A PIECE OF OUR MIND

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a quarterly newsletter by the colorado psychiatric society

Colorado Psychiatric Society

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Colorado Psychiatric Society

IN THIS ISSUE

CPS and DMS

Annual Spring Meeting

05.16.2020

Physician Leadership and the Urgency of the Moment in Medicine

Physician Leadership and the Urgency of the Moment in Medicine

Dr. Patrice Harris, a psychiatrist from Atlanta, GA, and the first African-American woman to serve as AMA president, will share her personal leadership journey in medicine, including the obstacles she's overcome and lessons learned along the way. She will also share the AMA's strategic and advocacy priorities with a particular focus on behavioral health priorities and achieving greater equity within the health system. She will discuss her experiences integrating health care and social supports, and the importance of all specialties working together on issues of common concern.

Denver Inverness
(by Hilton)
200 Inverness Dr. W.
Englewood, CO, 80112

Register Now!

Members = $75
Non-Members = $85
Residents/Fellows= $30*

* Students/Trainees will be reimbursed the registration fee after attending the meeting. Student/Trainees who do not attend the meeting will not be reimbursed.

REGISTER ONLINE
www.coloradopsychiatric.org/events

Schedule:

5:30 p.m. Registration and Cash Bar
The evening begins with a cocktail reception in the Exhibitor Hall.

7:00 p.m. Dinner

7:15 p.m. Welcome and Introductions

7:30 p.m. Patrice A. Harris, MD, MA

8:30 p.m. Discussion

8:45 p.m. Adjourn

About the Speaker

Patrice A. Harris, MD, MA

Patrice A. Harris, MD, MA, a psychiatrist from Atlanta, became the 174th president of the American Medical Association in June 2019, and the organization's' first African-American woman to hold this position. Dr. Harris has diverse experience as a private practicing physician, public health administrator, patient advocate and medical society lobbyist.

Full bio can be found at:
www.coloradopsychiatric.org/events

Colorado Psychiatric Society

Denver Medical Society EST. 1871

COLORADO MEDICAL SOCIETY

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SCHOOL OF MEDICINE
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BRAIN HEALTH for all, for life.

President's Column

By Patricia Westmoreland, MD and Rabbi Emily Hyatt

On being a physician mother: the struggle and rewards of flexibility and resilience

In her article "The truths and challenges of being a doctor mom," Nadia Sabri MD writes, "Being a doctor mom is a beautiful paradox of feeling like a badass one moment and a frazzled I-don't-know-what-the-heck-I-am-doing mess of a person."[1] As I write my final Presidential Column, this paradox represents the ultimate truism: the triumph of knowing that I can hold a lot while at times feeling like one of the caricatures in John Berendt's longest-standing New York Times bestseller, Midnight in the Garden of Good and Evil. I worry that I can't do everything all of the time without feeling at least a little off-kilter and unsettled.

These feelings are not uncommon. Studies have shown that irrespective of gender, physicians with children tend to be less satisfied with their careers than those without[2]. Women, in particular, appear more vulnerable to this than their male colleagues. The discord is likely due not only to societal expectations, but to our perfectionism in trying to demonstrate that we can have it all, do it all, and be all things to the people in our lives.

The societal and cultural expectations of perfection as a professional, parent, and person are unrealistic, despite such pressures being omnipresent. In reviewing articles from journals and newspapers, blogs and op-eds, the message resounds parenting while working demands resilience, a ton of flexibility, and the tenacity to swim against the current. A thick skin and the ability to eschew guilt is helpful, too. Unfortunately, apart from resilience, a career in medicine demands the exact opposite: an ability to commit to an exacting and rigid schedule, comply with rules, be sensitive and responsive to criticism, and always feel bad if you don't willingly take on an extra call shift or fit one last patient into your schedule.

While male physicians face similar pressures, it is inarguable that being a woman adds another layer of complexity. Although the proportion of medical school graduates who are women has increased from under 10% in 1965 to over 50% in 2017[3], two-thirds of women physicians report gender discrimination and a third of female physicians in academia report sexual harassment[4,5]. The estimated 80% of women who become mothers may experience discrimination based on maternal status. A qualitative analysis of 947 respondents to an anonymous online survey published in the British Medical Journal identified gendered job expectations, financial inequalities (including lower pay than equally qualified colleagues and more unpaid work), limited opportunities for advancement, lack of support during the pregnancy and postpartum period, and a challenging work-life balance as

as key concerns[6].

Discrimination against motherhood starts early. In her article, "Motherhood and Medicine should mix. So why is it such a struggle?"[7], trauma surgeon Dr. Qaali Hussein said she experienced discrimination starting early in her career. Pregnant during residency, she was labeled "selfish," told she should quit, and, despite performing well as a surgeon, advised to pursue more family-friendly specialties because it was perceived that her "priorities had changed." She noted that despite women comprising the majority of medical student classes, "motherhood continues to be a problem because the hospitals and clinics where we work have not changed to accommodate us."[7]

There is also no standard approach as to how medical schools, residency programs and professional practices handle maternity leave, which is not made easier by the United States lagging behind the rest of the world in maternity and paternity leave policies. Using four different categories to measure a country's "family friendliness," UNICEF evaluated 41 high- and middle-income countries on paid leave available to mothers, paid leave reserved for fathers, childcare enrollment for children under 3 years old, and childcare enrollment between age 3 and school age. Going up against 40 other developed countries, the U.S. came in dead last in terms of paid leave available to mothers and fathers. It was also the only country that offered "a whopping zero federally-mandated weeks of maternity leave"[8]. This, despite a workforce progressively becoming more female, and despite demands for equality since the advent of the feminist movement.

