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PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

ISSN 0033-2704

Altha Stewart, M.D. (right), will become president-elect of APA at the end of APA's Annual Meeting in May, when Anita Everett, M.D., becomes president.

Full election results appear on page 35.

Stewart Chosen APA's Next President-Elect

APA members have selected the current secretary as the next person in line to hold APA's highest elected leadership position.

BY CATHERINE F. BROWN

APA's voting members have selected Altha Stewart, M.D., of Memphis to become APA's next president-elect. Stewart ran against Rahn Bailey, M.D., of Winston-Salem, N.C.

Stewart, currently APA's secretary, is an associate professor of psychiatry and director of the Center for Health in Justice Involved Youth at the University of Tennessee Health Science Center in Memphis. Her career has spanned three decades of public sector administration, including director of public behavioral health systems in Michigan, New York, and Pennsylvania.

Bailey is the executive director and chair of the Department of Psychiatry and Behavioral Medicine at Wake Forest School of Medicine. Highly involved with APA since 1995, he is the chair of the Membership Committee and the black psychiatrists representative to the Assembly Committee of Representatives of Minority/Underrepresented Groups.

Stewart is the first African American to be chosen for APA's presidency in its 172-year history.

"Much is being made of the historical nature of this election," Stewart told *Psychiatric News,* "so of course I feel a certain sense of obligation as the first elected president whose identity represents the intersection of race and gender to facilitate discussions in the organization regarding those issues. Hopefully that will inform some of the decisions we make during my term in ways that will further APA's goals in the areas of diversity and inclusiveness."

Asked about what she expects to be her major priorities as APA's president, she responded, "I believe we must identify opportunities for APA to work on addressing the disparities in patient care and physician compensation facing those we serve and the profession. The uncertainty about the future of the Affordable Care Act must be closely monitored by APA to assure we oppose any loss of the gains achieved for psychiatric patients with its implementation."

To meet these challenges, she said, APA needs to continue building and maintaining coalitions with other stakeholders, including patients and families and other medical specialty organizations.

Noting that the future of psychiatry depends on its young members, she aims to engage with resident-fellow members and early career psychiatrists to assure their full participation in the organization and create a path to leadership succession that secures the future of the field.

Stewart is mindful of the many concerns that APA members have in this changing political and economic environment and the need to take vigorous action. Among the issues she will be putting on the front burner are the "significant financial and time burden of the current MOC requirements, physician burnout, the need for less restrictive regulations, implementation of full parity, the need for APA to address mental health issues related to climate change, and patient concerns/reactions coming into treatment settings that are related to

see ***Election Results*** *on page 35*

Courts Block Two Proposed Giant Health Insurer Mergers

Two district court rulings seem to put a halt, at least temporarily, to the trend toward increasing consolidation in the insurance industry, a trend that APA has seen as threatening to competition and patient choice.

BY MARK MORAN

Two rulings by the District Court for the District of Columbia have blocked the Aetna-Humana and Cigna-Anthem mergers.

On January 27 Judge John D. Bates ruled in favor of the U.S. Justice Department in a suit it had filed to block the Aetna-Humana merger. The Department of Justice (DOJ) had argued that it would substantially reduce competition in the Medicare Advantage market in more than 350 counties in 21 states, affecting more than 1.5 million Medicare Advantage customers in those counties.

Twelve days later, Judge Amy Berman Jackson ruled against the Cigna-Anthem merger, saying it would have worsened an already highly concentrated market and likely lead to increased prices. The DOJ had also filed suit to block the merger of Anthem and Cigna.

The Anthem-Cigna merger was proposed in July 2015; Aetna and Humana entered into an agreement that same month. The DOJ's suit to block both mergers was filed in July 2016.

The DOJ noted that before seeking to acquire Humana, Aetna had pur-

see ***Mergers*** *on page 35*

PERIODICALS: TIME SENSITIVE MATERIALS

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PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

APA's Methodical Approach to Communication

BY MARIA A. OQUENDO, M.D., PH.D.

I turned the key with a quick flick of the wrist. As usual, the mail came tumbling out of the mailbox. Bills, laboratory results, advertisements. But one thing in particular caught my eye: a plain white postcard. It was addressed to me as president of APA, with no return address and no signature. Using laborious cursive, the postcard's writer exhorted me not to be silent. The poignancy of the lack of any adornment, the eerie absence of identification or signature, and the urgent message made me gasp.

It has become a familiar refrain, with similar messages cramming my email inbox daily as well—many from psychiatrists I know, and just as many from members I have yet to meet. Psychiatrists around the country are asking to be heard. And I hear them.

The challenge for APA is to express the views that we hold dear and to protect our patients, our profession, and our members. But we must be clear that our overarching, long-term goal is to be at the table, to have the opportunity to be at the table with this and any future presidential administration. It is only by maintaining an alliance that we have any possibility of expressing our opinion to the administration.

Understandably, for many of our members, this is a frustrating situation. Some of you would prefer that we speak up immediately and vigorously when issues that affect APA's interests come up and that we be both visible and audible on the issues about which you are concerned. In contrast, others of you believe that APA should refrain from getting involved in political situations.

But our responsibility is to be methodical and careful; to speak up in such a way that the message might get through; to balance intended effect and unintended consequence.

What you as a member should know is that both the APA administration and elected officers are attuned to your concerns. We are listening to your entreaties and reading your notes in detail. We understand that the membership may at times be frustrated that there is not more action, but the apparent lack of action is not passivity. It is not fear. It is watchful and deliberate. We pledge to represent you and your concerns in an effective and strategic manner. PN

Is Your Correct Email Address on File With APA?

APA is improving its experience for members at its website, psychiatry.org. Starting in late February, you may have found that the log-in requirements changed. If you haven't done so already, you will need to log in with your email address and reset your password.

If you do not have an email address on file, please email it to **membership@psych.org** or call APA customer service at **(703) 907-7300**. If your email address is out of date, please enter your new address in your member profile.


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Register Now for San Diego!

Save on Annual Meeting fees by taking advantage of the low advance registration rates now in effect. Also, hotel rooms near the San Diego Convention Center are going fast, so don't delay reserving your room. Learn the latest about the meeting's special sessions and events and register today at www.psychiatry.org/annualmeeting.

IN THIS ISSUE

Departments

GOVERNMENT NEWS

Rule Governing Confidentiality Of Substance Use Data Updated

The rule allows patients to use a general designation to indicate individuals with whom information may be shared.

BY MARK MORAN

Federal regulations regarding the confidentiality of patient records regarding treatment for alcohol and other substance use disorders have been updated to account for the evolution of integrated care and other changes.

The update appears in the form of a final rule that was published January 18 in the *Federal Register.* The rule will go into effect on March 21; an executive order by President Donald Trump mandates that implementation of all new regulations issued by federal agencies must be delayed for 60 days while the White House reviews the rule.

The previous regulations governing the confidentiality of substance use disorder (SUD) records (referred to as "42 CFR Part 2") were promulgated in 1975 to protect the confidentiality of patients receiving services for alcohol and other substance use disorders through programs that receive federal assistance. The updated regulations are intended to reflect changes in the health care delivery system—especially the development of integrated care networks that depend on shared information—and permit appropriate research and exchange of data across entities.

Under the final rule, the Substance Abuse and Mental Health Services Administration (SAMHSA) will allow any lawful holder of patient-identifying information to disclose that information to qualified personnel to conduct scientific research, providing the researcher meets certain regulatory requirements. SAMHSA will also permit researchers to link to datasets from qualified repositories holding Part 2 data.

The rule applies to the clinicians or units that provide SUD treatment and referral within a general medical facility that receives federal assistance. It does not apply to the medical facility itself, such as hospitals, trauma centers, Federally Qualified Health Centers, or community mental health centers.

The rule is less clear about buprenorphine prescribers, saying the applicability of the regulations to those prescribers will be "fact specific"—meaning it will depend upon the nature of the prescriber's practice. For example, the prescriber will be governed by the rule if he or she is solely and exclusively providing SUD treatment and receives federal assistance.

When the final rule was published, Kana Enomoto, deputy assistant secretary of the Department of Health and Human Services who oversees SAMHSA, said in a statement that it will "further enhance health services research, integrated treatment, quality assurance, and health information exchange activities while at the same time safeguarding the essential privacy rights of people seeking treatment for substance use disorders."

Among the most potentially problematic aspects of the final rule is a provision that allows a patient to use a general designation—such as "my treating providers"—to indicate individuals or entities with whom patient information can be shared. This change is intended to allow patients to benefit from integrated health care systems while retaining patient choice, confidentiality, and privacy; patients do not have to agree to such disclosures.

The rule also includes a requirement allowing patients who have agreed to the general disclosure designation the option of receiving a list of entities to whom their information has been disclosed. However, APA staff are concerned that current technology may not digitally identify data as related to sub-

see ***Confidentiality*** *on page 34*

Key Points

Regulations regarding confidentiality of patient information related to substance abuse treatment have been updated. The rule was originally written in 1975.

- The regulations have been updated to accommodate the development of integrated care, which relies on sharing of information across networks.
- The rule applies to clinicians or units within a medical center that exclusively provide substance abuse treatment and that receive federal assistance.
- The updated rule will go into effect March 21, after a 60-day review by the president.
- APA has voiced concern that technology may not be adequate to tag data as related to SUD, thereby compromising patient confidentiality.

Bottom Line: The updated rule 42 CFR Part 2 allows any lawful holder of patient-identifying information to disclose it to qualified personnel to conduct scientific research. The rule will also permit researchers to link to datasets from qualified repositories.

