

The Westchester Psychiatrist

A quarterly publication of the Psychiatric Society of Westchester County

Fall 2014

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Message From Our President—The Art of Dying Carlo Bayrakdarian, M.D.



I was at the bedside of a close family member in the hospital when she asked: "Why is dying so labor intensive?" She had been diagnosed with a terminal illness and knew that, should she pursue radiation/chemotherapy, she would suffer terribly. So she chose comfort care.

She had lived a full life. Professionally, she was an accomplished dentist, but her personal life revolved around her family and spirituality. She had fully enjoyed her earlier years raising a family and traveling around the world, and then spent most of her retired life around her family—especially amongst her grandchildren, whom she adored and slaved for.

She was also a devout catholic who donated a great deal of her time and resources to God and her church. She volunteered and participated in many church events locally, as well as embarked on pilgrimages to different international Christian sites. Wherever she travelled, her prime focus was visiting the cathedrals and churches, where she regularly sponsored prayers to her loved ones.

So when it was our turn to care for her, we wanted to do the best we could. But although she had asked for comfort care, nobody around my relative could comfort her, regardless how hard we tried. The hospice team administered medications to alleviate her pain, expecting it would lead to comfort; but in between doses she would repeatedly say, "I don't feel good." I could sense her agony, struggling to come into

grips with her decision to die a dignified death. "They promised me comfort care," she would frequently comment. My medical mind would explore the opioid receptors and the intricacies of the P450 metabolisms to choose the right pain medication to comfort her, but to no avail.

I therefore appealed to my religious mind to explore the spiritual world. We decided to take turns reading passages from the Bible, with only some relief. Finally I called our Bishop and briefly explained my ordeal. Within hours he was in the hospital at her bedside. At first he held her hand and said a prayer with her. Then we went over to the family to console them and get more information about her situation. Surprisingly, the Bishop was asked to come back and hold her hand again. For the next two hours, while her hand was between his palms, the Bishop went through the Sunday sermon, hymns and prayers, with his soft and angelic voice, so soft we could barely hear him across the room.

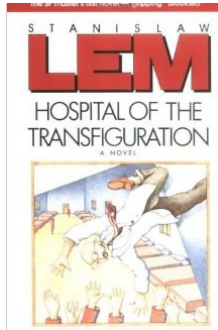
Suddenly, we all witnessed the miracle of true comfort. We couldn't hold back our tears as we felt her angst dissipate and her thoughts regress. We witnessed a gentle smile descend on her face, her muscles relax, and saw her retreat into a deep and comfortable sleep. A few hours later, she woke up and first asked for a sip of water. But then, like a child craving a desired treat, requested to listen to the Sermon again. With the advent of smart phones and YouTube we found the sermon online, and played the soothing hymns, realizing that she had finally gotten her wish for comfort care.

Rest in peace Babi. ■

Book Review— by Karl Kessler, M.D.

Hospital of the Transfiguration by Stanislaw Lem

English translation by William Brand, 1988



The Polish writer Stanislaw Lem (1921-2006) is known primarily for his many books of science fiction. However, his second published work, Hospital of the Transfiguration, is not science fiction, but rather the story of a young doctor who gets a job in an asylum (psychiatric hospital) in the Polish countryside at the onset of World War II. Stefan Tryznicki is the Polish doctor who meets a variety of interesting characters in the asylum.

Whatever treatment occurs in the asylum takes second place to descriptions of Stefan getting to know the other staff and some of the patients. As he tries to find the meaning of his life, he has extensive philosophical discussions with the poet Sekulowski, who is in hiding from the Germans at the asylum. Although Stefan meets some Polish resistance fighters near the hospital and has an unpleasant encounter with German soldiers while on a visit to his father, the asylum is a sanctuary from the war and from the Germans for both staff and the patients. The outside world eventually intrudes, when the asylum doctors learn that the Germans have slaughtered the residents of a nearby village and that they plan to exterminate the asylum patients. The Germans want to empty the asylum and then use it as a military hospital for German soldiers. The doctors discuss how they should react to the pending extermination of the patients. Should they set them free to fend for themselves or should they try to hide them all, or at least se-

lect “the most valuable ones” and hide them? When the Germans arrive, the doctors do nothing and are held in a room while the execution of the patients takes place. They are eventually released and allowed to go on their way. The novel ends with Stefan and a woman doctor walking through the woods to reach the nearest railroad station.

