Drug overdoses have become the leading cause of accidental deaths. Prescription and illicit opioids are the main driver of overdose deaths. The number of deaths and emergency room visits caused by opioid abuse has increased at a great rate since 2000.

From 2000 to 2014, the rate of deaths from overdosing has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). During 2014, 47,055 drug overdose deaths occurred in the United States; 61% (28,647) of those deaths involved some type of opioid, including heroin. (From the MMWR Weekly report January 1, 2016/64 (50); 1378-82)

All the causes of the current opioid abuse epidemic are unclear, but it seems in part due to the easier availability of opioid pain medication. The educational programs of the 1990s and early 2000s decried the under-treatment of pain (“take pain seriously!”) and included recommendations to increase the use of opioids to treat pain. (For this history, see The Joint Commission’s Pain Standards: Origins & Evolution, May 5, 2017). These recommendations have now been superseded by concerns about legally prescribed opioid pain medications being diverted to illicit use. Because of this heightened concern, recent warnings have counseled great caution about prescribing opioids and have led to regulations restricting their use. Rules for physicians, with the goal of decreasing illicit use of legal substances include: 1) New York State’s 2016 law limiting opioid drug prescriptions to 7 days of painkillers following a patient’s initial visit to a doctor for acute pain; 2) Prescription monitoring programs (PMPs), such as the program established in NY in 2013 under the “Internet System for Tracking Over-Prescribing (I-STOP) Law,” which requires physicians to check a patient’s PMP website prior to prescribing controlled substances; 3) Mandatory electronic prescribing, which became effective in NY in 2016.

The abuse of prescription medications was brought home to me by my own recent illness. I had severe pain caused by a herniated spinal disc. During my treatment, I noted the difference in willingness or unwillingness of prescribers (surgeons, orthopedists, physician assistants, primary care providers, and emergency room doctors) to prescribe controlled substances, including opioids. I needed to be hospitalized because of my pain, and I noted that the most liberal use of pain medication was in the hospital, where the prevention of possible patient misuse is the greatest. As an outpatient, my opioids were prescribed very carefully. All my prescribers warned me about the dangers of controlled substances. Everything turned out well, and I am very glad that I was able to receive adequate treatment for my pain.

Psychiatrists are at the forefront of treating individuals with substance abuse problems. Will psychiatrists be seeing more people who are withdrawing from opiates and seeing people who use illicit opiates because they are no longer able to get them legally? Or will we be seeing fewer substances abusers, because changes in treatment will lead to less availability of prescription opiates and that, in turn, will lead to fewer substance abusers? The short answer is, the less opioids are legally prescribed, the less prescription opioids will be available for abuse. But what about the treatment of pain? I hope that we physicians do not overcorrect on the wrong side of pain relief.
Psychiatry, Bigotry, and “Terrorism” By: Alexander Lerman, M.D., Director of Residency Training in the Dept. of Psychiatry at Westchester Medical Center

The day after the 10/31/17 mass murder incident in lower Manhattan, a resident who is an observant member of a religious minority came to see me. He told me that he dreaded coming in to work after learning that the assailant claimed to be a Muslim. Several other residents subsequently cited similar feelings after I released the following statement (below).

I believe that many IMG residents and psychiatrists, particularly those associated with specific minorities, are suffering in training. I think we should continue to make clear as an organization where we stand.

Here is my statement to the residents:

The attack in lower Manhattan on Tuesday is a tragedy for its victims, as well as our community – and a tragedy that has been deepened by retaliatory bigotry directed towards immigrants and Muslims, and presumably other groups who can somehow be differentiated from the rest of our community and characterized as “not us.” This seems like an appropriate moment to reflect on who we are and what we represent.

The Westchester Medical Center is an organization dedicated to a commitment to belief in the potential of human beings to recover, grow, and help each other. Our diversity contributes to our ability to serve one of the most diverse communities in the country in Westchester, to deliver care to people at every station in society. Our diversity fills me with pride. But I have to tell you that when I look at our faculty, our residents, or our patients, I don’t see a collection of Caucasians, Asians, Jews, Hindus, etc.

What I see are people, people who work hard, people who work hard to combine science and medical arts to help others, people who trust and support each other. I am proud to be part of this community, and I hope you are too. Together, we represent one of many communities united against bigotry, and hate; but we represent something more than mere opposition. We are part of the solution.

I know all of you share this sense of purpose, and are guided by the same hope when confronting all the problems we engage in our daily work. I hope we will talk about what’s going on and face this, as we face all our problems, together.

The Interconnectedness of Depression and Pain By: Jerry Liebowitz, M.D.

Our latest CME presentation, ”The Interconnectedness of Depression and Pain,” was held on November 8th at St. Vincent’s Hospital. The speakers were introduced by C. Deborah Cross, DB Past-President.

Naveed Iqbal, MD, secretary of our District Branch Executive Council, Chairman of the Department of Psychiatry at NY Presbyterian-Hudson Valley Hospital (Cortland Manor), and senior attending psychiatrist at the Albert Einstein College of Medicine, introduced and reviewed the subject. He pointed out how many of the diagnostic criteria for depression are like experiences of pain. He asserted that they are overlapping syndromes. “Depression is painful – it hurts,” he noted, and “pain is depressing.” Patients with pain often say that they “cannot take it, they might as well die!”

