Government is a very important player in healthcare financing and services. In the 1950’s, it was state governments that filled that role. Seventy years ago, when state mental hospitals were at their population zenith, they served over 550,000 patients and the largest proportion of hospital beds in the United States were for psychiatric patients. Since then, state mental hospital occupancy has fallen to less than 50,000. Despite the decline, healthcare still is one of the largest items in state budgets, primarily due to the states’ role in financing Medicaid. Meanwhile, since the enactment of Medicare and Medicaid in 1965, the federal government’s share of expenditures on health care has increased dramatically. The 2014 federal budget included 15% for Medicare and 9% for Medicaid, compared with 24% for Social Security and 17% for defense spending. Government spending on healthcare now accounts for 45-50% of all spending on healthcare. Any way that you look at these figures, the federal and state governments play a huge role in financing healthcare.

The federal government and the states enact many laws that affect the practice of medicine and the access to medical care. Important examples of such laws on the federal level are insurance parity laws, HIPAA and the Affordable Care Act. Examples in New York State include the laws regarding Assisted Out Patient Treatment (Kendra’s Law) and the law mandating insurance coverage for treatment of Autism Spectrum Disorder. In the past few years, New York State has also enacted mandatory electronic prescribing, the SAFE ACT (gun reporting by mental health professionals) and 1-Stop (electronic prescribing and monitoring of controlled substances).

The influence that governments have on medicine makes lobbying a very important issue. Any interested party will find it worth their while to become aware and involved with government legislation regarding healthcare. To that end, the American Psychiatric Association has a lobbying arm, the APA Political Action Committee. Similarly, the NY State Psychiatric Association (NYSPA) has their lobbying arm, the NYS Psychiatric Political Action Committee. New York recently passed a law raising the age of adult criminal responsibility from age 16 and 17 to age 18. NYSPA supported this change. NYSPA has also successfully fought legislation that could have raised the cost of medical malpractice premiums significantly by changing New York’s statute of limitations for date of discovery.

Because government is so involved in healthcare, psychiatrists need to raise their voices and make themselves heard. Contributing to the NYS Psychiatric PAC is an effective and efficient way to let our legislators hear our voice. Please go to nyspsych.org and click Contribute to PAC, in the upper right corner.
Message From Our Outgoing President - C. Deborah Cross, M.D.

FACING CHALLENGES TOGETHER

It has been a privilege and honor to serve as your DB President this last year. Westchester’s DB is great! I continue to encourage all members - AND NON-MEMBERS - to come to at least one meeting this upcoming year - and give our officers feedback as to what you enjoy, and want to have more of. The Executive Council and the Program Coordinator are planned a WONDERFUL teaching day in September, which was packed with new and interesting ideas and information. The more of us who come and share in this experience, the better it will be. As we all know, having more people in the audience leads to much better interaction and more sharing of ideas - and the presenter has a better time also!

Our DB, like our organization, faces a lot of difficult challenges in the upcoming year. Our membership needs to continue to grow, and the challenge is that our younger psychiatrists are not as member or organization oriented as those of us who are older. This is an APA-wide problem - the membership of the APA is more heavily weighted on the older end of the spectrum. We did hear at the last APA meeting in May that, for the first time in a long time, we are seeing some turn-around in this on the national level. However, we have a long way to go to get medical students, residents and Early Career Psychiatrists to join and continue as members in our APA. I have written before about the APA being our professional home and how important I think it is for every physician to have such a “home.” Having such a fellowship of like-minded colleagues to reach out to for support, encouragement, validation and partnership is critical for maintaining our commitment to our profession. We hear a lot about “physician burnout,” which is a very real problem! One of the best ways to deal with such burnout is to have colleagues to turn to - for support, for solutions, for feedback, and to help each of us maintain our commitment to be the best psychiatrist and human being we can be.

I would like to challenge ALL of our younger members to STICK AROUND. If there are things that you don’t like about our and your DB, let your voice be heard. Make the DB YOUR DB! Get involved; come to meetings, and not just the educational meetings - come to the Executive Council meetings; they are open to all members! Your input and views are vital to the life of our organization.

Over the last several weeks I have had the great pleasure of writing some recommendation letters for some of our members to be considered as a Distinguished Fellow of our APA. The criteria for such an honor are lengthy, and cover many years of your professional life. Our DB has many members who are already Distinguished Fellows and many, many MORE who are eligible to be awarded this very great honor. To receive the honor and then be able to display it marks you as a unique and qualified professional. I encourage all of you to begin to think about what you might need to do to meet the qualifications at the appropriate time in your career. Some of the criteria focus on what you give to the APA and DB in the way of time, skill sets, etc. Our DB Nominating Committee is ALWAYS looking for “new blood,” members who are curious and interested in how the DB functions. If you have a particular interest - private practice, child psychiatry, legislative or public affairs items - committees exist, and if you have an interest and we DON’T have a committee, then we REALLY need you to help start one and get other interested members!

Karl Kessler is our new President and I know the DB in is wonderful hands this year. I urge all of you to give him your support and your PRESENCE - at meetings, with feedback, with ideas, and most of all your encouragement for the DB and all our members. I look forward to continuing to work with our DB and all of you in the coming years. ■

Creating Learning Spaces for Patients in Acute Crisis: the Comfort Room Project

By: Sarah Vaithilingam, M.D., PGY 2 Psychiatry Resident, Westchester Medical Center

The repercussions of trauma have always been an interest of mine. During my first year of residency, I was shocked to learn that the majority of my patients suffered extensive traumas in their early life and were now being re-traumatized on our psych floors through restraint and seclusion techniques. We know that neurologically, an adaptive response cannot be forced using seclusion or restraint. But with meaningful therapeutic environments, in addition to skills training, it is possible to influence it. Studies have examined how psychotic patients interpret reality when they are having an acute episode. A study done by Freedman, et al., analyzed sensory processing dysfunction in schizophrenics.

