA will have an immediate and continuing impact on psychiatrists, including:

1. More medical malpractice lawsuits because of higher plaintiff attorney contingent fees, higher recoverable damages for pain and suffering, and a longer statute of limitations;
2. Increases in malpractice insurance premiums; and
3. An expanded risk of - Medical Board investigations, with restriction or loss of licensure; removal from approved insurance and health plan panels; and loss of board certification.

There will be mandatory reporting of malpractice settlements and judgments to two data banks (National Practitioner Databank, and California Department of Consumer Affairs databank). In turn, these databanks are reviewed by insurers, health plans, the Medical Board of California and the American Board of Psychiatry and Neurology, placing a psychiatrist who is the subject of a malpractice settlement or adverse judgment, at risk of a Medical Board investigation with subsequent restriction or revocation of license leading to likely loss of credentials with health insurers and health plans, and loss of board certification if there is a Medical Board restriction or revocation of license.

C. Prophylactic Measures.

Prudence suggests that every physician immediately review their malpractice insurance coverage as well as their office and recordkeeping procedures which relate to malpractice prevention. I expect malpractice insurers to have recommendations for their insureds on best practices in response to the amendment of MICRA. I shall write a column in the near future on these topics.
Thoughts from the Incoming Trustee
By: Barbara Weissman, M.D.

Thank you so much for this opportunity to write a brief column. I am so excited to be your new trustee. As I really haven’t served yet (technically I sat in on a ceremonial meeting to thank the outgoing Board for their service while at the recent APA meeting in New Orleans), I don’t have much to report at that level yet. But I thought it could be nice to take a few minutes to give you a little information about me, provide a couple of pieces of information from the last Assembly meeting, and bring up a couple things that have been on my mind recently.

I have worked in San Mateo County doing home visits to elderly patients since 1996. I thought this was a part time, temporary job while my children were young, but have enjoyed providing home based services to county patients so much that I never left, and my two children are now in their mid-twenties! When I remarried and we ended up with four of our five children all in college at once, so I picked up a second job in nearby Santa Clara County. I continue to do a bit of peer review work for them; I also do a bit of independent expert work for the Medical Board of California. I’ve been involved in organized medicine since I was a resident. This is a year of transitions as I have left the position of Trustee for the Specialty Delegation of the California Medical Association after six years there, and the American Psychiatric Association Assembly Executive Committee after serving there for eight years as your dep rep and rep. I have been my county medical society president for the past year, and also been an alternate delegate to the American Medical Association for about a year now. In my spare time I love attending and sometimes performing in community theater with my husband (we will be in the chorus of a coastal production of Spamalot in August), as well as West Coast Swing dancing and playing Board Games (Canvas and Tranquility are the latest two we played). We moved to a home that is a block from the ocean in Pacifica during the pandemic, and though the talk about my surfing is just rumors (supported by Facebook pictures of the one time I did stand on a moving surfboard), I find walking by or in the ocean to be a major source of wellness for me!

I am writing this on the flight home from the most recent Assembly meeting. In general, if writing articles I will tend to focus on a couple things that I found interesting about a meeting rather than making a comprehensive laundry list of what happened – my delegation seemed to appreciate this approach with the CMA Board of Trustees and formal summaries are always available elsewhere if you want them. The issue of area representation has felt like a “third rail” for the past several years in the Assembly, but I did not want to leave without attempting to address the issue for our midsized DBs who are only allowed to have one representative and thus do not get equal representation, mentoring, or diversity compared to the other state DBs. Our Area’s overall small size also makes it hard to fill all the committees that need representation. I had written an action paper for the Fall meeting which got postponed to this meeting. Although on clicker vote it initially appears our action paper would pass, it failed on a vote by strength with the vote being about 10K for and 12k against. I do believe we made progress in sharing with the other Areas our situation, and opening up the issue did not seem to cause major fractures, so I am hopeful that the issue of representation can continue to be looked at in the future.

The Assembly also heard from APA leadership. I was impressed with Dr. Saul Levin’s (CEO) remarks about the top issues for the APA being safe prescribing, MOC, payment for services, licensing questions, and preserving the patient-physician relationship. I also loved a slide by our outgoing president Dr. Vivian Pender that posed the following questions about Social Determinants of Mental Health:
- Does childhood sexual assault lead to being diagnosed with borderline personality disorder?
- Does a family history of SUD lead to violence and suicide?