The extermination of the mentally and physically disabled in Germany by the Nazi regime is a well known chapter in history, but their extermination in the countries occupied by the German armies is much less well known. The takeover of the Polish hospital was characteristic of the German occupation, when the Nazis murdered thousands of Polish patients.

The novel is a coming of age story and an encounter with the absurdities of life. The war is strangely distant in this novel until the very end, which is perhaps an accurate depiction of life in an asylum. It depicts people who simply wanted to stay out of the way of the occupying forces and continue their lives. The writer could have used the episodes of crisis to make a stronger depiction of the moral choices encountered by the doctors.

The book was written in 1948, but Lem had to revise it extensively to appease the Polish Communist censors before publication was allowed in 1955. One wonders what the book would have been like if it was published as he had intended. ■

The Westchester Psychiatric Society—Economics Committee

James P. Kelleher, M.D., M.B.A., Chair of Economics Committee and Past President, PSW

At last year’s final meeting, the Executive Council decided to form an Economics Committee of which I am the first chair. It is important for the Society to have designated attention in this area because many business developments are currently impacting psychiatry. The responsibility of the committee is to identify these changes, to put them in context, and to suggest responses. The leading change-maker is, of course, the Affordable Care Act (ACA). This legislation impacts both Medicare and Medicaid, and anticipates and promotes technological developments such as electronic medical records and telehealth. It is designed with flexibility for America’s changing demographics.

This legislation promotes care-delivery through Accountable Care

Organizations and Health Homes, and promotes teamwork and preventative approaches in the provision of care. A local Medicaid initiative, New York State’s Delivery System Reform Incentive Program, actually promotes collaboration between healthcare systems. Bundled payments (in which providers are paid for episodes of care) and capitated rates (in which providers are paid for services to a group of patients) will increasingly be utilized, putting the responsibility for the cost of care on the caregivers. It is becoming more clear that provider organizations will need actuarial skills to fulfill their missions efficiently.

For psychiatry, ACA-related changes will allow evaluation of services with regard to the savings achieved in primary care.

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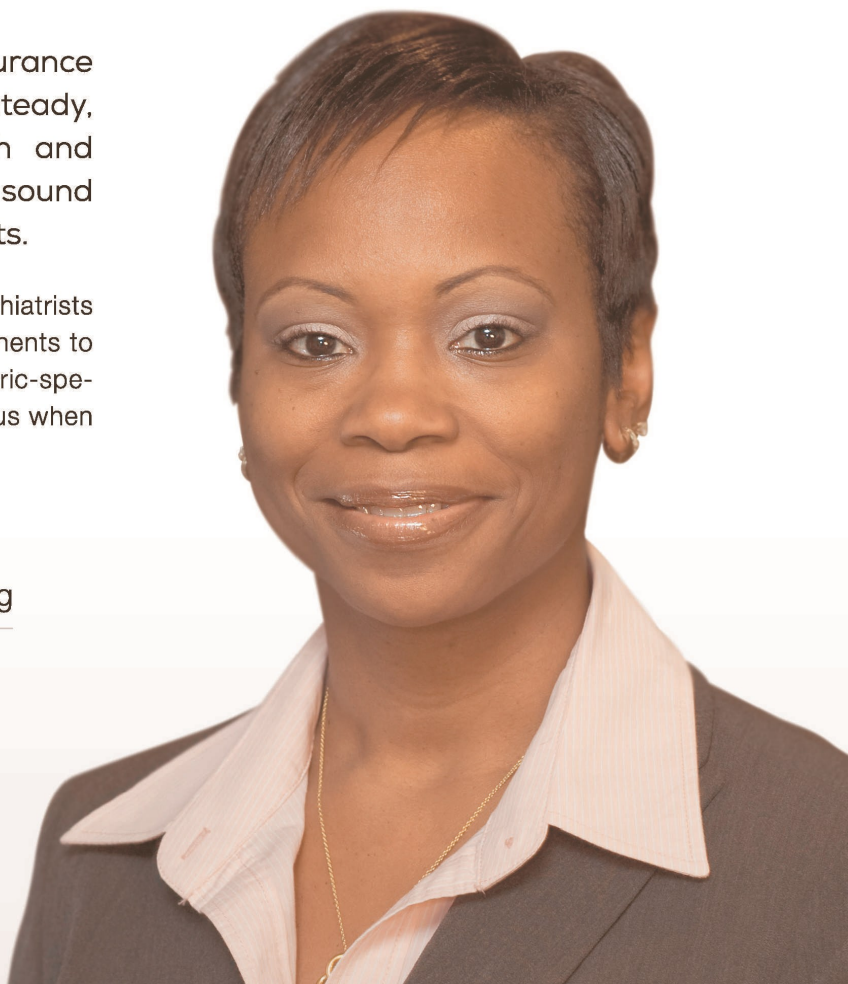
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The Westchester Psychiatric Society—Economics Committee (continued from page 2)

Available data support the fact that good mental health care can decrease the cost of asthma and diabetes for example. Separate mental health parity legislation should further benefit our field.