Authors of a 2019 JAMA article on gender disparities in work and parental status among early-career physicians also noted that, when it comes to balancing a medical career and a family, not much has changed over the years. In surveying 344 physicians from multiple specialties in a prospective longitudinal study, the researchers found significant gender disparity in work status emerging within the first six years of medical training. Almost three-quarters of women physicians reported reducing work hours to part-time or considering part-time work, and women who had children were significantly more likely than men with children to reduce their hours[9].

Although a recent New York Times article attempts to instruct us as to "How medicine became the stealthy family-friendly profession," offering doctors more control over their lives "depending on the specialty and job they choose while still practicing at the top of their training and being paid proportionally,"[10] the reality is often different. First off, working part-time means being paid less than full time - and salaries for female physicians are often lower than the wages of male peers. We may also forgo the opportunity for advancement afforded to our colleagues who work fulltime. Indeed, Frank et al cautioned that an income gap so early in physicians' careers may contribute to further gender inequities in compensation and promotion[9]. The New York Times article also missed that part-time, for a physician, may mean up to 50 hours per week and can include being on call. Not exactly what our non-medical counterparts would call "part-time."

Psychiatry, which is 50% female and supposedly requires about 45 hours of work per week, is one of the more family-friendly specialties. Child psychiatry is reportedly even more so[11]. However, not all psychiatry positions are created equal. Employers can mandate inflexible working hours, and some subspecialties (e.g., forensic psychiatry) require working within stringent deadlines. Also, female

psychiatrists appear to be no less immune to criticisms faced by counterparts in other specialties. I, too, have endured mumblings about "leaving early again?" to fetch my children, despite my work being complete and my availability by phone for emergencies. A bemused psychiatrist colleague, who was called by the school to pick up her sick child, said others had suggested she leave her young son in the car so she could be "available for patients." When she pointed out that this was not only unconscionable but illegal, the supervisor seemed surprised.

Mothers in other professions don't fare much better. In the January 2020 Presidential Debate, Senator Elizabeth Warren spoke of the difficulties of balancing her work as a law professor and motherhood. In a recent Politico article, Senator Amy Klobuchar, an Ivy League-educated attorney, talked about the discrepancy between men getting "commended or at least admired" for occasional child-rearing, while for the comparatively few women in her law firm, the "daily departure for pickup at daycare was often seen as a limitation."[12] And much as there are now more women in the House and the Senate, there still seems to be much hesitancy to elect a woman to the United States Presidency, even though around 90 other countries have had female leaders. Thankfully, at least our medical organizations (such as AMA, AACAP, APA, and AAPL) have also elected female leaders, perhaps a harbinger of things to come for our country.

In trying to make sense of the harsh realities of my experience (and that of other female physicians and non-physicians), I sought the counsel of a woman I respect, Rabbi Emily Hyatt, Assistant Rabbi at Temple Emanuel in Denver and a rising star in the Denver Jewish Community. She has also had to come to terms with the duality of motherhood and her passion for her chosen profession.

Rabbi Hyatt wrote, "I never questioned whether one could be a working parent and a present parent - because both my mother and father managed to do both. I never felt their absence in my childhood, though both of them held prestigious and high-level positions in the legal world. I took their graceful balancing act for granted, and it wasn't until this past Chanukah when I ended up leading prayer for hundreds with a toddler on my hip that I truly appreciated that my parents had so seamlessly spent decades with their brains split in half. That's what's so hard about being a working parent - in addition to the values conflicts and the constant need to be in two places at once - our minds are also always doing two things at once."

So, is there an upside to the struggle between motherhood and work life? And are we damaging our children by trying to do, per Rabbi Hyatt, "two things at once?" As it turns out, maybe not. A 2010 metanalysis of 69 studies over 50 years found that in general, children whose mothers worked when they were young had no significant learning, behavior, or social problems, tended to be high achievers in school, and had less depression and anxiety. The positive effects were particularly strong for children from low-income or single-parent families[13].