He discussed the pathophysiology of depression, noting that there are multiple types and subtypes of depression. “All treatments work through the monoamine system,” he stated, “including light therapy!” He also commented that “ECT is underutilized in the US … and it’s a shame.” It has fewer side effects than antidepressants and is often more effective.

Commenting on the placebo response, he reported that meta-analysis shows it to be a very powerful response – “as effective as antidepressants.” He highlighted the importance of rating scales to assess treatment and progress.

He then enumerated various similarities between depression and pain. For example, low monoamine levels lead to an increase in the signaling of pain. He noted the need for a continuum of care, which is often lacking.

In conclusion, Dr. Iqbal predicted that “a close communication between pain management physicians and psychiatrists will allow for an optimal treatment and improved quality of life.”

Huma Naqvi, MD, assistant professor and attending psychiatrist at AECOM/Montefiore, started as an anesthesiologist in obstetrics and pain management, then completed a residency in PMNR, and is now Director of Geriatric Rehabilitation. Dr. Naqvi, who sees and treats patients with acute and subacute pain, spoke about basic types of pain and various treatment methods, including those of alternative medicine, and illustrated several ways in which pain and depression are interconnected. Depression and chronic pain share some of the same neurotransmitters as well as some of the same nerve pathways in the brain and spinal cord.

She enumerated the basic types of pain – nociceptive (somatic and visceral), neuropathic (including peripheral neuropathy, post-herpetic neuralgia, and central or post-stroke pain), and mixed category pain.

(Continued on page 4)
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The Interconnectedness of Depression and Pain

By: Jerry Liebowitz, M.D.,

(Continued from page 2)

and illustrated the pain pathways and types of nerve fibers for each. She then discussed inflammation and how it is interconnected with both pain and depression.

The remainder of her talk focused on various treatment methods, emphasizing complementary integrated medicine, using non-mainstream approaches together with conventional medicine. She noted that when a non-mainstream approach is used in place of conventional medicine, it is considered “alternative” medicine. NSAIDs, opiates, and antidepressants are examples of mainstream approaches. Other approaches, such as acupuncture and herbal treatments, have also been shown to be helpful for pain management – and, more recently, depression.

Dr. Naqvi went into some detail, reviewing studies and meta-analyses and giving clinical examples, on the effectiveness of acupuncture for depression. Both manual acupuncture (a treatment method that has been used in East Asia for thousands of years) and electro-acupuncture (in which needles are manipulated by electrical stimulation) were studied in several randomized controlled trials, and the results were inconsistent. However, there was some evidence, she noted, that acupuncture was an effective treatment that could significantly reduce the severity of depression and that it has an additive effect when given as an adjunct to antidepressant drugs. She felt that further trials of electro-acupuncture are justified, since evidence suggests that acupuncture generates a sequence of events that include the release of endorphins that modulate pain and, perhaps, depression within the central nervous system. High or low frequency stimulation induced by electrical acupuncture has been shown to release different types of endorphins. And studies with CT scans and functional MRIs have shown positive effects post-acupuncture, including its effectiveness in post-stroke depression.

In a particularly fascinating part of her presentation, Dr. Naqvi discussed auricular (ear) acupuncture, noting that it is easy to learn and perform and has both diagnostic and therapeutic value. With the help of visual aids, she described the Chinese auricular somatotopic map on the anatomy of the pinna, like a homunculus representing various body parts and functions (such as muscle relaxation, hunger, tranquilization, allergy relief, among others).

She concluded with a discussion of herbal treatment for depression and anxiety. Saffron (active ingredients crocin and safranal), which is actually a spice, has been found to be effective for the treatment of depression without the adverse side effects of weight gain and sexual dysfunction. Turmeric (curcumin), a plant with potent anti-inflammatory, antioxidant, and neuroprotective properties, has also been shown to be effective in treating depression and appears to be safe and well-tolerated. All herbal treatments can cause side effects, she cautioned, including hypertension, but most of the side effects are mild and not like those of antidepressants. She suggested visiting the website site nutritionfacts (https://nutritionfacts.org) for information on herbal treatments and diet.

Dr. Naqvi concluded with a brief discussion of the NCCIH Clearinghouse (https://nccih.nih.gov), which provides information on complementary and integrative health approaches, including publications and searches of Federal database of scientific and medical literature.

The presentation was followed by a very active, enthusiastic Q&A period. Several questions related to the dosing of herbal supplements, while others related to fibromyalgia, “a diagnosis of exclusion,” according to Dr. Naqvi, who pointed out that fibromyalgia patients responded differently to acupuncture, probably because inflammation plays a big role.

Report from the Fall NYSPA Area II Council Meeting

By: Edward Herman, MD, JD - NYSPA Treasurer

The New York State Psychiatric Association (NYSPA), Area II Council of the American Psychiatric Association, held its Fall meeting at the LaGuardia Marriott Hotel on October 21, 2017.