Massachusetts healthcare reform provided the model for the ACA. Clinical outcomes have improved there, including fewer deaths. However, healthcare costs have risen significantly. Follow up legislation has been passed to address this in part by promoting more risk-based contracts.

The US Supreme Court is due to hear a challenge to the ACA in March. Specifically, four Virginia residents are seeking to block tax credits used by 4 million people in 36 states to pay for health insurance. Blocking the credits could make other ACA provisions ineffective and destabilize insurance markets.

My hope is that the Economics Committee will meet a vital growing need for our community. I welcome your input as our work progresses. ■

Doctor, can you make an exception? - By Aurora Dogaru, M.D.

I know you hear it too. Patients and their families, asking (sometimes demanding) of more: one extra call to the insurance, extra time in the office, one more form to fill. Sometimes asking us to accept less: less visits to the office while continuing to prescribe medications, less remuneration from them or their insurance. It is most interesting (or headache-provoking, depending on how one looks at it) when the patients ask the opposite of what their family just asked you 5 minutes ago, while whispering "please don't tell him what I said."

I do make exceptions. I try to only make a few (as I am not sure how large my "exception" supply is or how I might replenish it), but I do. Some colleagues believe it is a slippery slope. Would you know when to stop? Others think it is unfair to the other patients. Why take from the next patient's allotted time when the present one was late? Should the decision hinge on the reason for lateness or the pathology of the patient? Or the pathology of the person in the waiting room?

We have in psychiatry general guidelines of conduct as delineated in the Principles of Medical Ethics (with Annotations Especially Applicable to Psychiatry). We have been taught that some behaviors are always unethical (the first tenet: thou shalt not have sex with a patient), while others are to be considered on a case by case basis. In reading these principles most of us would agree that they are not only ethically sound, but also humane and compassionate, designed to serve the patient's interests. Then, why make exceptions? During training, I have met teachers who believed that we, as health care professionals, provide a structure for patients on whom they can depend and that exceptions would fracture that stable edifice. While a psychotic patient might greatly benefit from it, it might not be the case for a functional depressed individual. Our patients (and their families) know that

there are very few things in life that are immutable or unchangeable. We were all the recipients of "an exception" at one point in life. It implies, by definition, a deviation, and irregularity about it. But I would argue that it should not make the bestower (nor the recipient) exceptional. IT should be a justifiable act of kindness and compassion, without any implied "specialness" of the patient. It should be about going the extra mile for the benefit of patient but reinforce that it will not be repeated (otherwise, it will become a rule).

We are in many respects the teachers of our patients, so we teach there are rules in psychiatric treatment. But, should we not also teach that there are exceptions to rules and that our patients (fallible like the rest of us) deserve that? Yes, rules are there for a reason and they impart valuable lessons. Rules are simpler, easier to follow. They are impersonal (as they apply to everyone, regardless) but they teach discipline. They are usually our first impulse in unusual situations because they are the path well-trodden, the "tried and true" method, the mental knee jerk jump to "worked before, didn't it?" They make us feel secure and warm in our cocoon of familiarity, and it quiets doubts and quiets the uncomfortable, soft little voice that whispers "is this all I can do for him/her?"

But exceptions teach patients that there is hope when they falter and one catastrophic prediction that will not become true, in addition to a generous hand to help them get up. Exceptions are harder to make because they requires the ineffable, the human and, yes, the subjective. It puts a piece of who we are as a person in that decision, it reveals some of our inner thoughts and feelings and, oftentimes, it requires more work and a lot more courage. Rules are good. Inflexibility is not. ■

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New York's Safe Act: A Reasonable Response to Guns & the Mentally Ill? -

By: Karl Kessler, M.D.

On Wednesday, November 12, 2014, as part of the Psychiatric Society of Westchester County's continuing medical education program, David Lowenthal, MD, JD, gave a presentation at St. Vincent's Hospital entitled "**New York's Safe Act: A Reasonable Response to Guns & the Mentally Ill?**" Dr. Lowenthal is the Clinical Director of the New York State Psychiatric Institute and an Associate Professor of Psychiatry at Columbia University Medical Center.