In the study they hypothesized that deficits in processing the simplest stimuli are found in schizophrenia and may underlie more complex hallucinations and delusions in tow ways: [1] Neuropsychologically, which is failure to register basic sensory information correctly making poor decisions inevitable, and [2] Neurobiologically, showing mechanisms detected in sensory areas are likely to be present also in regions that have more complex executive functions. The team came to the conclusion that patients’ sensory perception of the surrounding world, even during treatment sessions, may differ considerably from healthy individuals; and a person’s ability to understand and interact effectively with the surrounding world ultimately depends upon an underlying sensory experience of it (perception). Therefore, intervention planning is necessary in the mentally ill and should involve recognizing specific triggers and explore strategies to cope. Thus, the Comfort Room Project at the Behavioral Health Center was established.

(Continued on page 4)
EMERGING RISKS REQUIRE ENHANCED COVERAGE

AS THE PRACTICE OF PSYCHIATRY EVOLVES, SO SHOULD YOUR MALPRACTICE COVERAGE.

The dedicated experts at PRMS® are pleased to bring you an enhanced insurance policy that protects you from the emerging risks in psychiatry.

**MEDICAL LICENSE PROCEEDINGS**
Psychiatrists are more likely to face an administrative action than a lawsuit.
Separate limits up to $150,000

**HIPAA VIOLATIONS**
HIPAA enforcement continues to increase at the federal and state levels.
Separate limits up to $50,000

**DATA BREACH**
The use of electronic media in psychiatric practice has increased.
Separate limits up to $30,000

**ASSAULT BY A PATIENT**
Violence by patients against psychiatrists is more common than against other physicians.
Separate limits up to $30,000

These are just a few of our enhanced coverages included at no additional cost. Visit us online or call to learn more and receive a free personalized quote.

More than an insurance policy
(800) 245-3333 | PsychProgram.com/EnhancedPolicy | TheProgram@prms.com
Creating Learning Spaces for Patients in Acute Crisis: the Comfort Room Project

By: Sarah Vaithilingam, M.D., PGY 2 Psychiatry Resident, Westchester Medical Center

(Continued from page 2)

The Comfort Room Project has been a challenging feat to orchestrate. The initial idea was to create a project that encouraged interdisciplinary teamwork. As a first-year resident, it was exciting to be surrounded by such a diverse group of people. However, it quickly became evident that extremely intelligent people staffed the Behavioral Health Center, and their talent was not being reflected in the quality of the physical building. After discussing ideas with multiple people in different specialties, we agreed upon remodeling the comfort room. The team started a fundraiser so that we would be able to implement our own ideas when it came to creating the space. The initial fundraiser was a success thanks to the generosity of many private business owners from the Bronx and Valhalla.

The most challenging aspect of this project however was convincing administration that the space was necessary. Our team wanted a Snoezelen room, which although effective and supported by the scientific community, is expensive. Snoezelen rooms stimulate the primary senses, allowing the person to freely explore a variety of objects and materials, such as fiber-optic cables, water columns, aroma therapy, different music/sounds, tactile objects, screen projectors, etc. We chose the Snoezelen room because of its success with autistic children, which seem to be the most challenging patients on the child and adolescent units. After several months of bargaining, the team finally made some headway. We are currently meeting with a company who specialized in the Snoezelen model to design the room. We hope to complete the project by the end of this year so that we can push to start building these rooms on the adult units. Ultimately, the goal of the comfort room project is to ensure that patients treated at BHC will be provided with therapeutic comfort rooms to better manage disorganized and aggressive behavior.

The group spearheading the Comfort Room project is also hoping to bring other quality programs to BHC, such as animal therapy and yoga/meditation classes. In addition, we are considering writing a proposal to restart the ECT program at the behavioral health center. We are motivated to make our mental health patients a priority in hospitals and have gained a tremendous amount of knowledge from each other as we work together towards these goals. We are reaching out to the psychiatric community to advice on how to navigate the hospital systems and encourage administration to make physical changes to the Behavioral Health Center.

2017 Fall Teaching Day

Reported by: Jerry Liebowitz, MD

On Saturday, September 23rd, The Psychiatric Society of Westchester presented its Fall Teaching Day at St. Vincent’s Hospital with three CME presentations.

After a refreshing breakfast buffet, Sally Ricketts, MD, Program Coordinator, introduced Moira Wertheimer, Esq., RN, CPHRM, Assistant Vice President of Allied World Assurance Company’s Healthcare and Psychiatry Risk Management Group. She presented a risk management workshop on Overcoming Barriers to Implementation in Telepsychiatry, focusing on standard of care issues, as well as ethical, legal, licensure, informed consent and privacy concerns when using telepsychiatry with patients. Using real life examples, she examined the benefits of providing telepsychiatry services and explored the potential risk and liability concerns for the psychiatrist, including understanding professional boundary, safety, and security considerations and issues.

Wertheimer pointed out how the Affordable Care Act (ACA) led to an increase in the number insured but no increase in psychiatrists - therefore the need for integrated care and telepsychiatry, which she defined as “a two-way, real-time interactive communication between a patient and a physician or practitioner at a distant site through telecommunications equipment that includes, at a minimum, audio and visual equipment.”

A brief discussion of the evolution of telemedicine included the first telephone consultations (to reduce unnecessary office visits) in 1879, a 1906 paper on telecardiograms, the military’s use of diagnosis by radio in the 1920’s, teleradiology in the 1940’s, and the first use of telepsychiatry in Nebraska in the 1950’s, although it did not become more widely used until recently.

She opined that telepsychiatry has been the most successful of all the “telemedical” applications to date. The benefits of telepsychiatry include providing care in remote locations, linking psychiatrists to provide care and consultation, obtaining second opinions, and improved collaboration. However, she warned that Skyping with a patient is not truly telepsychiatry, since Skype is not HIPAA compliant. These are other reduced-fee platforms that are. (See APA website and the National Organization of Mental Health for such platforms.)

Areas of practice for telepsychiatry include its use in forensics (med management and evaluations), home-based sessions, underserved areas, emergency psychiatry, and other areas like military bases, cruise ships, and disaster sites. In addition to its use for doctor-to-patient purposes, it is also often used for consultations with other health care providers and supervision (especially of non-MDs). When talking about underserved areas, Wertheimer noted that there are only five child & adolescent
2017 Fall Teaching Day
Reported by: Jerry Liebowitz, MD

(Continued from page 4)

psychiatrists in all of rural upstate New York!