Anthem Ends Prior Authorization for Opioid Treatment

The New York attorney general has ordered Anthem to stop violating the parity law with regard to medication-assisted opioid treatment.

BY AARON LEVIN

Anthem, the nation's second-largest health insurance company, agreed in January to halt its use of prior authorization for medications used to treat individuals for opioid use disorder.

The agreement with the New York state attorney general's office ends such requirements when medications are prescribed by specially trained clinicians who are authorized by the Substance Abuse and Mental Health Services Administration. Those medications include buprenorphine and buprenorphine/naloxone.

The settlement is part of an ongoing effort to enforce parity by New York Attorney General Eric Schneiderman, who announced a similar agreement with Cigna in October 2016 (*Psychiatric News,* December 2, 2016).

The agreement applies to Anthem nationally, and its New York affiliate, Empire Blue Cross Blue Shield, must also end use of prior authorization for injectable naltrexone.

Imposition of prior-authorization requirements on medication treatment for opioid addiction has been an issue with several health plans doing business in New York, said Seth P. Stein, J.D., executive director of the New York State Psychiatric Association, in an email to *Psychiatric News.*

"The New York State Psychiatric Association [NYSPA] brought some of these improper requirements to the attention of the attorney general," said Stein. "NYSPA is very pleased that the attorney general's office has taken decisive action on this issue to ensure that individuals with substance use disorders are not subjected to discriminatory coverage provisions and are able to receive necessary medications without undue restriction and delay."

"There is a need for more adequate networks of providers who are certified to treat opiate addiction," said APA President Maria A. Oquendo, M.D., Ph.D. "Hopefully, elimination of administrative barriers like prior authorization will encourage more clinicians to become certified in treating opioid addiction and more patients to access care."

In July 2016, the Department of Health and Human Services announced a rule change expanding from 100 to 275 the number of patients a specially trained physician can treat with buprenorphine, following a 100-patient limit for at least a year (*Psychiatric News,* August 5, 2016).

The disparities created by the need for prior authorization were inconsistent with state and federal mental health parity laws, said Schneiderman in a statement. "We're committed to continue working with health insurers across the country to eliminate barriers to lifesaving opioid addiction treatments."

Anthem's prior authorization requirements for medication-assisted treatment were ended as of January 19, said Lori McLaughlin, communications director for the company, in response to a query from *Psychiatric News.*

"Anthem Inc.'s decision to remove prior authorization for oral medication-assisted therapy was based on a lengthy internal review that took place over the course of the past year," said McLaughlin. "We appreciate the attorney general's attention to this critical issue."

The settlement ends a significant barrier to treatment access for opioid addiction, said Colleen Coyle, J.D., APA's general counsel. "Continuous application for prior authorization for treatment, which is often denied, wastes the time and resources of the clinician and delays or eliminates life-saving treatment." PN

The agreement is posted at https://ag.ny.gov/sites/default/files/final_letter_agreement_anthem-empire_mat_010117.pdf.

LEGAL NEWS

When Is it OK to Communicate With My Adult Patient's Caregiver?

MOIRA WERTHEIMER, J.D., R.N.

Consider the following case example and whether the Health Insurance Portability and Accountability Act (HIPAA) permits a health care provider to disclose information without patient consent to a patient's family and/or caregivers:

You have been treating Mrs. B for depression for several years. She is 32 years old, married with two children, and recently lost her job. She also has been having marital difficulties. Her husband has not been involved in treatment, and Mrs. B did not provide consent to speak with her husband or other family members.

Recently, Mrs. B had been staying at her sister's apartment and was found unresponsive lying next to an empty prescription bottle and brought to the local emergency department. The bottle of pills found next to her had your name on it, and the attending physician calls you upon Mrs. B's arrival. The attending physician indicates that he left messages for both Mrs. B's husband and sister. You would like to follow up with them as well to ensure appropriate follow-up is planned.

Are you permitted to call Mrs. B's husband and/or sister?

As was covered in an earlier column (*Psychiatric News*, June 17, 2016), HIPAA recognizes the vital role that family and friends can play in a patient's health care, and allows some communication between health care providers and some third parties. Under certain conditions, such communication can occur without prior patient consent.

According to guidance issued by the Department of Health and Human Services (HHS), the HIPAA Privacy Rule permits a health care provider to disclose protected health information without prior patient consent when the patient is not present or is unable to agree or object to a disclosure due to incapacity or emergency circumstances, if the health care provider determines that the disclosure is in the best interests of the patient. If a provider determines that such a disclosure is in the patient's best interest, the provider is permitted to disclose only that protected health information that is directly relevant to the person's involvement in the patient's care or payment for care.

In making this determination about the patient's best interests, the health care provider should take into account the patient's prior expressed preferences regarding disclosures of their information, if any, as well as the circumstances of the current situation. Thus, in the case example described above, Mrs. B's written authorization is not required to make disclosures to notify, identify, or locate her family members, personal representatives, or other persons responsible for the patient's care. However, once Mrs. B regains the capacity to make these choices for herself, the health care provider should offer the patient the opportunity to agree or object to any future sharing of her information.

On the other hand, if Mrs. B is alert and has capacity to make health care decisions, the health care provider may disclose protected health information for notification purposes only if the patient agrees or, when given the opportunity, the patient does not object. Keep in mind, however, that even if a patient objects to disclosing information, HIPAA does permit health care providers to receive information from family members or other caregivers regarding the patient.

While there are no easy answers, HHS addresses issues concerning HIPAA and mental health in detail on its website at http://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/.

In addition to HIPAA, please remember that state privacy laws must also be considered when determining whether a particular disclosure is permitted. You should always contact your local attorney or risk management professional with any questions regarding whether a certain disclosure is allowed. PN

Moira Wertheimer, J.D., R.N., is assistant vice president of the Psychiatric and Healthcare Risk Management Group of AWAC Services Co., a member company of Allied World.

ETHICS CORNER

Ethical Motivation in Terms of Developmental Stages

BY CLAIRE ZILBER, M.D.

Much attention has been paid to ethics in the national news coverage of the recent Senate confirmation hearings. It reminds us that there is a range of ethical behavior, including concerns about conflicts of interest, dual relationships, and the establishment of boundaries. These ethical challenges are no less relevant to physicians, so a review of a psychological theory of moral development may be helpful.

Lawrence Kohlberg was an American psychologist who adapted Jean Piaget's theory of psychological development over the lifespan to address the question of moral development. He conceived a model with six stages of development according to how individuals justify their actions. The stages are subdivided into three levels: Preconventional, Conventional, and Postconventional. These levels may be used to examine the ethical developmental level of our own and others' decisions and to identify the standards expected of physicians.

The Preconventional level encompasses the first two developmental stages: Punishment and Obedience, and Instrumental Relativist. In the Punishment and Obedience stage, an action is judged morally good if it doesn't result in punishment. Think of a young child taking another child's toy: if he's not punished, taking the toy must not have been wrong. In the Instrumental Relativist stage, the child learns to get what he wants through negotiation, such as a brother agreeing to share his toys with his sister in exchange for a cookie. The child is learning morally good behavior, but the motivation is egocentric: getting a cookie. This is much like a physician accepting a lavish gift from a pharmaceutical company in exchange for prescribing that company's product. This Preconventional morality is inappropriate in medicine.

The Conventional level of moral development includes the stages of Interpersonal Concordance and Law and Order. In the first of these, good actions are those that please others, resulting in a "good boy" or "good girl" affirmation. At the Law and Order level, the individual is motivated to obey the rules and respect authority. Viewed from one perspective, these may seem adequate for a well-functioning society when people are choosing actions that please others and follow the rules. However, the Law and Order level of morality has limitations: if a rule can be circumvented via a loophole or ambiguity, the individual may feel his or her actions are ethically acceptable, while others may disagree. The public should not tolerate a physician exploiting a loophole concerning professionalism.

The Postconventional level of moral development involves the stages of Social Contract and Universal Ethical Principles. In the Social Contract stage, the individual is oriented toward the greater good and right action according to society's standards. This is the motivation for people to perform altruistic behaviors, such as picking up trash they find on the ground even if they didn't put it there.

In the stage of Universal Ethical Principles, individuals are motivated by abstract principles of justice and respect for human dignity. Actions stemming

see ***Ethics Corner*** *on page 35*

Claire Zilber, M.D., is chair of the Ethics Committee of the Colorado Psychiatric Society, a consultant to APA's Ethics Committee, and a private practitioner in Denver.

Focus Journal to Add Section on Creative Ways For Treating Complicated Cases

The new section offers a place for submissions from clinicians discussing treatments that can be applied in clinical practice.

BY MARK MORAN

Mark Rapaport, M.D., editor of *Focus* and chair of APA's Council on Medical Education and Lifelong Learning, says that the new "Applied Armamentarium" section will fill a gap in the existing published literature.

The randomized, controlled clinical trial (RCT) is often considered the "gold standard" for evidence-based practice.

Yet experienced clinicians also know that results from studies relying on trial-eligible patients don't always generalize to patients with more complex illnesses who show up in a clinician's office. Moreover, broadly inclusive effectiveness trials—such as the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) or Sequenced Treatment Alternatives to Relieve Depression (STAR*D)—suggest that psychiatric medications that show effectiveness in RCTs may be substantially less efficacious in routine clinical practice.