Recent studies have also indicated that the positive effects of having a working mother persist into adulthood. Kathleen McGinn, a professor at Harvard Business School, conducted a study of 50,000 adults in 25 countries. McGinn and Colleagues found that daughters of working mothers completed more years of education, were more likely to be employed and in supervisory roles and earned higher incomes[14]. Having a working mother didn't influence the careers of sons, which researchers said was

unsurprising because men were generally expected to work — but sons of working mothers did spend more time on childcare and housework[14]. The effects were particularly strong in the United States, where daughters of working mothers earned 23 percent more than daughters of stay-at-home mothers, after controlling for demographic factors, and sons spent seven and a half more hours a week on child care and 25 more minutes on housework[14,15]. Professor McGinn was quoted in a 2015 New York Times article that her study indicated that parents seemed to be serving as role models, leading by example and teaching their children, "Here's a way to behave, here's a way you can cope with the various demands of work and home."[15] Rabbi Hyatt agrees with that. She noted, "This is also the beauty of being a parent. In Judaism, we are required to teach our children - it is a moral imperative. And so, when my brain and my heart are busy trying to multitask, I take comfort in the fact that I am teaching my own son by modeling for him what it means to be a parent while contributing to my community and to society. He too will be forced to make choices in his life."

As I continue down the path of physician motherhood, I also try to lead by example. Many of you have seen my young daughter accompany me to CPS meetings and events – sometimes by choice, and sometimes by necessity. Although I have always thought her to be an observant child, I didn't realize how much of my daily struggles and life lessons she was taking in until I overheard this futuristic conversation with another five-year-old (interestingly, one whose mother does not work outside the home). Friend: "I am going to be a mommy." My daughter: "I am going to be a doctor – and a mommy."

My 11-year-old son, contrary to Professor McGinn's prediction for him, is still somewhat lacking in the doing more chores department. However, as a budding attorney, he is particularly fascinated with my work as a forensic psychiatrist. He has also developed a sense that, with work comes the opportunity to travel and expand one's horizon, accompanying me around the U.S. and internationally for work-related meetings.

During their childhood years, my children have experienced firsthand both the joys of my career as well as the struggles that it brings. They have witnessed the sleepless nights and the hurried schedule changes that arise when one of them has a fever and I have to find someone to cover the inpatient unit at the last minute so I can stay home. They have seen me juggle play dates and report deadlines. They have seen me running late and remembering to get gifts for their friends' birthday parties at the last possible minute. My children have seen me frazzled and frustrated, filled with self-doubt and angst, but they have also witnessed the triumphant moments when I get the job done, meet a deadline, or get to school on time for their recitals despite a tough schedule. As my career has developed, my children have witnessed my growth in flexibility and resilience. Just as learning to play the piano, or becoming a gymnast or long-distance runner takes practice, developing the flexibility and resilience to practice psychiatry and be a responsible, caring and present parent takes practice. In his book The Outliers, Malcolm Gladwell writes that 10,000 hours is the time it takes to master a new skill[15]. The rewards of developing those skills benefit our patients and our careers. I believe that we are also less susceptible to burnout if we feel a sense of mastery and genuine love of our profession. Our children benefit too. As Rabbi Hyatt noted, "As parents, sometimes the biggest gift we can give our children is the knowledge that we struggled too, and that the struggle only made us love harder."

Dr. Westmoreland has a private forensic practice in Denver, CO.

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Do you know a colleague who could benefit from joining CPS and the APA? Send them an invite!

There Are No Crocodiles in Kansas

By John L Fleming, MD, DLFAPA

"The physician must be able to tell the antecedents, know the present, and foretell the future"
- Hippocrates

"Assumptions are dangerous things to make, and like all dangerous things to make -- bombs, for instance, or strawberry shortcake -- if you make even the tiniest mistake you can find yourself in terrible trouble. Making assumptions simply means believing things are a certain way with little or no evidence that shows you are correct, and you can see at once how this can lead to terrible trouble."
- Lemony Snicket, The Austere Academy

"The real things haven't changed. It is still best to be honest and truthful; to make the most of what we have." **- Laura Ingalls Wilder**

In Kansas, there are wide open, empty spaces. Wheat and cornfields. Hot in summer, very cold in winter. And, most importantly, no wild crocodiles roaming about. None, as in absolutely **none**. The land is not welcoming and the weather formidable to a crocodile. But difficulties with truth and assumptions are as common as anywhere else.

Like all of the mid-west, long winters set in and the wind howls and the sun sets early, making for long nights when one could get lonely and isolated, and see in one's mind or in one's deep depression things that were not there. A man who lived far from any large city grew increasingly troubled, withdrawn, and depressed. The family brought him to the hospital after his many weeks of not eating and losing weight, fears of being followed, constant persecution by dark beings, and thoughts of suicide.

This all happened seventy years ago in the days before psychiatric medications, and help came from building relationships and trust, of slowly rebuilding bridges to other people and to the reality severed by internal demons. While medications can be essential these days, before therapeutics we used our understanding of the mind's ways to help chart the path away from the madness. There were two overwhelming features of this man's experience: his deep and utter loneliness despite being surrounded by family, and the non-stop presence of beings chasing him both day and night. In a word, paranoia. When he tried to share these fears, others would look at him in disbelief or try to reassure him that the concerns were fantasy. Both reactions, while well-intended, had the impact of further isolating him.

