President’s Column: Practice of Psychiatry during COVID 19
By: Richard McCarthy, M.D.

Just before the last issue, a Psychiatrist called me to inquire if phone sessions were going to be allowed to be done in order to meet with patients. As it happened, that day I also received an email from the Federal Government that informed me that the Government decided to approve phone sessions for Psychiatry. I passed that bit of information on to the Psychiatrist.

All of that seems like it was ages ago. Over the last several weeks there have been extraordinary changes in how Psychiatrists practice their profession. A few years back, I was allowed to visit with doctors and their patients across New York State. I was given access to a set of computers and a schedule for my work. I tried to do this on several occasions, but I found that the computer problems were excessive, and the patient problems were equally strained. Many patients simply did not want to be on a computer screen or a TV with me. This dragged on for more time than I thought was useful, and, after a several failed cases, I gave up. I was frustrated by how difficult the process was to set up and how easy it was for patients to absent themselves from the proceedings. To meet the requirements of my job, I agreed to go to where the patient was. This worked.

Thus, when I learned that phone sessions were going to be allowed to meet with patients, I was not at all interested in pursuing this as a part of my practice. Unfortunately, the COVID-19 Pandemic got much, much worse. Most of my patients began to request phone sessions, and I concurred. Indeed, almost all my patients did not want to come to my office. At present, I rarely see a patient live in my office, and only a few patients request it. What has changed? Computers are ubiquitous, and programs like Zoom, Skype, FaceTime, and such are available for the meetings. I understand that this will be changing, and that more precise HIPPA-compliant programs will be required, but it is quite easy to set up these appointments. Moreover, patients do not really object to being on screen. This has certainly made it quite easy for patients to make their appointments and it has had a similar effect on me and my life. It is much more efficient and can be easily arranged and I am no longer required to sit in my office to do the work. Nevertheless, I am not fully on board with this.

It is difficult to stay focused in some of these sessions, for me and for the patient. It is often difficult to hear everything that the patient says, but most importantly I cannot see the whole patient. I do not know if they are shaking their feet, and I have a much more difficult time assessing their level of engagement. Of course, some of this is me, but not all of it. I have begun to detect problems in a few of my patients. They are not really involved in the treatment, or they regard it as relatively unimportant, and sometimes both. I have begun to consider having patients come into my office once a month to sort this out better. I would be interest in hearing back from any member about these problems and what they may see as solutions as well.
**Book Review by Karl Kessler, MD:**

**Brain On Fire: My Month Of Madness by Susannah Cahalan**


Legend on Page 3:

- Brain on Fire is a memoir by the journalist Susannah Cahalan of her experience with a rare form of autoimmune encephalitis. The book is an interesting medical case study, posing the question to psychiatrists, “what would you do?”, if presented with such a case.

Cahalan was in her 20s and working for the New York Post when she noted changes in her personality and in her thought processes. She became emotionally over-reactive. She had sensations of pins and needles and numbness in her hand. She consulted her physician and was referred to a neurologist. Her neurological exam and basic blood tests were normal. Her brain MRI was normal except for a small number of enlarged cervical lymph nodes. She was given a diagnosis of mononucleosis.

She began having problems with memory and with doing her job. She had trouble writing down her thoughts. Some days she felt better and other days worse, but there was a gradual worsening of her problems over this prodromal period of 2-3 weeks. Then she had a seizure. Her EEG was normal, and her seizure was explained by the possibility that she had a drinking problem, which she denied. She was placed on Keppra.

She had a psychiatric evaluation, and the psychiatrist concluded that she was having a “mixed episode” of manic and depressive symptoms typical of bipolar disorder. There were other

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**REPORT FROM THE APA ASSEMBLY AND THE NYSPA/AREA II SPRING MEETING**

**APRIL 25, 2020**

By C. Deborah Cross, MD, APA Assembly Representative

The NYSPA/Area II Spring meeting this year was held on Saturday, April 25, from 9:00-10:00 am, just prior to the APA Assembly meeting. Both meetings were held via Zoom. The meeting was an abbreviated one due to the public health emergency secondary to COVID-19. The results of the NYSPA Election were announced, with the NYSPA newly elected officers being: President, Jeffrey Borenstein, MD; Vice-President, Edward Herman, MD; Secretary, Marvin Koss, MD; and Treasurer, Jose Vito, MD. Glen Martin, MD was elected Area II Trustee.