That's why APA's *Focus: The Journal of Lifelong Learning in Psychiatry* has initiated a new editorial section called "Applied Armamentarium." The goal of the section is to fill the gap between the results derived from regulatory trials and psychopharmacological management as it occurs in the clinic.

The section, which will make its first appearance in the fall 2017 edition of *Focus*, will be edited by Boadie Dunlop, M.D., M.S. (Focus is an APA journal whose mission is to disseminate up-to-date information while facilitating lifelong study skills and critical self-assessment for improving patient care and preparation for Maintenance of Certification.)

Journal editor Mark Rapaport, M.D., who is chair of the Council on Medical Education and Lifelong Learning, told *Psychiatric News* that the new editorial section will provide a place for psychiatrists to submit their ideas about how the full range of the psychiatric armamentarium is applied in real-world clinical practice. "We want to have a forum available for clinicians who are doing

see **Focus** on page 30

PROFESSIONAL NEWS

AMA *Code of Medical Ethics* Gets Long-Awaited Update

The AMA's modernized *Code of Medical Ethics* includes opinions on topics as diverse as reporting clinical test results, use of social media, telemedicine, and more.

BY MARK MORAN

The *Code of Medical Ethics*, the document that since 1847 has reflected the American medical community's understanding about the ethical practice of medicine, has been fully updated for the first time in 60 years.

The update of the *Code* began in 2008 and involved a labyrinthian process of review and refinement by the American Medical Association's Council on Ethical and Judicial Affairs (CEJA), the AMA House of Delegates, and ongoing feedback from AMA members and others. The result—receiving final approval at last year's Annual Meeting of the House of Delegates—is an 11-chapter manual containing 161 opinions on the ethical conduct of practitioners of contemporary medicine.

The *Code* includes opinions on topics as diverse as reporting clinical test results, withholding or withdrawing life-sustaining treatment for patients with terminal illness, use of social media, telemedicine, umbilical blood banking, and physician stewardship of health care resources.

In interviews with *Psychiatric News*, B.J. Crigger, Ph.D., who is the director of ethics policy at the AMA and secretary to CEJA, and psychiatrist Jim Sabin, M.D., a member of CEJA, described an iterative process in which outdated opinions were jettisoned, multiple opinions addressing the same subject were condensed, and the language of the new *Code* was revised using a uniform style presentation.

Sabin said the update should be of interest to psychiatrists because APA's *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* are essentially the AMA *Code* with opinions that are specifically relevant to psychiatry.

"The format of the modernized *Code* is going to be useful to psychiatry and to the APA code because, in the updated version, the ethical underpinnings of the opinions stand out more clearly," he said. "I hope and expect that as new ethical issues emerge from the perspective of psychiatry, the AMA *Code* will be a source of even more valuable guidance than it has been in the past because of the way it has been revised to emphasize the underlying ethical principles."

A prominent example of ethical opinions that were removed in the update were most of those dealing with genetics. "Many of the opinions on genetics and medicine relied on science from the 1980s that was no longer reflective of contemporary scientific understanding," Crigger said.

In other areas, the prior *Code* contained multiple opinions on the same topic. For instance, there were six separate opinions on ethical responsibilities in managing medical records, and these opinions overlapped significantly in content. The unique guidance of the individual opinions was distilled to create a single, overarching opinion.

Crigger emphasized that the modernized *Code* is grounded in the AMA Principles of Medical Ethics (see box below) which are not laws, but standards of conduct that define the essentials of ethical behavior for physicians. She said one of the most critical (and time-consuming) aspects of updating the *Code* was the effort to emphasize throughout that the ethical opinions are not guidelines for clinical practice, let alone laws dictating how physicians must behave in every situation.

"For the first time, the modernized AMA *Code of Medical Ethics* addresses practical concerns about interpreting its guidance," she said. "In a new preface that describes the use of key terms and offers examples, the modernized *Code* explicitly acknowledges that no guidance can ever be fully self-interpreting. It recognizes that fundamental ethical challenges can present themselves in different guises to physicians in different specialties or contexts of practice."

New Opinions Formulated Alongside the Update

The process leading to the modernized *Code* was a laborious one that began in 2008 (see box above). Work groups within CEJA were first assigned to conduct a preliminary review of existing opinions in individual chapters, and in 2010 all member organizations of the AMA House of Delegates were invited to provide input on those opinions.

CEJA developed a new, uniform format for arranging the chapters and opinions, and in 2013 an Open Forum was held providing an overview of the update process and describing the new format. Between 2013 and 2016, CEJA revised the *Code* four times, each time incorpo-

see **AMA** on page 34

Lengthy, Collaborative Process Produced Modernized Code of Ethics

The process leading to the modernized *Code of Medical Ethics* began in 2008. Work groups within the Council on Ethical and Judicial Affairs (CEJA) were assigned to work on a preliminary review of existing opinions in individual chapters, and in 2010 all member organizations of the AMA House of Delegates (HOD) were invited to provide input on those opinions. A new, uniform format for arranging the chapters and opinions was developed, and each successive draft update was presented for feedback and comments to the HOD, online and at Open Forums. CEJA revised the draft multiple times in response to feedback from the HOD and online and live forums before the modernized *Code of Medical Ethics* was adopted by the HOD in 2016.

Nov '08	CEJA introduces Code Update project to the HOD.
Dec '08	Preliminary review of existing opinions begins.
Jul '10	CEJA invites feedback on existing opinions from the Federation of Medicine.
Nov '13	Open Forum at Interim 2013 HOD meeting provides overview of project and new format.
Jan '14	CEJA posts draft updated code online for comments.
Jun '14	Open Forum at 2014 Annual Meeting of the HOD invites comments on draft update.
Sep '14	CEJA revises draft in response to online and in-person comments.
Nov '14	CEJA presents draft modernized code at Interim 2014 HOD meeting.
Apr '15	CEJA posts draft update to online forum.
Jun '15	CEJA presents draft update at HOD Annual Meeting 2015.
Aug '15	CEJA revises draft again in response to online forum comments.
Nov '15	CEJA presents draft update at Interim Meeting of the HOD 2015.
Apr '16	CEJA revises draft again in response to comments.
Jun '16	House adopts modernized *Code of Medical Ethics*.

Source: B.J. Crigger, Ph.D./American Medical Association

AMA Principles of Medical Ethics

These are the principles upon which the AMA's *Code of Medical Ethics* are founded:

- A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- A physician shall continue to study, apply, and advance scientific knowledge; maintain a commitment to medical education; make relevant information available to patients, colleagues, and the public; obtain consultation; and use the talents of other health professionals when indicated.
- A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
- A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- A physician shall support access to medical care for all people.

ANNUAL MEETING

Annual Meeting Town Hall To Address Physician Burnout

APA leaders hope the event will promote discussion by members regarding the drivers of burnout, strategies for promoting wellness, and factors that contribute to professional satisfaction.

BY MARK MORAN

Are you burned out? Exhausted and demoralized by administrative demands and regulatory requirements that take you away from the satisfaction that comes with patient care?

APA wants to hear about it. APA President-elect Anita Everett, M.D., will chair "Physician Wellness and Burnout: A Town Hall Discussion With APA Leadership" at this year's Annual Meeting in San Diego. Also joining in the town hall discussion will be APA CEO and Medical Director Saul Levin, M.D., M.P.A., and Trustee-At-Large Richard Summers, M.D.

In an interview with *Psychiatric News*, Everett said professional burnout is a significant issue affecting physicians in all disciplines, impacting health and quality of life and the quality of care they provide. "We want to target the town hall to APA members who may be experiencing some degree of burnout," she said. "We would like to be able to quantify some of what members are experiencing, collect information, and later survey members so we understand the extent of the problem and the numbers of people affected by it."

Everett emphasized that the phenomenon of burnout exists across a continuum from routine fatigue to extreme depression. "At the extreme end, physicians become so demoralized that it impairs functioning and becomes a form of pathology requiring treatment. But we want to make clear that we see this problem encompassing a spectrum of severity."

A substantial body of literature has already documented the extent of the problem across disciplines. A December 2015 report in *Mayo Clinic Proceedings* found that in 2014 46.9 percent of U.S. physicians reported high emotional exhaustion, 34.6 percent high depersonalization, and 16.3 percent a low sense of personal accomplishment. In aggregate, 54.4 percent of the physicians had at least one symptom of burnout based on a high emotional exhaustion score and/or a high depersonalization score. Only 40.9 percent of the physicians felt that their work schedule left enough time for personal/family life. When compared with

continued on next page

> "At the extreme end, physicians become so demoralized that it impairs functioning and becomes a form of pathology requiring treatment. But we want to make clear that we see this problem encompassing a spectrum of severity."
>
> —Anita Everett, M.D.

NIDA Series to Explore Ways Psychiatrists Can Help Patients in Pain

Best practices for recognizing and treating patients with chronic pain and opioid use disorder and federal plans to address the nation's opioid epidemic will be among the topics covered at APA's Annual Meeting in a special track.

BY VABREN WATTS

Since 1999, the number of Americans who have died from opioid overdose has quadrupled, as has the number of prescription opioids sold in this country. What can psychiatrists do to support patients struggling with chronic pain and/or opioid use disorder?

"[T]he reality is that the epidemic was in part born by the inappropriate treatment of pain and overreliance on prescription opioids," National Institute on Drug Abuse (NIDA) Director Nora Volkow, M.D., told *Psychiatric News*. NIDA will sponsor multiple sessions at APA's Annual Meeting in San Diego on how psychiatrists can help patients with chronic pain and/or opioid use disorder.