Liability issues, regulations, and ethical considerations were also discussed, often with case examples, including: licensure, provider-patient relationship, standard of care, credentialing and privileging, prescribing, informed consent, patient selection (e.g., paranoid and suicidal patients may not be suitable), privacy and security, HIPAA compliance, reimbursement, and documentation issues. Concerning licensure, she noted that laws regarding provider-patient relationship and scope of practice vary by state (and five say it must be face-to-face). The Interstate Medical Licensure Compact, which would allow treating patients in another state, has not yet been approved in New York, except for patients in CT, NJ, and PA. It is also important to remember, she emphasized, that the standard of care does not change with location!

Security concerns regarding mobile devices and social media were highlighted, including protecting and maintaining control of date with encryption and secure connections (disabling Wi-Fi and Bluetooth). In this part of the talk she noted that Face Time is now HIPAA compliant and, maybe, What’s App?

Wertheimer concluded her presentation by discussing risk-reduction strategies and providing a list of policy resources, including, among others, the Center for Telehealth and eHealth Law (ctel.org), the American Telemedicine Association (www.americantelemed.org), and the APA Telepsychiatry resource document.

Sally Ricketts, M.D., Medical Director of Behavioral Health Integration at Montefiore Care Management in Yonkers, NY, then discussed Integrating Behavioral Health into Primary Care: Rationale and Results. In this talk, she presented the initial models proposed for integrated care, which was followed by a review of the expansion of the model over the last 20 years.

She first posed several questions to consider regarding integrated care and psychiatry: 1) Should care standards be defined by what is billable? 2) Does value based payment belong in mental health care? 3) How to measure value - process, outcome or cost measures? 4) What is the psychiatrist’s role? 5) What is the role of psychotherapy? 6) Can care be provided telephonically? 7) What about privacy and mental health? The remainder of her presentation answered these questions, and more.

Dr. Ricketts discussed the rationale for integrating mental health care into primary care, noting that 50% of psychiatrists do not contract with insurance companies or accept insurance company payments. And most psychiatrists in private practice do not see Medicare or Medicaid patients, because reimbursement is low and paperwork is onerous.

However, most clinics contract with most insurers. Managed care, which arrived in the 1990’s, led to a rationing of both in and outpatient care, she pointed out, where providers had to argue for reimbursement for care in advance, their objective being to “make money from mental health”.

She then discussed the current status of the care model, distinguishing between the traditional model based on referrals, (primary care, ER, self) and the co-location model (psychiatric comes to primary care), which, she believes, failed because it is not available in many settings (e.g., rural), access is still problematic (slots fill up quickly, no shows), and there is limited availability for follow-up or to make sure recommendations are carried out. Because of the many problems with availability and access of both models, care is not adequate. Only 20% of patients with diagnosable mental health problems see a mental health specialist; another 20% are seen by general medicine; the remaining 60% receive no treatment at all. Regarding depression treatment in the US, she noted that only 10% see a psychiatrist while 40% receive treatment in primary care. And 65% of primary care physicians report poor access to be a big problem.

So, what is integrated care? It is NOT consultation-liaison, she emphasized. It is collaborative care, in which mental health care is provided by a team that includes PCPs, a shared medical record, universal screening for mental health symptoms at every visit to PCP, and objective outcome measures (treating to target). The Behavioral Health Care Manager is a crucial link between the patient, the PCP, and the consulting psychiatrists and other behavioral health clinicians. She also noted that this model provides not only meds, but other forms of therapy, as well.

The evidence she presented using real-life examples showed that integrating depression management into primary care leads to positive impact on treatment outcomes, including relapse prevention. Recognizing the effect of integrated care on the field of psychiatry, she noted that many more patients are engaged, while roughly the same percentage respond to treatment. And such care has no ethnic bias, with 50% or greater improvement in depression at 12 months compared to less than 25% with care as usual in one study.

“The delivery of mental health is changing rapidly,” she stated emphatically. She discussed the expansion requirements for screening for depression in primary care and governmental financial support for developing integration, noting that Montefiore now has a fellowship in integrative care. Integrative care, she noted, is “an important piece of healthcare in general.”

She then delineated the Triple Aim for health care reform: better care
The Non-Disclosing Patient
Written by: Alexander Lerman, M.D.

This article is an adaptation of Dr. Lerman's introduction to a clinical workshop on “The Non-Disclosing Patient” held at the 2017 APA Annual Meeting in San Diego in May. Dr. Lerman is the Director of Residency Training in the Department of Psychiatry at Westchester Medical Center.

Over the course of my career, I’ve repeatedly been humbled by the discovery of how wide the discrepancy can be between what I think I know about my patients, vs. their actual history and circumstances. A good bit of this discrepancy can be accounted for by my own various limitations. At the same time, like everyone else in our profession, I discovered how often, and how profoundly, patients either fail to tell their whole story, or in many cases lie.

This has lead me to wonder

- What kind of people lie to (or provide distorted facts to, or withhold facts from) their psychiatrists?
- Why do people lie to their psychiatrists?
- How do psychiatrists react when their patients lie to them?

And as my thinking has progressed, I’ve come up with more questions, like

- Is there a way to turn these lies into data, which we can use to better understand and help our patients?

I don’t always say “lie” by the way. I feel more intelligent when I use more words, so I’ve come to call this behavior “distortion, non-disclosure, and deceit” or DND.

I think there’s also a subtext to the conversation, namely

- What does it mean to be a psychiatrist?

How is this a relevant subtext? Well, I think most of us will agree that contemporary psychiatry assessment is focused on the collection of facts. Our diagnostic criteria are based on facts. The innumerable coders, auditors, and quality assurance personnel who review our records are almost exclusively focused on the facts we record; in fact, they are primarily concerned that something is being recorded as fact, and must less concerned with whether it’s actually true.

This focus on facts is in part the effect of the work of Goodwin and Cuze in 1970, who developed the concept of the “psychiatric syndrome”, which led to the DSM-III in 1980, which led in turn to all the checklists and rating scales which we use to standardize our diagnoses, and which we record in electronic medical records filled with facts, which insurance companies use to base their reimbursement, and regulatory agencies review to see that we’ve entered the right facts in the right places.

All well and good. We see plenty of patients who report their symptoms accurately, and if their symptoms fit neatly into a treatment algorithm, many of them experience symptom remission with an effect size of 1.5 to 2.0 compared with controls, and we have reason good about ourselves, right? And if you dig into the statistics of that 1.5-2.0 effect size, you’ll find many individual success stories, and we have reason to feel good about that too.