The man came to the hospital and was introduced to his doctor, the staff, and the other patients. Over many weeks and months, on into the spring and summer and subsequent fall, he began to discuss his fears and constant persecution. He described the men in dark coats following him, the dark birds peering at him, and most frighteningly, the crocodile appearing whenever he went outside to follow and try to eat him. In group therapy, others listened, empathized, and slowly came to understand that the tormented fears replaced something even more frightening: the utter loneliness, brought on by winter, that triggered memories of an empty childhood under the care of a depressed single mother on a remote farm who left him alone in the crib. As he shared the story over many weeks, the patient became more energized and trusting. He worked in the greenhouse, did art projects, talked to others, and began to smile. Gradually, all the followers, demons, birds, and black-coated men disappeared and the paranoia receded. All but the crocodile which continued to plague him.

The physicians' dilemma was clear. They had an improved patient who wanted and needed to go home, who was now functioning well in the hospital environment, but who still had a paranoid delusion. Was it safe to discharge him? Could they predict the future well enough to determine if he would be safe? This, too, was discussed among the staff, with the patient, and in group therapy. Eventually, he took a few short passes to his home. These went well and he was discharged provisionally. After a few weeks, the follow-up meetings and phone calls revealed he was happy, energetic, making new friends and no longer troubled by the crocodile or any other delusion. A good outcome.

All was well until several months later. A psychiatrist and a patient, both feeling restless and cooped up, walked the grounds to take advantage of a warm spring day. As they strolled near the duck pond, onto the path crawled a six-foot-long crocodile! A real crocodile! How in the world? The duck pond was fed by a drain near a zoo and reptile house. The reptile may have escaped the zoo, entered the drain and exited into the pond, and made a living eating ducks and frogs for years.

Now, what to do? In therapy, we work to connect, not to refute or reason, and to build a bridge of understanding and connection across which we connect and heal using the truth of the feelings as our guide. At a staff meeting, all reflected that despite their best efforts to listen, they failed to test assumptions. They called the patient and he was relieved to find out he had not been imagining the crocodile. This reaffirmed his recovery and sense that there was something different about the crocodile as compared to the black-coated men and birds which had also seemed so very real, but different. But as he too knew there were no wild crocodiles in Kansas, he had decided he must be wrong. The other patients were told that the crocodile was captured and returned to the zoo. "But tell me," my father, who was head of the hospital, asked, "Didn't the rest of you ever see the crocodile?" A few patients hesitated, raised their hands, and acknowledged seeing it. Finally, one patient explained the silence to say, "Doctor, everyone knows there are no crocodiles in Kansas. We didn't want you to think we were crazy."

Honesty is tough. Assumptions are powerful. We all expect to be disbelieved and shape our narratives, and then get into terrible trouble. We are not always good at being honest and truthful...or in following the road toward good mental health. There are no wild crocodiles in Kansas. Mostly.

Contract Negotiation Program

On Tuesday, November 12, 2019, CPS Platinum Partner Professional Risk Management Services (PRMS) hosted Contract Negotiation: the good, the bad and the effective seminar to 20 CPS members and guests. Andrew Nickel, Esq and Kendra Smith, Esq of Hall and Evans LLC presented information on employment contracts and negotiation techniques. PRMS Risk Management Vice President Donna Vanderpool, MBA, JD was also present to answer questions. All CPS members were invited to attend the event that was part of the 2019 Resident-Fellow Fall Series of Events.

CPS Platinum Partner PRMS secured Andrew Nickel, Esq and Kendra Smith, Esq of Hall and Evans LLC to share tips on contracts and negotiating for the CPS event.

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CPS Legislative Committee and Training

By Jennifer Hagman MD, Immediate Past Chair, Legislative Committee

APA Director of State Government Relations Erin Berry Philp, MA, JD and APA Senior Regional Director of State Government Affairs Amanda Blecha, JD present at the Legislative Training.

The Colorado State Legislature is in session from the beginning of January to the beginning of May. During this time hundreds of bills are introduced. Members of the CPS legislative committee, along with our lobbyist, Debbie Wagner, and our executive director, Anna Weaver-Hayes, screen all the bills that could have an impact on the practice of psychiatry, mental health and systems of care. While we engage at different levels on many bills, there are some on which we take significant action to support and try to pass the bill, or oppose and try to prevent the bill from passing. We often take action to change language in bills to improve the outcome of the legislation. Medical marijuana was a significant issue again in 2019. We testified in opposition to adding Autism to the list of conditions for which a recommendation for a MMJ card can be written. After being vetoed by Governor Hickenlooper after the 2018 session, the bill passed again and was signed by Governor Polis in 2019. Some provisions to protect children and to encourage

2020 Legislative Committee Meeting Dates

Location: Mental Health Center of Denver (4455 E 12th Ave, Denver)

Time: 6:30 pm

Dates:
Monday, March 9th
Monday, April 6th

If you would like to be added to the Legislative committee e-mail list, please email anna@coloradopsychiatric.org

recommending providers to consult with provider actively engaged in the care of the child were added to the bill. CPS also testified in opposition to adding "any condition for which an opiate might be prescribed" to the MMJ list. Despite opposition from CPS, CMS, CCAPS and the Pediatric organization (AAP-CO), this bill also passed and was signed by the governor. CPS, along with other medical groups, were successful in adding language that requires CDPHE to develop a process for shorter term MMJ cards. CPS members testified in support of a bill that finally passed in the 2019 session, which bans the practice of conversion therapy in Colorado, and a bill that prohibits expulsion of preschool children for behavioral reasons.