"Psychiatrists can play an extremely important role in highlighting other therapies, besides opioids, to treat pain," she said.

The NIDA symposium will begin Sunday, May 21, with a session on how psychiatrists with no background in pain management can recognize pain in patients. Tips on how best to treat these patients—including pharmacological and nonpharmacological approaches to pain and how to avoid common pitfalls in pain management—and when to refer to specialty care will be discussed.

David Hathcoxck

Nora Volkow, M.D., director of the National Institute on Drug Abuse, points out that psychiatrists have many tools that can help fight opioid use disorder and chronic pain.

Recognizing and treating patients with a history of pain and opioid use disorder can be particularly challenging. As part of the NIDA series, Sean Mackey, M.D., Ph.D., chief of the Division of Pain Medicine at Stanford University School of Medicine, will present a series of cases of patients with opioid use disorder and chronic pain in a session on Monday, May 22.

Among other topics, the session will address the importance of nonopioid adjuvants for pain management, such as acetaminophen and nonsteroidal anti-inflammatory drugs; nonpharmacological pain management therapies; and appropriate monitoring and risk mitigation strategies.

Also on Monday, Volkow will give an overview of the current opioid epidemic and the multipronged strategy by federal health agencies to reduce rates for prescription opioid misuse and overdose. These strategies include improving the education of health care professionals on pain management, providing treatment to individuals misusing prescription opioids, and increasing the availability of the opioid antagonist naloxone, which blocks the effects of opioids and reverses an overdose.

Volkow will also discuss the efforts of federal health agencies to explore the effectiveness of nonopioid treatments for pain, including cognitive-behavioral therapy, antidepressants, and neurostimualtion therapies.

The symposium will conclude on Wednesday, May 24, with the session "What Is Pain to The Brain?," co-chaired by NIDA Deputy Director Wilson Compton, M.D. The session will include a discussion of the involvement of endogenous opioid, endocannabinoid, and dopamine systems in the regulation of pain as well as how emotions contribute to pain amplification and suffering.

"If you are in pain, you have a greater risk of developing depression. If you are depressed and have pain, you are at a greater risk for transitioning to chronic pain," Volkow said. "Psychiatrists can play an important role in treating patients suffering from chronic pain." PN

Dates, times, and locations of the NIDA sessions will be published in the Annual Meeting program distributed at the meeting.

ANNUAL MEETING

continued from previous page

2011, rates of burnout among physicians were higher in 2014 and satisfaction with work-life balance was lower (40.9 percent versus 48.5 percent).

A 2013 report by the Rand Corporation, sponsored by the AMA, looked at factors associated with physician satisfaction and wellness, and those associated with burnout and exhaustion. Among the key findings:

- Excessive productivity quotas and limitations on the time spent with each patient were major sources of physician dissatisfaction. The cumulative pressures associated with workload were described as a "treadmill" and as being "relentless," sentiments especially common among primary care physicians.

- Physicians described the cumulative burden of rules and regulations as being overwhelming and draining time and resources away from patient care.

- Perceptions of collegiality, fairness, and respect were key factors affecting whether physicians were satisfied. Within the practices studied, frequent meetings with other doctors and other health professionals fostered greater collegiality and satisfaction.

Summers, who was appointed by Everett to chair the Work Group on Psychiatrist Well-Being and Burnout during Everett's presidential year, said opportunities exist to enhance physician wellness through research, education, and intervention. "APA leadership wants to hear from members regarding drivers of burnout, strategies for promoting wellness, and factors that contribute to professional satisfaction," he said. "I hope members will attend [this town hall session] because they will have the chance to express their concerns and ideas directly to APA leadership."

He added, "My hope for the work group going forward is that we will review what we know about psychiatrist well-being and burnout and provide educational materials, self-assessment tools, and potential interventions for our members. We will make recommendations for APA activities in this area, including taking a leadership role in providing information about effective interventions for burnout and depression to our colleagues in other specialties." PN

"Physician Wellness and Burnout: A Town Hall Discussion With APA Leadership" will be held Sunday, May 21, from 10 a.m. to 11:30 a.m. in Room 30B of the San Diego Convention Center. "Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014" is posted at http://www.mayoclinicproceedings.org/article/S0025-6196(15)00716-8/abstract. "Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy" is posted at http://www.rand.org/pubs/research_reports/RR439.html.

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More information is posted at www.psychiatry.org/annualmeeting. After April 20, you may register online only or on site at the late advance/on-site registration rates.

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San Diego Offers World-Class Cuisine From Seafood to Hamburgers

Whether you are looking for a good meal accompanied by craft beer or a night of fine dining with friends, San Diego has it all.

BY STEVE KOH, M.D., M.P.H., M.B.A.

Welcome to San Diego—it's America's finest city! There are the obvious reasons as to why we San Diego residents love our city. One just has to look out the window and see the gorgeous weather year round, beautiful downtown area, miles of beaches and hiking trails, friendly locals, historic Balboa Park, and many other progressive venues. We treasure it, and we are happy to welcome our friends and colleagues from around the world to our fine city.

Our city boasts world-class cuisine and wonderful views to match. I want to take this chance to point out some restaurants that are within walking distance of the San Diego Convention Center. However, I would be remiss to not point out some areas that are a short drive away.

Old Town San Diego is the oldest settled area in San Diego. It boasts Mexican heritage foods, arts, craft, and music. If you are looking for authentic Mexican food, the Old Town area is worth a visit. Little Italy of San Diego is well known for excellent food, bars, and lounges. It has recently become one the more popular areas for a night out. A bit further north is the famous La Jolla area whose restaurants are often cited as some of the best in San Diego. Hugging the Pacific Coast, you can expect spectacular views and ever-present seals and sea lions lounging on the beach.

Now, a bit more about the area surrounding the convention center. The Gaslamp Quarter is the main downtown entertainment area of San Diego. How do you find it from the convention center? Simply walk outside, and you are there! The Quarter is lined with multiple entertainment and food options and boasts five-star dining as well as quick stops for a bite. Many places have live music and entertainment.

While in San Diego, you must take advantage of the bountiful, fresh seafood available throughout the year. I recommend Blue Point Coastal Cuisine, Water Grill, Spike Africa's Fresh Fish Grill & Bar, The Oceanaire Seafood Room, Nobu, and Mariscos El Pulpo.

For meat lovers, look for the Gaslamp Strip Club, Morton's Steakhouse, Donovan's Steak and Chop House, Greystone Prime Steakhouse & Seafood, Fogo de Chao, and Rei Do Gado. For internationally influenced and modern cuisine, look no further than Café Sevilla, Meze Greek Fusion, Double Standard Kitchenetta, La Puerta, and Searsucker. Some other staples are the Werewolf for good burgers, Barleymash to watch the game, Gaslamp Tavern for American fare, and famous Hodad's burgers.

Another great feature of San Diego is that it is a craft beer lover's paradise. Some locally brewed craft beers you should consider are Societe Brewing Company, Ballast Point Brewing, Green Flash Brewing Company, Latitude 33 Brewing Company, Second Chance Brewing Company, The Lost Abbey, and Stone Brewing Company. You can find them at many local restaurants and even visit their breweries.

There simply is not enough room to describe all the things that the Gaslamp Quarter offers. Some other areas deserving of a visit are Petco Park, where the San Diego Padres play, and nearby tourist attractions like the Seaport Village and USS Midway Museum. Also worth a visit are rooftop bars and lounges such as Altitude Sky Lounge, The Nolen, The Omni, and J Six.

There is no need for motor transportation as everything is a short walking distance from the convention center. So get out there, explore, and sample some of what San Diego can offer.

We are excited to have you join us in San Diego! I know that you will fall in love with our city and enjoy your time at APA's Annual Meeting! PN

Steve Koh, M.D., M.P.H., M.B.A., is vice chair of APA's Scientific Program Committee. He is also, among other positions, director of the TeleMentalHealth Program at the University of California, San Diego.

PSYCHIATRY & INTEGRATED CARE

Integrated Care: The Canadian Story

BY NICK KATES, M.B.B.S.

Integrated care efforts in Canada share some strong similarities to integrated care efforts in the United States. For over 20 years, Nick Kates, M.B.B.S., has been a leader in these efforts and has explored ways to increase access to mental health care, build the capacity of primary care to manage mental health problems, and enhance the experience of the patient and provider.

—Jürgen Unützer, M.D., M.P.H.

Canada's 10 provincial and three territorial health care systems are built upon a strong foundation in primary care, which is usually the entry point to specialized services. While mental health care is seen as central to the role of primary care and an integral part of the Canadian concept of the "patient's medical home," as in other jurisdictions, family physicians frequently experience problems with accessing secondary mental health services, the length of waiting times for service, communication with their mental health colleagues, and coordinating the care of their patients.

Over the last 20 years, however, Canada has made substantial progress in improving collaboration between mental health and primary care services and integrating mental health services within primary care settings, guided by two joint position papers produced by the Canadian Psychiatric Association and College of Family Physicians of Canada in 1997 and 2011. These outlined the principles, goals, and practices of effective collaborative care and presented a common framework for new initiatives. Since then, a wide variety of projects aimed at improving collaboration and building new partnerships have emerged across the country, and all share one or more of the goals of (1) increasing access to care; (2) building the capacity of primary care to manage mental health problems; and (3) enhancing the experience of the patient and provider. A national conference brings providers, planners, administrators, and consumers together annually, and a quality framework is now being introduced to define the goals of projects and measurement of their outcomes.