But we also know that there are many patients who are more complicated, who don’t fit into the templates. Generally speaking, we force them in anyway, and treat accordingly to clinical judgment, as psychiatrists have always done.

(Continued on page 10)
We’ve got you covered.

For over 30 years, we have provided psychiatrists with exceptional protection and personalized service. We offer comprehensive insurance coverage and superior risk management support through an “A” rated carrier. In addition to superior protection, our clients receive individual attention, underwriting expertise, and, where approved by states, premium discounts.

Endorsed by the American Psychiatric Association, our Professional Liability Program Provides:

- Risk Management Hotline – comprehensive 24/7 service for emergency issues
- Insuring Company rated “A” (Excellent) by A.M. Best
- Telepsychiatry, ECT coverage & Forensic Psychiatric Services are included
- Many discounts, including Claims-Free, New Business & No Surcharge for claims (subject to State Approval)
- Interest-free quarterly Payments/Credit Cards Accepted

Visit us at apamalpractice.com or call 877.740.1777 to learn more.
for individuals (evidence-based), better health for populations, and lower per capita costs. She showed how the Montefiore Pioneer Accountable Care Organization (PACO) population benefitted from such a program. Psychiatrists, she said, “need to do better as a group… measuring outcomes.” Integrating behavioral health and medical care “can improve outcomes, increase patient satisfaction, and reduce expenditures on health care.” she noted.

Cross-discipline cooperation is crucial, she emphasized, noting that patients with comorbid depression and diabetes or CHD have poorer self-care, increased medical symptomatology, greater functional impairment, and increased mortality. Depression leads to cost increases of 50-70% in these patients.

Socio-economic and political factors were also elaborated on, including the fact that clinics that serve poorer populations cannot make enough money unless Medicaid is increased. She also pointed to the cost savings of collaborative care exemplified in the IMPACT study, which showed a cost savings over 4 years of $3,363 on average compared with usual care. The return on investment was $6.50 per dollar spent.

She illustrated these points by providing details of the Montefiore program, the goals of which are treating to target and removing barriers to wellness, by improving the identification and treatment of depression and at-risk alcohol use through screening and outcomes-based interventions, improving patient adherence to evidence-based guidelines, and facilitating communication and care coordination between primary care and behavioral health. She described in detail how the program works, including rule descriptions for the different professionals, screening methods, talking points for patients. The need for care coordination was highlighted by looking at potentially preventable readmissions.

She concluded with a description of NY State’s Delivery System Reform Incentive Payment (DSRIP) program, in which NY is divided into geographical regions with a health care provider in each region designated as the lead. The DSRIPs enroll providers into their program and choose 5 out of 98 possible projects to implement. The financial objective is to move from fee-for-service to case rate or value-based payment.

Dr. Ricketts summarized the impact on current psychiatric care delivery, by pointing out "costs lower, care better with the integrative care model." Her take home message was that the delivery of mental health care is changing rapidly, as the psychiatrist’s role is evolving and systems of care are remodeling to meet the Triple Aim. At this point, she said, “money drives what and how care is provided.” She also emphasized how measuring outcomes is crucial for psychiatry. “Cross-discipline collaboration” will be the rule.

After a break for lunch, Paul Gross, M.D., family physician and faculty member of the Family Medicine Program at AECOM, presented a workshop on The Role of Reflective Writing in Clinical Practice and in Teaching.

Dr. Gross, noting that this topic could also be called “Narrative Medicine,” discussed the potential role of reflective writing for practicing psychiatrists and for their students. His interest in the intersection of writing and medicine began with his search for the “truth” and a way to process his experiences in medical school, and he was drawn to reflective writing as a means to achieve that. After giving several personal examples of the types of experiences he was referring to, he went on to explain how he uses reflective writing in his teaching of medical students in their third-year clinical clerkships in his course on patients, doctors and communities.

These experiences led to the creation of a publication devoted to reflective writing: Pulse - voices from the heart of medicine (pulsevoices.org). He based this publication on the JAMA column, “A Piece of My Mind,” to highlight “the personal side of medicine.” Another strong influence on him was Peter Selwyn’s book, Survey the Fall, concerning the AIDS epidemic and his father’s suicide when he was 12.

We were then all invited to practice reflective writing by composing and then sharing our narratives. This led to a lively, informative, and, at times, poignant discussion of our personal experiences as medical students and psychiatrists.
Q: Does the risk of malpractice lawsuits increase if a physician treats colleagues, colleagues' family members, or other “VIP” patients?

A. Treating “VIP” patients brings to mind images of celebrities being whisked in and out of rehab facilities via limousines surrounded by paparazzi. But a much more common situation for physicians and other healthcare professionals, is being asked to treat colleagues or colleagues' family members.

The “VIP Syndrome” has been recognized as occurring when a person with a particular status (a Very Important Person) presents for treatment, and the person’s status impacts the decisions that healthcare professionals make about the VIP’s care. This phenomenon can occur in instances where the patient is not a celebrity or political figure or other high-profile individual. The VIP syndrome may operate when the status of the patient, or the preexisting relationship with the patient, causes the healthcare professional(s) to treat this patient differently than he/she would normally treat a patient. The potential alteration in treatment is where an increased risk of professional liability can occur. Consider the following case scenario:

A young adult male (Mr. D) was brought to the hospital emergency department (ED) via ambulance after he attempted suicide by cutting both wrists. The patient was an EMT well known to the staff of the hospital as they frequently worked with him when he was part of an emergency transport team bringing critical patients to the ED. The emergency physician assessed Mr. D and contacted the psychiatric crisis team at the neighboring psychiatric hospital for further evaluation, per ED policy. A member of the crisis team, a psychiatric nurse, met with the patient in the ED. Mr. D told the nurse that he had not meant to kill himself. He stated that he now realized it was a “stupid thing to do,” and that he had cut his wrists in an attempt to get “my wife’s attention.” He wanted her to focus on problems in their marriage which she was avoiding. Furthermore, Mr. D stated that as an EMT “if I really meant to kill myself, I know how to do it.”