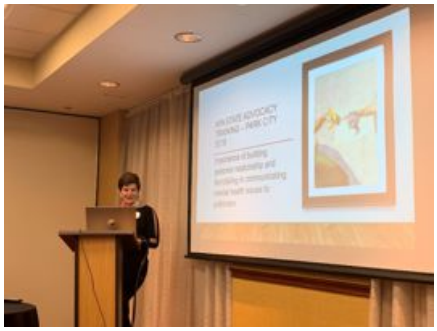
CPS members roleplay testifying at the CPS Legislative Training.

CPS Lobbyist Debbie Wagner and Beth Cookson discuss 2020 legislation while Kartiki Churi and APA Director of State Government Relations Erin Philp talk about meeting with legislators.

The 2020 session is off to a fast start and the legislative committee has already reviewed a number of bills of interest and we will continue to take positions and organize our efforts as the session moves forward. This is an "election year", which can impact the bills different representatives and senators sponsor.

In preparation for the 2020 session, CPS was awarded an APA Expedited Grant to provide training on the legislative process in Colorado, guidance on how to testify and speak to the media and CPS/APA legislative priorities in 2020 and beyond. The training was led by CPS expert lobbyist Debbie Wagner; APA Director of State Government Relations Erin Berry Philp MA, JD; APA Senior Regional Director of State Government Affairs Amanda Blecha JD; CPS Legislative Chair Liz Lowdermilk MD; and CPS President and Colorado Physicians for Mental Health PAC Chair Patricia Westmoreland MD.

CPS would like to thank the APA for funding Legislative Training in Colorado through the APA Expedited Grant.



CPS President and PAC Chair Patricia Westmoreland shares her experience as an advocate.

LEARN MORE!

To learn about the legislative process, how a bill becomes a law, how to talk to a legislator, how to testify and more, please check out the CPS Legislative Handbook (also available in the Legislative Center of the Member Center on the CPS website)

Winter Party 2019

CPS held its annual Winter Party on December 5, 2019. The festive gathering included nearly 50 medical students, residents, early career psychiatrists, and seasoned members. The CPS Winter Party is one of our most anticipated events every year, and this one did not disappoint.

CPS members enjoy conversation at the Winter Party.

President Patricia Westmoreland and President Elect Claire Zilber thank CPS Office Administrator Beth Pippin and Administrative Assistant Niki Selz for their hard work in 2019.

28
STATES
(and 3 countries!)

16
SPEAKERS

14,406
WORDS EXCHANGED IN THE CHAT

The inaugural PsychSummit on January 15th and 16th 2020 brought together participants from across the United States—as well as Canada and Brazil!—to discuss some of the most pressing issues in psychiatry before delving into the future of the profession. The event consisted of 4 sessions covering the topics of Mass Shootings, Climate Change, the Next Opioid Crisis, and a special discussion on the future of psychiatry by thought leaders in the profession.

Panelists include the mother of one of the Columbine shooters; past presidents of AAPL, the AMA, APA, and AAEP; many other experts and emerging leaders; and members.

As the session video played, a chat ran simultaneously where members and speakers made personal connections and had robust discussions. There were over 900 chats exchanged! Participants were able to share their own experiences and ideas in a meaningful and practical way. All registrants will receive an eBook, capturing the collective knowledge and resources shared during the event from both speakers and attendees alike. Although the live event is over, the sessions are available to watch on-demand. Register to access the recording of the conference here and stay tuned for future PsychSummit events.

PsychSummit is a project of the Colorado Psychiatric Society, the New York County Psychiatric Society, and MatchBox Virtual Media. We were thrilled to have the support of numerous Contributor organizations, including the American Academy of Psychiatry and the Law (AAPL) and District Branches from Maine to California. We are also grateful to PsychSummit sponsors PRMS and APA, Inc.

e-Prescribing:

Adapting to Fraud Reduction in the Opiate Crisis

Claire Zilber, MD

A federal law taking effect on January 1, 2021, will require electronic prescribing (e-prescribing) of all controlled substances for Medicare Part D beneficiaries. Similarly, Colorado law mandates that all controlled substances will require e-prescribing by July 1, 2021, although they will extend the deadline to July 1, 2023, for solo and rural providers (and dentists). Optum Rx has elected to get in front of the trend and require e-prescribing for home delivery of controlled substances by January 1, 2020 (after the publication of this article). They offer a brief grace period through February 29, 2020, during which they still will process written prescriptions.

The e-prescribing impetus is an attempt to reduce fraudulent opiate prescriptions. Although most psychiatrists don't prescribe opiate pain medications, we do prescribe other controlled substances, including buprenorphine, stimulants, and benzodiazepines. Those of us who are employed by large health care systems with electronic medical records (EMR) are probably already e-prescribing through the EMR. According to the AMA's 2017 data on physician practice ownership (https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf), although only 16.5% of all physicians were in solo practice in 2016, 31.9% of psychiatrists were in solo practice. Thus, nearly a third of us are on our own when it comes to adapting to mandated e-prescribing.