Collaborative mental health care is also increasingly prominent in mental health and primary care service planning both provincially and nationally, although there is local variation in the way collaborative projects have been implemented. In general, these initiatives take one of four approaches:

- Making changes to the mental health service to improve communication and coordination of care by working more closely with primary care providers, including telehealth consultation.

- Providing educational interventions and resources that increase the skills, comfort, and capacity of primary care providers when managing mental health problems in their practice.

- Integrating primary care providers within mental health settings to address the problems of individuals with mental illness who do not have access to a primary care provider.

- Integrating mental health services within primary care settings. While this may include a visiting psychiatrist, a visiting team, or a mental health team based permanently in primary care as part of the primary care team and usually working with the entire population of a practice, the common elements in the Canadian approach bear many similarities to the collaborative care model developed at the University of Washington. These include the following:

Key personnel

- A care manager or therapist whose roles can include assessment, psychological treatments such as cognitive-behavioral therapy and interpersonal psychotherapy, care coordination and case management, support for self-management, system navigation, and patient education.

- A visiting psychiatrist who provides consultations and selected follow-up, case discussions and reviews, telephone back-up,and continuing education for the primary care team.

- An engaged family physician who is the lead, ambassador, and liaison for the project and assists in solving problems as they arise.

Principles to guide care

- The care is team-based, patient- and family centered, and evidence-informed.

- The physical integration of mental health personnel within the primary care setting is essential.

- Personal contacts and "warm handoffs" between providers are central to effective collaboration.

- Systematic (proactive) follow-up of patients is required after treatment is initiated or completed.

- Progress needs to be measured regularly once treatment has started.

- Roles and expectations of all providers in the partnership need to be clear.

Supports to enhance care

- Treatment protocols and pathways.

- The use of case registries.

- Support by leadership in both organizations.

- Clear goals for any project.

- Opportunities to meet regularly to review the progress and success of the relationship.

- Realistic preparation and orientation, and ongoing support of mental health providers.

While initially addressing problems with access and communication, collaborative care has also demonstrated its potential for addressing other issues facing Canada's health care systems. It allows for the better integration of physical and mental health care and early intervention and relapse prevention while improving access, transitions, and flow, including reducing avoidable emergency room visits. It can also reduce stigma, enhance the patient's and family's experience, and promote early childhood development and the identification of children at risk. PN

Nick Kates, M.B.B.S., is a professor and chair of the Department of Psychiatry and Behavioural Neurosciences at McMaster University in Hamilton, Ontario, and the co-chair of the Canadian Psychiatric Association and College of Family Physicians of the Canada National Working Group on Collaborative Mental Health Care. Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington, where he also directs the AIMS Center, dedicated to "advancing integrated mental health solutions."

CLINICAL & RESEARCH NEWS

Glucose Dysregulation May Occur Early In Patients With Schizophrenia

Rates of type 2 diabetes are estimated to be two to three times higher in individuals with schizophrenia than the general population.

BY VABREN WATTS

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Although individuals with schizophrenia are significantly more likely to develop type 2 diabetes than those in the general population, it is unclear whether the illness alone confers an inherent risk for glucose dysregulation. Findings from a meta-analysis published in January in *JAMA Psychiatry* suggest that individuals with schizophrenia may already be experiencing glucose dysregulation at the onset of the psychotic condition.

"This is a wake-up call that we need to consider diabetes prevention right from the onset of schizophrenia," said Toby Pillinger, M.R.C.P., a clinical researcher at the Institute of Psychiatry, Psychology, and Neuroscience at King's College London and lead author of the meta-analysis. Such efforts include routine diabetic screening and educating patients about the importance of a healthy diet and exercise, he told *Psychiatric News*.

Pillinger and colleagues conducted a systematic review of case-control studies reporting on fasting plasma glucose levels, fasting insulin levels, insulin resistance, and hemoglobin A1c (HbA1c) levels in patients with first-episode schizophrenia. Patients who had no or minimal antipsychotic exposure (14 days or less on antipsychotics) were compared with controls. A total of 16 case-control studies were included in the analysis, including 731 patients and 614 controls.

Fasting plasma glucose levels, plasma glucose levels after an oral glucose tolerance test, fasting plasma insulin levels, and insulin resistance were all significantly elevated in patients with schizophrenia compared with controls. HbA1c levels were not altered in patients compared with controls.

"These results underscore the urgent mandate for mental health care professionals to routinely screen people with

continued on next page

FROM THE EXPERTS

Motivational Interviewing for Clinical Practice: Just Do It

BY CARLA MARIENFELD, M.D., BACHAAR ARNAOUT, M.D., AND PETROS LEVOUNIS, M.D., M.A.

Motivational interviewing (MI)—the clinical style for engaging patients in treatment, enhancing motivation to reduce substance use, and supporting adherence to recommended behavioral or pharmacological treatments—seems to be everywhere these days.

My son smokes marijuana all day—how do I talk to him? MI. My patient yeses me to death all the time but never follows up with anything—what should I do? MI. I would like to spice up my psychopharm practice with some behavioral modification tricks—can you help? MI. MI has become the psychiatric equivalent of dermatology's corticosteroids or advertising's social media.

MI was first described in a paper by William R. Miller, Ph.D., and later in books Miller wrote together with Stephen Rollnick, Ph.D. The technique contains simple ideas, and the basic concepts are not particularly challenging to grasp.

Instead of repeatedly asking closed questions, telling patients what to do, or confronting patients who do not follow your recommendations, MI uses a combination of open questions, reflections, affirmations, and summaries to engage the patient in treatment, as well as giving information and advice in a respectful and collaborative manner.

In *Motivational Interviewing: Helping People Change*, Miller and Rollnick describe how MI has been refined and expanded to also include partnership, acceptance, compassion, and evocation.

- **Partnership:** Similar to collaboration, clinicians practicing MI approach the patient as a partner in a consultation with emphasis on working together to decide how to proceed.

- **Acceptance:** Clinicians accept the patient "as is," with all their strengths and weaknesses, successes and flaws.

- **Compassion:** In MI, clinicians see compassion as a fundamental commitment to understand and pursue the best interests of the patient.

- **Evocation:** Clinicians understand that the patient has amazing capabilities, and our goal is to draw them out.

In our everyday MI work, we structure our treatments around the four processes of engaging, focusing, evoking, and planning. These processes overlap, build upon each other, and are flexible enough to allow us to return to a previous process for reinforcement prior to continuing our MI trajectory.

- **Engaging:** Engaging refers to establishing, building, and nurturing rapport. We continue to cultivate engagement throughout the entire treatment to solidify trust—trust that we are compassionate and knowledgeable.

- **Focusing:** Focusing shapes the treatment toward a specific agenda, develops goals for behavioral change, and adds direction to the conversation.

- **Evoking:** Once a direction has been identified, evoking is the process through which we elicit the person's own motivation for changing behaviors and maintaining gains. We first explore and then hone in on the aspects of the patient's ambivalence that are in favor of change (cultivate change talk) and resolve or soften arguments that disfavor change (soften sustain talk). We elaborate on the patient's motivations for a healthier life and bring focus to the patient's change-supportive statements.

- **Planning:** Assuming there is (1) sufficient engagement, (2) a clear and shared goal, and (3) sufficient commitment to initiate behavior change, the patient-clinician partnership develops a change plan. The plan typically consists of setting clear, achievable goals; exploring options for change; deciding on a plan; and committing to the plan.

And that's all, folks.

Well, not exactly. While there is a lot to appreciate and master in MI beyond what can be covered in this article or in any one book, we strongly believe that the fundamental MI concepts are straightforward and easily accessible to most therapists.

In 2017, MI is, arguably, the essential style for helping patients to change and maintain their new, healthier behaviors. Learn it, use it, and enjoy its delightful results! PN

Carla Marienfeld, M.D., is an associate professor of psychiatry at the University of California, San Diego. Bachaar Arnaout, M.D., is an assistant professor of psychiatry at Yale School of Medicine. Petros Levounis, M.D., is chair of the Department of Psychiatry at Rutgers New Jersey Medical School and chief of service at University Hospital. They are co-editors of *Motivational Interviewing for Clinical Practice* from APA Publishing. APA members may purchase the book at a discount at https://www.appi.org/Motivational_Interviewing_for_Clinical_Practice.

CLINICAL & RESEARCH NEWS

continued from previous page

psychotic disorders for all aspects of glucose dysregulation, including increases in body mass index, fasting blood glucose, fasting blood lipids, and blood pressure,"

Hofstra Northwell School of Medicine

Christoph Correll, M.D., says that metabolic risk factors should be assessed at onset of illness and at least once annually.

Christoph Correll, M.D., a professor of psychiatry at Hofstra Northwell School of Medicine, said during an interview with *Psychiatric News*. Correll, who was not involved with the study, noted that metabolic risk factors should be assessed at onset of illness and at least once annually. He explained that there should be "more frequent assessments in people who are obese, gain at least 7 percent of their baseline weight, or have abnormal glucose, lipid, or blood pressure results."

Correll added that using caution when prescribing medication and monitoring metabolic risk factors must be top priorities when treating any individual with a psychotic disorder, even in very young people and those who are of normal weight.

The meta-analysis was supported by the Medical Research Council. PN

An abstract of "Impaired Glucose Homeostasis in First-Episode Schizophrenia" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2597705.

Get Help With MACRA Payment Reform

The federal government released its final rule on the Medicare Access and CHIP Reauthorization Act (MACRA) this past October, and reform of the Medicare payment system went into effect January 1. APA wants to help participating members adjust to this landmark transformation of the way physicians are paid for their services.