The psychiatric nurse contacted the on-call psychiatrist and related this information to her. Both had both worked with Mr. D on numerous occasions. The psychiatrist then briefly conferred with the emergency physician. The patient’s wife was not contacted and the treatment team did not inquire about any past psychiatric treatment. The emergency physician, the nurse, and the psychiatrist decided on a treatment plan that included stitches to the cuts and instructions for Mr. D to set up an appointment to see a therapist or psychiatrist within the next week. Mr. D promised to do this and stated he would find his own therapist or psychiatrist. He was then discharged from the ED. Three days later, Mr. D killed himself with a gunshot to the head.

A medical malpractice lawsuit was filed by wife against the emergency physician, the psychiatric nurse, the psychiatrist, the general hospital, and the psychiatric facility. During the discovery phase of the lawsuit it was found that Mr. D had previously been in treatment for depression and, also, that his wife was not aware of the recommendation that he seek treatment within a week. At trial, a verdict was returned for the plaintiffs and all defendants were found by the jury to have been negligent in the assessment and treatment of Mr. D.

The healthcare professionals involved in this case made assumptions about the patient that they probably would not have made if they had not had a prior work relationship with this patient. Additionally, they failed to gather all of the information they would typically gather to thoroughly assess the patient and implement an effective treatment plan. These shortfalls were, at least in part, responsible for the tragic outcome for this patient. Here, the patient was also signaling to the clinicians “don’t treat me like a regular patient because I’m not” in a number of ways - including his comments about knowing how to kill himself if he really wanted to, and by providing no information about prior treatment. The VIP patient may experience his or her own feelings, such as shame and discomfort about sharing sensitive information with colleagues, which may prevent him/her from taking a productive patient role.

Key risk management strategies for minimizing potential professional liability risk include:

1. VIP Patients must be provided the same standard of treatment as other patients. For example:
   * When applicable, informed consent should be provided as thoroughly as it is for all patients. For the VIP who is a medical professional, do not assume that he/she already knows and understands the treatment you are recommending
   * If you find your objectivity as a clinician is wavering (such as taking shortcuts in treatment, ordering more than or less than the usual tests, avoiding a thorough history and exam, etc.) obtain clinical supervision and/or refer the treatment to another clinician
   * Special privileges for VIP patients may compromise their care and ultimately their health
   * Do not avoid extra-sensitive topics such as the possibility of alcohol or substance use/abuse, suicidal behavior, issues around sexuality, infections diseases, etc.
The Non-Disclosing Patient
Written by: Alexander Lerman, M.D.

(Continued from page 6)

And then we have the special case, when a patient lies to us. What happens then?

The fact-based interview
Here’s what happens: if an assessment is based on facts, and all you’re training psychiatrists to do is collect facts, and the facts are false - then the assessment is meaningless. The larger the discrepancy between the patients’ report and the actual facts, the more serious the problem is going to be; and, generally speaking, the more serious the underlying psychopathology is going to be, and the more likely it is that the clinician will miss something really important.

Now some may respond “Okay, some people lie. So - are you going to give up on facts? What else is there, other than facts?”

And that’s precisely the question: What do we have, beyond facts?

In my opinion, there is something “beyond facts,” namely the human relationship between the patient and clinician, the clinician’s determination to understand and help as best he or she can, and the patient’s desire for help, and participation in the process.

Not always so easy, we know. But, set in a human relationship that is at the same time a professional relationship - even lies have meaning, even a patient’s sabotage of the treatment relationship can have diagnostic significance - and we’re going to be talking about how to get to that meaning and significance through something I call the “transactional interview.”

The transactional interview

Patient Vignette:
Before attempting to define what a “transactional interview” is, let me give you an example, albeit somewhat negative example.

Some time ago, one of my patients committed suicide. Up until that point, I considered my treatment of him to be a clinical success stories. The last time I saw him, he wasn’t feeling well, but I thought we had put an excellent treatment plan in place - but, as he was leaving, he turned around and asked me: Did I think that people who committed suicide were condemned to eternal torment in the afterlife?

I said I didn’t pretend to know, and the patient said, “Well, I do.” There was an unusually intense look in his eyes as he said this. I had a sense of communication between us, without a sense of what was being communicated.

I then remember thinking “Well that’s good,” because the idea of a negative consequence of suicide in the afterlife is a protective factor. A few days later, this man nevertheless killed himself in what was clearly very carefully-planned fashion. I have had many years to reflect on what I’d missed, and my role in this catastrophe.

One of the conclusions I came to was that I never knew this man at all. He shared some aspects of his life with me - but I’m pretty sure there was a great deal I never knew about. I suspect that there was a level of guilt and self-hatred driving him that he never shared with me, that he never shared with his family.

I don’t know that for a fact: I’m basing that on speculation derived from the look in his eyes when he told me that he felt people who killed themselves suffered in eternity, knowing that he would soon be one of those people. I sensed something in the look at the in his eyes, but I didn’t follow up - partly because it was late and I wanted to go home; and partly because, I realize this in hindsight, I had stopped trying to understand him a long time before, in part because of a certain passivity on my part that I identified only in hindsight.

This is one of a series of clinical encounters that left me with a belief that there are patients for whom the psychiatric interview must go beyond the collection of facts.

Yes, a psychiatrist must gather facts and document basic behavioral and mental status observations. But the interview is also an encounter between two human beings and engaging the patient in this encounter is what being a psychiatrist is all about. But this brings us back to the question what do you do when a patient lies?

Clinician apathy as a lie detector
It has taken me a long time to learn that my own emotional response is the most sensitive indicator I have that a patient is lying.

I became a psychiatrist because I want to understand people, and help them understand themselves. My father was disappointed that I didn’t follow my other interest in cardiology, but once I gathered my courage and took the plunge into psychiatry, there was no stopping me. When I started my career I was very excited about getting into clinical work with a patient, and then – it would get a little like relationships I had in high school, a little “Oh god this is boring”, maybe the patient would miss a session, maybe I would miss a session - and then both my enthusiasm and the quality of my work would go down.

Sometimes I’d blame the patient, other times I’d feel bad about myself - or simply wonder why I didn’t go into cardiology like my father wanted me to.

It took me a long time to realize how important this crappy feeling was. I came to recognize that it was something that was induced in me when I wasn’t getting something - or more importantly, when the patient wasn’t telling me something. Yes, my father still wished that I’d gone into cardiology. But once I realized that this “crappy feeling” was actually a

(Continued on page 11)
The Non-Disclosing Patient

Written by: Alexander Lerman, M.D.