Among the purported benefits of e-prescribing are greater convenience for patients because they will no longer need to drop off prescriptions at the pharmacy, reduced risk for error from poorly legible handwriting, improved patient safety through drug interaction checkers built into e-prescribing software, increased checking of the state PDMP via integration with the e-prescribing software, and reduced risk of fraud from stolen and forged prescriptions. Unfortunately, fraud will not be completely eliminated because employees and colleagues can access e-prescribing portals through a shared EMR to generate unauthorized orders under a physician's license and electronic signature. Nevertheless, even a partial reduction in fraud and diversion is a step in the right direction.

Among the potential disadvantages of e-prescribing is the hassle factor that may add to provider burnout, and the inconvenience to the patient and provider if a prescription is sent to a pharmacy that doesn't have the medication in stock. Unlike a paper prescription, which the pharmacist can hand back to the patient to take to another pharmacy, an e-prescription cannot be transferred. The patient will need to contact the prescriber and ask that a new prescription be generated for another pharmacy, and the prescriber must both create a new e-prescription and cancel the outstanding order to reduce the risk that it would later be filled and diverted or overused. If the patient has waited until they are out of medication to ask for the prescription, the delay caused by this process may have

significant consequences, especially if the therapy is a benzodiazepine or buprenorphine.

For the solo or small group practice that doesn't have an EMR with integrated e-prescribing, the Optum Rx mandate announced in mid-September 2019 left a small window to research, select and implement an e-prescribing software program. The APA has a webpage with some resources (https://www.psychiatry.org/psychiatrists/practice/practice-management/health-information-technology/e-prescribing) but does not provide information about specific stand-alone e-prescribing products. The webpage is being revised and hopefully will soon offer more practical information.

Given the short notice and my own limited time for research, I looked into only four products. There was no rationale for these particular choices, and I fully acknowledge there may be superior software programs that I neglected. I share this information in the spirit of collegiality and not in any way as an endorsement of a particular product.

DrFirst, a company that offers an a-la-carte suite of electronic resources, launched iPrescribe approximately one year ago. It is a phone app and a keychain fob for two-factor authentication for each controlled substance prescription. Two devices are necessary to set up an account, so I used my laptop to register and my phone for the two-factor authentication. The initial registration took less than an hour to complete, and I was able to e-prescribe non-controlled medications right away; however, there are additional hurdles for controlled substance prescriptions and these took close to a month to navigate successfully. Although there are aspects of the software that are less than intuitive, necessitating several calls to their helpline for assistance, the people who staff the helpline were friendly and eager to resolve problems. Had I known in advance about the helpline, I would have used it to set up my account as that would have mitigated at least one missing data field that delayed my ability to e-prescribe controlled drugs. The product is free for now, but they will begin charging a monthly fee in about a year.

DAW Systems offers a web-based program for those of you who prefer to prescribe from a tablet or computer. It requires the use of Google Chrome. They have a similarly rigorous authentication system, so it takes a few weeks before you can prescribe controlled substances. A colleague who opted for this product reported, "Once I got in the system, it works beautifully." They also offer staff assistance with set-up if you don't want to do it on your own. This product costs about $250/year, with the option to purchase either a monthly or an annual license.

I contacted a third company, EazyScripts, because of the promise suggested by its name. In November 2019, they told me they're in the process of building their self-service portal designed for solo or small practices. They anticipate the portal will be operational in February 2020, and that the monthly per-prescriber fee might be $59.95.

Just before this article went to press, a fourth company reached out to CPS. Called Treat, it offers two stand-alone e-prescribing products, one for legend prescriptions (no CS), and one for all orders including controlled substances. It requires a similar process to set up controlled substance prescribing as the other two described above. A monthly subscription to the controlled substance version is $30, or an annual subscription is available for a discounted $306/year. The most significant

difference I saw from perusing the website is that their helpline is open M-F 8 am-6 pm Eastern time, whereas iPrescribe's helpline is available 24/7.

Before you start e-prescribing, you must comply with HIPPA regulations. This means each patient for whom you plan to e-prescribe must receive the HIPPA Notification of Privacy Practices and sign an acknowledgment form, repeated annually. Both are available on the APA's practice management webpage (https://www.psychiatry.org/psychiatrists/practice/practice-management/hipaa).

Is the refusal to adapt to e-prescribing an option? If you are in solo private practice, you set the rules for your practice. For patients with Optum-Rx, you may still use paper or faxed prescriptions for 30-day prescriptions filled at a local pharmacy. Unfortunately, this means these patients will lose the cost savings of 90-day mail-order prescriptions, and for patients with limited resources, this may create an unacceptable burden. Once the grace periods for Medicare and Colorado prescriptions expire, you may inform your patients that you will no longer prescribe any controlled substances, and refer them to their primary care provider if they need benzodiazepines or stimulants. This approach is not likely to endear you to these patients' PCPs, and may not be the most ethical course of action because it places your interests above those of the patient. On the other hand, if you are late in your career, plan to retire soon, and have few patients on controlled substances, it may be a reasonable alternative.