NYSPA committees met from 9:30 – 11:00. These committees included Legislative, Addiction, Economic Affairs, RFM, and Presidents/Presidents-Elect.

At 11:00, a presentation on Telepsychiatry was held. Moira Wertheimer, Esq., President of the CT. Society of Risk Management, Seth Stein, Esq., Executive Director of NYSPA, and Dan Dunlop, from Arcadian Telepsychiatry, were the presenters.

The presenters defined Telemedicine as two-way real-time interactive communication. Telemedicine has been used since the 1950’s. The benefits of Telemedicine include increased access to care for patients in rural or underserved areas and cost-effectiveness. Telepsychiatry has been implemented in a number of settings, including Forensic/Correctional settings, underserved areas, emergency rooms, the VA, cruise ships, and disaster areas.

The presenters described the various methods that have been used to perform telepsychiatry, including VTC (video teleconferencing), social media, and via mobile devices.

The presenters raised a number of concerns regarding the use of Telepsychiatry, including appropriate patient selection, establishing standards of care, and maintaining a professional environment. Legal and regulatory issues were also discussed, including the need for appropriate licensure in the state where the patient is located, specific informed consent for Telepsychiatry, privacy issues, including HIPAA compliance, and appropriate documentation for reimbursement.
Report from the Fall NYSPA Area II Council Meeting
By: Edward Herman, MD, JD - NYSPA Treasurer

(Continued from page 4)

purposes. The additional challenge of prescribing controlled substances was also discussed, as it is unclear whether the requirement to see a patient in person at least once to prescribe a controlled substance, established under the Ryan Haight Act, would be satisfied through the use of Telemedicine.

At the end of the presentation, Arcadian Telepsychiatry presented a demonstration of their software platform.

During the Council session held in the afternoon, a number of presentations were made. Richard Gallo presented the Legislative Report. He described that NYSPA successfully advocated for the passage of a law to raise the age of criminal responsibility from 16 to 18, a $150,000 appropriation for NYSPA's Veteran Mental Health Primary Care Training Initiative, extension of the Physician Excess Medical Malpractice Program, renewing Kendra's Law, and the allocation of an additional $1.5 million for the purpose of making physician loan repayment awards to psychiatrists who agree to work in OMH-operated settings for at least five years. A number of NYSPA's legislative priorities continue to be worked on, including the prohibition of the use of "conversion therapy" for minors.

Seth Stein and Sam Muszynski discussed the award of Parity Enforcement grants to assist NYSPA in its efforts to enforce parity requirements for our patients access to mental health care.

One of the highlights of the afternoon session was the presentation of awards to the winners of the NYSPA Scientific Paper Contest. This contest solicits psychiatric residents throughout the State to submit original scientific papers (case reports, literature reviews, research reports, etc.), with the winner receiving a check for $500 and the opportunity to present a summary of the paper at the Fall NYSPA Meeting. The judges for the contest were Seeth Vivek, Aaron Satloff, and Edward Herman.

There were 17 papers submitted for review. The top three winners were:

♦ 3rd Place: Navjot Brainch, MD - Maimonides - Paper Title “Psychiatric Emergency Services - Can Duty-Hour Changes Help Residents and Patients?"

♦ 2nd Place: Youngjung Kim, MD, Ph.D. - Mt. Sinai - Paper Title “Medication Non-Adherence Secondary to Choking Phobia (Phagophobia) in an Adolescent with Significant Trauma History: Addressing the Issue of Mental Contamination.”

♦ 1st Place: Raymond St. Marie, MD - Buffalo - Paper Title “The Neurologic Evidence of a Mind-Body Connection: Mindfulness and Pain Control.”

Dr. St. Marie received the cash reward and made a stimulating presentation of his paper.

The Spring NYSPA meeting will take place on March 24, 2018 at the LaGuardia Plaza Hotel. All are invited to attend.

Microanalysis of mother-infant communication and the origins of disorganized attachment
WMC Grand Rounds - Dec. 5, 2017 - Reported by: Alexander Lerman, MD

What is it to stare into another’s eyes? For humans and other mammals, direct eye contact is a provocative gesture for sexual or aggressive reaction. For infants and their mothers, it is a key component of intimacy and psychic growth. This is the report of Beatrice Beebe PhD, who gave a Grand Rounds titled “Microanalysis of mother-infant communication and the origins of disorganized attachment” at Westchester Medical Center on 12/5/17. Dr. Beebe is a Clinical Professor of Psychology in Psychiatry at Columbia University Medical Center and a member of the faculty of the Center for Psychoanalytic Research and Training at Columbia.

Based on a second-by-second analysis of videotaped mother-infant face-to-face play interactions of 84 dyadic pairs, Dr. Beebe reported, it is possible to predict secure and insecure attachment styles. Much of dyadic play engages the infant’s well-developed capacity for timing, repetition, and contingent expectations, which may be a precursor to language acquisition.

In her clinical work with mothers who present for treatment, she also states that she is able to detect and correct pathogenic mother-infant interactions, with potentially profound favorable consequences for both members of the dyad.