(Continued from page 10)

psychopathology detector, I was back into the business understanding people that brought me to the field in the first place.

In my opinion, this is the first thing you must do when a patient lies – recognize your own emotional response. This phenomenon of withdrawing from non-disclosing patients is almost universal, and it can be dangerous – as in my example. You need to understand it for what it is, and trace back to the source.

A diagnostic goldmine

The second thing you must do when a patient lies is to recognize that you've just wandered into a gold mine. From a certain perspective, when people tell the truth it's very boring.

When people lie – there you have a window into their aspirations, their fears, the things they can’t even admit to themselves.

So that's what the transactional interview is all about: how to get beyond facts. How to work in a gold mine, without it caving in on you.

The four principles of the transactional interview

Let me say a few words about our simulated patient program at WMC. We wanted to challenge our residents, and get beyond checklist diagnoses. Each scenario is “gated” – in other words, designed so that taking a fact-based history will only get you so far. The patients drop hints, there are non-verbal cues, there is data in the supporting paperwork that contradicts what the patient says – and leaving it up to the interviewer to begin to discern what is going on.

For example, one case is a woman who minimizes a lethal overdose, and insists she is ready to leave the hospital. Another is a corporate executive presenting in the ER with police, who denies assaulting his wife. A third is a young man presenting with factitious symptoms, as well as a severe, unrecognized underlying depression – but to discern this, the interview must first establish that the patient is lying, and why the patient is lying.

In other words, we wanted these cases to be as dirty and as complicated as many the ones we see in real life. The first thing I learned was that we had to work hard to break residents out of using the interview to create a checklist-driven differential diagnosis. Some felt threatened, many felt ashamed of their performance in these challenging scenarios. Many reverted to “templating” (i.e. guiding the interview by DSM criteria or other arbitrary conventions), even though they were specifically directed to try to engage the patient more comprehensively.

I did my best to assure these trainees that the cases were designed to be difficult, or possibly impossible for someone at their level of training. But I realized also that the burden was on the WMC faculty, to provide clear, simple principles on how to engage a patient in this environment. This is the origin of the transactional interview.

We call this the “transactional interview” because the focus is on the moment-to-moment interactions between the interviewer and the patient, rather than the facts. Let me re-state: we have nothing against facts. But facts will only get you so far.

And this brings us to the first principle of transactional assessment

Transactional assessment can only take place within the “frame” provided by a clinical formulation. In other words, listen to what the patient tells you in the context of everything else you know about them. Does it fit with everything else you know, or is something missing?

Let me use the example of my suicidal patient: he made eye contact with me and asked: Did I think that people who committed suicide were condemned to eternal torment? And then said I do. I felt momentarily anxious, then relieved. Something didn’t fit.

That would have been a good cue to have the patient sit down, and ask more questions. Fact-based assessment is based (obviously) on facts. In a transactional assessment, a question mark may be of greater importance. In the case of my patient, I experienced a moment of intense anxiety that in hindsight should have been flagged with a question mark, rather than dispelled by what I knew - or thought I knew - about “protective factors”.

This brings us to the second principle:

A clinician’s emotional or “countertransference” response is the most sensitive indicator of DND.

But why didn’t I follow it up? In hindsight, I think I had withdrawn from this patient for many years. I stopped trying to understand him when he rejected my effort to treat him more deeply all those years before – and that set the stage for my failure to understand him three or four years later.

And this instance illustrates the point I made before about finding myself wishing I’d been a cardiologist: unrecognized DND leads almost invariably to clinician disengagement and/ or clinician self-disparagement. Within the fact-based interview, this disengagement is put into action, the clinician withdraws and the assessment stalls.

In the transactional interview, you have a chance to diagnose what is happening, and re-engage based on your awareness of what is happening. This involves getting to know yourself better, and self-monitoring during the interview.

The third principle is:

(Continued on page 12)
The Non-Disclosing Patient
Written by: Alexander Lerman, M.D.

(Continued from page 11)

The “why” driving DND is almost always more important than the “what” that is being concealed.

In the fact-based interview, we focus on facts.

In the frame of a transactional interview, when we engage DND, and we focus on the motivation for non-disclosure, rather than the content – in the context of everything else we understand about the patient. While there are often many reasons for non-disclosure, the motivation is at its core almost always a matter of emotion rather than facts.

And if you bring out the usual suspects, its anxiety, shame, and paranoia, with a side-helping of dissociation, or even transient psychosis.

Many patients who are unwilling to share specific facts nonetheless broadcast their emotional state through smirks, sighs, posture, and other non-verbal behavior – which often serve as more-candid indicators of the patient’s actual feelings.

Another critically important way to access a patient’s emotional life is through the classic standby of “genuineness, empathy, and warmth”. Patients who feel an interviewer is sympathetic to their emotional state are much more likely to share both feelings and information. But bear in mind that warmth may backfire with a patient who is paranoid, angry, or experiencing the interview as a contest.

This brings us to the fourth principle:

“Follow the affect”

There is nothing you’re doing, and no question you were about to ask, that is more important that the whatever it is that just caused the patient to flood with emotion. Sometimes this is simply a matter of asking the patient what’s going on – for example I could have said to my patient “what’s happening – it sounds like you’re going through torment right now”

I’m not claiming that anything I could have done would have made a difference. This isn’t magic. But framing, managing countertransference, and engaging your patients emotionally will help you every time.

Conclusion

This brings us back to what I said I felt was the subtext of the issue of interviewing: what does it mean to be a psychiatrist? For me, part of the answer is this: a psychiatrist works at the point of contact between many different systems, and many domains of knowledge. This is a point of vulnerability as well as opportunity; for there will always be so much, in any given moment, that a practicing psychiatrist doesn’t know.

Nowhere is this vulnerability and opportunity more evident than during the diagnostic interview. No transaction is more treacherous as when a patient lies. Within the mind of the psychiatrist, properly engaged, this lie can become a window into the fears, hopes and psychopathology of the patients it is our duty to understand.