Saul Levin, MD, APA CEO and Medical Director, joined the NYSPA meeting by Zoom and reported on APA activities with the majority of staff working from home and finance staff going into the office on a rotating basis. He stated that the APA developed a website resource page for members regarding the COVID-19 crisis and conducted a webinar on COVID-19 and its impact on inpatient services.

Bruce Schwartz, MD, APA President, also joined the NYSPA meeting and provided an update on APA activities, including the annual meeting and the role of psychiatry in the COVID-19 crisis.

Ann Sullivan, MD, OMH Commissioner, provided an update on several items, including redeployment of psychiatric beds to accommodate patients with COVID-19, the NYS emotional support hotline, which has received 8,000 volunteers to date, OMH residences and the NYS budget and Medicaid Redesign Team II updates.

The winners of the Fifth Annual NYSPA Resident Poster Contest were announced. There were 24 submissions this year and the judges selected 12 finalists. The winners were: 1st Place, Miranda Greiner, MD from Weill Cornell/NY Presbyterian; 2nd Place, Josh Wortzel, MD, University of Rochester Medical

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Center; and 3rd Place, Rishab Gupta, MD from SUNY Downstate.

Dr. Martin, Chair of the NYSPA Committee on Legislation and Mr. Gallo, NYSPA Government Relations Advocate reported on the 2021 NYS Budget and the areas of interest to NYSPA, including $3 million in loan forgiveness for psychiatrists who agree to work for OMH, and budget provisions for the Behavioral Health Parity Compliance Fund.

Seth Stein, Executive Director of NYSPA, reported that NYSPA had sent out a variety of E-bulletins on topics relating to the coronavirus and telemedicine. He also reported that NYSPA staff is planning to conduct webinars and trainings this summer and fall regarding the new E/M documentation requirements slated for 1/1/2021.

The APA Assembly was held immediately following the NYSPA/Area II meeting, from 10:00-11:30 am. A tremendous amount of work went into planning the meeting, including having several meetings prior to the Assembly meeting to be able to bring reports regarding Action Papers and such directly to the Assembly for a vote. There were special rules of the Assembly, which also allowed deferral of some of the Action Papers that were not considered time-sensitive to the November Assembly meeting. The election of Assembly officers was also held by email prior to the Assembly meeting. The election results were announced at the meeting: Speaker-Elect, Mary Jo Fitz-Gerald, MD (Area 5) and Recorder, Adam Nelson, MD (Area 6) are the new officers.

A number of Proposed Position Statements were approved by the Assembly, including one on the Use of Antipsychotic Medication in Patients with Major Neurocognitive Disorder; Banning of Pharmacy Benefit Management Policies that Require the Provision of Dangerous Quantities of Medications; and Mental Health Needs of Undocumented Immigrants.

Action Papers discussed and voted on at the Assembly included: To support all means of ordering or prescribing medication, including electronic, written, fax and telephonic; To support fair and equitable Medicaid funding for states and territories alike, including Puerto Rico; and To have the APA expediently approve a Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth.

There were a number of written reports from Work Groups and Committees that had been distributed online prior to the meeting for review.

Additionally, the Assembly Awards announcements were made prior to the Assembly meeting:

The Ronald A Shellow Award for 2019 was presented to Charles Price, MD (Area 7) and the 2020 award was presented to Bhasker Dave, MD (Area 4) and Robert Cabaj (Area 6) (posthumously).

The Assembly Resident-Fellow Member Mentor Awards were presented to each area and Jose Vito, MD received the Award for Area 2.

The District Branch Best Practice Award: Colorado psychiatric Society and New York County Psychiatric Society.

The Assembly Award for the District Branch and Area Council with the Highest Percentage of Voting: Mid-Hudson Psychiatric Society (34%) and Area 2 Council (23%).

The APA Annual meeting followed immediately after the close of the Assembly, also on Zoom.

All future governance and business meetings of the APA will be conducted virtually for the remainder of 2020. The November Assembly will also be a virtual meeting.