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Do system failures lead to loss of opportunity and depression? 
Can a family’s income and food insecurity lead to anxiety disorder? 
Does the criminal justice system lead to psychosis and dx of sociopathic personality disorder? 

I’ll end with something that has been on my mind lately which is the role of virtual meetings versus in person gatherings. The virtual Fall Assembly meeting did not go well; this in person meeting went much better. While wanting to be financially and ecologically responsible, I really worry that if we spend too much time virtually, we will lose some of the human connections that are so important for us. For example, after the Assembly was adjourned, I was able to go in person to talk to one of the people who had been most vocally opposed to my action paper on representation. I was able to ask for her ideas about other possible solutions, and just chat a minute. She mentioned she had liked the virtual song I had arranged for the last meeting [https://youtu.be/rxY21HqSvpw](https://youtu.be/rxY21HqSvpw). Although we did not come to a meeting of minds about the representation issues, I do believe we both walked away feeling less adversarial than if the meeting had just been virtual and we had left the meeting without that contact. My transition off the CMA Board this year was at a virtual meeting; this recent transition off the AEC was in person. I’m finding my sense of closure and transition is much more complete with the in-person meeting than it was with the virtual one. And I think things like the delegation dinner we had on Saturday night, though not attended by everyone, also help build a group that then will work together better at future meetings. I hope as we continue to take advantage of virtual technology, we are able to find the right balance between virtual and in-person communications. I was going to talk about my further thoughts my recent thoughts about the intersection of criminal justice and the mental health system in light of my recent experiences with my brother being caught in this system, and the intersecting ways the problematic nature of our EHRs has been catching my attention, but these may have to wait for another article!

Thank you so much for invitation to write something here, and please feel free to contact me if you have concerns around issues that affect organized psychiatry and organized medicine. I am looking forward to keeping communication open during the next three years and would be happy to visit in person at some point (my daughter is currently living in Los Angeles!) My first Board meeting will be in July in Washington D.C. (an in person meeting!), so I assume you may next hear from me shortly after that.

Barbara.yatesmd@gmail.com
(Outgoing AEC Rep, Incoming Trustee)
On Saturday, May 7, 2022, SCPS held its first (small) in-person event since the Covid-19 pandemic began. As opposed to the traditional co-event of the Installation and Awards Ceremony, SCPS held the Installation outdoors in a beautiful garden. The Awards Ceremony was held subsequently online. Please enjoy the photos from the in-person event.

Incoming President, Zeb Little, M.D., and his wife, Susan

Outgoing President, Ijeoma Ijeaku, M.D.

Rod Shaner, M.D., Ara Darakjian, M.D., and Haig Goenjian, M.D.

Emily Wood, M.D.

Happy to be seeing each other again!

Matt Goldenberg, D.O., incoming president-elect and editor extraordinaire
Councilmember, Danielle Chang, M.D. and Chair of the Disaster MH Relief Committee

Ijeoma Ijeaku, M.D.

Presidential Commendation Awardee, nurse April Trujillo, who gave a moving acceptance speech.

Presidential Commendation Awardee, Brenda Scott, Inland Empire NAMI.

Ijeoma Ijeaku, M.D. and Galya Rees, M.D.

A surprise tribute to celebrate Mindi Thelen’s 30 years—and counting—at SCPS.
Enjoying the presentations

Manal Khan, M.D., incoming MURR Deputy Rep

Ijeoma Ijeaku, M.D. and Haig Goenjian, M.D.

Outgoing RFM Rep, Weei LoAllen, M.D.

Past President, Erick Cheung, M.D.

Ijeoma Ijeaku, M.D. and Heather Silverman, M.D.
We are sure to have an exciting year with Dr. Little, as we did with Dr. Ijeaku!

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A host of writers explain motivations, passions, and how to find meaning at work. According to a large-scale study, only about a third of employees find a sense of occupational engagement. Work sites are cited as arenas for opportunities to learn, expand, and empower a sense of accomplishment and self-worth. They note ‘meaning and purpose’ to mean different things to different people – an acquisition of titles and power for some - or a sense of belonging and involvement for others. Turns out that one doesn't need to have all of these motives as one may be enough.