Most of us are familiar with Ainsworth’s classic “Strange Situation” test of infant attachment. In the Ainsworth assessment, a toddler is left playing with a stranger by his or her mother, who then rejoins her child after a few minutes. “Securely attached” children often weep during the separation, but easily are comforted by their mothers; while the “avoidant” toddler withdraws, and the “resistant” toddler rejects mother on her return.

More ominous are signs of “disorganized attachment” (characterized by disorientation, confusion, freezing, contradictory expressions of affect). Disorganized attachment is a powerful predictor of child and adult (Continued on page 10)
The Biological Basis of Consciousness - WMC Grand Rounds - Oct. 10, 2017
By: Paul Crisofano, MD - PGY 2 Psychiatry Resident, Westchester Medical Center

During our October 10th grand rounds, esteemed professor Dr. Richard Brown presented his research talk entitled “The Neurobiology of Consciousness,” in which he discussed the current prevailing theories of consciousness in the mind and the latest research on the topic. His discussion focused on phenomenal consciousness, a term expanded upon by Nagel, which he describes as “a subjective felt experience.” While some may discuss alternative concepts of consciousness in terms of levels of arousal and awake, phenomenal consciousness is dichotomous, either occurring or not.

Dr. Brown’s talk centered on three major questions: What are we conscious of? Is higher order awareness necessary for phenomenal consciousness? And what areas of the brain are active during conscious experiences? The answers are more complex and more heavily debated than one might initially postulate. Giving the example of simply opening one’s eyes and viewing an image in the world, Dr. Brown discussed theory that suggests one may need to be ‘thinking about thinking’ to have a conscious experience. This calls to mind the application of mindfulness. Further discussion stimulates the protracted debate of dualism versus physicalism – is there a dual process of connected mind and body, or can all behavior and action be explained by the physical processes of our brain?

Interestingly, research continues to navigate the question whether there is more to consciousness than what the brain is physically doing. The rich vs sparse theory contests the following: if you see something, but you deny seeing it when asked, because you are seemingly unaware you saw it, did you experience it? Rich theorists would argue yes, while sparse would argue no. Research demonstrates that those that deny seeing it will have visual cortex activity, and if, for example, it was a fear-inducing image, would also show activity in the amygdala. However, those that saw it and indicate they saw it, also had activity in the prefrontal cortex. This had led researches to speculate the prefrontal cortex is particularly involved in consciousness, although some have argued that the prefrontal cortex is activated in these instances due to the reporting itself. Other experiments performed further identify the dorsal lateral prefrontal cortex and link its involvement in higher order awareness.

These concepts may become increasingly important to the field of psychiatry as we continue to develop the psychopathology of illness and disorder. Dr. Brown illustrated this point through his discussion of our current treatment of anxiety. While patients that are compliant with anxiolytics may seemingly alter anxious behaviors, many still report experiencing anxiety. Targeting not only the behavior, but the conscious perception of the behavior, may be a new frontier and even necessary in effectively treating anxiety and other mental illnesses.

Reflections on “The Show” - Literally and Figuratively
By: Sarah Vaithilingam, MD - PGY 2 Psychiatry Resident, Westchester Medical Center

I came across the movie “The Show” this weekend. I was looking for something light to enjoy my lazy Saturday with. It had an interesting concept: the story line was based on a fictional reality television show that helped individuals orchestrate their suicide attempt. In the movie, these attempts were glorified because the person was killing himself or herself for the benefit of some other purpose.

My knee jerk reaction of course was “here go the borderlines.” But what I soon realized was that, as a resident, I am so detached from the emotional experience a patient is having after a legitimate suicide attempt.

As a second-year psychiatry resident, I see so many patients come in after a suicide attempt. Our hospital is also a level one-trauma center, so I’ve pretty much seen everything from femoral fractures, to complete liver failure due to overdoses, to self-mutilation, which involved removal of all five fingers with a metal cutter. These patients come through the ER, so it is a matter of listening to their story, writing a decent HPI, processing them, and placing admitting orders. It’s a well-run machine, to say the least.

Compassion and empathy are lost, because I am preoccupied with getting the necessary information to fill out an evaluation note in our electronic record. Most of the information I get for that note is irrelevant anyway – it’s the story the insurance company wants to hear, and it protects me if this patient decides to sue. I wonder how legal documentation became more important than respecting the nature of a patient’s illness.

For example, I follow a template: chief complaint, history of presenting illness, past psych history, etc. You get the point. I never focus on the words my patients are using to identify themselves, better yet identify the circumstance that led them to this point. Even worse, the privacy they deserve is stripped from them because now they are “a risk to self.”

If anything, the movie gave me perspective and a clearer understanding of my role as a psychiatrist and how unique and impactful that role is. I guess I wrote this perspective piece as a reflection of my own practice. I’m sure the well-run machine will continue to function, but there is no harm in adding a little humanity to my practice.
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Report on the APA Assembly Meeting - November 2017

Editor’s Note: This is a brief review of events at the three-day November Assembly meeting held in Washington, DC. 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 yet official APA policy. Present at the Assembly meeting were our DB members Richard Altesman, MD, Ed Herman, MD and Deborah Cross, MD. Please feel free to contact any of them for questions or further information. And if something here peaks your interest, please speak up. Any of us can submit an Action Paper for the next Assembly meeting in May 2018!