As usual, do not hesitate to contact me (deborahacross@usa.net) if you have any questions or wish further information regarding the work of NYSPA or the Assembly. The Fall NYSPA meeting will be Saturday, October 24, and the Fall Assembly meeting will be Saturday, November 7. ■
Book Review by Karl Kessler, MD: (cont’d)

(Continued from page 2)

explanations for her problems, such as the stress of her relationship with her boyfriend. She developed paranoia (e.g., that people were making critical comments about her, that her parents were working against her, etc.). She became demanding and impulsive. “I want coffee. Get me coffee. Now.” She reported further seizures.

She was hospitalized at NYU to get 24-hour EEG monitoring. In the hospital, she was sometimes agitation and often psychotic. “From here on, I remember only very few bits and pieces, mostly hallucinatory, from the time in the hospital.” She believed that her father was “… turning into different people to play tricks on me” or that he was an imposter (Capgras syndrome). A psychiatric consult gave the diagnoses of Mood Disorder NOS and Psychotic Disorder NOS. A second psychiatric consult gave the diagnoses of possible Post-ictal psychosis and Schizoaffective disorder. She had no seizures in the hospital and consideration was given to a strictly psychiatric illness and transfer to a psychiatric unit.

Several other specialists were consulted: infectious diseases, rheumatology, an autoimmune disease specialist, and an internist, but they found nothing. With antipsychotic treatment, her psychosis receded, but her short-term memory had been “obliterated.” During her 2nd week in hospital, she developed slurred speech. Eventually, a neurologist who specialized in difficult cases was called to consult. Spinal taps found elevated WBCs. A brain biopsy was done, and a diagnosis made: anti-NMDA receptor encephalitis, originally characterized in 2007. Treatment consisted of steroids, IVIG, and plasmapheresis. She had spent 4 weeks in the hospital until she received the correct diagnosis.

The last third of the book is about her gradual recovery. She returned to normal and wrote this best-selling memoir of her illness. Spread through the book are useful reviews of the brain and nervous system, to help the reader better understand her illness. A film was made from the book (Brain on Fire, 2016).

The author speculates that there are people diagnosed with schizophrenia or other serious psychiatric illnesses but who actually have her disease. The disorder, treated or untreated, can cause permanent brain damage. The estimated occurrence is less than 1 per 1,000,000 per year. Although the disease was first described in 2007, it has likely been present for many centuries. Does this mean that a certain fraction of people with adult onset chronic psychotic disorder suffer from anti-NMDA receptor encephalitis? Do they receive a diagnosis of schizophrenia? These are interesting questions.

Cahalan’s interest in psychiatry continued with the publication of her second book. The Great Pretender examines a famous psychiatric research paper, which asked the question, “What is mental illness?” This groundbreaking study, published in Science in 1973, is David Rosenhan’s “On Being Sane in Insane Places.”

Cahalan provides context by examining the deficits and excesses of 19th-century psychiatry, particularly regarding the involuntary institutionalization of women. She then looks at Rosenhan’s study, which posited that psychiatry had no reliable way to tell the sane from the insane. “Eight people --- Rosenhan himself and seven others, a varied group that included three women, five men, a graduate student, three psychologists, two doctors, a painter, and a housewife --- volunteered to go underground in twelve institutions in five states on the East and West Coasts and present with the same limited symptoms: They would tell the doctors that they heard voices that said, ‘thud, empty, hollow.’ … With this standardized structure, the study tested whether or not the institutions admitted the otherwise sane individuals…” Of the eight pseudo-patients, seven were given a discharge diagnosis of schizophrenia and one a diagnosis of manic depression. Rosenhan concluded that, “… any diagnostic process that yields so readily to massive errors of this sort [as revealed by his study] cannot be a very reliable one.”

The study caused a major uproar in psychiatry at the time. It was a factor in the re-examination of psychiatric diagnosis and in the eventual publication of the DSM-III, published in 1980, which revised psychiatric diagnoses. “Arriving on the scene when it did, Rosenhan’s “On Being Sane in Insane Place” ended up falling right in line with other, more theoretical, rebukes that had been building from inside the ranks of psychiatry from people who asserted that mental illness didn’t even exist…” The author puts Rosenhan’s study into context by reviewing the anti-psychiatry sentiment that developed during the tumultuous 1960s and was common in the 1970s. The study was also critical of psychiatric treatment, which Rosenhan characterized as inhumane. The book

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has interesting digressions about the attempts at treatment reform at that time, such as the special ward at a California state hospital that tested the treatment theories of R.D. Laing and Esalen.