(Continued from page 11)

Claims Examiner’s Perspective: Treating “VIP” Patients
Written by: Profession Risk Management Services, Inc. (PRMS)

(Continued from page 9)

2. The same level of confidentiality and professionalism must be afforded the VIP patient as is provided to all patients

* Members of the treatment team must resist the temptation (and sometimes the urging of other healthcare providers) to share patient information with those who have no need to know.

* Colleagues’ family members have the same rights of confidentiality as all other patients. Their information should not be shared with their family members without proper authorization, although colleagues may have unreasonable expectations to the contrary.

3. Be aware of legal issues related to reducing or waiving fees (“professional courtesy”) when treating colleagues or their family.
Westchester Medical Center Grand Rounds 2017-2018

Tuesdays, 11:00 a.m.-12:00 noon
Behavioral Health Center, Third Floor, Westchester Medical Center
100 Woods Road, Valhalla, NY 10595

October 24, 2017
Klaus Miczek
“Mechanisms underlying the early risk to develop anxiety and depression: A translational approach”

October 31, 2017
Wade Anderson
Accepting Uncertainty: The Legacy of Bion

November 7, 2017
Klaus Schreiber
Child Psychology

November 14, 2017
Les Citrome
Long-Acting Injectables in Clinical Practice

December 5, 2017
Beatrice Bebe
“Microtransactions in Parent Infant Attachment”

December 12, 2017
Mark Solms
“Neuropsychoanalysis”

January 9, 2018
J. John Mann
Molecular Imaging and Neuropathology

November 8, 2017
Interconnectedness of Depression & Pain
Presented by:
Naveed Iqbal, MD & Huma Naqvi, MD
St. Vincent’s Hospital
Harrison, NY

January 21, 2018
Legislative Breakfast
Crowne Plaza Hotel
White Plains, NY
Report on the APA Assembly Meeting - May 2017
Written by: Richard Altesman, MD, PSW Assembly Representative

This is merely a brief review of events at the three-day May Assembly meeting held in San Diego in conjunction with the last APA meeting. It is based on an excellent review by Adam Nelson, MD, Assembly Rep from California. Some of the Items have since become APA policy after acceptance by the APA Board of Trustees. Other items are still pending review and are NOT official APA policy, at least not yet. Will keep you posted about those. Also present at the Assembly meeting were our DB members Ed Herman, MD and Deborah Cross, MD. Please feel free to contact any of us for questions or further information. And if anything here peaks your interest, please speak up. Any of us can submit an Action Paper for the next Assembly meeting!

Speaker Dan Anzia, M.D., welcomed everyone to the fall 2016 meeting of the APA Assembly. Dr. Anzia called on Evan Eyler, M.D. and Manuel Pacheco, M.D., Area 1 Representative and Deputy Representative, respectively, to offer a few words in memoriam to Dr. Brian Benton, who recently passed away due to cancer.

Saul Levin, MD, MPA, CEO/Medical Director of the APA, presented his report, much of which can also be found in the Assembly packet. Highlights include: 1) development of APA’s new home in the Waterfront Project in the SW corner of Washington, D.C. due to open in 2018; 2) continued growth of membership, which now exceeds 37,000; 3) opposition to the AHCA bill recently passed by the US House of Representatives, and liaison with 13 influential Senators currently drafting their own bill; 4) APA’s registry now accessible for QI and to increase CMS reimbursements for psychiatrists; and 5) celebrating appointment of Elinore McCance-Katz, MD as the country’s first Assistant Secretary for Mental Health and Substance Abuse for HHS under the recently passed 21st Century CURES Act. Dr. Levin also emphasizes Assembly initiated APA accomplishments, such as the APA accreditation as a consulting NGO to the United Nations; creating new CPR codes for reimbursement; increasing diversity in membership in the Assembly; and Assembly led call for MOC reform, which has now led to at least 13 states proposing or passing removal of MOC legislation.

A. David Axelrad, MD, chairman of the Assembly Committee on Procedures, reported that the Assembly approved the following changes to the Procedures Code:
   1) Allowing for Electronic Voting on APA Practice Guidelines
   2) Allowing for a special meeting, to be held electronically, in the case of vacancy of an office of the Assembly.

The winners of the Assembly vote for new officers were announced: James R. Batterson, MD for Assembly Speaker-elect, and Steven Davis, MD for Assembly recorder. As Dr. Davis may have a potential conflict of interest, this will be addressed by use of newly approved Assembly Procedure Code changes, if necessary. Congratulations to our new officers and commendation to all of the candidates for a hard fought and close election campaign.

Anita Everett, MD, the APA-President-elect, presented a summary of her three main objectives for the coming year as President of the APA: 1) Aspiration; 2) Innovation; and 3) Physician Well-Being. She recently attended a meeting for PsychSIGN, an organization for medical students aspiring to become psychiatrists. She has appointed a Workgroup on Access to Treatment through Innovation. She has also appointed a Workgroup on Physician Burnout. Expect to hear more about these efforts in the upcoming year.

Jenny Boyer, MD, JD, PhD announced that the Assembly Awards Committee presented the District Branch Best Practices Award this year to NY County DB. NCPS was the runner up. The Ron Shallow Award was presented to Laurence Miller, MD from Area 5 and to Ramaswamy Viswanathan, MD from Area 2. In addition, David Skasta, from Area 3 was awarded the Ron Shallow Award retroactively from 2016. Dr. Skasta proposed a change to the rules regarding this award which had glaringly omitted from eligibility for consideration members of ACROSS. Once this oversight was corrected, he was given the award for this and his many other pioneering efforts in the Assembly. Recognition for highest voting percentage of members in the last election went to Area 2 (24%) and to Mid-Hudson DB (32%).

Patrick A. Harris, MD, MA, Chair of the AMA Board of Trustees outlined Strategic Objectives for the AMA: 1) Accelerating Change in Medical Education – to create the Medical School of the future. 2) Professional Satisfaction and Practice Sustainability, including coping with professional burnout. Currently, >50% of US physicians experience burnout, many of whom are quitting the profession. Bureaucracy is a leading cause, including needless prior authorizations, when 95% are approved, Electronic Medical Records, which were largely created without physicians’ input. 3) Improving Health Outcomes. While chronic disease accounts for most PCP visits and >75% of total healthcare spending, 90% of persons with diabetes aren’t even aware of their disease. AMA is developing online tools for the field with partners in innovation for the next generation in medical technology through partnerships including Matter, Sling Health, Health 2047, and Xcerto. In addition, AMA is devoting resources to improving the ACA, through efforts such as Patients-First-Politics. Finally, AMA’s Task Force to Reduce Opioid Abuse has led to reduced Opioid prescriptions and increased PDMP use.

