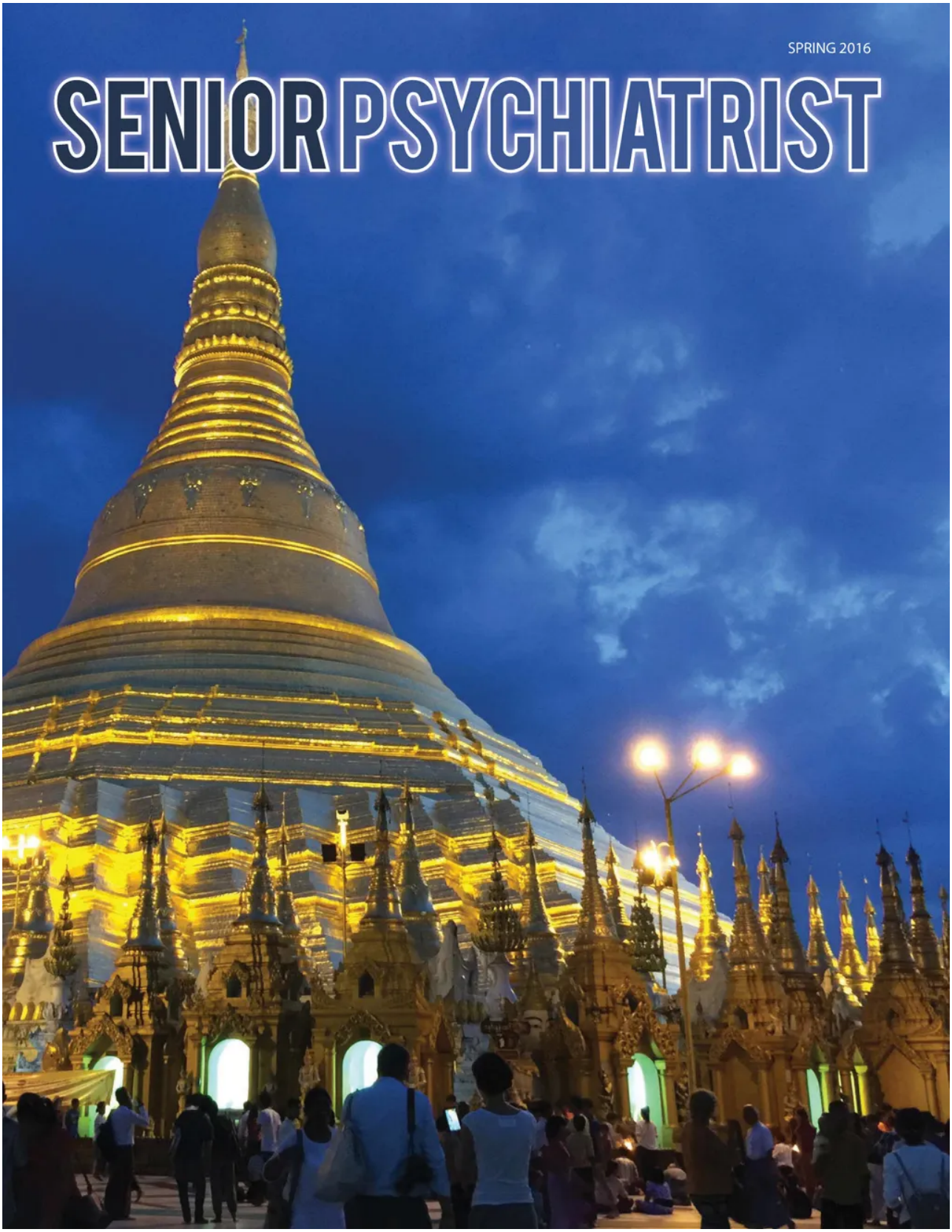
SPRING 2016
SENIOR PSYCHIATRIST

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FROM THE EDITOR

SENIOR PSYCHIATRIST

By Philip M. Margolis, MD

In this issue, we begin to focus on the History of the Senior Psychiatrists. We are also continuing a series of oral histories of distinguished senior psychiatrists in our midst.

Secondly, I am intrigued by Joe Silverman's article which he appropriately labels as "An Editorial," entitled "Whatever Happened to Idealism?" His piece is subtitled "American Psychiatry's Super-Ego Deficit." Dr. Silverman believes that the House of Medicine in the United States is in trouble. I agree. He iterates that physicians have "played "defense" against the social, political forces that are working against the medical world. Dr. Silverman poses several questions for Senior Psychiatrists and he requests our replies.

You will note in The Magazine that Barbara Matos has given us an initial look at the Lifers from its beginnings in the early 1990s. According to written and oft-noted very positive feelings about Barb, she was the heart and soul of the Lifers. I doubt that we could have survived without her. She knew when to support, when to goad, and she was always there for us.

Garry Vickar verbalizes many good feelings about the Lifers. Paul Wick suitably describes the transition to the new organization called the Senior Psychiatrists.

What is there to add? A bit of history not well documented states that the APA Lifers organization was founded in 1989 by Harold Berson and Doris Berlin. Another note says that Harvey Bluestone was also in on an early meeting with Berson. Other founding members as I recall them were Robert Campbell and myself. The early years involved a seminar in Las Vegas on gambling (1992) and the development of a mentoring program in 1994 which has been revived by Nada. There was a seminar on estate planning in 1995. We began going to APA annual meetings and would meet there as a small group. We even went to a joint meeting with the American Academy of Geriatric Society in Tucson in 1996. In essence, we met and were helpful and we enjoyed ourselves and one another.

The Senior Psychiatrists has evolved from the Lifers. We are now in the process of evaluating our relationship with the APA. APA leaders have now become leaders of the Senior Psychiatrists. For example, Dr. Nada Stotland, former president of the APA, is now president of the Senior Psychiatrists.

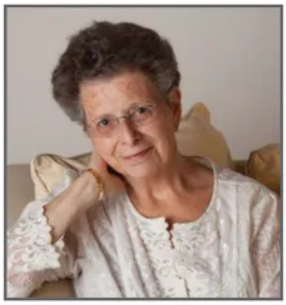
As you note, the title of my editorial column is, The Future Lies Ahead! That's where we are headed. Our newsletter and now our magazine were devised to encourage communication with one another and hope that this is happening.

The Senior Psychiatrists also has an active website: seniorpsych.org. The website provides the opportunity for all members to submit articles and to exchange ideas. Be sure to visit the site often. It can be a forceful catalyst to effect change and growth. The website can become the cutting edge of our raison d'ĕtre.

The Future Lies Ahead

Philip M. Margolis, MD
Editor, Senior Psychiatrists

MESSAGE FROM THE PRESIDENT



By Nada L. Stotland, MD, MPH

Welcome to the magazine for senior, and all, psychiatrists. There are over 9000 life fellows in the American Psychiatric Association, and all the other members are moving inexorably towards that status every day! After many decades in the profession, we are happy to share our rich array of experience and expertise. We address the particular challenges, decisions, and opportunities of the senior stages of our careers. Some of us are retired. Others are working full time. Still others have devised ways to combine paid work, volunteering, and devoting time to avocations, families, travel—and rest. Having chosen the last option, I've shared photos from my recent psychiatry-oriented tour of Myanmar in this issue (a similar trip to Argentina and Chile is planned for November 2016).

Some questions are particularly troublesome. How do we know whether we, or a colleague, is losing professional competence, and what to do about it? What preparations should each of us make in case our practice should have to close suddenly? If we retire, how do we balance the pleasure of unaccustomed freedom with the loss of our professional identity? In this issue, on our website, and at the outstanding educational events at the APA May meetings listed, we offer answers to each of these questions. Please join us at the educational events, at our business meeting and reception—open to all—and join your senior colleagues as a member? We look forward to seeing and hearing from you.

The Lifers

By Barbara Matos

In the early 90's Harold Berson, MD, along with others (Harvey Bluestone, MD, Doris Berlin, MD, and Robert Campbell III, MD) created and developed a group called the Lifers as a kind of social group. Soon, the Lifers evolved into a real organization that became much more than social.

Many of the Lifers were APA Life Fellows/ Distinguished Life Fellows. We all assisted in the work of the APA, engaged in charitable, educational and/social endeavors and served as a cohesive force to bring themselves into close contact for the benefit of all.

Those Lifers who were members of the APA Assembly held a caucus at every Assembly meeting, which allowed sharing of views on the various issues presented.

The Lifers developed events at the APA annual meetings which soon grew from just a social reception to a business meeting where members met to hear about activities, vote for leadership and listened to presentations of considerable interest. Also a workshop was held at the annual meeting and occasionally at a District Branch Get-together. An annual reception heralded the new Berson Award presented to a Lifer who had contributed outstanding service to the APA.

(See Article by Paul Wick concerning the new organization called Senior Psychiatrists).

Voting for AMA Senior Physicians Section

For those AMA members 65 and older, there will be an election for members of the AMA Senior Physicians Governing Council in March. If you are an AMA member, you should receive an email ballot.

Paul Wick, MD, is a candidate for re-election to the seven person governing council. He is the immediate past chair of the governing council and his nomination is sponsored by APA. Believing that senior physicians remain a valuable resource to AMA, he believes that their interests and involvement need be encouraged. The governing council has been involved in encouraging study of issues such as senior physician competency, wellness, burn out, mentoring and volunteerism. Dr Wick is also a Delegate to AMA representing APA.

Psychiatry is well represented on the governing council as Barbara Schneidman, MD, is chair-elect.

Editorial

Whatever Happened to Idealism?
American Psychiatry's Superego Deficit

Physicians have a fiduciary duty to advocate, not only for the welfare of our individual patients, but also more broadly for improvement and justice in healthcare and the human condition.
— Carlyle Chan, MD, Professor of Psychiatry at Medical College of Wisconsin and its Institute for Health and Society

The term "economic imperialism" (1) refers to the abandonment, for monetary gain, of time-honored, intangible professional and humanitarian values. We senior psychiatrists have seen this phenomenon play out in our profession and our specialty.

By Joseph S. Silverman, MD, Psychiatrist at James E. Van Zandt Veterans Affairs Medical Center and at UPMC Altoona

In the past five decades, repeated economic 4.5 earthquakes have shaken the House of Medicine in the United States. Medicare, Medicaid, the malpractice crisis, DRGs, managed care, electronic health records, the shift away from proprietorship to employment in group practices - all have altered the nature of medical practice in general and, with particular force, the specialty of psychiatry.

Insurance companies and the Medicare and Medicaid programs, increasingly responsible for reimbursing physicians for their services, exercised more power over our practices.

Striving to protect their financial well-being, most psychiatrists adapted their practices. Gaming the system to maximize profit became a principal preoccupation. Responding to inducements from third-party payers, many of us threw psychotherapy overboard. The 50-minute treatment hour gave way to 15-minute "med checks." To some of our employers, even 15 minutes came to seem too lengthy.

Meantime, minions of nonmedical psychotherapists rose up to replace psychiatrists.