Much of the book involves the author’s extensive detective work in trying to track down the real people who participated in the study. She found and examined Rosenhan’s papers regarding the experiment. These include Rosenhan’s uncompleted and unpublished manuscript about his experiment, which had been solicited by a publisher. Rosenhan took the publisher’s advance, but never provided the book, causing the publisher to eventually sue him. His files contained descriptions of each of the people who pretended to be ill, but the author could not easily identify the actual subjects, because Rosenhan used pseudonyms in his personal notes. The author concludes that one subject was Rosenhan himself. When she examined the medical records of Rosenhan’s own hospitalization as a pseudo-patient in Haverford Hospital in Pennsylvania, she found discrepancies between the actual medical records and the report of the hospitalization in Rosenhan’s Science study. Rosenhan had downplayed some of the symptoms he used to gain admission and made it appear easier to be hospitalized and treated than was actually the case.

The author discovered the identity of two other pseudo-patients, one of whose data was not included in the published study. At the time of the study, the excluded pseudo-patient was a graduate student in psychology, Harry Lando. Lando later wrote an article for the journal Professional Psychology, in which he was generally positive towards his experience in the psychiatric hospital. “Harry felt it was pretty obvious what happened… [that led to his exclusion from the published study] … Harry’s data – the overall positive experience of his hospitalization – didn’t match Rosenhan’s thesis that institutions are uncaring, ineffective, and even harmful places, so they were discarded.”

Despite her intensive sleuthing, the identity of the six remaining pseudo-patients remains unknown. Cahalan notes that, “throughout Rosenhan’s notes, I kept running into sloppiness that seemed unprofessional and possibly unethical…” “Now the question was: had Rosenhan outright invented pseudo-patients up to his ‘n’ --- or the number of subjects in his data set --- to lend more legitimacy to his findings? Had getting away with his exaggerated symptoms emboldened him to go ten steps further and invent pseudo-patients? Did he get caught up with a book deal and out of desperation decide to fill in the blank pages? This elaborate ruse no longer seems impossible…” She notes that, “… after he published his classic work, the study that would help bring psychiatric care as he knew it crashing down, except for a brief follow-up he never again published research on the subject of serious mental illness and psychiatric hospitalization.” Rosenhan died in 2012.

Was Rosenhan’s study fraudulent? To contextualize, Cahalan gives numerous examples of scientific fraud, in psychology and elsewhere, as well as critiquing the exaggerated claims made for psychopharmacology. She concludes, “I don’t know what happened to the six other pseudo-patients. Did they exist at all?… Rosenheim’s paper, as exaggerated, and even dishonest, as it was, touched on truth as it danced around it… the dismissal of psychiatric conditions as less legitimate then physical ones; the depersonalization felt by the mentally ill ‘other’; the limitations of our diagnostic language. The messages where worthy; unfortunately, the messenger was not.”

The book is well written, in journalistic style. It is nonlinear, with the author going back and forth in time and subject matter, with interesting digressions into the history of psychiatry and psychiatric diagnoses. The footnotes are very helpful in seeking out further knowledge about the issues she addresses. The book is especially good in the way it makes one want to look further into some of these issues.

We want to hear from our Members!

INTERESTED IN WRITING AN ARTICLE? LETTER TO THE EDITOR OR AUTHOR? HAVE A CLASSIFIED YOU WOULD LIKE TO INCLUDE?

Please e-mail Megan Rogers at Centraloffice@wpsych.org

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NOTE: We are operating in uncharted territory and there are very few clear answers currently. This is a very fluid situation and the risk management recommendations below may change. This document will be updated on our FAQ page, and should be checked regularly. Nothing presented here is legal advice.