The following Position Statements were decided on at the Assembly, including:

Retain:
* Use of Stigma as a Political Tactic (2007)
* Resolution against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health (2006)
* Discrimination against International Medical Graduates (2001)
* Diversity (1999)

(Continued on page 15)
Report on the APA Assembly Meeting - May 2017
Written by: Richard Altesman, MD, PSW Assembly Representative

(Continued from page 14)

*Psychiatrists from Underrepresented Groups in Leadership Roles (1994)
*Resolution Opposing Any Restriction on the Number of IMGs Entering Graduate Medical Training (1994)
*Affirmative Action (1977)
*Adoption of AMA Statements of Capital Punishment (2008)
*No “Dangerous Patient” Exception to Federal Psychotherapist-Patient Testimonial Privilege (2010)

Revise:
*Role of the Psychiatrist in Long Term Care Setting (from 2003)
Abortion (from 1978) – approved unanimously
Use of the Concept of Recovery (2015) – referred back to Council

Retire:
*U.S. Military Policy of “Don’t Ask Don’t Tell” (2009)
*Joint Statement on Anti-Substitution Laws and Regulations (1976)
*Doctors against Handgun Violence (2001)

Proposed:
Risk of Adolescents’ Online Behavior – approved unanimously
Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement – approved unanimously
*Legislative Attempts Permitting Pharmacists to Alter Prescriptions

Among the Actions taken during this session, the Assembly voted to:

- Develop a position statement on Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders
- Oppose Psychologist Prescribing
- Promote the international Neuroscience-based Nomenclature (NbN) for medications
- Revise Nomenclature, Definition, and Clinical Criteria for PHP and IOP levels of Psychiatric Care
- Defeat (74 yea/101 nay) a proposal to survey the APA membership on Medical Aid-in-Dying as an Option for End of Life Care
  - This issue generated strong arguments on both sides of the issue. Those in favor were largely concerned that this issue needed attention as more countries and jurisdictions are legalizing this controversial practice. Those opposed were concerned about potential bias in methods and results of a membership survey, but still feel the issue is in need of urgent attention of the APA.
- Provide Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice
- Expand Access for graduates of AOA Accredited Schools to ACGME Approved Psychiatry Subspecialty Fellowships
- Develop Educational Strategies to Improve Mental Illness Perceptions of Medical Students and Non-Mental-Health Medical Providers and Develop Training Opportunities to Foster Medical Student Interest in Psychiatry
- Urge the APA to Draft a Position Statement on Prescription Drug Monitoring Programs
- Urge the APA to Immediately Support the AACAP and AMA Positions on Solitary Confinement in Juvenile Detention Settings, and for the APA to develop a Position Statement of its own.
  - This paper was originally changed to request a Position Statement by the APA by November 2017. The author refused to consider without also calling for immediate support for policies put forth by the AACAP and AMA as there were juveniles presently suffering the consequences of draconian practices of solitary confinement. The Assembly concurred.
- Take a leadership role to Address Physician Burnout, Depression, and Suicide among APA members and beyond and revise its Position Statement on Physician Wellness
- Urge the APA to Adopt the Position Statement: “Health care, inclusive of mental health care, is a Human Right.”
  - Dr. Eliot Sorel noted that health is inherent to “life, liberty, and the pursuit of happiness. Debate arose over the importance or danger of emphasizing mental healthcare as distinct from healthcare, or as Dr. Renee Binder noted last year in Atlanta: “There is no health care without mental health care.”
- Urge the APA to improve member voting participation in APA Elections
- Support dues relief to APA members from Puerto Rico
- Streamline the Process for former APA Members to re-enter the APA
- Repair the broken APA Referendum Voting Procedure
  - As the author noted, this is the fifth time this paper has been brought, and the fifth time the Assembly approved it. The past 4 times it failed to gain approval by the BOT.
- Move Assembly November meeting dates to avoid conflicts with national elections
- Approve the APA Practice Guideline for Pharmacological Treatment of Patients with Alcohol Use Disorder
- Ratify an Amendment to the APA Bylaws reflecting a new nomination and election process for the M/UR Trustee
  - Dr. Binder reported on the recent finding of the APA Bylaws being out of compliance with Washington, D.C. law on equal opportunity for representation in an organization. To restore compliance, the Bylaws have

(Continued on page 16)
Report on the APA Assembly Meeting - May 2017
Written by: Richard Altesman, MD, PSW Assembly Representative

(Continued from page 15)

been amended to reflect the appropriate change for M/UR Trustee nomination and election procedures. While both primary and secondary reference groups approved the proposed changes, the M/UR Caucus representatives to the Assembly were divided, slightly favoring ratification.

[Items with a * were approved by consent.]

A full summary of all Actions of the Assembly may be found at https://app.box.com/s/skdhp47za4elygp3s4cwptdv6hql4.
Final Action Papers can be found by going to https://goo.gl/jLvB6D.

Reports and Next Steps from the Assembly Work Groups and Committees:

MOC Committee - L. Russell Pet, M.D.: The Assembly supported unanimously the recommendation of the MOC Committee for the APA to adopt a position that decisions regarding licensure, hospital privileges, and credentialing and/or participation on insurance panels should not in any way be conditioned upon the physician's completion of or participation in MOC or Osteopathic Continuous Certification. This is consistent with the position of the ABPN and would significantly reduce physician burnout. The Assembly further supported unanimously that the position be brought to the BOT at the earliest opportunity (July 2017) for their approval on this position.

Dr. Daniel Anzia oversaw formal farewells to those Assembly members who are stepping down as of the end of this session. Best of luck to all who are leaving. Your presence and your efforts have been appreciated and will be missed.

(Continued from page 15)

We're On The Web!
www.wpsych.org

https://www.facebook.com/PSWinc

The Psychiatric Society of Westchester County
400 Garden City Plaza, Suite 202
Garden City, New York 11530
T: (914) 967-6285
F: (516) 873-2010
E: centraloffice@wpsych.org