Speaker Theresa Miskimen, MD, welcomed everyone to the fall 2017 meeting of the APA Assembly. Dr. Miskimen offered words of concern regarding the unusual number of disasters that have befallen so many areas of the country recently, including the victims in the tragic Las Vegas shootings, and the hurricane damage to coastal Texas, Florida, and especially Puerto Rico, from where she originally hails, which currently remains without water, healthcare access, and basic infrastructure. Dr. Miskimen also expressed special thanks to all those who have provided support in relief of those affected by these tragedies.

American Psychiatric Excellence Awards luncheon
This year, as an added treat, the Assembly was invited to a luncheon in honor of this year’s recipients of the American Psychiatric Excellence, or APEX, Awards. The APEX Awards were first proposed by Past President Renee Binder, MD. This year’s recipients include Kathryn Farinholt, Executive Director of NAMI Maryland, Representative Jennifer González-Colón of Puerto Rico, Senator Brian Schatz of Hawaii, Eric Eyre, reporter for the Charleston Gazette-Mail, and Senator Debbie Stabenow of Michigan. More information is available at https:// goo.gl/yiqXnU

Report from the APA President – Anita Everett, MD
Dr. Everett identifies 3 priorities to be addressed through workgroups she has convened during her term as president of the APA. To support our membership, one workgroup is exploring ways to expand member involvement and access to the APA’s autumn Institute for Psychiatric Services meeting. Another workgroup explores and develops strategies for the state district branches and associations in addressing scope of practice legislation. A second priority is innovation to enhance the practice of psychiatry. Dr. Everett showed a video featuring Robert Graboyes’ comments on the reluctance of medical providers and insurers to embrace innovation. Dr. Everett seeks feedback from Assembly reps and APA members as to their ideas why we psychiatrists seem to have been slow to embrace innovation in our own practices. Finally, Dr. Everett introduced Richard Summers, MD, the chair of the workgroup on physician well-being and burnout.

Dr. Summers presented some of the preliminary recommendations of the workgroup. The “Triple-Aim” of healthcare reform should be reformulated as the “Quadruple Aim”, which should include physician well-being as its 4th leg. Toward this end, healthcare organizational systems must be designed to reflect human needs. For physicians especially, this should include autonomy of

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Report on the APA Assembly Meeting - November 2017

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practice. The workgroup also recommends developing leaders in healthcare with participative management competency, rather than those without practice experience. Other recommendations include developing social communities, removing sources of frustration and inefficiency, reducing preventable harm and supporting secondary victims, and bolstering individual wellness. Upcoming products from the workgroup include an online portal, toolkits, and advocacy resources.

The APA has a website: www.psychiatry.org/wellbeing. Everyone is encouraged try this link, which will give you a self-assessment of your own wellbeing and risk for burnout. The data is being collected without identifying information.

Special Election and Nominations for Speaker-elect and Recorder

The Assembly held a special election for the office of Recorder, formerly won by Steven Daviss, MD last spring. However, Dr. Daviss has resigned to avoid further potential conflict of interest between the APA and SAMHSA, where he has recently been hired. To replace him, 3 candidates were nominated. As a result of today’s vote, Paul O’Leary, MD will be the Assembly Recorder for this year. Regular elections for officers will be held in May 2018. The nominees for office for next year are:

Speaker-elect: Paul O’Leary, MD (Area 5) and C. Deborah Cross, MD (Area 2)
Recorder: Jake Behrens, MD (Area 5) and C. Deborah Cross, MD (Area 2) and Seeth Vivek, MD (Area 2)

Report of the CEO/Medical Director of the APA — Saul Levin, MD, MPA

Dr. Levin announced that the APA membership has exceeded the number of members we had in 2002, the last year that Pharma was involved with the APA. APA continues to use TCPI-SAN Grant funds awarded from CMS for training psychiatrists to integrate with primary care providers in Collaborative Care (CC). APA opposes efforts by the Joint Commission to enforce CMS regulations regarding ligature-use risks. As a result of a recent incident involving a patient in restraints, the JC declared all risks will be corrected, but the rollout has been unduly burdensome. APA will participate in a CMS task force in December to improve the implementation process with new guidelines due in 6 months. APA is mobilizing to provide disaster relief for the many affected around the country. These efforts include the Lindemann Disaster Relief Grant and dues relief for psychiatrists whose practices are directly impacted by disasters, as well as APAF efforts to raise funds for the Red Cross (see below). In addition, APA members have created “Crear Con Salud” non-profit to provide supplies and mental health resources to Puerto Rico. APA spoke to members of Congress against the Graham-Cassidy Bill. APA joined with other medical groups – AAFP, AAP, ACP, ACOG, and AOA – calling themselves the “Group of 6”, which eventually helped defeat the bill. APA is also supporting efforts to preserve the ACA and CHIP, both of which face cuts in funding which threaten their continued existence. APA continues to work for MOC reform and to ensure insurers do not limit their network panels to physicians with MOC only. APA participates in a commission to evaluate the MOC process across ABMS boards. Expect a guidance report from the ABMS by 2019. Finally, work continues toward completion of the APA’s new K Street headquarters in Washington, DC.