While we do not know exactly what will happen next in terms of the country re-emerging from the COVID-19 Public Health Emergency (PHE),

1. **RE-OPENING YOUR PSYCHIATRIC OFFICE**
   
   In addition to your local community guidelines, review guidelines and best practices from the AMA, MGMA (Medical Group Management Association), CMS, and others.
   
   **Tip:** Links to these resources are in our FAQs.

2. **FOR PATIENTS THAT REMAINED LOCAL, DETERMINE WHETHER THEY NEED TO BE SEEN IN-PERSON, REMOTELY, OR A COMBINATION OF BOTH**
   
   This determination should be based on your assessment of the patients’ clinical needs, not on the patients’ preference for telepsychiatry.

3. **FOR PATIENTS CURRENTLY OUT-OF-STATE, DETERMINE IF THEY HAVE IMMINENT PLANS TO RETURN TO YOUR AREA.**
   
   Manage patient expectations – let them know that the rules may be changing soon and you may not be allowed by law to continue to treat remotely.

4. **TRACK STATE LICENSURE WAIVERS IN YOUR PATIENTS’ STATES**
   
   They may expire on specific dates, or be extended, or withdrawn at any point.
   
   **Tip:** PRMS will continue to track these licensure waivers in our FAQs.

5. **ONCE LICENSURE WAIVERS HAVE EXPIRED IN STATES WHERE YOUR PATIENTS ARE LOCATED, DETERMINE WHAT IS NEEDED TO CONTINUE TO TREAT YOUR PATIENT VIA TELEMEDICINE**
   
   States may require full licensure, a telemedicine registration, or there may be no requirements other than licensure in your own state to treat existing patients.
   
   PRMS will help our insureds find this information.

6. **IF AFTER THE WAIVER ENDS, YOU ARE ALLOWED TO CONTINUE TO SEE THE OUT-OF-STATE PATIENT, DETERMINE AND FOLLOW THAT STATE’S STANDARD TELEMEDICINE RULES THAT WILL LIKELY BE BACK IN EFFECT**
   
   States can have laws addressing requirements for in-person visits, informed consent, documentation, etc. If your patient’s state does not have such laws, follow the telemedicine guidelines developed by the Federation of State Medical Boards.
   
   PRMS will help our insureds find this state information.

7. **IF AFTER THE WAIVER ENDS, YOU ARE NOT ABLE TO CONTINUE TREATING THE OUT-OF-STATE PATIENT (I.E. FULL LICENSURE IS REQUIRED), TERMINATE TREATMENT**
   
   Although this should be done quickly, do not abandon your patient—consider giving 30 days’ notice.

8. **IF AFTER THE WAIVER ENDS YOU WANT TO CONTINUE TREATING YOUR PATIENT REMOTELY AND HAVE DETERMINED THAT YOU ARE IN COMPLIANCE WITH LICENSING REQUIREMENTS, ENSURE YOU ARE ALSO IN COMPLIANCE WITH THE PATIENT’S STATE’S PRESCRIBING LAWS**
   
   There may be specific state laws, particularly for controlled substances.
   
   You should also register with and use, to the extent possible, the state prescribing drug monitoring program.
   
   **Tip:** PRMS will be tracking this in our FAQs.

9. **IF YOU ARE PRESCRIBING CONTROLLED SUBSTANCES FOR OUT-OF-STATE PATIENTS, BE ALERT TO WHEN HHS DECLARES THE END TO THE PHE**

(Continued on page 8)
The current PHE declaration is set to expire in January. It can be revoked earlier, or extended.

Tip: PRMS will be tracking this in our FAQs.

When the PHE ends, two currently suspended federal requirements for prescribing controlled substances will likely go back into effect.

First, the requirement that there be an in-person visit prior to prescribing controlled substances will likely go back into effect. It is unclear whether the DEA will require those who began treating patients during the PHE to have an in-person visit after the PHE expires in order to continue prescribing controlled substances to these patients.

Second, the requirement to have a federal DEA registration in the patient’s state (as well as in your state) will likely go back into effect.

10. WHEN THE PHE ENDS, EXPECT HHS TO REINSTATE THE REQUIREMENT THAT TELEMEDICINE MUST BE CONDUCTED VIA A HIPAA-COMPLIANT PLATFORM

This generally means that you will need a Business Associate Agreement (BAA) from the vendor.

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