Analysis by APA staff of the final rule implementing MACRA indicates that the "low-volume threshold" defining the minimum patient volume required for clinicians to report is high enough to exempt many psychiatrists—particularly those in small group practices—from reporting in the first year. Specifically, a clinician or practice group that has "Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Part B–enrolled Medicare beneficiaries" is exempt from reporting.

Nevertheless, it is wise for members to educate themselves about MACRA. To this end, APA has created a web-based toolkit to help members understand and meet the requirements of MACRA and the Merit-Based Incentive Payment System (MIPS). The APA Payment Reform Toolkit includes the following resources:

- MACRA 101 Primer.
- Detailed fact sheets on MIPS reporting categories.
- A series of webinars designed to walk members through the nuts and bolts of how to be successful quality reporters and use the data to inform clinical practice.

The toolkit and webinars can be accessed at APA's Payment Reform website at www.psychiatry.org/PaymentReform.

PSYCHIATRY & PSYCHOTHERAPY

Developing Psychotherapy Skills and a Practice After Residency

BY THOMAS FRANKLIN, M.D.

For generations, psychiatrists could expect to have a significant part of their practice devoted to psychotherapy, but in recent decades this has been on the wane. Today, some reports indicate that nearly half of all psychiatrists do not offer psychotherapy.

Forces mitigating against psychotherapy by psychiatrists are many, but most notably the rate of reimbursement for psychotherapy is not at an appropriate level. Young psychiatrists enter practice settings where their skills as psychopharmacologists are more valued, and their opportunities to develop the psychotherapy skills they learned in residency are limited.

Many early career psychiatrists (ECPs) wonder how or whether they should make providing psychotherapy a part of their professional lives. I would argue that you should. Despite the challenges, it can be a rewarding part of a career and is harder to take up later after practice patterns have been firmly established. Additionally, the evidence base for psychotherapeutic treatments is robust and side effects are few. As the leader of the clinical team, psychiatrists are expected to have a familiarity with psychotherapy and be able to help less trained clinicians with their cases.

So how does one develop a psychotherapy practice and expertise after residency? Here are several steps you might consider:

- **Make time for therapy cases.** Whatever practice setting you are in, you should advocate for time to see patients for psychotherapy at least four hours a week, as it is difficult to grow as a therapist with less.

  If you have control of your own schedule, so much the better, but if you don't, just ask! Make it a part of the employment agreement. Don't allow yourself to be pigeonholed as the "med doctor."

  You can also consider renting space in someone's office one evening a week and see therapy patients there. How will you get your therapy patients? In most communities, a psychiatrist that will see therapy cases is a sought-after commodity.

  Many patients with psychiatric or medical comorbidities will benefit from having a physician doing their therapy, as we have a broader range of expertise and a generally higher risk tolerance than other therapy providers. We are also adept at knowing when to pursue medical complaints versus watchful waiting.

- **Continue to develop your psychotherapy skills.** Like many skills acquired during residency, psychotherapy skills are not well developed at graduation, especially since the story arc of a therapy case extends over time periods that are longer than many residents have during training.

  Take advantage of classes at meetings, courses at local psychotherapy or psychoanalytic institutes, and self-study. The best way to learn to be an excellent therapist is through supervision. Often group supervision is available.

- **Seek the advice of experts.** Find the style of therapy you enjoy working in, and take the time to meet with an expert in that area to discuss your cases. The Internet has made fitting a supervisory hour into your schedule easier than it has ever been. There are even supervision groups that meet online. Expect to pay your colleague for their time, and expect that investment to come back to you many times over as you develop the confidence and skill to treat a broader range of patients and your extra value is noticed by referrers, peers, and administrators.

  What if you want a practice that is primarily providing psychotherapy? Unfortunately, third-party payors do not pay psychiatrists as much to see therapy cases—even those with accompanying medical issues or medication management—as they do to see higher volumes of patients in psychopharmacology. Many psychiatrists decide not to participate in insurance plans for this reason. In many communities, this strategy is a viable one, with most psychiatrists helping their patients obtain partial reimbursement via out-of-network benefits.

  Some clinicians choose to tolerate a lower income to be able to do work they find more interesting. Today there are billing services and technology that make running a small private practice easier than ever. If you are considering this route, take an honest appraisal of yourself, ideally with a mentor who is also a therapist:

*see **Psychotherapy** on page 32*

Thomas Franklin, M.D., is the medical director of The Retreat at Sheppard Pratt in Baltimore. This column is coordinated by the Committee on Psychotherapy of the Group for the Advancement of Psychiatry.

CLINICAL & RESEARCH NEWS

Modafinil May Help Improve Memory In Patients With Remitted Depression

Attention and memory problems are commonly reported in patients with a history of depression.

BY VABREN WATTS

Cognitive dysfunction is a core symptom of depression that tends to persist even after treatment and improvements in mood. A study published December 13, 2016, in *Biological Psychiatry* suggests that modafinil—a wake-promoting agent approved to treat patients with narcolepsy—might be able to help patients with remitted depression who are experiencing cognitive deficits.

"This study points toward an often-overlooked problem in treating depression, which is the assumption that once the depressive symptoms remit, our clinical job is done," said Katherine Burdick, Ph.D., a professor of psychiatry and neuroscience at the Icahn School of Medicine at Mount Sinai, who was not involved with the study. "In reality, a fair number of patients [with remitted depression] will suffer from persistent difficulties in attention and memory functions. These problems need to be addressed," she told *Psychiatric News*.

Past studies have highlighted the cognitive-enhancing effects of modafinil in patients with schizophrenia and attention-deficit/hyperactivity disorder as well as healthy controls, but few have looked at the potential of the medication to treat cognitive deficits in patients with remitted depression.

Katherine Burdick, Ph.D., says that before health care professionals start prescribing modafinil for persistent cognitive dysfunction to patients with remitted depression, more studies must evaluate the long-term effectiveness and safety of the drug.

For the current study, Barbara Sahakian, Ph.D., of the University of Cambridge and colleagues recruited patients in remission from depression (score of less than 12 on the Montgomery-Asberg Depression Rating Scale for at least two months). A total of 60 patients (48 were taking antidepressants) were evaluated using the Cambridge Neuropsychological Test Automated Battery, which includes tests of episodic memory, working memory, planning, and attention. One week after the baseline evaluation of cognitive function, the patients were randomized to receive either a single dose of modafinil (200 mg) or placebo, followed by another round of cognitive tests two hours later.

The researchers found that the modafinil group significantly outperformed the placebo group on episodic memory and working memory tests. There was no significant difference between the groups on planning and attention tests.

Although none of the study participants reported significant adverse events during the testing or 24 hours after the study, two patients taking modafinil reported sleep disturbances on the night of the study session.

"To our knowledge, this study is the first to investigate the effects of modafinil in remitted depression," wrote Sahakian and colleagues.

"People with persistent cognitive symptoms often experience poorer outcomes such as impaired work functioning and are at increased risk for relapse," Sahakian told *Psychiatric News*. "Modafinil may have potential as a therapeutic agent to help remitted depressed patients with persistent cognitive difficulties."

Both Sahakian and Burdick noted limitations in the study's design, such as investigating only the acute effects of modafinil. Sahakian mentioned that longer-term studies with modafinil are needed to determine the drug's direct impact on quality of life. Burdick, who is currently studying modafinil in patients with bipolar disorder, was concerned about long-term safety.

"Safety will be an additional important focus, as modafinil appears to be safe in single-dose studies, but little is known about what happens if a person takes it daily over the course of a longer period," said Burdick.

The study was funded by the Medical Research Council and the Wellcome Trust. PN

"Modafinil Improves Episodic Memory and Working Memory Cognition in Patients With Remitted Depression" is posted at http://www.biologicalpsychiatrycnni.org/article/S2451-9022(16)30181-1/fulltext.

MED CHECK

BY VABREN WATTS

FDA Approves Latuda for Use in Adolescents With Schizophrenia

The Food and Drug Administration (FDA) in January approved a supplemental New Drug Application for ***Latuda*** (***lurasidone HCl***) for the treatment of schizophrenia in adolescents aged 13 to 17 years.

Latuda is already approved in the United States for the treatment of adults with schizophrenia and for the treatment of adults with major depressive episodes associated with bipolar I disorder (bipolar depression) as monotherapy and as adjunctive therapy with lithium or valproate.

According to a statement on the website of Sunovion, which manufactures Latuda, the approval is based on results from a randomized, double-blind, placebo-controlled, six-week study in which adolescent patients with schizophrenia received fixed doses of Latuda 40 mg/day, Latuda 80 mg/day, or placebo.

At the study endpoint, Latuda 40 mg/day and 80 mg/day were associated with statistical and clinical improvement in symptoms of schizophrenia compared with placebo. Latuda was also generally well tolerated with limited effects on weight and metabolic parameters.

Companies Aim to Develop Fast-Acting Antidepressant

Amorsa Therapeutics Inc. announced in January that it will be teaming up with Janssen Pharmaceuticals Inc. to develop and commercialize a novel small molecule drug candidate for treatment-resistant depression based on Amorsa's proprietary ***ketamine*** analog technology.

As part of a research, option, and license agreement between the companies, Amorsa will manage the preclinical development program, while Janssen will assume responsibility for subsequent clinical, regulatory, and commercial development of the licensed drug candidate.