Report of the APA President-Elect — Altha Stewart, MD

Dr. Stewart addressed the Assembly, offering a summary of her upcoming agenda when she assumes her role as President next year. Among her priorities will be the issue of improving psychiatry workforce numbers and distribution, with an emphasis on increasing diversity of membership and of patients receiving care. Dr. Steward is also concerned about the potential limitations imposed on our ability to provide care by government assaults on healthcare reform and collaborative care. Finally, Dr. Stewart wants to address the needs of our patients by improving policy through practice partnerships of APA, implementing current parity legislation, decreasing health disparities, and promoting recovery through consumer and family engagement.

Presentation of the Speaker’s Award — Theresa Miskimen, MD

Dr. Miskimen presented the Speaker’s Award to Roger Peele, MD. In her speech, Dr. Miskimen touched on the highlights of Dr. Peele’s longstanding work in the Assembly since 1975. She recalled his welcoming manner at their first encounter and his message: Psychiatrists have an ulcer mission to serve our patients and our communities. Dr. Peele has been the most prolific author of Action Papers in the Assembly, including a call for practice guidelines and development of PIP guidelines. Dr. Eliot Sorel added his praise for Dr. Peele as one of the most influential members in the history of the Assembly. In accepting his award, Dr. Peele reminded us that he also proposed a referendum which did not pass, but in which 57% of members who did vote wanted the Assembly to be the governing body of the APA, rather than

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Microanalysis of mother-infant communication and the origins of disorganized attachment
WMC Grand Rounds - Dec. 5, 2017 - Reported by: Alexander Lerman, MD

(Continued from page 5)

psychopathology.

The “Strange Situation” is performed at age one at the earliest, and is a behavioral measure. Beebe studies face-to-face communication patterns between mothers and 4-month old infants, and believes that these patterns give rise to mental operations behind different attachment styles.

Optimal communication patterns, Beebe states, “provide each partner with ways of knowing whether one’s feelings are shared and thereby acknowledged by the other…. The joint ability of mother and infant to co-create patterns of correspondence is … important because these correspondences contribute to attachment security and capacity for intimacy.” Nonverbal cues such as facial expression and vocal tone are associated with particular patterns of physiological arousal, which in turn can make it possible for an attuned mother to share joy, and to calm and stabilize a distressed infant.

Beebe demonstrated a variety of vignettes in which a mother of an infant who would be classified securely attached at one year mirrored and adjusted her expressions to follow those of her infant; and diminishing engagement when an infant showed signs of overstimulation. Over time, such interactions build the infant’s capacity for optimal patterns of self-and interactive regulation, based upon Winnicott’s “sacred moment” of knowing and being known: “I know that you know that I know.

Most of the interactions Beebe displayed consisted of less than 30 seconds of film, gone through at intervals of one second or less. Many of the interactive patterns took place in even shorter segments of time, and were “non-conscious” to both the mother and observer in real time.

Beebe demonstrated less-attuned mothers who responded to infant withdrawal by pursuing the infant, seeking higher levels of stimulation, persisting in stimulating play when an infant was distressed. This is the “chase and dodge” interactions, and it predicts the resistant form of insecure attachment.

Other mothers smiled or showed surprise faces when their infants become distressed. Or they remained impassive, or looked away, when the infant escalated distress. Using frame-by-frame analyses that recall the Zapruder film, Beebe demonstrated extremely rapid transient displays of withdrawal, sarcasm, anger and disgust exhibited by poorly-attuned mothers, and corresponding withdrawal and rising distress on the part of the infant. Such discordant and poorly regulated interactions, Beebe stated, give rise to disorganized attachment.

In one vignette, Beebe demonstrated a transient expression of disgust on the part of the mother to her infant’s distress, accompanied by mother’s bared teeth. In another vignette, a baby’s back arches in discomfort, as mother smiles broadly to the infant’s increasing facial and vocal distress.

In the less-predictable and more-distressing patterns of interaction, typical of those of infants on the way to disorganized attachment, the infant has difficulty coming to anticipate what the mother will do, and difficulty knowing what he or she feels.

Dr. Beebe’s presentation was extremely well-received, and was followed by an extended Q&A driven by questions from residents.

Residents Trivia Night

Where did Abraham Lincoln keep important documents? What is the official summer sport of Canada? Who performed the 80’s hit “Hit Me with Your Best Shot”?

These and other important questions were discussed over beer and sandwiches on Wednesday night, December 6th, at the Captain Lawrence Brewing Company – a brewpub hidden away in an industrial building not far from NY Medical College, where a Trivia Night is held on Wednesdays. Members of the Westchester APA Division Branch were joined by quite a few of the psychiatry residents. By coincidence, there was also a table full of third year medical students from NY Medical College, two of whom were currently doing their psychiatry clinical rotations. The medical students were each rewarded with a free drink/food ticket by PSW.