Like other recent technological directives, e-prescribing requirements are well-intentioned, designed to improve patient care and safety. Solo practitioners will have to decide which product to choose based on their features and costs, and all prescribers will have to learn to adapt to the technology and its inevitable glitches. Although it is easy to feel resentful about yet another unfunded mandate, this can be at least partially offset by recognizing some helpful features offered by the technology. For me, the ease of checking a patient's PDMP profile from within the iPrescribe app means I am more readily adherent to best practices for controlled substance prescribing. This replaces a less efficient PDMP process, reducing stress.

I invite readers to describe your own experiences with e-prescribing products via letters to the editor so we may all learn from each other. Which product do you use? How has it helped your practice? What would make it better?

Letters to the Editor may be sent to
office@coloradopsychiatric.org

Resident's Column

David A. Brown, DO

The Reality of Virtual Reality

It was the start of a new integrated care rotation and during orientation at the family medicine clinic, I shadowed staff in each department. I sat in the corner and watched as my preceptor described treatment recommendations to her eleven-year-old patient.

> It's really cool. There are three options. In one scenario, you're floating down a river, watching the world go by you. It's very relaxing, very cool. In another, you're doing tai chi, holding a wand in each hand and following the movements. Also, very cool, very fun. And in the last one, you're moving through a field mindfully, with text on the screen that guides you. Which one do you want to do today?

"All of them!" he responded excitedly.

She was, of course, talking about virtual reality, or VR. I noticed how my preceptor emphasized the "cool" factor of the treatment, trying to hype the treatment to engage the patient. In truth, she didn't need to. As soon as the patient saw the VR headset, he was hooked and exclaimed, "I really want one of these! It's at the top of my list." I watched the preceptor put the headset on herself to configure a treatment scenario as the boy eagerly awaited his turn. He could not get the headset on fast enough. I, too, was excited, and secretly wished that I could try it out myself. In fact, when a co-resident who had previously done the rotation found out I was starting, it was the first thing he mentioned. "Make sure you try out the VR they have there, it's pretty cool." Even in the University outpatient psychiatry clinic, I noticed the excitement in my colleagues setting up VR for the clinic. It didn't take long for the director of the clinic to share in the excitement either.

If VR is anything, it is cool. While VR technology is not new (it was first introduced in the 1950s), the tech is only now becoming truly immersive. But as I watched the eleven-year-old put on the headset with glee, I couldn't help but wonder¬ does it work? Is it actually a helpful and effective treatment for psychiatric problems? Or is it just a flashy gimmick?

In attempting to answer this question, I came across a literature review of about 30 small studies that evaluate VR for psychiatric diagnoses. As with any new treatment, the number of enrolled subjects was small and the quality of evidence varied. The most straightforward application may be using VR in exposure therapy to treat phobias and Post-Traumatic Stress Disorder, recreating environments that provoke a fear stimulus that the patient then works to tolerate. VR can also evoke calm scenarios that

let a patient practice mindfulness activities, that may be able to help manage depression, anxiety, post-surgical pain, or even allow the bedridden patient to "leave" the hospital through the VR simulation. Some of the uses surprised me, such as VR-based social skills training to manage the negative symptoms of schizophrenia or for autism. There are even studies looking at using VR to detect mild cognitive impairment or to bolster episodic memory in Alzheimer's Disease.

The results are promising even if difficult to interpret. One study showed a reduction in PTSD symptoms in veterans. VR reduced specific phobias, such as fear of spiders, social situations, flight, needles, or heights. For schizophrenia, VR therapy has shown benefits to teach medication management skills, job interview techniques, and vocational techniques. Individuals with autism had a higher job search rate, more knowledge of activities such as riding the bus, and a higher success rate with employment applications. Side effects of VR included motion sickness, headaches, nausea, or dry eyes. The study also suggested the possibility of compulsive VR use as might happen with video games.

While there may be benefits to VR, I still can't help but wonder is it worth it? Is VR more effective than simply teaching someone a mindfulness exercise or an imaginal exposure that they can do on their own, at any time, without equipment? And will the benefits outweigh the extra cost? We don't know yet.

We should not take lightly that no mindfulness workbook can yet compete with the "cool" factor of VR, especially in younger patients more familiar with the medium. VR is a powerful tool to help break through some of the stigmas younger people have to mental health treatment. VR makes psychotherapy seem less like homework and more like a video game. Maybe VR will help to create a more positive treatment experience for our patients, which will make them want to come back each week, fostering engagement in their psychiatric care.

One thing is for sure: I will be looking forward to a chance to try out VR myself on my next day of integrated care.

Reference

Park, M.J., Kim, D.J., Lee, U., Na, E.J., & Jeon, H.J. (2019). A Literature Overview of Virtual Reality (VR) in Treatment of Psychiatric Disorders: Recent Advances and Limitations. Frontiers in psychiatry, 10, 505.