Schizophrenia Patients May Benefit From Adjunctive Sodium Channel Blocker

Newron Pharmaceuticals in January announced positive results from a phase 2a trial of the company's novel sodium channel blocker ***evenamide*** (***NW-5309***) as an add-on treatment for patients with schizophrenia. Patients who took the medication daily with risperidone or aripiprazole for four weeks experienced a reduction in schizophrenia symptoms, the company reported.

The randomized, controlled trial included 89 patients with schizophrenia, who were experiencing breakthrough psychotic symptoms while on risperidone (mean dose: 4.2 ± 2.0 mg/day; n=70) or aripiprazole (mean dose: 19.7 ± 7.0 mg/day; n=19). Patients were randomly assigned to receive twice daily evenamide (15 to 25 mg) or placebo, in addition to their current antipsychotic for four weeks.

Patients taking adjunctive evenamide showed greater improvements in symptoms (as assessed by the Positive and Negative Syndrome Scale) as well as functioning (as assessed by the Strauss-Carpenter Level of Functioning scale) compared with those taking adjunctive placebo.

Evanamide was generally well tolerated, with somnolence, insomnia, and headache among the most commonly reported adverse effects.

McKesson Fined $150 Million for Failure to Flag 'Suspicious Orders'

The U.S. Department of Justice (DOJ) announced in January that McKesson Corp., one of the nation's largest drug distributors, has agreed to pay a $150 million fine for alleged violations of the Controlled Substance Act. The nationwide settlement also requires that the company suspend sales of controlled

see ***Med Check*** *on page 36*

CLINICAL & RESEARCH NEWS

Early Identification of People With Psychosis Linked to Educating Outpatient Providers

An analysis of electronic health records from several health care systems reveals that more than half of the cases of first-episode psychosis are reported in outpatient settings.

BY NICK ZAGORSKI

Early detection and intervention are known to be critical for the successful treatment of psychotic symptoms. But effectively implementing intervention programs requires a good understanding of the population trends—who is showing symptoms and where they are first presenting in the health care system.

To provide a clearer picture of first-episode psychosis prevalence and the settings where patients most commonly presented with these symptoms, researchers examined electronic health record data from five large health care systems (Group Health Cooperative of Washington State and the Colorado, Northern California, Southern California, and Northwest regions of Kaiser Permanente).

The analysis revealed the incidence of first-episode psychosis to be about 86 per 100,000 among people aged 15 to 29 and 46 per 100,000 among those aged 30 to 59; this translates to approximately 56,000 and 58,000 new cases of psychotic symptoms in the United States each year, respectively.

The study, published January 3 in *Psychiatric Services in Advance*, first compiled all the cases in which new psychosis symptoms were reported in patients aged 15 to 59 who attended one of the five health systems between January 1, 2007, and December 31, 2013; this resulted in 37,843 diagnoses of first-episode psychosis. (Older patients were excluded given the high occurrence of psychosis associated with dementia or other neurodegenerative disorders that might conflate the results.)

The researchers then selected 300 random diagnoses from the records of each of the five health care systems for a more detailed chart review to confirm reported symptoms. The percentage of confirmed cases, based on this chart review, was used to determine the final incidence rates.

Lead author Gregory Simon, M.D., M.P.H., a senior investigator at Group Health Research Institute in Seattle, told *Psychiatric News* that while the rates of first-episode psychosis identified (86 and 46 per 100,000) are slightly higher than some previous estimates, they are within the range of these reports.

"This is also not the first study to report that new-onset psychosis is common in older adults, but it's still a prevailing idea that psychosis is a young person's disorder," he said. That misconception can be consequential when planning intervention strategies. "Programs that work for a 17-year-old will not necessarily work for someone who is 40."

> "I think the findings speak to how we should define the problem of new-onset psychosis. If you define it as symptoms that require someone to be admitted to a hospital, then you are missing a whole lot of patients."
>
> —Gregory Simon, M.D., M.P.H.

Still, Simon said he believes the more telling finding from the study is where the patients with first-episode psychosis were presenting. Only about one-third of diagnoses were made in emergency departments or mental health inpatient settings; the rest of the patients were diagnosed in outpatient settings.

"I think the findings speak to how we should define the problem of new-onset psychosis," Simon said. "If you define it as symptoms that require someone to be admitted to a hospital, then you are missing a whole lot of patients."

James Kirkbride, Ph.D., a Sir Henry Dale Fellow in the Psychiatry Department at University College London, commended the researchers' detailed efforts to calculate and validate where people with first-episode psychoses are being identified in the United States.

Kirkbride recently completed a similar study, which appeared in the February issue of the *American Journal of Psychiatry,* looking at where people with new psychosis were presenting in eastern England.

Even with the rigorous design employed by Simon and his team, Kirkbride noted that many cases of psychosis were likely missed—most notably among the uninsured, homeless population.

While Simon acknowledged that the results—which were based entirely on presentations within an insured population—likely underestimate the full extent of first-episode psychosis, he said they highlight the importance of educating patients and providers at outpatient facilities about signs of psychosis.

Moving forward, "the big challenge will be striking the balance between identifying first-onset psychosis as early as possible and identifying it as accurately as possible," Simon said. Regardless, educating providers in outpatient settings about the symptoms of early psychosis could help expand efforts to guide patients at high risk of psychosis to care or social support earlier, he said.

The study was supported by a grant from the National Institute of Mental Health. PN

An abstract of "First Presentation of Psychotic Symptoms in a Population-Based Sample" is posted at http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201600257. A related study by Kirkbride, "The Epidemiology of First-Episode Psychosis in Early Intervention in Psychosis Services: Findings From the Social Epidemiology of Psychoses in East Anglia [SEPEA] Study," is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2016.16010103.

JOURNAL DIGEST

BY NICK ZAGORSKI

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Gout, Malaria Medications Reduce Opioid Withdrawal in Rodents

The anti-gout medication probenecid and the antimalarial mefloquine may help to alleviate symptoms of opioid withdrawal, according to a recent animal study by researchers at the University of Calgary. The medications act on the pannexin-1 (Panx1) channel—which the researchers determined plays a key role in morphine withdrawal.

While previous research on withdrawal has focused on the spinal cord itself, the investigators in this work observed that microglia—the resident immune cells of the central nervous system—around the spinal cord were facilitating some of the nerve changes brought on by the withdrawal.

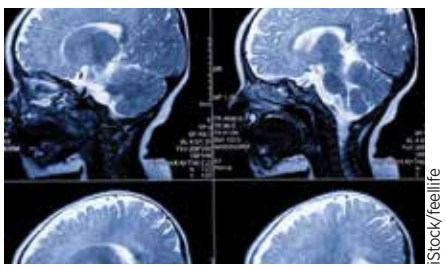
Subsequent genetic knockout studies identified the Panx1 gene as a key regulator of this microglial function.

When the investigators treated rodents with the clinically used Panx1 blockers probenecid and mefloquine they found the medications alleviated the severity of withdrawal.

"Opioids are the pharmacological cornerstone for treating chronic pain in a large variety of diseases," said study author Tuan Trang, Ph.D., in a statement. "Understanding why opioid withdrawal occurs and how to alleviate it is of critical importance in improving pain therapy and may have implications for substance abuse."

This study was published in *Nature Medicine*.

Burma N, Bonin R, Leduc-Pessah H, et al. Blocking Microglial Pannexin-1 Channels Alleviates Morphine Withdrawal in Rodents. *Nat Med*. January 30, 2017. [Epub ahead of print] http://www.nature.com/nm/journal/vaop/ncurrent/full/nm.4281.html



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Brain Scans May Predict Future Depression, Anxiety

Internalizing symptoms in children, such as extreme shyness or separation anxiety, are known to be indicators of future depression or anxiety disorders. A study in the *Journal of the American Academy of Child and Adolescent Psychiatry* now suggests that these differences may be evident in the brains of

continued on next page

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infants who are just a few days old.

Researchers used functional magnetic resonance imaging (fMRI) to take brain scans of newborns (65 full term and 57 preterm) and map out the strength and pattern of neural connections between the amygdala (a key region involved with processing emotions) and other parts of the brain.

When these babies reached two years of age, a subset (17 full term and 27 preterm) received psychological assessments, which evaluated internalizing symptoms including as general anxiety and separation distress. Such symptoms have been linked with an increased risk of clinical depression and anxiety disorders in older children.

When comparing the infant brain scans with the toddler assessments, the authors found certain connectivity patterns between the amygdala and the insula or prefrontal cortex (brain regions that are affected in depression and generalized anxiety in adults, respectively) were associated with greater internalizing symptoms at age two. These patterns were present in both full-term and preterm infants; the latter simply had weaker amygdala connections. Despite these differences, full-term and preterm infants had the same prevalence of internalizing symptoms at age two.

"These results suggest that the seeds of future anxious and depressive symptoms for some individuals may be detectable at birth using amygdala connectivity patterns," the authors wrote.

Rogers C, Sylvester C, Mintz C, et al. Neonatal Amygdala Functional Connectivity at Rest in Healthy and Preterm Infants and Early Internalizing Symptoms. *J Am Acad Child Adolesc Psychiatry.* February 2017; 56(2):157-166. http://www.jaacap.com/article/S0890-8567(16)31931-1/abstract

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Cosmetic Professionals Know About BDD, But May Miss Signs

While cosmetic professionals have some awareness of body dysmorphic disorder (BDD) and the challenges it poses, they may be underdiagnosing the condition, reports a survey study published in *Plastic and Reconstructive Surgery*.