What had been ethical imperatives – personal on-call coverage, peer substitute coverage when the psychiatrist was unavailable, and telephone answering services – faded out. Clerical staffs shrank. Physicians had to endure monitoring by business-oriented personnel indifferent to the medical mission.

Inpatient mental health lengths-of-stay contracted as admission criteria became indistinguishable from criteria for involuntary commitment. Steven Sharfstein memorably declared that "hospital treatment" had become an oxymoron.

Computerization of medical records, which promised more legible documentation and better communication among caregivers, metamorphosed into an army of Frankenstein monsters that turned with a vengeance on their masters.

The doctor-patient relationship had been the very battle cry of the 1970s, when physicians trembled at the prospect of governmental subversion of professional autonomy. That partnership-for-healing became a casualty as *productivity* and *profit* became the new ideals, and pit crew the recommended model for care. The medical profession as a whole lost respect and prestige.

Membership in the American Medical Association and its state and local components dwindled. Some specialty societies, including the American Psychiatric Association, lost members.

Critics of these developments were not lacking, their contributions scattered among a variety of medical publications. Many psychiatrists editorialized that the detailed understanding of a patient and targeted psychotherapy should not be left to non-medical professionals.

But for the most part, we physicians have "played defense" against the social, financial, and political forces. We failed to assume primary responsibility for improving care, reducing costs, increasing efficiency, and preserving professional values.

Questions for Senior Psychiatrists

1. 1. Is there *anything* we can do to restore values we used to treasure?
2. If so, where would we begin?
3. Should this topic be brought to the attention of the APA leadership? To the rank and file of psychiatrists?
4. If so, in what fashion?
5. Are there issues that should be added to those mentioned?
6. Are there issues mentioned that should not be emphasized?
7. Given the psychiatrist shortage, are mini-treatment sessions here to stay?
8. Is private practice, at least part-time, the best and/or the only refuge from the status quo?
9. If the situation (Q. 1) is hopeless, should we just express regret and let it go at that?

The author requests feedback. He can be reached as follows:

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1. Schwartz Barry. The creation and construction of values. Am Psych 1990:45 (1): 7-15.

Nada Stotland, M.D., MPH is Chosen to Receive the Berson Award

The Awards Committee of the Senior Psychiatrists is pleased to report that it has chosen Nada L. Stotland, M.D. MPH to receive the Berson Award at the American Psychiatric Association Annual Meeting. We encourage you to attend the reception of the Senior Psychiatrists on Tuesday, May 17, 2016 from 7 to 9 P.M. at the Atlanta Marriott Hotel where Dr. Stotland will be honored. The award is in recognition of her leadership of the Senior Psychiatrists and her many contributions to American psychiatry.

Dr. Stotland attended college, medical school and completed her residency and did a fellowship in consultation/liaison (C/L) psychiatry at the University of Chicago. She began her academic psychiatry career there as well. She served as the Director of Psychiatric Education and the Director of the C/L service. It is on this service that she launched her work as a liaison to the obstetrics and gynecology department which served as the basis for her many contributions to the literature and her lectures on women's issues in psychiatry. She has also served as the Medical Director of Mental Health Services for the State of Illinois. Dr. Stotland completed psychoanalytic training at the Chicago Institute for Psychoanalysis and earned her master's degree in public health at the University of Illinois at Chicago. In 1997 she was made Professor of Psychiatry at the Rush Medical College of Rush University and remains on the faculty to this day. Throughout her career she has maintained a private practice.

Dr. Stotland's service to the field of psychiatry culminated in her election as the President of the APA in 2008-2009.

She has been sought after for her expertise and has testified in state courts and in the U.S. Congress. She has made appearances on Oprah, Larry King Live and the Bill O'Reilly show.

She has had the support of her husband Harold Stotland throughout her career and they are the parents of four daughters and grandparents to four grandchildren

Lastly, Dr. Stotland is completing her two year term as President of the Senior Psychiatrist where she was a devoted servant to our organization.

The Awards Committee:
Stephen C. Scheiber, M.D., Chair
Irwin Cohen, M.D.
Leah Dickstein, M.D.
R. Viswanathan, M.D.

The Transition of Lifers of APA to Become Known as Senior Psychiatrists

By Paul Wick, MD, DLFAPA

As the last President of the Lifers of APA and first President of the Senior Psychiatrists , I was asked to contribute a history of the events of this transition.

The Lifers of APA as an organization was formed some years ago after the APA developed the membership categories of Life Member, Life Fellow and Distinguished Life Fellow. Membership in the Lifers was open to all APA members in those categories. Officers, an executive committee and an active committee structure led that organization through the years. The Lifers organization had accomplishments of an excellent newsletter, Lifersline, sponsored workshops at the annual meeting and IPS, recorded history interviews, mentoring efforts and awarded the Berson Award to an outstanding member. The Lifers received capable administrative staff support from the APA Foundation enabling the organization to function smoothly over the years.

In late 2012, the newly revised American Psychiatric Foundation informed us that under their reorganization and tax status they could no longer collect dues for us or provide any administrative staff support. As a result of this, we were deemed to not have official standing as an organization within APA. That is to say, we were not recognized as a component, a caucus, an Assembly connection or an allied organization within APA per its operations manual.

We did have encouragement from APA leadership to find a place within the APA structure. Initially we sought approval to be an official section within the Assembly but a section was not defined within the rules. The remaining choices were to become a caucus or an allied organization.

I would say that this was agonizing for our group to understand that as long standing APA members we could not be recognized as an official group within the umbrella of APA. We did have support within the Assembly that later allowed our organization to become an Allied organization within the Assembly with a voting delegate.

Our leadership (Steve Scheiber, Nada Stotland, Bernard Katz, Michael Pearce, Pierre Loebel, S R Thorward, Phil Margolis, Norman Clemens, Don Brada) struggled with finding a new name since we were not either representing Lifers or the APA specifically. We came up with the name Senior Psychiatrists. Our governance structure, officers and committees changed little except we were operating as an independent organization.

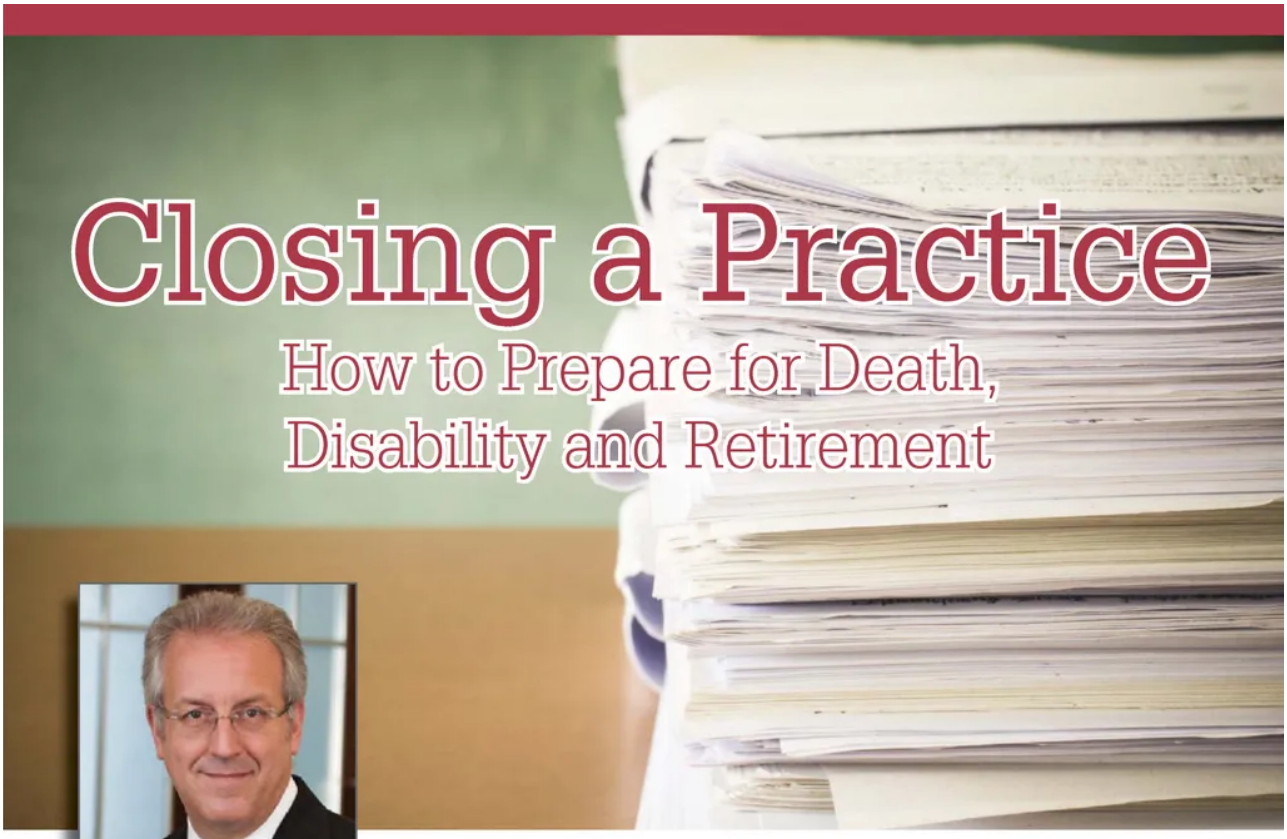
Our Mission remained the same being to support the interests of late career psychiatrists and to be a spokesman (or give them a voice) for them in the Assembly and to support APA activities as requested.

Determined not to let the organization succumb under my shift, I had the good fortune of meeting with Pat Troy CAE and her Next Wave Group to provide administrative services. As the District Branch Executive Director for the Washington Psychiatric Society, Pat was very knowledgeable about the functioning and staff at APA. The Executive Committee approved contracting with her. Pat has been enthusiastic, encouraging and supportive.

We were then able to incorporate as Senior Psychiatrists, Inc. in Maryland and could open a bank account, collect dues and contributions, have a website and fund our basic activities. The newsletter Lifersline was changed to a magazine format and called Senior Psychiatrists. A reception and award presentation has been held at each annual meeting of APA.

The Assembly did approve Senior Psychiatrists as an allied organization having a voice and vote in the Assembly. Our delegate Jack Bonner has represented us very well. Nada Stotland has been very active as the second President, and Phil Margolis continues to do yeoman work as our magazine editor.

And so, Senior Psychiatrists continues to function. We have appreciated the support of many APA members and continue to seek ways to be involved and support our senior members.



Closing a Practice

How to Prepare for Death, Disability and Retirement

By Scott D. Hammer,
Of Counsel with Wilson, Elser,
Moskowitz, Edelman & Dicker LLP

Believe it or not, the chances of becoming disabled, dying or retiring are pretty good. Although some therapists believe their therapeutic efficacy will lead to immortality, I hate to tell you, but one day your caring heart will cease beating. Either death or your patients will eventually kill you. This article focuses on how to plan for Death, Disability and Retirement ("DDR"). Retirement is usually planned, but death and disability often come without warning.