We fielded three trivia teams (composed of residents and PSW members) and won several of the individual rounds. But none of our teams won the overall trivia contest. The medical students did! (They do lots of studying.) President, Karl Kessler assured us that next time PSW will win!

Our resident representative to the Executive Council, Sarah Vaithilingam, won the Amazon gift card in the raffle. She told us later that the residents really enjoyed themselves. Our members did, too.

The Executive Council expressed its gratitude to Megan and Donna with a gift for all their hard work during this year.

Trivia Night members of the Westchester APA Division Branch and Westchester Medical Center residents
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the BOT.

Report from the APA Foundation – Dan Gillison, Executive Director
Contributions by the Assembly to the APA Foundation this weekend have been nearly $30,000 from 57% of Assembly members. Contributions to the Annual Fund were $16,000, and to Disaster Relief another $11,000. A Saturday evening reception and fundraiser organized by Dr. Batterson for disaster relief raised $6550 alone! The Foundation's Disaster Relief fund directs contributions to the Red Cross Disaster Services, MH Program, which deploys MH volunteers to affected areas and addresses the psychological impact of trauma and disaster-related events. The Foundation also funds projects involving research, clinical training, mental health awareness, public safety, and grants and fellowships. In the new APA Headquarters APAF will have historical exhibits, an expanded library and reference room, rare book collection, an artifacts exhibit and memorabilia.

Report from the Committee on Assembly Procedures – A. David Axelrad, MD, chair
The committee welcomes input from Assembly members as to how the latest Sturgis Code of Parliamentary Procedure should be implemented in the future. The Association of Women Psychiatrists has applied to become an Assembly Allied Organization/subspecialty or section. The committee is recommending efforts to clearly distinguish between the terms “specialty”, “caucus”, and “section” and their requirements and structures in the Procedures Code of the Assembly (articles V and VI).

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

Retire:
Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment
Psychiatry and Primary Care Integration across the Lifespan

Retain:
♦ Endorsement of United States Ratification of the Convention of the Rights of the Child
♦ Use of Jails to Hold Persons Without Criminal Charges Who are Awaiting Civil Psychiatric Hospital Beds
♦ Psychiatric Services in Jails and Prisons
♦ Assessing the Risk for Violence
♦ Firearms Access: Inquiries in Clinical Settings
♦ Homicide Prevention and Gun Control
♦ Segregation of Prisoners with Mental Illness
♦ Remuneration for Psychiatrists’ Time Performing Utilization Review (Endorsement of AMA policy H-385.951)
♦ Universal Access to Health Care

Proposed:
Human Rights
Human Trafficking
Police Interactions with Persons with Mental Illness
Lengthy Sentences Without Parole for Juveniles
Domestic Violence Against Women
Prevention of Violence

The following Position Statement was rejected by the Assembly:
Revisions to Position Statement: Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness

Action Papers/Items
Among the Actions taken during this session, the Assembly voted to:
• Approve Civil Liability Coverage for District Branch Ethics Investigations by informing DB’s of their liability protection coverages, amending APA Operations Manual to reflect current coverages for DB Ethics Committees investigations, and develop policies and protocols to protect Ethics Committees
• Have the APA Create a Council on Women’s Mental Health.
• Create a Task Force Addressing the Negative Impact of the Rule of 95 on Membership Dues Revenue
• Developing Measures to Help Members Join Caucuses by including a link on new and renewal membership dues statements
• Achieve Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions, by having the authors of the APA Commentary on Ethics in Practice revise their language to be more consistent with that of the AMA Principles of Medical Ethics, which would apply to ALL psychiatrists, regardless of standing in a benefits organization.
• Recommend Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity

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and Addiction Equity Act (MHPAEA or parity law) as proposed by the authors of the Action Paper, including details on development, implementation, and oversight of MHSUD treatment coverage by insurers and other third parties. The paper did not pass a vote to forward immediately to the BOT for a vote.

- Approve an Additional Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups at the September APA Components Meeting (which was also approved by the JRC).
- Have the APA Annual Meeting Scientific Program Committee Address Conflicts of Interest Not Limited to Pharmaceutical Companies.
- Create a Non-Physician Registration Fee for Allied Health Professionals to attend APA Annual Meetings.
- Adopt a proposed Position Statement: Recommending Twelve Weeks of Paid Parental Leave.
- Enact APA Positions: State Medical Board Licensure Queries regarding Mental Health of physicians by enforcing current APA positions opposing such enquiries and gathering and reporting data regarding which licensing boards are or are not in compliance.
- Have APA develop a Position Statement on Recognition of Psychiatric Expertise: Efficiency and Sufficiency in which MOC should not be a requirement for licensure (including interstate compacts), hospital privileges, insurance panels, or employment and to support Self-Assessment CME as a sufficient alternative to MOC for these purposes.
- Reject a Proposal of an APA Member Survey on Medical Aid in Dying as Option for End-of-Life Care.
- Designate Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service by advocating for such scholarships at the state and federal level.
- Encourage Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities through state and federal advocacy.
- Advocate for improved patient access to Transitional Care Services Post-Psychiatric Hospitalization through increased federal funding and greater focus in training programs.
- Urge APA to Address the Negative Impact of New Joint Commission and CMS Policies on Ligature Risk on Inpatient Psychiatric Units by delaying implementation until CMS review of the policy is completed.