The health benefits and construct of evolution are discussed - a longitudinal study reveals that those who demonstrate a sense of purpose have a lower risk of early death. Readers are advised to seek purpose on a continual basis, as time and circumstances can change. Studies demonstrate that those who perceive their work as a form of giving consistently rank their jobs as more meaningful; psychologists describe purpose as the pathway to greater well-being. A ‘declaration’ of purpose is stressed in order to help one live each day in a setting where personal purpose shines. Passion, innovation and commitment are cited as hallmarks of a purposeful mindset.

For those whose heart isn’t in their work anymore - authors emphasize the need to reassess what one wants, which may differ from earlier aspirations - those who see their work as a calling tend to exhibit higher performance and a greater sense of job satisfaction. They remind us that work is not everything - as a hobby or side gig can be important outlets and balance the monotony of the daily grind.

Other topics include goals and long term relationships - turns out that even the most mundane job can be seen as meaningful with the right mindset and good leadership. They note people to be more creative and productive when their inner lives are positive and happy - ‘small wins’ can boost inner life tremendously. Characteristics are outlined that determine the ability to make others jobs more meaningful. They stress the need to sustain positive emotions, intrinsic motivation and favorable perceptions.

The concluding chapter ends on a higher ground with a reminder to garner inspiration and advice when needed – and to know the importance of why you’re doing what you’re doing. Eventually, they emphasize what really matters are actions - not words. In the end, many support what’s meaningful to them, and report better well-being and a more clear sense of engagement. This read can be a good reminder regarding intentions, unseen opportunities, and to question oneself – why do I do this? The answers can reveal awareness, realizations and opportunities.
PRESIDENT’S REPORT  
Dr. Ijeaku

A. Stipend for Trustee ($250) - NCPS, on behalf of Area 6 Trustee Barbara Weismann, has requested from SCPS a stipend to pay for her travel expenses to APA’s annual meeting. Discussion centered around the lack of precedent, which resulted in the following motion.

Motion: To move that we ask NCPS for foundation as to specifically why this is being asked of the DBs, as opposed to the multi-decade tradition of people funding their own once a year travel to the APA meeting, as has been the precedent in the past. And that with this foundation, we would like all the DBs to meet together to decide what we are doing in the future. If NCPS presents this as an emergency request, we are happy to send $250 as a one time payment but with no agreement to commit to further funding without discussing with all DBs what the policy is in the future.

Passed: 17 yes, 1 no, 1 abstention

B. SCPS Installation – Please RSVP - on May 7th

C. Awards at May Meeting - Awards will be presented at next May meeting. Meeting to start early at 6:30 pm

D. George Mallory Award - Award in the social justice arena. Motion from Diversity and Culture Subcommittee to nominate Jack Barber: passed unanimously.

E. Docuseries Project - Filming has completed, with final series airing next month. Next month is focused on Psychiatry in Marginalized Communities. Dr. Ijeaku plans on this being the first part of more future series.

F. Action paper: Climate & Mental Health
- Support position deferred till Area 6 meets

G. Action paper: Social Determinants Mental Health
- Support position deferred till Area 6 meets

PRESIDENT-ELECT’S REPORT  
Dr. Little

- High level discussion regarding membership and finances. Dr. Little advised that we need to be thinking about how we want to spend the money that we have, and where/how we want to generate more money in order to remain viable. The newsletter has been a source of revenue, as well as the programs, and member dues. We need to think about how we are going to grow our membership, make our programs more productive, and how to keep the newsletter vital, particularly to keep the advertising coming.

NEWSLETTER COMMITTEE REPORT  
Dr. Goldenberg

- Most recent report was on Ukraine and Disasters.
- May Edition: Psychiatry in Marginalized communities which also highlights the upcoming docuseries.
- June: Ethics committee chair, Bill Arroyo, will be guest editor.