Your sudden and unexpected death or disability as a therapist will leave your family with a large number of professional and personal tasks needing attention. Those burdens on your family are heavy enough, and then they have to contend with the needs and nonsense of patient care. Numerous decisions have to be made quickly, and during the period of mourning. Advance planning is the best solution for dealing with the complexities of your death.

You need to understand and appreciate how your DDR will affect your family, friends, colleagues and, equally important, your patients. Clients often suffer feelings of loss, abandonment and grief surrounding the DDR of their therapist. Closing a practice for expected or unexpected reasons must be done carefully to protect the patient, the clinician and the clinician's family. Although most mental health providers have their personal probate affairs in relatively good order, few will have any professional probate documents or directions prepared….and then they die.

When closing a practice, the clinician's first and foremost duty is to the patients. Therapists must never abandon their patients. Closure of the practice due to retirement should be accomplished in a manner that allows patients sufficient time to secure the services of another mental health practitioner of their choice. However, even after death, the mental health professional cannot abandon their patients. If you die, don't worry, your patients will still blame you: "How dare you die in my time of need." So alive or dead, you still have the responsibility not to abandon your patients.

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If you don't make proper professional probate plans for your patients during your life, they will haunt you from death to eternity.

My client Dr. Michael recently passed away. Like many mental health professionals, he was a solo practitioner with no assistant. He died suddenly on a Sunday, and I received a frantic call from his son on Monday. Patients were standing outside Dr. Michael's office. With his attention focused on burying his father and supporting his mother, the son was confronted with the fact that his father's patients were like family members who needed to be comforted and consoled. But the son soon realized he didn't have basic information to tend to his father's practice. The son didn't know which of his father's keys opened the door to his office; the password for his father's computer; the password to his father's desk phone and cell phone; where his father kept his calendar; how to contact his father's patients; and what to tell the patients.

General Guidelines for Closing Your Practice

Here are some general guidelines to consider for DDR. If you are planning to retire, you or your staff can accomplish all of these actions. If you die or become disabled, someone should be "appointed" now to take on these activities.

Short-term coverage: In the case of death or disability, who can provide short-term coverage for your practice? For long-term treatment, to whom are you going to refer your patients? You should contact a number of colleagues to determine who can take on new patients and how many. My late client Dr. Michael told his son to transfer all his patients to his colleague Dr. Greene. When I called that therapist to facilitate the transfer, he told me, "I might be able to take on 2-5 patients, total." Dr. Michael had 300 "current" patients.

Notify all employees: If possible, retain one key employee full time to open mail, respond to patients, and handle all documentation, file transfers and billing.

Notify all patients: If you retire, send out notice/ letters to all patients at least 90 days before retirement. This will allow the patients to hopefully have a final session with you and transfer to a new clinician. For death and disability, notice should go out immediately. The notice sent to patients regarding DDR should be a standard termination letter and provide at least three referral sources. Written notice must include an explanation of how copies of the therapist's records may be accessed by patients. Patients should be informed that copies of their mental health records may be obtained and sent to a clinician of their choice with proper consent and payment of a reasonable fee. Copies of the letter should be placed in each patient's file. The individual who takes on this job should also personally, and with therapeutic sensitivity, contact each patient over the phone to advise of the death or disability.

The question is always who is a "current" patient? Some patients are seen very rarely, others are seen too often. Although termination with patients who have not been seen for more than 12 months is more the subject of another article, for DDR purposes, the person in charge should contact all patients seen in the past two years.

Send notice to a local newspaper: Illinois Statutes require notice be given by publication in a newspaper of general circulation in the geographical area in which the health care professional is located.

Staff privileges: Call all medical staff of all hospitals and other facilities where the clinician had membership and privileges.

Pharmacies: Contact local pharmacies so no further prescriptions can be obtained.

Insurance networks: Contact all insurance networks. Contact all health care plans, HMOs and PPOs and Medicare and Medicaid. Also determine what needs to be done to "process" recent bills that have not been sent for payment.

Licenses: For those with a license issued by the Illinois Department of Financial and Professional Regulation and/or an Illinois Controlled Substance License issued by the IDFPR and Federal Drug Enforcement Administration (DEA), notice should be given to the IDFPR at the time of DDR.

Prescription pads and medications: All prescription pads and all (sample) medications must be disposed of appropriately. For controlled substances, federal rules require notification to the DEA prior to disposal of controlled substances in a specific manner. Non-controlled medications may be destroyed in any appropriate manner.

Donate: Continue to bring hope to the hopeless by donating the stored medications, books, supplies and furniture. A donation may be tax deductible and is definitely good for the soul.

Professional and business insurance: The professional liability insurance company must be notified upon DDR; there may be a partial refund of unused premiums. More importantly, inquire and purchase "tail" coverage for all "claims made" insurance policies. Also, check the "occurrence" policy to make sure there is coverage after the therapist's DDR.

Attorneys and accountants: Contact the clinician's personal and corporate attorney along with the business's accountant. Review all tax considerations, legal requirements for closing a practice, and the clinician's own life, disability and employment contracts.

Records and files: Document all computer usernames/passwords/logins/security questions (What's your first dog's name?)/social security number/email accounts. Record all bank account information.

If you do nothing else today, write down this information where someone can find it. It's easier to do now than after you're dead.

Utilities and vendors: Contact public utilities, landlords, vendors, creditors, phone/cell companies, equipment vendors, Internet providers, etc.

Referral sources and professional colleagues: Notify other clinicians who were close associates of the therapist or were a source of referrals.

Professional societies: Inform state and national professional societies (IPS, APA) where the clinician had membership.

Post office: Contact the local post office and other delivery contractors and arrange for all mail to be forwarded to a new address or PO Box.

Professional Wills

It's in the therapist's best interest to create a "Professional Will" that dictates the steps needed to close their practice and assist their patients and, indirectly, help their own family. Professional Wills are not recognized in Illinois. They cannot be probated and court-directed. Therefore, they have no "legal" meaning or standing. However, a Professional Will can provide direction following death or disability and should specifically address all issues regarding the clinician's patients and records.

Items to consider in a Professional Will:

Name an executor/administrator: It may be beneficial to name a trusted colleague who understands the nature of your practice. You should consider compensation for the executor's time and expense. Obviously, this person should confirm that they are willing to take on these responsibilities and tasks.

Name a records custodian: Most of your patients will request a transfer of their charts to their new therapist. Furthermore, you can still be sued after you die, so records should be kept for at least four years after your death. Records custodians should notify all patients of death, offer referrals, send copies of records to patients' new therapists (with proper authorization/consent), arrange for storage of charts and files, and have keys to all locked filing cabinets. Therapists still have a duty to maintain and retain records after death or disability.

Below is basic information that can be used to create a Professional Will. My suggestion is to keep this document with your personal will and treat it with equal respect. The following sample contains items you might want to include, but keep in mind it is not intended to be a legal document or offer legal advice. Each practitioner should consult an attorney regarding professional practice issues.

SAMPLE PROFESSIONAL WILL

Date created_____

By_____

My professional will can be found at _____

All other legal documents involving my practice (employment contracts, leases, real estate contracts, rental agreements) can be found at_____

My Illinois State License #_____

My offices are located at _____

The keys to my office can be found at_____

The keys to my locked patient file cabinets can be found at _____

My Professional Executor/Adminsitrator_____/phone_____/address_____

My instructions to Professional Executor_____

_____

My Records Custodian_____/phone_____/address_____

My instructions to Records Custodian_____

_____

My Attorney _____/phone_____/address_____

My Tax Accountant _____/phone_____/address_____

My Financial records are located at_____/phone_____/address/_____

My Business Bank Account #_____/password_____/bank info_____

My Office phone # password_____

My Business Cell # password_____

My Answering Service_____/phone_____

My Practice Computer password_____

Email address/password_____/_____

My IT person_____/phone_____

Software billing program_____/password_____

My Appointment book/professional calendar is located at_____

My Billing Service_____/phone_____contact_____

(should be told to make final balancing of all accounts)

My short-term/emergency covering practitioner_____/phone_____/address_____

My key employee/office manager/assistant_____/phone_____/address_____

My Landlord_____/phone_____/address_____

My Vendors_____

My old files are located in storage_____/phone_____/address_____

My Professional Liability Insurance carrier_____/phone_____/policy_____

My Business Insurance Broker/Agent_____/phone_____/address_____

My Utilities_____

My magazine subscriptions_____

My corporate credit card info_____

My NPI Number_____

My FEIN_____

My Social Security Number_____

I practice at the following hospitals, clinics, nursing homes, etc._____

Persons to contact with questions/information_____/phone_____/address_____

_____/phone_____/address_____

_____/phone_____/address_____

By: _____ Date: _____

Communicating Your Wishes About End-of-Life Health Care Planning: A Primer

By Jessie Martine Smith Nibley, Esquire

Call it morbid (I prefer "practical"), but deciding what kind of medical care you would like at the end of your life is an important undertaking. Many people wait until old age or some major life event — surgery, illness, or overseas travel — to think about their end-of-life health care decisions. But in a world where anything can happen, right now is the best time to decide whether you want your loved ones to pull out all the stops to keep you alive or to let you go if it becomes clear you won't recover. Having a plan in place eases the burden on family and friends; without one, many people — spouses, children, doctors — may have to agree on a course of action for you. This is a very difficult thing to ask people to do when they face losing you. Once you have an idea of what you want, here are three important ways to help ensure that your wishes are followed.

First: Living Will

A living will is a document in which you specify what kinds of life-prolonging measures you would like taken in the event that you are permanently incapacitated and unable to articulate your own medical decisions. These measures may include blood transfusions, breathing machines, feeding tubes, etc. This document is truly about "end-of-life" care — it comes into play only if you are not going to recover, as determined by your health care providers.

Generally, living wills are not an airtight way to make sure your wishes for end-of-life care are followed. Their purpose is more to guide your doctors and loved ones with an advance expression of the specific types of life-prolonging measures you want taken, if any, and to release your health care providers from liability for following your expressed wishes. In many jurisdictions a living will may be overridden by loved ones who simply can't bear to let you go. For this reason, it is best used along with a health care power of attorney.

Second: Health Care Power of Attorney

A health care power of attorney or health care proxy allows you to designate someone you trust to make binding health care decisions for you in the event you are unable — physically or mentally — to express your own wishes. This document may come into play when your incapacity is temporary, such as if you are in an accident, as well as near the end of your life. Your proxy has the authority to authorize medical treatments (or lack thereof) on your behalf, in accordance with your wishes. The document also releases your health care providers from any liability for carrying out the decisions of your proxy. Obviously, the person you designate should be a level-headed person who knows you well and will be available if the need arises. Although choosing a backup proxy or two is a great idea, I frequently counsel clients against designating two or more proxies to share the authority, as any medical decision must then be agreed upon by all proxies, and it may be difficult to contact one or more of them or to reach a unanimous decision.

For end-of-life care, the power of attorney works in conjunction with the specific wishes you laid out in your living will. This way your proxy is less likely to be put in the position of actually making decisions about your end-of-life care and can simply sign off on decisions you've already made. This also somewhat insulates your proxy from anger or disputes with other loved ones who might have made a different decision.