(Items with a * were approved by consent)

A full summary of all Actions of the Assembly can be found here.

Reports and Next Steps from the Assembly Work Groups/Committees

- **Assembly Committee on Public & Community Psychiatry** - Group members have authored several action papers this session and addressed issues in several groups and caucuses.
- **Assembly Committee on Psychiatric Diagnosis & the DSM** – The Committee urges Assembly representatives to solicit feedback on DSM-5 from constituent DB members.
- **Assembly Committee on Access to Care** – Discussions focused on grassroots organizations and the psychiatrists that serve them. Need to stay alert and aware to issues that affect access: manpower shortages, managed care, immigrant access, and restrictive formularies. NY has developed a hotline to increase access for immigrants.
- **Assembly Committee on Maintenance of Certification** – Committee members authored a successful AP this meeting. The committee is pleased that APA CEO is involved in the issue. The ABPN will roll out an alternative "third pathway" to MOC, beginning in 2019.
- **Assembly Liaisons to the Committee on Practice Guidelines** – Several guidelines will be coming up for review. A commercial group had been doing the researches. This will be changing to a private group that will do the searches that allow the workgroups to develop the questions to query the development of the guidelines.
What the Opioid Crisis Has Meant to a Budding Psychiatrist

By: Daniel Vaithilingam, MS-IV, Ross University School of Medicine

The Opioid crisis has launched the problem of addiction medicine into the spotlight. Today two million suffer from substance use disorder related to opioid medication in America, and in 2016 more than forty thousand Americans died as a result of an opioid overdose, a fourfold increase from fifteen years earlier. The question of how we got to this point has been examined from several angles, from the influence of powerful drug companies, to the illegality of "lesser evil" drugs.

As a medical student interested in psychiatry, the opioid crisis spelled great opportunities in the field I love. But, at some level, the excitement I have for my future is predicated on the growing suffering of those touched by this crisis—and the bigger the crisis, the better my outlook. Here lies the antagonism.

The antagonism illustrated is the same ethical dilemma that brings into question the actions of drug manufacturers and private prisons. The idea that an individual's prosperity comes at a growing cost to society—Individual gain versus Justice.

A Report in Esquire by Christopher Glazek sheds light on some of the individuals who have gained the most from the opioid crisis. He describes the use of advertising, manipulative drug names, and influence on clinical research as a means for increased profitability. The field of psychiatry is no stranger to such tactics. A New England Journal of Medicine (NEJM) article from 2008 by Turner, et al., on the selective publication of anti-depressant trails, concluded that "Not only were positive results more likely to be published, but studies that were not positive, in [their] opinion, were often published in a way that conveyed a positive outcome." This problem was so bad that it prompted Dr. Marcia Angell, former editor and chief of the NEJM, to declare, "It is simply no longer possible to believe much of the clinical research that is published." In her article in The New York Review of Books, she implicates individuals and drug companies in promoting the ill practice of diagnosing "children as young as two... with bipolar disorder and [treating them] with... powerful drugs not approved by the Food and Drug Administration (FDA) for that purpose." She also outlines several questionable financial ties to drug companies that involve psychiatrists publishing work on drugs controlled by those same companies.

Even if the allegations are false, the mere existence of such a contradiction should bring our mode of serving society into question. There have been attempts to lessen the rift between patients and physicians, by compensating clinicians who maintain healthier patient populations as seen with the rise of pay for performance healthcare. But could our system continue such compensation as this crisis subsides? With the growing euphoria emanating from Silicon Valley about the coming automation revolution and people like Ray Kurzweil, Google’s Director of Engineering, predicting the end of all illness in the near future, we are pushed to face such a situation, one where all our jobs seem to be in imminent peril. When it comes to Kurzweil’s claim, we may have to wait and see. However, a recent article from the University of Oxford by Frey & Osborn seems to indicate that Physicians are safe from the threat of automation, with a likelihood of future automation at 0.4%.

What worries me is that my initial reaction is defensive. The lofty goal of ending illness would be great for society. It may never happen, and I am still banking on there being a need for psychiatrists long into the future. But, why am I inherently adverse to such a notion? Perhaps, with this insight, I can examine the pressures that the doctors in Angell’s article faced. Were they just bad apples, or, as students, did they too feel that “helping people” was a motive for their studies. As I examine my own feelings towards the opioid crisis, I tend to think the latter, and that our system with built-in antagonisms produces conditions where people feel the need to check their morality at the door.

In an interview on his article, Glazek explained, “You know, we tend to think of big social problems, like drug epidemics, as the product of these large, impersonal forces that are hard to understand. And there’s some truth to that. But that can also distract from the fact that a lot of social problems also have their origins in actions taken by individuals.” I agree with his sentiment, but I am inclined to expand back to the impersonal. The actions of these individuals are promoted by our large impersonal system. Perhaps such problems will only be resolved with systemic change. For me, I wonder, what such a system would look like—one where I could be happy to see the end of mental illness.