Dr. Lowenthal gave an overview of research on the relationship between violent crime and the seriously mentally ill. The evidence indicates that this population commits a higher level of violent crime than a comparable population without severe mental illness, but because the seriously mentally ill are such a small percentage of the total population, their overall contribution to violent crime is very small. However, because they are sometimes responsible for notoriously violent acts, such as the Virginia Tech shooting, the shooting of congresswoman Gabrielle Giffords and the Sandy Hook school shooting, the perception of their role in violent crime is greatly exaggerated. Such events sometimes lead to a rapid front of an oncoming subway train, the response was the rapid passage of Kendra's Law, which allowed for judicially-ordered involuntary outpatient treatment in New York. Such was also the case with the passage of the New York Safe Act following the Sandy Hook shooting.

Dr. Lowenthal reviewed federal legislation aimed at controlling access of guns by the mentally ill and also reviewed various state laws, but especially looked at New York's Safe Act, which, among other things, requires reporting by psychiatrists (and others) of persons with mental problems who are "likely to engage in conduct that will result in serious harm to self or others." The Safe Act can restrict access and possession of guns by these individuals.

The effectiveness of such laws may be greater in reducing suicide than in reducing violent crime, Dr. Lowenthal noted. Statistics indicate that only 1 in 70,000 patients with schizophrenia will kill a stranger each year. And the MacArthur Study of Mental Illness and Violence showed that one year post-hospitalization only 2-3% of violent acts by the mentally ill involved a gun. And most of those violent acts were with individuals known to the patient.

The effectiveness of the New York Safe Act remains unclear, but even if it were maximally effective, it would only have a small effect in reducing violent crime, because the population it is affecting is such a small proportion that commits violent crime. The vast majority of violent crimes are committed by criminals and not by the mentally ill. ■

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Contact Megan Rogers to have your article, classified or opinion featured in our next newsletter!!

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EDITOR'S COLUMN:

Current Controversies in Psychiatry: We want your opinion!



In an effort to make this newsletter - and our website (www.wpsych.org) - a more "interactive" journalistic endeavor, I propose that, in each issue, we focus on one of the many current controversies in our field. And not just with informative articles about the DSM, ICD-10, electronic prescribing, non-physician prescribing, etc., but with informed opinions that invite

comments and debate.

In our last newsletter, our new President (then President-Elect), Carlo Bayrakdarian, commented on the movement to have non-MD's prescribe medication, suggesting that "our profession is perilously close to a slippery slope." He invited all of us to email or send in our comments and opinion.

In this issue (pages 7&8), we have a thought-provoking opinion piece by Tony Stern, in which he reflects on what he calls "the

never-ending DSM adventure." He is concerned that "in practical terms, we have all nearly come to the point in our profession that is the equivalent of someone trying to appreciate the Mona Lisa almost purely in terms of the chemistry of the oils and pigments that da Vinci used for his paints." What do you think?

Once our website is sufficiently overhauled to make it more user-friendly (hopefully by the beginning of the new year), perhaps that might be the place to continue some of these discussions. We could then select particularly interesting commentaries for publication - a kind of "Letters to the Editor" column. What do you think?

We frequently ask our patients, "What do YOU think?" Isn't it time that we ask that of ourselves - and let our colleagues know? I believe we would all benefit from such airing of opinions. What do you think?

Please let us know by emails your comments to our Executive Director, Megan Rogers, at centraloffice@wpsych.org. Or, you can e-mail me directly at jliebo@optonline.net. ■

GK CHESTERTON RIDES TO OUR RESCUE: Reflections on the Never-Ending DSM Adventure - By: Anthony Stern M.D.

The great British man of letters GK Chesterton was a wise and witty man. One of his many well-known admirers was C.S. Lewis, who reported that GK's book about Jesus, The Everlasting Man rescued him from atheism and made a believer out of him. GK had a wild and wicked way with words and a quip for almost everything. Among his countless provocative remarks was that Original Sin is the only provable doctrine of Christian theology.

I'm not so sure about that, but it does get you to thinking. It also implies a larger insight, one of several pet peeves that Chesterton held dear, and one that is helpful to consider if we want to contemplate the past, present, and future of the DSM. After all, "Original Sin" offers one model for comprehending human nature and how we got this way, and the DSM provides its own grid of understanding. Or does it? And so that question naturally segues to GK's critique of modern thinking in its entirety.