Third: Communication with Loved Ones

So now you have all of your decisions clearly laid out in black and white with a trusted proxy to carry out your wishes. But none of this is any good if nobody knows about it. Thus, the most important thing you can do to make sure you have the final say in your end-of-life care is to talk through your preferences, in detail, with everyone who matters. Talk to your loved ones (and, if applicable, your doctors) early and often about your specific choices; show them your living will, tell them who your proxy is (and definitely talk to your proxy and any backups about the authority and responsibility you are entrusting them with), so everyone will know what to do for you if you are unable to speak for yourself. Although you should consult with an attorney for the first two steps, this one's free — and it's crucial.

With a little, ahem, "practical" preparation, important questions about end-of-life care become opportunities to preserve your dignity and autonomy while lightening the load on grief-stricken family and friends down the road.

Jessie Nibley is a litigation attorney at Blank Rome in Philadelphia. In addition to her litigation practice, she also regularly counsels clients on advance planning matters and has given continuing medical education lectures on the intersection of law and health care. Jessie's husband is a fourth-year medical student at Drexel University, preparing for a residency in emergency medicine. They have one son.

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My Journey to "Senior" Status

By Garry Vickar, MD FRCPC, DLFAPA

Ok, I lived long enough! End of story.
Well, like all stories this is a bit longer.

I first learned of the "Lifers" when I met Barb Matos at the APA booth at annual meetings, too many years ago to remember the first time. Then, she was working with the "Golfers of the APA" (GAPA), another great story with a sad ending to be written about another time.

So, there were brochures and I learned about what it took to be a "Lifer".

Of course in the early years of my career I went to hear the "names" and thought leaders, and somehow discovered that many of them were Lifers.

Also, I started attending the Convocation of Fellows (more regularly after I became a Distinguished Fellow) and was always impressed with the vigor and volume of this group of colleagues.

I honestly don't remember when I first met Phil Margolis, but suspect it was when I became an Assembly Rep. And I also met and became friendly with another wonderful man, Herb Peyser. We hit it off because I gave him Cuban cigars and he gave me Shakespearean quotations! He was never my instructor, nor was Phil, so we seemed to meet somehow as equals, or at least I felt accepted as such. I always kidded Phil about wanting to join his "club" and every Convocation for years till I graduated to Senior counted down the number of years left.

When I became a Distinguished Life Fellow, it was truly one of the proudest moments of my career. I was joining the ranks of some wonderful, brilliant, talented psychiatrists and felt simply honored to be amongst them.

So, there I was; a new Life Fellow, now Senior, and eagerly awaited this because of the wonderful staff at the APA booth, the Assembly and the people I got to know there.

But what about the vast majority of younger colleagues who are not privileged to serve in the Assembly? Do they even know what Seniors do, how they became Seniors, or even want to know?

Sure, by virtue of age many automatically ascend to that status, but to get involved, (pay dues!) go to sessions given by Seniors, is there an interest?

I think APA has missed the boat here! I think there should be wider dissemination of what we are all about, not just some old folk looking for a purpose, but a brain trust of enormous potential to benefit the organization as a whole.

I propose a survey by mail, or email, or through an article in Psych News asking members their opinions. Some examples of questions: do you know what Senior status is all about? Do you think dues should be paid? Should there be a role in APA governance ? I am sure there many other questions that can be generated. Some answers may be very well known, but I submit that there is a whole new generation or two (or three) who may not see any value in something about which they know very little. Maybe they are right! I hope not.

Maybe we should even do such a survey on our own Senior membership (dues paying, non dues paying).

So, dear fellow Fellows (I still like the term Lifers, sorry), what should we do to encourage APA to do more to help us out: Anything, nothing, something in the middle.

Meanwhile, my Senior brain has run out of ideas but I hope not enthusiasm.

Maybe some of us should have a drink or go to dinner in Atlanta to discuss this further....Anyone want to plan that?

PSYCHIATRIST'S CAMERA

Dr. Nada Stotland Travels to Myanmar

Golden Pagoda

Floating Farm

Keeping his hands free for fishing

Buddhist Temple Complex

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I recently returned from a psychiatry-themed trip to Myanmar: the country we seniors may remember by its colonial name, Burma. As you know, Myanmar was essentially closed to the outside world for decades. That makes it a special place to visit today. On the streets of Myanmar, unlike those almost everywhere else in the world, American chain fast-food restaurants are rare. Instead, there is tasty food deriving from Myanmar and the many neighboring countries. There are markets where farmers sell a huge variety of fruits, vegetables, meats, and prepared food--and handicrafts that make perfect gifts and souvenirs.

Butterfly Costumes

Largely Buddhist Myanmar has preserved pagodas, temples, and artifacts dating back many centuries. There are thousands of statues of Buddha, from small to enormous. There is beautiful scenery. We spent a couple of days in luxurious hotel rooms on stilts in a lake, zooming around in long teak canoes powered by outboard motors, passing fishermen who stand in their canoes and row with their legs. Everywhere, local residents were friendly and helpful.

Not surprisingly, many of us on this trip were 'seniors'--not surprising because our careers and family obligations may allow us some long-anticipated travel at this stage. I'm writing now to report on another opportunity that may appeal to us. The Dean (or "Rector") of Myanmar's major medical school, Dr. Zaw Wai Soe, made a request/invitation. There is little or no organized psychiatric education for medical students and other trainees in Myanmar. They would love to learn from us, either by visiting our psychiatric programs and facilities or paying our way to Myanmar to spend a week, or several, providing intensive psychiatric education there. Either would be a rich and exciting experience.

Baby Eggplant

Evolution of APA Conventions Over 4 Decades

By Henry A. Nasrallah, MD, DLFAPA,
Saint Louis University School of Medicine
Sydney W. Souers Professor
Chair, Department of Neurology & Psychiatry

For all of us APA lifers, the annual pilgrimage in May each year to the APA Convention has been the perpetual thread that brings us together for education, connection and reunions. In May 1974, I attended my first APA meeting as a PGY3 resident to present the data of my IRB-approved research project (plasma CPZ levels and clinical response). The venue was in Detroit at Cobo Hall, but never again did the APA return to the Motor City. It was a thrilling experience for me as I witnessed the myriad educational offerings, multiple social gatherings and the impressive organizational complexity. I was proud to be a member-in-training. Over the next 41 years, I never have missed a single annual meeting and always gave at least 1 presentation and sometimes up to 8 at the same meeting. When Garry Vickar invited me to write an article for the Newsletter, I decided to reminisce with you, my fellow lifers and colleagues, about the remarkable evolution in the various aspects of the APA Annual Meeting over the past 4 decades.

1. Science:

The past 4 decades witnessed a massive change in topics, from psychosocial issues to psychopharmacology, neuroimaging, neurobiology and neurogenetics. The diversity of topics is still there but the emphasis shifted dramatically. This is reflected in the lexicon of the psychiatry over the past 40 years which I discussed in one of my editorials (1).

2. Handouts:

Attendees used to receive a thick printed syllabus of the abstracts of all presentations. Over the past decade, the APA stopped printing the syllabus and provided a CD of the abstracts for a few short years and then stopped that as well and provided an online website. In addition, the attendees (and non-attendees) were encouraged to purchase the recorded portions of the meeting on a flash drive for a hefty price after the meeting.

3. New Research Sections:

The APA introduced this section in the 1970's and I recall the first "pamphlet" containing about 16 abstracts (one of which was mine when I was an NIMH research fellow). Over the years, the New Research abstract book grew to hundreds of abstracts, including a substantial number of industry clinical trials data as well as secondary analyses. Those abstracts are now available only online.

4. DSM:

At my first meeting in 1974, the chaotic DSM-II was the diagnostic "Bible" of Psychiatry. The APA launched the "disruptive" diagnostic approach of DSM-III in 1980, the revised DSM-III R in 1987, the DSM-IV in 1994, the DSM-IV TR in 2000 and DSM5 in 2013. Each of the editions was met with loud skepticism and even vicious attacks (especially at DSM 5), but all were eventually accepted by practitioners. The RDOC/DSM-5 skirmish at the time of launch was certainly an awkward moment (2).

5. A-V Equipment:

The audio-visual logistics are a key component of the annual meeting, and it underwent drastic changes mirroring the technological advances of the computer revolution that began in earnest in the early 19080's. Left behind was the clunky (but sentimental) carousel with a wire and an advancer, boring black and white slides constructed by a special lab (which were not updatable without the costly construction of new slides). The computerized power point and other software made the old set-up look like the stone-age,

producing eye-catching, animated color graphics that we could only dream about in the 1970's. Better A-V certainly jazzed up that of these presentations, although some presenters never upgraded their monotonous delivery…

6. Industry-Sponsored Symposia:

Those large 3-hour CME symposia were a staple of the annual meetings for many years until about 10 years ago when they were abruptly discontinued by the APA. They were very well-attended (600-1000 people_ and featured the latest psychopharmacology topics, and provided breakfast, lunch and dinner as well. There were enough of them (up to 40 over 6 days) that some scheming meeting attendees did not have to purchase meals for about the entire meeting! However, the anti-industry sentiments (including criticism of the APA by a prominent politician) prompted the APA to discontinue those CME symposia although tie contributed millions of dollars to the APA coffers. I recall some of the symposia tended to focus on the products of the industry sponsor but many of those symposia featured distinguished national experts with excellent objective updates.

7. Industry Receptions:

Many lifers may remember the very lavish receptions sponsored by various pharmaceutical companies throughout the APA meeting. I recall when the entire campus of Disney World in Anaheim was reserved for APA members by one of the companies, along with a sumptuaries food selection and open bar. However, I also recall many embarrassing moments of attendees physically fighting over some food items or getting too inebriated. Those extravagant affairs were discontinued about 2 decades ago (and good riddance!).

8. Exhibit Area:

The exhibit booths used to be shock-full of giveaways like pens, mugs, clocks, calculators, and recently published books [with onsite autographing by the authors] , along with food and drink. All those freebies eventually disappeared due to the tightening of policies by big Pharma itself, not just by the APA. This change greatly reduced the traffic in the once-teeming exhibit area, so much so that some of the attendees (and exhibitors) describe it as practically "dead".

9. The Submission Process:

In the pre-online era, all abstract submissions had to be made on paper forms provided by the APA, which had to be mailed (and later faxed) to the Program Committee. That was particularly cumbersome for multi-speaker symposia submissions, but we all cheerfully did it. We could never imagine how easy it will become when converted to online submission…

10. Attendees from Foreign Countries:

For many years, hundreds of non-member attendees from South America, Europe or Asia were invited by industry (who covered their entire trip expenses including the sky-high registration fees). I noticed that their activities were structured so they attend specific symposia sponsored by the company, and most of them were more interested in sight-seeing than in attending scientific sessions! This has dwindled significantly in recent years.