- Motion from Executive Committee regarding the Newsletter: (Goenjian)
  In years that the newsletter editor position is unfilled, the President Elect will serve as the acting Newsletter Editor.
  The Newsletter consists of 11 editions per year. For 10 of these editions, 2 rotating council members, who are not committee chairs, will contribute an article. Therefore, each council member will be responsible for submission of one article per year. The 11th edition (February) is a special themed edition for Black History Month; this edition will not require council contribution (as it will be covered by the Diversity and Culture Committee). The Newsletter Editor or President-elect (as acting Newsletter Editor) will be responsible for making sure council members sign up for article contributions and that articles are received each month and are reviewed by the newsletter advisory committee.
  The GAC will provide an article for each monthly edition.
  The Committee Chairs will provide updates of their committees in the form of articles for 2 editions a year, unless they would like to take a month as their whole theme, and then will only need one month’s contribution.
  The new duties will be added to the incoming council members position description and committee chair responsibilities
  Passed Unanimously

TREASURER’S REPORT

Dr. Goldenberg

March Financials and Cash on Hand Report:
Regarding Income: For the month income approx $3500 under budget
For the year we are under approx $22K

Regarding Expenses: For the month over budget approx $6500
For the year, under budget approx $7k

Overall, we are approx $78k over cash in hand compared to last year. 50k if from mutual funds, $10k went back to reserves, and we have $40k less in reserves due to movement of advocacy funds. We’ve made one payment to CSAP already, $61k left in that account; this is a new account so no comparison to last year.

Passed unanimously

GAC REPORT

Dr. Shaner

Overview was provided regarding the most recent GAC meeting. The below provides a summary, which includes two motions and then a series of Legislative Reports or Bills which the GAC received to review on behalf of CSAP.

Motion 1: The SCPS Council shall add the Chairs of The Diversity and Culture Committee and the Access to Care Committee or their designees to the membership roster of the SCPS GAC
Passed Unanimously

Motion 2: The membership of the SCPS GAC shall be expanded to include, when available, one additional member-in-training or ECP from each committee that has ex officio GAC representation. Each committee with ex officio membership may propose for the GAC one additional member of that committee who is a member in training or ECP, subject to approval by Council
Pass Unanimously

Legislative Reports: The GAC report includes a set of Bills which they reviewed. These Bills were
passed along to our GAC by CSAP. Their positions are listed on the attachment (See Attachment) Only a portion of these Bills were discussed at length during this council meeting. One note highlighted by Dr. Shaner was revisiting the process by which the GAC and then subsequently the SCSP council review these Bills given the time commitment.

One Bill discussion resulted in a longer discussion, AB 2055. AB 2055 is with regards to shifting the CURES system away from the DOJ and to another entity. Currently at a watch position by CSAP and GAC. Discussion led to:

“Motion to change Watch to Oppose unless amended for AB 2055”
Vote: 3 yes 13 against 1 abstain: Watch position kept

A second, unrelated motion was presented. This was seemingly related to the long list of Bills which had already been reviewed by the GAC.
Motion to accept as a consent those positions on Bills consistent with CSAP: Passed Unanimously

COMMITTEE UPDATES Chairs/Thelen

A. Disaster - Brief overview from Dr. Chang. No new business discussed.
B. Diversity and Culture - Mallory Award - as above
C. Fellowship and Awards - PER: Dr. Asani PGY 4 USC
Raghu Kiran Appasani, M.D
Brittany Vasae Burdick, M.D
Ann Crawford-Roberts, M.D
Rouzbeh Darvishan, M.D
Madeleine Lipshie-Williams, M.D
John J. Mauch, D.O.
Syed Nasrollah Hosseini Navid, M.D.
Oleksandr Trofymenko, M.D. Passed unanimously
D. LGBTQI - Current chair may be moving and we may need a new chair.
E. Alternative Crisis Response - Update re AB 988, noting the current opposition from phone companies.
F. Access to Care - Plan to meet with NAMI to coordinate advocacy interests. Paul Yoder will be attending the next meeting.
G. Program – EC Report: Considering doing January as a face to face; up for further discussion after budget and finance meeting.

IX. MEMBERSHIP REPORT Dr. Ijeaku
A. Membership Report
7 new RFMS, 1 GM
Passed Unanimously

ADJOURNMENT Dr. Ijeaku 9:29 pm
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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.................................................. Aaron Gilmore, D.O. (2024)
San Fernando Valley ............................. Danielle Chang, M.D. (2025)
.................................................. Michael Feldmeier, M.D. (2024)
San Gabriel Valley/Los Angeles-East. ........ Hanumantha Damerla, M.D., M.S. (2024)
.................................................. Eric Wagreich, M.D. (2024)
Santa Barbara ....................................... Vacant (2024)
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Desktop Publishing ............................... Mindi Thelen

SCPS Newsletter

Editor ................................................. Matthew Goldenberg, D.O.
Writer ................................................ Kavita Khajuria, M.D.

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