"The collective we" have at times succumbed to the notion that human nature, or for that matter any phenomenon, can be discussed without having a shred of "doctrine" or philosophy attached to the approach we take. But if we are taking any approach, which is unavoidable, this doesn't hold water. It would make as much sense to appreciate a Monet or Chagall or da Vinci painting yet insist that there be no frame around it, nor even a place to gaze at it; nor, for that matter, a museum to house it and in which to view it.

There's just no way around the stubborn fact that everything we see, we see within a particular frame; within a particular point of view. And if this is true for a picture hanging on a wall, it pertains all the more for any serious effort to grasp the in's and out's of mental illness.

In our wisdom, a number of us in the psychiatric profession have

Continued on next page

GK CHESTERTON RIDES TO OUR RESCUE: Reflections on the Never-Ending DSM Adventure (continued from previous page)

tried our best recently to pit our wits against common sense and the wisdom of the ages by putting this simple trust to the test. We thought we could pull off the trick of pretending that there's no frame and absolutely no need for one.

It turns out that this just can't be done! In 1984, in an attempt to put some of the unfounded assumptions of Freud, Jung and others in the psychoanalytic field behind us, we brought "DSM-III" into the world, believing that our unbiased brain child could name and categorize mental disorders without recourse to the slightest underlying philosophic assumptions at all.

Lo and behold, it has since been revealed, or at least driven home to us through heated debates that flare up to this day, that it's impossible to assume nothing, particularly if we want to proceed to think anything of intelligence about any specific something.

Nature abhors a vacuum, and in the interesting recent history of DSM, this means that natural science, in this case the applied biological discipline of psychopharmacology, in barely the time it takes to utter "scared cow" or "unarmed coup", swooped in to dethrone Freud and his followers and enthrone in their place "True Scientists." In the bargain, as somewhat of a shock even to the generals leading the coup themselves, at least a half century of psychology and psychotherapeutic inquiry went largely down the toilet, replaced by the alleged absence of prejudice inherent in the lingo of neurochemistry.

In practical terms, we have all nearly come to the point in our profession that is the equivalent of someone trying to appreciate the Mona Lisa almost purely in terms of the chemistry of the oils and pigments that da Vinci used for his paints.

If we had taken the trouble to listen, or to read what Chesterton or other astute writers had tirelessly pointed out, this might have saved us a good deal of trouble; they would have reminded us that every picture needs a frame, that every frame needs a wall, and that every wall needs a room in which to live. Indeed, many critics of modern culture grew hoarse trying to remind anyone who would stop, look and listen. We did not. So now we have learned anew what we could not hear then: that by necessity,

science and philosophy are joined at the hip, as was once simply assumed in the olden days before 1800 or so.

From the advent of quantum physics and Heisenberg's Uncertainty Principle, we should have re-realized the truth. Because of the new physics and our own blunders and eighteen other reasons, we are once again reawakening to that inevitability. It's both a little reassuring and humorous, isn't it? Mental health professionals everywhere are on the road to recovery! Oh world, we wounded healers are caring for our wounds! Oh you the masses we are meant to help, we are on the mend!

This is not to suggest that DSM since 1984 is all bad or all misled, and that what preceded it was so great. For example, whatever its follies and frailties, one of the central ideas that DSM gets right is that the main hallmark of mental illness is RIGIDITY. By definition, when we are mentally ill, we are all too stuck in certain patterns of thinking, feeling, and behaving. This is indeed one foundation of DSM on which we might build a sturdier edifice.

The next logical step would probably be to begin to try to clarify, what causes this rigidity?

Here is one potential answer: In one way or another, unfaced fear is a direct route to the curse of rigidity living at the heart of every mental illness, no matter how long or short-lived. Fear hardens us; it fatigues and confuses us; once established as a habit, it confines what we feel, where we go, who we are.

But delving into etiology, as all of us DSM-driven thinkers might say, is a venture filled with hints and guesses. In any case, let's kick that can of worms down the road; it's a discussion for another day. ■

[EDITOR'S NOTE: Please e-mail us and send in your comments or opinion about this controversial topic.]

SAVE THE DATE

On Saturday, January 24, 2015,
the Psychiatric Society of Westchester County will sponsor a Teaching Day.

Possible presentations:

Electronic Prescribing/Electronic Health Records

Maintenance of Certification

Starting & Maintaining a Private Practice

Details about the Teaching Day will be forthcoming! Make sure we have your e-mail address so you can receive the most up-to-date information regarding the Society's upcoming events!

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