11. Mother's Day:

Last but not least, the timing of the APA convention was a controversial one for decades. It always overlapped with Mother's day [second Sunday in May], depriving many psychiatrists from celebrating the day with their moms or wives [or taking them out to dinner]. Finally, about a decade ago, that "maternal conflict" was resolved! However, another dilemma lives on: May is well known to be the highest suicide month in the year, and it is ironic that psychiatrists are out of town exactly when their patients need them the most! I am not sure the APA will move its annual meeting to another month…

I hope you enjoyed those reminiscences about the APA convention over the past 4 decades. If you have some interesting memories or comments about the APA meetings, please send them in to the Newsletter.

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Overview of the International Classification of Diseases,

10th Revision, Clinical Modification (ICD-10-CM)

By Roger Peele, MD, DLFAPA

On October 1, 2016 the ICD-10-CM went into effect. I thought that a historical overview of the ICD would be of interest. Toward the end of the 19th century, an international organization decided that it was important for the world-wide medical community to adopt a nomenclature with codes that would be used by all to facilitate communication about illnesses from country to country. It was hoped that a new version could be published every decade. In the listing below, you will see that psychiatry did not have its own conditions in the book until ICD-6 because the first five ICDs only listed fatal conditions. Of course, psychiatrists treated many lethal conditions, such as tertiary syphilis, but those disorders were regarded as part of neurology.

In 1968, with the ICD-8, the United States adopted an "amplification" of the ICD and this has continued ever since. The major amplification of ICD-10 is called the ICD-10-CM (Clinical Modification) and it contains four characters. Canada's amplification is ICD-10-CA.

At times, the U.S. has decided it wanted an amplification. For example, Manic episode without psychotic symptoms is "F30.1" in ICD-10, but ICD-10-CM expects a fifth character to explicate if the episode is Mild [F30.11], Moderate [F30.12], severe [F30.13], or an Unspecified [F30.10] Manic episode without psychotic features. Using just ICD-10's "F30.1" on a billing submission, I gather will be rejected. That is, one will have to use the ICD-10-CM designation.

Why the 23 year delay after ICD-10 was published? First, it takes a few years to develop a CM. But twenty year delay in implementing ICD-10-CM was partially because of concerns about the additional costs of the first character being a letter rather than a number. A second reason for the postponement was the concern about the increased granulation in some medical specialties. A broken radius bone, for example, has 1,800 different possible codes (!). For psychiatry, the number of codes expanded some, but nothing like the expansion in orthopedics or dermatology.

If the County becomes interested in improving ICD-10-CM, I have listed the author of ICD-10-CM's below, NCHS. In theory, anyone can send a recommendation to NCHS. But we have heard informally that NCHS will only consider recommendations coming in from a professional organization. If the County wants to make a change to or addition to the mental health part of the book, we would probably want to approach the Washington Psychiatric Society and hand them the football to pass on to medical organizations.

ICD-1	1900
ICD-2	1910
ICD-3	1921
ICD-4	1930
ICD-5	1939
ICD-6	1949 [the first ICD to contain psychiatric entities]
ICD-7	1958
ICD-8A 1968	[A = Adapted for use in US]
ICD-9-CM	1979 [CM = Clinical Modification for US]
ICD-10 1992	[Yet to be used in US except to report deaths]
ICD-10-CM	Release took place on October 1, 2015
ICD-10-CM's	Chapters of special interests of psychiatrists:

- **Chapter 5:** Mental and behavioral disorders [entities begin with letter "F']
- **Chapter 6:** Diseases of nervous system [entities begin with letter "G"]
- **Chapter 18:** Symptoms, signs, and abnormal clinical and laboratory findings not classified elsewhere. [Entities begin with the letter "R"] Examples: Auditory hallucinations: R44.3; Dyslexia: R48.0
- **Chapter 19:** Injury, Poisoning and Certain Other Consequences of External Causes [entities begin with "S" or "T" Examples: Concussion with loss of consciousness of 30 minutes or less: S06.0X1; Child neglect, confirmed, initial encounter: T74.02XA
- **Chapter 21:** Factors influencing health status and contract with health services. [Entities begin with the letter "Z" Examples: Homelessness: Z59.0; High expressed emotional level within family: Z63.8

  ICD-11 2017 (?)

  ICD-11-CM [some say after 2020]
- ICD-11-CM may use prototype matching for all medical conditions, as can be found in the Merck Manual and may not use criteria sets. If so, we would go back to the style of DSM-I and DSM-II, but more specific definitions than those two in order to preserve recent DSM's reliability.

Retaining & Discarding Psychiatric Records

By **Professional Risk Management Services, Inc. (PRMS)**

It should go without saying that a patient record exists for a reason — it exists *primarily* to support good patient care. A good patient record accomplishes several things: It substantiates clinical judgment and choices; it demonstrates the knowledge and skill exercised during treatment; it provides a contemporary assessment of the patients' needs and behaviors; and it documents explanations of the provider's decisions, significant events, and revisions to the treatment plan. In short, it allows someone else (e.g., another physician) to know and understand what has happened during treatment and why.

A secondary benefit derived from a good patient record is the ability to provide a defense in an adversarial situation such as litigation or an administrative or ethics complaint. The importance of patient records in these types of situations cannot be overemphasized.

Retaining Records

How long should records be kept? There is no clear answer. Due to the variety of statutes, regulations, legal principles, and professional obligations affecting psychiatric records, the best risk management advice dictates that records should be kept for as long as possible. The safest and most conservative option is to keep records indefinitely. Perpetual maintenance may seem excessive, but there are many reasons your records may be needed in the future. If records cannot be kept indefinitely, they should be kept as long as possible.

How long am I "legally" required to keep records?

Many states have statutes and/or regulations governing the creation and maintenance of patient

records, including the time period for which records must be kept. Federal statutes and/or regulations may also address record maintenance. The time periods mandated in these statutes and regulations represent the length of time you are "legally" required to keep patient records, at a *minimum*.

In addition to statutory and/or regulatory requirements, there may be contractual obligations regarding record creation and maintenance in provider contracts, both explicit and implicit. Frequently, provider contracts include provisions mandating how long records must remain available to patients and insurance companies. If a contract requires you to keep records for a different amount of time than is laid out in the relevant statutes and/or regulations, then you should keep the records for whichever time period is the longest, at a minimum.

Absent explicit requirements, records should be kept *at least* until well after your state's statute of limitation for medical malpractice actions and/or statute of repose have run. The statute of limitations laws and/or the statutes of repose establish the time period during which a legal action may be brought against you. However, you cannot absolutely rely on these statutes to protect you from litigation. Depending on the nature and wording of a complaint, an action may be brought against you even though it is not brought within the limitation periods. In addition, statutes of limitations or repose do not apply to disciplinary actions by licensing/medical boards or to ethics proceedings. Professional complaints may be made against you at any time.

Why should I keep records indefinitely?

1. Continuity of Care

One of the most important reasons for retaining records is continuity of care. Patients may receive care from a patchwork of healthcare providers over time, and the psychiatric records may be necessary to ensure that patients continue to receive the care they need. Patients who find that they are unable to obtain their medical information whenever requested can initiate complaints with professional and licensing bodies. Increasingly, medical boards and state/federal regulators are starting to insist that patient records be available *whenever needed*.

2. Potential Lawsuits

Another reason records may be needed is litigation. In a legal proceeding against you, the record is the primary means of supporting and defending the care that was given. As mentioned above, your state's statute of limitations laws and/or statutes of repose exist to limit the time period during which an action may be filed, however there are exceptions to these statutes. For example, state law usually also contains provisions for "tolling" the statute of limitations in cases where the patient (i.e., prospective litigant) is a minor or suffers under some other legal disability or incompetence. This means that for some patients, the time in which a suit can be filed is extended.

Additionally, your state's statutes of limitations that limit the time during which malpractice actions may be filed against physicians may not limit the time litigation resulting from allegations involving fraud, conspiracy, or criminal acts may be brought against you. Furthermore, these laws are not applicable to professional and ethical complaints or allegations involving federal laws, rules, and regulations (e.g., Medicare billing complaints).

3. Other Situations

There are other situations in which a record may be needed, besides defending you. For example, a patient may need the record to support his case against another individual (e.g., another healthcare professional or an employer) or to back-up a claim for disability benefits. Custody proceedings are another common example.

How do I store records?

Records should *always* be stored somewhere safe and secure, and should be accessible only to authorized individuals. All psychiatrists are ethically obligated to keep the psychiatric record secure. There may also be legal requirements under state law, as well as federal law. For instance, per HIPAA's privacy and security regulations, covered providers must comply with standards to ensure security and prevent unauthorized disclosure. Remember that the duty to maintain the confidentiality of patient records does not diminish over time, nor does it cease to exist upon the death of the patient.

Should you choose to keep your records indefinitely or for an extended period of time, you may want to consider using a professional records storing company. Such companies may be found online or through the records department of the local hospital or medical society. Your personal attorney or accountant may also be able to suggest a company.

If a storage company is used, it should have experience handling confidential medical information, guarantee the security and confidentiality of records, and allow access by authorized individuals. You should have a written agreement with the storage company. Topics which should be addressed specifically in the written agreement include but are not limited to confidentiality and privilege, release of information, time in which it will take to retrieve records, and destruction of information. If you are a covered provider under HIPAA's Privacy Rule, you will need a "Business Associate Agreement" with the storage company. All contracts should be reviewed by personal counsel.

Discarding & Destroying Records

If, after careful consideration, you do decide to discard and destroy patient records, there are some important considerations to keep in mind. Primarily, you should develop and implement a retention schedule and destruction policies and procedures. Records involved in open litigation, investigation, or audit should not be destroyed.

How do I discard & destroy records?

Should you choose to discard and destroy records, it is *imperative* that you establish and follow written policies and procedures for doing so. Following an established procedure may help to mitigate potential allegations that a record was destroyed in order to conceal unfavorable information. It cannot be guaranteed to protect you from situations in which you need the record; the absence of a record is problematic in any type of proceeding.

Some jurisdictions require that you notify patients that their records will be destroyed. Even if not required, notifying patients is always prudent. Patients may want copies forwarded to them or their current physician for future use. Remember to always obtain a proper release authorization prior to releasing any information.

Destroy *completely* all records and copies of records selected for discarding. Different media require different methods of destruction: shred, burn, or pulverize paper records; recycle or shred microfilm or microfiche; purge and destroy computerized records. Whatever method is used, ensure that third parties cannot discern or reconstruct patient information from destroyed records.

Retain a log of what records were destroyed, how and when they were destroyed, the inclusive dates covered, what method of destruction was used, a statement that the records were destroyed in the normal course of business, and the signatures of the individuals supervising and witnessing the destruction. Maintain destruction documentation permanently.

In addition, you may want to consider keeping an abbreviated patient record containing basic information, including the intake form, dates of treatment, diagnosis, release of information forms, termination forms, and case summaries, etc.

Who else can I contact for information?

For additional information on retaining and discarding records, contact your state medical board, your local medical society, your local APA district branch, and other professional medical organizations to which you belong. The American Health Information Management Association (AHIMA), a professional healthcare information organizations, is an invaluable resource.

Below are some risk management tips regarding retaining & discarding psychiatric records.