Ethics Article

Claire Zilber, MD, DFAPA

Occupational Advance Directives

November 2019

Someone dear to me has developed a neurological illness that affects her cognition. Although she is aware of some of her deficits, she has a curious neglect of others, reminiscent of hemineglect after a right-sided stroke but in her case, it is not about paralysis. A brilliant researcher, she struggles to complete the final grant of her career. Fortunately, she has help from her team and the grant will be submitted with a group effort. Witnessing this makes me wonder, "What if this happened to me?" I want a mechanism to create an auxiliary observing ego in case my internal one fails. According to the Association of American Medical Colleges, over one-third of US physicians are 55 years old or older and likely to retire in the next decade. Presumably, I may not be the only physician thinking about the effects of aging on my ability to practice.

I told a colleague that if I ever become cognitively impaired, and I don't realize it, she is to bluntly insist that I stop seeing patients. She replied, "Put it in writing." Which got me thinking, we have advance directives about resuscitation, medical treatments, and psychiatric advance directives about how to handle the next psychotic or manic episode, but no advance directives about occupational fitness. In a much earlier column, I wrote about contingency planning for our sudden illness or unexpected death, detailing suggestions for how to create procedures to help family and colleagues in the event we are too ill to close our practices ourselves ("Contingency Planning: The Essential Euphemism"). Another facet of such contingency planning may be occupational advance directives (OAD).

A query of three search engines did not show any specific reference to occupational or employment advance directives. What might such a document entail? I looked for guidance in medical and psychiatric advance directives resources. AARP has a directory of state-specific legal documents for medical advance directives (AARP Advance Directives Forms), and SAMHSA provides a guide to psychiatric advance directives (A Practical Guide to Psychiatric Advance Directives). Borrowing elements from both of these directives and my contingency plan, an OAD would state, "I agree to have an evaluation for competency to practice if [adviser] says the time has come to do so." The directive would designate one or more friends, colleagues, or family members to serve as advisers. My OAD will designate three colleagues and my spouse as advisers because while I could imagine disregarding one colleague's expression of concern, the concern of two or three people is likely to pierce the veil of denial.

The OAD would also contain declarations about the person's intentions and preferences. For example, one could distinguish different courses of action depending on whether cognitive impairment was likely temporary (say, for the duration of a treatment protocol) or permanent. Courses of action could include referral to the state physician health program, neuropsychological screening and/or testing, a leave of absence from work, or permanent cessation of practice. If the person has a contingency plan document, this could be the time to put it into practice. Alternatively, the OAD could include sample letters to patients for each of these hypothetical circumstances. It would list detailed instructions about how to manage or close the practice and who would be in charge of elements like notification and transfer of patients, management of medical records, and disposition of the office and its contents. The OAD would include signatures of the person declaring their recommendations and the advisers designated by the document, and each of these people would receive a copy.

The OAD is a logical extension of medical ethics principles. It supports nonmaleficence (the imperative to refrain from harming patients through misconduct or negligence) by ensuring that a cognitively impaired physician receives appropriate medical attention and refrains from practice during a period of impairment. When combined with a contingency plan, an OAD also protects patients from abandonment. The OAD upholds the virtues of diligence, self-awareness, and openness to feedback. Furthermore, it protects the physician's autonomy by voluntarily setting up parameters for seeking evaluation and/or stepping out of practice, rather than waiting for an adverse outcome or a licensing board complaint.

I would never want to be in a position where impaired judgment caused a poor treatment decision that harmed a patient. Nor would I want a patient to feel worried or embarrassed by any change in my functioning. Having an OAD in place will also ease the burden on colleagues and family who might otherwise struggle with how to manage my medical decline if I was in denial. As a further benefit, this auxiliary observing ego will spare me a measure of humiliation, for I wouldn't want to be perceived by patients or the profession as practicing in an impaired state. Like similar documents, an OAD is something I hope never needs to be invoked, but I will feel better for having one in place just in case.

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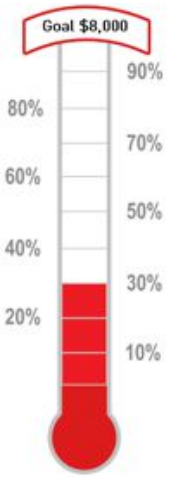

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Speaker

8:15—8:30pm
Q&A

8:30pm
Adjourn

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LEARNING OBJECTIVES:

1. To increase knowledge about screening for depression in youth
2. To increase knowledge about the evidence base for the treatment of major depression in children and adolescents
3. To increase knowledge about factors affecting treatment response

BIO:

Karen Dineen Wagner, M.D., Ph.D. is the Titus H. Harris Chair, Harry K Davis Professor and Chair of the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical Branch in Galveston.

Dr. Wagner is an internationally recognized expert in the pharmacological treatment of childhood mood disorders. Her work has led to the development of evidence-based treatments for children and adolescents with major depression and bipolar disorder.

Dr. Wagner has served in leadership positions in professional organizations and has been a member of the National Advisory Mental Health Council of the National Institutes of Health. She is Deputy Editor of the Journal of Clinical Psychiatry. Dr. Wagner is Immediate Past President of the American Academy of Child and Adolescent Psychiatry and is past President of the American Association of Directors of Child and Adolescent Psychiatry.

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