DO review and be familiar with statutory, regulatory, and contractual obligations regarding records creation, retention, and discarding. In addition to federal law, including HIPAA, most states have statutes and/or regulations governing the creation, maintenance, and discarding of patient records. Even when such

requirements are absent, it is the standard of care to create and maintain a record for each patient. The safest and most conservative option is to never destroy patient records.

DO understand that you cannot absolutely rely on your state's statute of limitations for medical malpractice or the statute of repose to protect you from legal actions. Depending on the nature and wording of a complaint, a legal action may be brought against you even though it is not brought within the limitation period.

DO understand that the records of minors and patients with some other legal disability or incompetence may fall under statutory tolling provisions. This means that for some patients, the time in which a suit can be filed is extended.

DO understand that your state's statutes that limit the time during which malpractice actions may be filed against physicians would not be applicable in litigation resulting from complaints or allegations involving fraud, conspiracy, criminal acts, or federal laws, rules, and regulations. For example, your state's statute of limitations laws would not apply to allegations of Medicare billing fraud.

DO remember that there is no "statute of limitations" or "statute of repose" for disciplinary actions by licensing/medical boards or for ethics proceedings. Absent state and/or federal or contractual requirements, legal experts advise keeping records indefinitely and, at a *minimum*, until well after your state's statute of limitations for medical malpractice and/or statute of repose have run.

DO keep records somewhere safe and accessible only to those who have authorization.

DO consider using a professional records storage company. Since you are responsible for ensuring the confidentiality of your patients' records, make sure that the records storage company agrees to protect patients' confidentiality in your agreement/contract with the company. If you are a covered provider under HIPAA's Privacy Rule, the confidentiality agreement with the records storage company is a "Business Associate Contract," containing all the elements required under that regulation.

DO develop and implement a retention schedule and written policies and procedures for destroying records. Following an established procedure may help to mitigate future potential allegations that a record was destroyed in order to conceal unfavorable information. It *cannot* be guaranteed to protect you from situations in which you need the record.

DO NOT destroy records involved in open litigation, investigation, or audit.

DO destroy completely all records selected for discarding. Different media require different methods of destruction. Ensure that third parties cannot discern or reconstruct patient information from destroyed records.

DO retain a log of the destruction. Include information about what records were destroyed, how and when they were destroyed, the inclusive dates covered, what method of destruction was used, a statement that the records were destroyed in the normal course of business, and the signatures of the individuals supervising and witnessing the destruction. Maintain destruction documentation permanently.

Additional Resources:

American Health Information Management Association (AHIMA): www.ahima.org

American Psychiatric Association (APA): **www.psych.org**
American Medical Association (AMA): **www.ama-assn.org**
American Hospital Association (AHA): **http://www.aha.org**

Compliments of PRMS
www.psychprogram.com

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Oxford Loebel Lectures and Research Programme

The Oxford Loebel Lectures and Research Programme (OLLRP) form an interdisciplinary scientific and philosophical project dedicated to exploring and explicating the causal and conceptual links between the biological, psychological, and social factors that contribute to mental processes, mental health, and in particular mental illness. Its aim is to lay the ground work for a unified theory that can form the basis for clinical work in psychiatry. The first two of the three Annual Lectures planned were presented by Professors Kenneth Kendler and Stephen Hyman respectively.

The field of psychiatry uncomfortably spans biological and psycho-social views of mind and behavior. As a branch of medicine, psychiatry has long been under pressure to conform to the sort of reductive, biological model that has traditionally defined medicine. According to this biomedical model, diseases are characterized primarily in biological terms (e.g. genetic influence, molecular changes in the body's organs, abnormalities detectable via blood tests, MRI scans, etc.) As well as being a branch of medicine, however, psychiatry draws heavily on the psychodynamic tradition. This makes no reference to the biological underpinnings of mental life, concerning itself instead with psycho-social elements. Patients' mental distress, on this approach, is explained with reference to life experience and treated by reflecting on past experience and current feelings in psychotherapeutic treatment.

The biomedical approach and the psychodynamic approach ought to inform and complement each other—after all, both aim at understanding the mind, and each contributes something unique and important to this understanding. However, historically, this has not happened. With no theory creating global, systematic links between the two approaches, psychiatry is divided between those clinicians who adopt a psychodynamic view of the mind, those who take a biomedical approach, and those who subscribe to an uneasy eclecticism under the rubric of the biopsychosocial model.

Generally, however, the latter view involves little more than an acknowledgement that biological, psychological, and social factors are relevant to understanding mental illness. It has been criticized both for failing to specify how mental illnesses may be diagnosed and characterized in biopsychosocial terms, and for failing to provide directions for treatment (McLaren 2006, 2007; Ghaemi 2009).

The term 'biopsychosocial' was first introduced by the psychiatrist George Engel, building on the work of Adolf Meyer (1917). Engel (1977) drew upon general systems theory—according to which the various ways of conceptualizing the mind (biological, psychological, social) form a hierarchy, with some laws and principles applying only within a level and others applying to the system as a whole—to envisage a holistic way of understanding and scientifically studying the mind. In recent years, evidence for interactions between these levels has begun to emerge. For example, progress has been made in understanding how the brain changes at the cellular molecular level when we learn and retain information (Kandel 2001); the relationship between genetic factors, life events, and psychiatric disorders (Nemeroff and Vale 2005); the neural basis of mental illnesses (Andreasen 1997); the effects of psychotherapy on the brain (Gabbard 2000); the neuroscience of free will (Haggard 2008); and how to characterize mental illnesses in biopsychosocial terms (Kendler 2012).

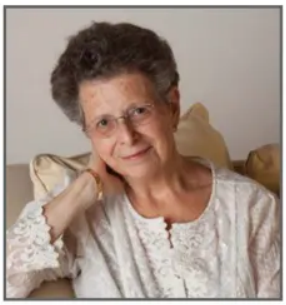
The Oxford Loebel Lectures and Research Programme will present the best evidence of interaction between the biological, psychological, and social factors that contribute to mental illness, and philosophically analyze the conceptual relationships between these. Its aim is to strengthen the biopsychosocial approach to psychiatry such that it is able to provide a coherent basis for further research and clinical decision-making. The project is motivated by the aphorism ascribed to Hippocrates translated as 'it is more important to know what sort of person has a disease than to know what sort of disease a person has'. Thus, while the reductive, biomedical approach will always continue to be useful, we anticipate that it will come to be seen as one component of a biopsychosocial view and methodology.

The Oxford Loebel Lectures and Research Programme were established in 2013 through the generosity of Dr. Pierre and Mrs. Felice Loebel. Dr. Loebel's concerns about the theoretical basis of psychiatry have been formed during a career of over forty years as a psychiatrist.

ORAL HISTORIES

Interview with Nada Stotland, MD, MPH

By J. Pierre Loebel, MD



Interviewee Nada L. Stotland, MD, MPH

What was the most influential experience/teacher/book(s) that directed you to psychiatry?

My mother was fascinated by psychiatry and very envious of psychiatrists. One of her best friends was the secretary of the Director of the Psychoanalytic Institute.

What was your most influential training experience?

My most influential training experience was realizing that 'behavior modification' and psychoanalysis had more in common than either acknowledged.

How if at all would you change present training in psychiatry?

I'm not current enough to say.

What were/are the most satisfying aspects of your work?

- Seeing patients improve
- Teaching students, residents, and other physicians
- Enjoying my colleagues

The least?

- Realizing that many psychoanalytic precepts were entrenched but unproven
- Dealing with a few unscrupulous and destructive colleagues

How has the profession influenced you personally?

- It has enabled me to have a varied and stimulating career while earning a good living
- My two training analyses freed me from much suffering and inhibitions.

What are the chief differences in psychiatric theory that you perceive between now and when you entered practice?

- Evolution away from parent-blaming.
- Recognition of fascinating synergism among brain, mind, and behavior

In clinical work:

- Minimal health insurance coverage for patients
- Minimal available inpatient care
- Profusion of 'med checks'

Do you regard the current theory and practice of psychiatry as mindless or brainless?

Only for some of us.

What do you regard as the greatest challenges and opportunities facing psychiatry today?

See above: too little time for understanding and treating each patient

Are there any professional (or related) activities that you have engaged in after retirement (if applicable)?

I haven't retired but am doing much less of the same things.

What are your interests outside your professional work?

Family, music, needlework, learning

If you were not a psychiatrist what would you do?

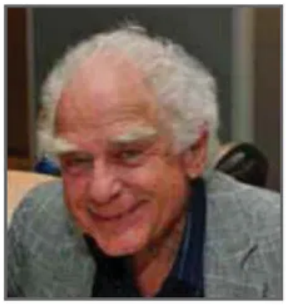
Family or public interest law?

What is the most important advice you would give a physician or medical student contemplating entry into psychiatry?

- Get lots of mentoring
- Question orthodoxy
- Have an open mind
- Never undervalue psychiatry
- Enjoy

Other comments?

Thank you.



History Project

By J. Pierre Loebel, MD

I have for some years conducted interviews with older psychiatrists who are members of the AAGP and the Lifers (now Senior Psychiatrists, Inc). I have adapted the format from similar interviews that have regularly appeared in The Psychiatrist, published in conjunction with the British Journal of Psychiatry. The interviews are not intended or designed to provide a detailed record or analysis, but to capture some of these persons' professional experiences, especially as they have changed during their careers.

The process is explained to the interviewee and signed consent obtained. Following the interview which originally was recorded and lasted about 1 hour, it was transcribed, edited, reviewed by the interviewee and submitted for publication in the LifersLine, then posted on the website.

It has been decided to replace this process by a brief phone introduction, followed by the completion of a questionnaire and consent form. The follow-up phone call will provide the opportunity for additional comments.

I will edit the completed questionnaire and submit it in the form of an article to the editors of Senior Psychiatrist for approval. This is a great opportunity to assimilate the experiences of senior psychiatrists and there will be value for teaching and research.

If you would like to be considered for an interview, please contact **admin@seniorpsych.org**.

Interview with Leah Dickstein, MD

At the time of the interview, Dr. Dickstein gave her age as "eighty-one and a third."

By **Nada L. Stotland, MD, MPH**

Interviewee Leah Dickstein, MD

Leah Dickstein was born in Brooklyn, the older by six years of two daughters, into a close-knit extended family. Her mother had gone to teacher's college, but was working in a bakery. Her father was an immigrant to the United States. After he dropped out of City College, they met and married. When Leah was eighteen months old, she developed whooping cough. Cradled in her grandmother's arms, she was taken to Kings County Hospital, where she spent three weeks. When she was two years old, in 1936, the national financial depression threatened the ability of her grandparents to keep their house. Therefore she and her parents moved in with them. There was one bedroom for little Leah and her parents, one for the grandparents, one(without windows)for her two aunts, and a sofa in the living room that provided a bed for new immigrants while the family helped them adjust to the United States. Her grandmother, who was shorter than five feet, did all the cooking for the close family. (When circumstances moved Leah and her husband to Louisville, Kentucky, years later, the loss of nearby family was a painful one.)

When it was time for Leah to start kindergarten, her parents moved to a first-floor walkup across from Kings County Hospital so that she could go to school. Tradesmen, including the local butcher, helped her cross the street on her way to and from school. During elementary school, she skipped a grade. She wore hand-me-down clothes from her mother and aunts. There was only enough money to provide two new pairs of shoes a year: at the Passover and Rosh Hashanah holidays. Leah was the president of the Girl Guards and the editor of the school paper, but 'only' second in her class; she feels that she has always been 'second.' She took piano lessons. Her mother played and sang, her aunt played the violin; it was lovely. However, Leah was told to move her lips rather than singing with the group in school; apparently she wasn't good at keeping to the tune.

The family had no car. Once every six weeks, with her baby sister in the stroller, Leah and her mother walked a long distance to the public library. Leah wanted to read all the time. She borrowed big, fat books to tide her over the intervals between library visits. At night, she put a lamp under her blanket(without the shade)in order to read, but changed to reading in the bathroom at night after the bed began to smell of smoke from the lamp. In the summer, Leah slept on the fire escape, where it was cooler than in the apartment. Unfortunately, the fire escape was across from the polio unit at the hospital, and she could hear the children in iron lungs crying. A psychiatrist from Downstate Medical Center noticed Leah and invited her to play with his daughter in their mansion across the street. Once she and her first (and continuing) friend Gwen sold lemonade outside the hospital for three cents a glass.

While her father served in the Navy during World War II, Leah's mother was depressed and diabetic, spending much of the day in bed, reading. Leah had to carry the milk bottles to and from the store and take care of her sister. Her father was sent to the South Pacific. The family did not hear from him for nine months, but he survived. When it came to junior high, Leah's mother wouldn't allow her to go to a school some blocks away. Instead, she went to Erasmus Hall High School, walking through the hospital across the street to get a bus or subway.

As the time for college approached, Leah dreamed of going to medical school some day, but medicine was not considered to be an appropriate aspiration for a "nice Jewish girl." She kept her aspirations to herself, but, in hopes of increasing her chances

to become a doctor, asked her father whether she could attend a private college. He answered that it was more important to rent a bungalow for the summer. She attended Brooklyn College, where Carol Nadelson was pre-med while Leah prepared for a teaching career. She had a job at the switchboard at her uncle's printing plant, earning $3 each Saturday as a copy holder while in high school. Herb Dickstein needed a date for New Year's Eve, and a blind date was arranged with Leah, a seventeen year old college freshman. (On the night preceding this interview, Herb baked Leah a cake to celebrate the 64th anniversary of the evening they met.

After college graduation, she and Herb got married and went to Ghent, Belgium, so that he could continue at the medical school. Leah had learned to speak French, and her Aunt Gladys got her a job selling bras wholesale. She had business cards and traveled all over Belgium, once getting an order from the largest store in Brussels. Their apartment was pleasant, but did not come with central heating. There was a water heater, which "only blew up once, scorching off my eyelashes." Herb filled the stove with coal each morning before leaving for medical school. In the winter, they moved the mattress from the bedroom to the living room. There was a toilet, but no shower; Herb got a big paint can and a hose so that they could wash themselves; after bathing, she threw the water out the back door. However, she declined to scrub the sidewalk in front of the apartment each day, earning the wrath of the neighbors. They had no telephone and, at first, no refrigerator. Leah kept the milk outside on the window ledge until they acquired a "little refrigerator." Their furniture came from the flea market. Occasionally her mother sent her a dollar in a letter. She attended a psychiatry class, earning no credit, but a diploma which is the only one she's displayed on the wall in their Louisville home. (She never hung a diploma in her office. She started a medical school elective on art and hung the students' art on her office walls.) When a Berlitz school opened, Leah was able to get a job teaching English. Earning 85 cents an hour, she had more students than anyone else.

After Herb finished medical school in Belgium, they moved back to New York City. Leah got a master's degree in education. For seven years, she worked as a schoolteacher; her students were children from public housing projects. There were forty in a class. Many of them had never even been on the subway. She took them not only on the subway, but to the Metropolitan Museum of Art, Yankee Stadium, and the United Nations, among other visits. Finally Leah decided to apply to medical school. Her mother couldn't understand why Leah had to be a doctor, since she was already married to a doctor. Her role models were Elizabeth Blackwell, Eleanor Roosevelt, and Jackie Robinson, whose dictum 'no one can make you feel inferior without your consent' was important. She was rejected by nineteen medical schools, but finally accepted at the University of Louisville when an accepted student turned out to have cheated. Herb was warned that if he left his job as a pathologist in New York in order to accompany her to Louisville, he would never be able to get a job in New York again. That was true, and they both spent the rest of their medical careers in Louisville.

When Leah began medical school, their son Stuart was twenty-two months old. There were few women role models; that was not easy, but some male members of the faculty were nice. Women patients assumed that she was a nurse and expected her to bring bed pans. A secretary who was African-American was tremendously supportive to Leah and successful in her own career; she went to law school and joined a large firm.

Leah graduated eleventh in her medical school class, completed a residency in psychiatry, and passed the examinations for board certification. She would have liked to undergo psychoanalytic training, but there was no psychoanalytic institute in Louisville; although being a psychoanalyst no longer carries the prestige it once did, her disappointment is still palpable. She spent two months at Maudsley Hospital in London, England, as a resident, but only psychoanalysts were allowed to treat patients. She started the mental health section of primary care at the University of Louisville and was director of student mental health, earning $20,000 a year. She treated more than 800 medical students, many residents, and other health center science students, giving each her home telephone number; never did one of her patients commit suicide. She still receives Christmas cards from one of them. Nevertheless, she was fired when the school decided that her salary was too high. She became the medical school Dean of Student Affairs, then the Associate Dean for Advocacy, originating many student programs.

Outside of the medical school, Leah developed rich interests, often focused on the rights and well-being of women. She started a chapter of the American Medical Women's Association at her kitchen table, invited Mary Jane England(an APA President), and eventually became AMWA President, testifying at the United Nations.
At one meeting of the American Psychiatric Association, a group of female members got together; Mary Jane England was the only one Leah knew. She met Alexandra (Allie) Symonds, who formed a new organization of women psychiatrists, of which Leah was the Secretary. Allie called twice a week and "changed Leah's life." Allie and her husband Marty, who worked for the Police Department as a world expert on domestic violence, were wonderful family friends as well. Leah and her family came to New York for the Thanksgiving Parade and slept in Allie's Manhattan office afterwards. They vacationed on Cape Cod, Marty caring for Leah and Herb's two younger sons while Leah and Allie strategized about preventing Bork from becoming a Justice of the U.S. Supreme Court.

Another major project has been her research on holocaust survivors, particularly women, who were treated differently than men. Not all targets of the holocaust were Jewish. Leah interviewed two hundred survivors in Israel, Poland, and elsewhere. She found ethical non-Jewish women who risked their lives to help Jews and were sent to concentration camps as punishment. Leah declares that "social justice is my middle name." She was enormously impressed by the courage of the survivors, and thinks it important that people are aware of the goodness, not only the badness, people manifested in those times; she documented her research in a book and has been invited to lecture widely on the subject.

Leah was raised, and raised her family, as a cultural Jew. They have belonged to the synagogue. Her sons had Bar Mitzvahs and learned to do housework; Leah has only had a maid twice and is a champion bathroom cleaner. Her sons are all wonderful to their very accomplished wives.

Now Leah and Herb live in Cambridge, Massachusetts, in the same building as one of their sons and his wife and children. They enjoy loving relationships with the whole family. Paul Summergrad, Chair of Psychiatry at Tufts, offered her a place on his voluntary faculty.

Looking back-and forward-Leah reports that she loved being a psychiatrist. She cherishes memories of the students she treated, some of whom keep in touch to this day. Having suffered frustrations and disappointments, as noted above, she concludes that one must "ignore stupidity and just keep doing the right thing. The most important thing is to be able to live with yourself."

Special Workshops at APA Annual Meeting

There will be two Senior Psychiatrists sponsored workshops at the APA Annual Meeting in Atlanta of special interest to our group.

The first will be a very entertaining presentation by Glen Gabbard, MD, titled "The Aging Physician: Possibilities and Perils". This will be Sunday, May 15th, 8:00-9:30 AM , at the Georgia World Congress Center, Building G, Level 2, B218.

Recent surveys of physicians indicate that late-career physicians, compared to those in early or mid-career, are generally the most satisfied and have the lowest rates of distress. Perhaps it is the profound gratification medicine offers physicians that makes aging a challenge. For many doctors trying to slow down or retire may equate with losing one's sense of purpose in life and even one's self image. Hence physicians frequently struggle with aging gracefully. In this session, the difficulties and gratification of the "golden years" will be discussed.

The second workshop is titled "Acknowledging and Accommodating Age and Ability" and presented by a panel including Paul Wick, MD, Norman Clemens, MD, Sheila Gray, MD and Nada Stotland, MD. This is scheduled Monday, May 16th, 11AM-12:30 PM, at the Georgia World Congress Center, Building G, Level 2, B403.

Many senior physicians practice medicine safely and effectively but there is a pivotal point where age and competence intersect. The presenters will explore ways that physicians and health care organizations may anticipate and prepare for late-career transitions that promote well-being and avoid unprofessional manifestations. Panelists will discuss ways to plan for retirement in a way that maintains integrity and promotes mental health.

ORAL HISTORIES

Interview with H. Steven Moffic, MD

By J. Pierre Loebel, MD

Interviewee H. Steven Moffic, MD,
Editorial board member of and regular contributor to Psychiatric Times. Retired Professor of Psychiatry & Family and Community Medicine at the Medical College of Wisconsin

What was the most influential experience/teacher/book(s) that directed you to psychiatry?

I've actually been asked this question frequently recently as I've begun to work on my work memoir, tentatively titled OETHIPAL: Trying to Stay on the Ethical Way, or Is It Trying to Get Off of the Oedipal Way!?

At that time, right after World War II and the Holocaust, most Jewish mothers in the USA wanted their son to be a doctor or a lawyer. Mine wanted her son, me, to be a doctor, in part to replace her beloved and brilliant older brother Herbert (who I am named after), who dead shortly after graduating medical school due to Hodgkin's Disease. Moreover, she herself had gradually worsening heart disease from rheumatic fever.

My father was a lawyer and preferred me to go into that field, which seemed to be one of the sources for our Oedipal conflict during my teenage years. My younger sister, Jo-Jo, did end up becoming a very successful lawyer, and my daughter Stacia is a career counselor and administrator in a law school. That was a partial resolution of the problem.

However, as it turned out, I never really liked the biological sciences, but I did love reading Freud, especially his The Interpretation of Dreams, which I read on my own in high school. When I found out that he was a psychiatrist, a medical doctor, that seemed to solve my career choice dilemma.

That choice was confirmed early in college at the University of Michigan, when I took a psychology class in 1966 with my muse and soon wife-to-be, Rusti, that centered on visits to a state psychiatric hospital. The despair, overcrowding, and needs were heartbreaking, sort of akin to the movie One Flew Over the Cuckoos Nest (which I happened to discuss at a recent annual APA meeting). Coupling that with the Jewish value of Tikkun Olam, trying to save the world, my path toward becoming a psychiatrist serving the underserved, was cemented.

What was your most influential training experience?

Perhaps it was a tie between a "positive" and "negative" experience, for both can have powerful educational influences.

I'd have to say that the positive one was a seminar series with Heinz Kohut, M.D. at his house during my psychiatric residency at the University of Chicago from 1972-1975. He was recognized as the chief theoretician of the school of self-psychology, which seemed to complement the depth psychology of Freud. This seminar experience was so fortunate because he spoke so much clearer than he wrote. Somewhere in my archives I have a transcript of these seminars. I still readily use what I learned then, as, for example, a recent Internet broadcast and interview on Love, Narcissism, and Narcotics on Valentine's Day and in our Presidential Campaigns. The self-psychology of narcissism, with the need to be mirrored or idealized, certainly seems relevant to some of our current candidates and their followers.

The "negative" finally became more obvious to me only in recent years, such is the power of repression and unresolved grief. For a Yom Kippur study session, I was asked to present the psychiatric view of suicide, or why would one want to take one's life when the holiday centers on forgiveness and asking to be put in the "Book of Life" for the next year?

The precipitation for this session was the recent suicide of a teenage Jewish girl. I decided to present my one case of suicide in order to make this come alive, so to speak, and convey some empathy to this family and other similar ones. This suicide happened early in the first year of my residency. An elderly, depressed man had walked into Lake Michigan after our second session, when I thought that he was improving after being put on an older anti-depressant. Little did I know then that some improvement could provide a depressed person with the energy to kill oneself.

I thought then, though, that this meant that I wouldn't be cut out to be a psychiatrist. Instead, the faculty was supportive, including saying that the patient was perhaps too depressed to be referred to a new resident. Then came the words of initiation: "many think that you are not a real psychiatrist until you have a patient who commits suicide". I never had another, despite always seeing high-risk patients.

As I got up to deliver my talk, all of a sudden I started to sob uncontrollably. I looked toward my wife for help, but she was far back. In the front row, though, a man softly said: "Relax and take a minute". That did it. I was able to continue and finish, but who was this man? I went to thank him, and it turns out that he was the father of the girl who had committed suicide! As we talked, I realized that I had never really grieved that loss, never even crying about it until then.

How if at all would you change present training in psychiatry?

Having spent almost all of my career in academic psychiatry, first at Baylor College of Medicine and then The Medical College of Wisconsin, I've watched as psychotherapy, at least psychoanalytic psychotherapy, has been devalued as psychiatrists do more and more psychopharmacology, though even that requires some psychodynamic expertise. We need to emphasize that training once again. I was most fortunate to begin when there was a combined emphasis on psychotherapy and medication, a combination that really only psychiatrists can do alone for many patients. Correspondingly, trainees are not expected to get their own psychotherapy during residency anymore.

Late in my career, I also came to see how an experience with those incarcerated can be invaluable. You have to be able to deal with manipulation, as well as learning how poor, young black males are being over-represented in prisons, which could be a mild version of apartheid, or what I have called apart-time. So many of them have underlying PTSD.

What were/are the most satisfying aspects of your work?

I've had the opportunity to lead and/or work in most all the major systems and settings in psychiatry. That includes managed care, for which I was called a Nazi and "evil" by a couple of prominent psychiatrists. So what's satisfying about that, unless one is masochistic? Eventually that led to being asked to write The Ethical Way: Challenges & Solutions for Managed Behavioral Healthcare (Jossey-Bass, 1997), the first on the subject and the first to be re-reviewed a few years back in Psychiatric Services due to its unfortunate continued relevance. This focus on ethics included related work, including leading various psychiatric ethics committees, writing ongoing ethics columns, and being designated "da man in ethics" by a former president of The American Association of Community Psychiatry.

Also satisfying was being the President of the American Association For Social Psychiatry at the turn of the new Millenia, being the Medical Director of a clinic processing those with gender identity challenges, and being honored as a "Hero of Public Psychiatry" by the Assembly of the American Psychiatric Association.

Nevertheless, my most satisfying was when my two children were asked to speak at a Workshop on The Children of Psychiatrists at our annual meeting of the APA in New Orleans. Both talked about their own careers of service in helping others. My son Evan has become a Rabbi, and a psychiatrist having a clergy child is much rarer than the other way around.

The least?

The least has to do with the increasing encroachment into patient care as the years went on. That included authorization denials by for-profit managed care companies, briefer and briefer med "check" visits, inadequate reimbursement, and the time diversion it took to document on electronic health records. Such changes were a major reason why I decided to retire from clinical care and my tenured professorship in July, 2012.

In addition, there were two major disappointments with bosses. One was convicted of buying and selling country mental health buildings. The other asked me to step down from my position as a requirement of his own stepping down. Both, though, asked for forgiveness before a Yom Kippur holiday.

On the other end of the spectrum, I had to ask for a young psychiatrist to be removed from his position under me, a psychiatrist I was mentoring, because he would not get treatment for his rapidly escalating bipolar disorder.

How has the profession influenced you personally?

How can you not learn more about yourself as a psychiatrist? And how can you not learn more about people and society, both from your psychological understanding, as well as the diversity of lives of the patients you see?

What are the chief differences in psychiatric theory that you perceive between now and when you entered practice?

The lessening influence of Freudian psychodynamic theory is well apparent to most everyone in the field. The same is true in the other depth theories of personality, including self-psychology and Jungian. Now, the theory, if you will, is more superficial and geared to how medications might work, including the very simplified explanation off "chemical imbalance". This change seems reflected,in the cookbook recipes for diagnosis in our more recent DSMs.

In clinical work?

The shift to 15 minute med checks has spread among our profession. That seems due to the influence of Pharma on us and their advertising to the public, as well as the power of managed care. There also seems to be less involvement of psychiatrists with group and family therapy.

On the plus side, there is a new and more successful resurgence of integrating psychiatry and psychiatrists into the rest of medical practice. I briefly had federal grants to do so in the late 1970s, but such funds dried out.

Do you regard the current theory and practice of psychiatry as mindless or brainless?

It not only seems mindless, but social less, environmental less, and spiritual less.

If you do mainly brief medication checks, then, as Dr. Steven Sharfstein has written and presented, psychiatry has become bio-bio-bio, rather than Dr. George Engels bio-psycho-social model, or like I and some colleagues prefer, a bio-psycho-social-spiritual model. For instance, I added the question, What Gives Your Life Meaning as the fulcrum for a brief med check. It also seems that as other medical specialties have become more humanistic, including such popular writers as the surgeon Sherwin Nuland and the neurologist Oliver Sacks, that we have become less humanistic. Where are our comparable writers and commentators for the public?

What do you regard as the greatest challenges and opportunities facing psychiatry today?

The greatest challenge may be to avoid the profession mainly becoming assembly line like psychopharmacologists. We also need to try to regain some of the leadership we've lost in various settings to other disciplines and business professionals, which I tried to address recently in the solicited article Ethical Leadership for Psychiatry for the new two volume book on Psychiatric Ethics for Oxford University Press. Of course, stigma continues to adversely affect the public and patients, as well as ourselves, and added to that is the anti-psychiatry movement of former disgruntled patients and families.

The opportunities, though, are extensive. Finally, we have some emerging tools to better investigate our well-protected brains, and if we can couple that with our older traditions, the field may become much more successful and renowned.

Are there any professional (or related) activities that you have engaged in after retirement (if applicable)?

Although I assumed that I would ride off into the sunset, so to speak, with my wife, and maybe to continue to write a bit, many surprising requests

started to come my way, as if I've become less stigmatized. That includes being asked to serve on community boards, discuss movie showings with the public, and presenting and writing even more than in the past. I continue to be the lead blogger for two publications, Psychiatric Times and Behavioral Healthcare, and will be involved in four presentations at our upcoming APA annual meeting.

A new major focus, with a new best friend and former emergency room physician, is physician well-being. We have about an epidemic rate of burnout, as it has continued to increase to an average of 50 per cent.

With an old best friend, we are putting together some of my blogs with his computer generated images for a model monograph of long-term friendship.

My advocacy is focused on addressing the psychological and psychiatric aspects of climate instability that threatens the future, including that of my grandchildren.

What are your interests outside of your professional work?

My wife and I have been fortunate to travel to many other countries, including South Africa, Southeast Asia, South America, Easter Island, Morocco, and Israel, some related professionally, but most for pleasure. This, though, dovetails nicely with my long-term focus on cultural psychiatry, including going to the countries of origin of many of the refugees I previously treated under federal and state grants.

I've also been able to spend more time doing my art collages. One of them, a photo collage of my wife, won a prize at an APA Art Association annual meeting exhibit.

My wife and I also go to several cultural events a week. I've also been able to have the time to read novels again, including for a book club, as well as Proust, so important and evocative writer for memoir writing.

Perhaps most importantly, we have more time to spend with our four grandchildren, 13, 11, 9, and 7, who live nearby. As a grandparent, you can see more clearly the interaction of temperament and nurture. I've presented on how grandparents can gift values to their grandchildren, among other things.

If you were not a psychiatrist, what would you do?

I've loved jazz just about as long as I've loved psychiatry. I've written jazz record reviews in the past under the moniker Dr. Jazz. Not only do I love the music itself, but jazz seems to be a metaphor for improvisation and working together, especially in diversity and integration, in life. So, perhaps, I'd do something much more extensive in jazz.

What is the most important advice you would give a physician or medical student contemplating entry into psychiatry?

I'd give, as I do, a message that although the field is still stigmatized, there is little more rewarding than helping one recover from whatever is making their brain function less than optimally and comprising who we are as a person. Moreover, what you learn in psychiatry can pertain to so much else in the world.

Other comments?

Soon after I "retired", I was surprised to find myself so much lighter emotionally, as if I didn't realize how much our work was taking out of me. Now others have also noticed how much more available I am emotionally to them and to what is going on around me. Given that, I'd suggest all younger psychiatrists to watch for burnout building up and to save up for retirement if possible, even though we usually can practice until late in life.

HELP THE FUTURE WORK OF OUR ORGANIZATION

Senior Psychiatrists is now a 501(c)3 organization which allows your contributions to be deductible as a charitable contribution. Previously known as the Lifers of APA, Senior Psychiatrists was separately incorporated in Maryland and was notified by the Internal Revenue Service on November 13, 2014, of its status as a 501(c)3 organization.

Senior Psychiatrists is the organization specifically formed to meet the particular needs of psychiatrists at this stage of their professional career whether they are retired, partly retired or fully in practice. It will meet those needs by:

- Educational activities at APA meetings
- Educational articles in its magazines and website
- Other informational resources relevant to members
- Representation and education regarding the needs of senior psychiatrists at the APA Assembly

The organization needs your support to carry out its mission. It is dependent on the support of contributions from members, corporations and other individuals.

Help the work of Senior Psychiatrists by making a contribution today! All contributions are tax deductible to the fullest extent allowed by law. You may use the form below for your donation.

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