The findings were based on the feedback of 173 cosmetic professionals in The Netherlands, who completed an online survey that inquired about knowledge of and interactions with patients with BDD.

Most of the professionals surveyed said they were familiar with BDD and its diagnostic criteria and had encountered BDD patients in their clinics. Approximately 70 percent of the respondents also said they had refused to perform cosmetic procedures in a patient they suspected of having BDD.

However, based on the professionals' estimates, only about 2 percent of patients going to their clinics had BDD, whereas other studies have estimated that up to 10 percent of people who go to cosmetic clinics have BDD.

"Ideally, cosmetic professionals should be explicitly educated about recognizing and managing psychological contraindications during their clinical training, just as they are informed about numerous somatic contraindications," the study authors wrote. "This would make the exploration of body image problems a standard topic in every patient encounter in a cosmetic clinic."

Bouman T, Mulkens S, van der Lei B. Cosmetic Professionals' Awareness of Body Dysmorphic Disorder. *Plast Reconstr Surg.* February 2017; 139(2):336-342. http://journals.lww.com/plasreconsurg/Fulltext/2017/02000/Cosmetic_Professionals__Awareness_of_Body.16.aspx

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Bilingualism May Help Brain Compensate for Neurodegeneration

Recent studies have suggested that lifelong bilingualism may help delay the onset of dementia, but the underlying neural mechanism of this potential protective effect is unknown.

A study in *Proceedings of the National Academy of Sciences* found that people who speak two languages may have stronger neural connections that allow them to compensate for neurodegeneration in other regions of the brain.

A total of 85 patients (45 German-Italian bilingual speakers and 40 monolingual speakers) with probable Alzheimer's disease (AD) underwent positron emission tomography (PET) scanning.

The scans showed that even though bilingual individuals with AD had stronger metabolic deficiencies in some brain regions than monolingual individuals, they outperformed monolinguals on verbal memory and visual-spatial tasks. Bilingual patients also had stronger neural connections between the anterior and posterior brain regions than those who spoke one language only.

"Overall, these findings strongly suggest that bilingual individuals with AD compensate better for the loss of brain structure and function," the authors wrote.

Perani D, Farsad M, Ballarini T, et al. The Impact of Bilingualism on Brain Reserve and Metabolic Connectivity in Alzheimer's Dementia. *Proc Natl Acad Sci USA.* January 30, 2017 [Epub ahead of print] http://www.pnas.org/content/early/2017/01/24/1610909114.abstract

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Crisis-Response Plans Found to Cut Suicidal Behavior in Military

Crisis-response planning can be effective in reducing suicidal behavior in military personnel, reports the *Journal of Affective Disorders*.

The findings come from a randomized study of 97 active service military who had sought help for suicidal ideation or attempt at an emergency behavioral health clinic. The participants were divided to receive one of three risk management strategies: a contract for safety in which a patient provides a commitment to avoid self-harm; a standard crisis-response plan, which involves writing down how to identify suicidal warning signs as well as coping strategies or support services that can be used in a crisis; or an enhanced crisis-response plan in which patients write down all of their reasons for living in addition to the other elements of the plan.

The patients were followed for six months. Those who received crisis-response planning reported a faster decline in suicidal thoughts than those who received a contract for safety. The number of inpatient hospitalizations were also lower in patients who received the crisis planning.

Crisis-response planning also resulted in a 75 percent reduction in suicide attempts, though the total numbers were small (three attempts among the two crisis-plan groups and five attempts in the contract-for-safety group).

There were no significant differences between patients in the two crisis-response-plan groups.

Bryan C, Mintz J, Clemans T, et al. Effect of Crisis-Response Planning vs. Contracts for Safety on Suicide Risk in U.S. Army Soldiers: A Randomized Clinical Trial. *J Affect Disord.* January 23, 2017; 212:64-72. https://linkinghub.elsevier.com/retrieve/pii/S0165-0327(16)31947-4/abstract

iStock/AndreyPopov

Alcohol Abuse Increases Risk Of Cardiovascular Problems

Alcohol abuse increases the risk of atrial fibrillation, heart attack, and congestive heart failure to an extent similar to that of other well-known cardiovascular risk factors, reported a study published in the *Journal of the American College of Cardiology.*

The findings come from an analysis of data from nearly 15 million adult California residents who received ambulatory, emergency, or inpatient care in California between 2005 and 2009. The researchers quantified the occurrences of alcohol abuse, cardiovascular outcomes, and other health data using International Classification of Diseases-9th Revision (ICD-9) and Current Procedural Terminology (CPT) codes given for each patient visit.

After adjusting for other potential risk factors, a diagnosis of alcohol abuse was associated with a 2.14-fold increased risk of atrial fibrillation, a 1.45-fold increased risk of heart attack, and a 2.34-fold increased risk of congestive heart failure. These magnitudes were on par with other well-established risk factors including male sex, smoking, obesity, hypertension, and chronic kidney disease. Among atrial fibrillation risk factors, for example, alcohol abuse was second only to congestive heart failure in terms of independent fibrillation risk.

"Although nearly all subgroups exhibited increased risk in the setting of alcohol abuse, those without a given risk factor for each outcome were disproportionately prone to enhanced cardiovascular risk." However, while the relative risk of atrial fibrillation, heart attack, or heart failure rose significantly in this group, the absolute risk was still low, they added.

Whitman I, Agarwal V, Nah G, et al. Alcohol Abuse and Cardiac Disease. *J Am Coll Cardiol.* January 3, 2017; 69(1):13-24. http://www.onlinejacc.org/content/69/1/13

LETTERS TO THE EDITOR

Discussing Patients' Personal Views

Dr. Claire Zilber, in her ethics column in the January 6 issue titled "Politics, Group Identification, and Professionalism" appropriately points out both the temptations and dangers of endorsing political, religious, or other partisan views, as such, in discussions with patients. However, inasmuch as such positions often encapsulate ethical principles, I believe that in one's role as an ethical person, it may be not only permissible but beneficial to find a way to encourage a patient, especially a young person who is struggling with personal ethics, in his or her expressions of ethical concern regardless of the context. This discussion, naturally, would need to be carefully framed, nonconfrontational, patient-centered, and empathic, as would any discussion of the patient's personal feelings and beliefs, to promote insight and avoid the objective of gratifying the therapist's self-esteem.

NANCY T. BLOCK, M.D.
Berkeley Heights, N.J.

21st Century Cures Act Said To Benefit Underserved Communities

We as psychiatrists join our mental health advocacy colleagues in applauding the signing of the 21st Century Cures Act by President Obama on December 13, 2016 (*Psychiatric News*, January 6). This law aims to provide support and funding for programs that will tackle some of America's most difficult health challenges. In an era of divided government, we welcome bipartisan legislation, which will advance the treatment of mental illness, the opioid epidemic, Alzheimer's disease, and cancer and address suicide prevention.

We anticipate this law will have numerous benefits for our patients and mental health care systems. The 21st Century Cures Act establishes specific leadership positions and a strategic plan for improving mental health treatment in the United States.

The legislation includes parity provisions designed to ensure that insurance coverage for mental health and substance use disorders are equal to, or at parity with, other medical conditions. This will improve access to mental health/substance use treatment. The law complements the findings of President Obama's Mental Health and Substance Use Disorder Parity Task Force, which requires health insurance companies to provide people with access to life-saving mental health and substance use treatment

Furthermore, this law provides additional funding to promote mental health treatment and service delivery. There has been approximately $14 million authorized for promoting innovation and evidence-based practices through the newly formed National Mental Health and Substance Use Policy Laboratory. The law also authorizes $30 million to be used between 2018 and 2022 for suicide prevention grants—addressing the 10th leading cause of death in America.

The University of California, Riverside, School of Medicine (UCR) was founded with the mission of improving access to health care for the underserved community in Riverside County, which suffers from a severe shortage of physicians and mental health professionals. The county recently received a Health Professional Shortage Area score of 23, the lowest in California. The new law will greatly assist our efforts in addressing this shortage through grants for residents and fellows who practice psychiatry

and addiction medicine in underserved communities.

Evidence of the widespread bipartisan support for the law included support of the California and inland Southern California delegation, including Reps. Mark Takano, Raul Ruiz, Ken Calvert, Paul Cook, and Pete Aguilar, as well as Sens. Dianne Feinstein and Barbara Boxer. We at UCR Psychiatry experience firsthand the ravages of the opioid epidemic and the all-too-common tragedies of suicide. We are most thankful to our lawmakers for passing this legislation.

The 21st Century Cures Act is a major step toward improving health care in the United States. There has been considerable media coverage of its authorization of over $6 billion in funding. Encouragingly, a substantial portion of this law is dedicated to mental health reform and advancing treatments for those suffering from mental illness. By spurring innovation and providing much needed support to address important health issues facing our communities, the new law will help save lives. PN

JEANNIE D. LOCHHEAD, M.D.
Riverside, Calif.

GERALD A. MAGUIRE, M.D.
Riverside, Calif.

Both writers are faculty members of the University of California, Riverside, School of Medicine.

Focus

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interesting things in the treatment of challenging patients," he said. "They can submit case histories or small-scale studies, discuss the strengths and limitations of the work they are doing, share the results, and talk about where these innovative strategies need to go next.

"It will give clinicians who are treating patients with complex disorders new ideas about what their colleagues in the field are doing," said Rapaport, who is also the chair of the Department of Psychiatry and Behavioral Sciences at Emory University School of Medicine. "We believe this fills a gap in the published literature and will be unique."

Examples of the sorts of submissions Rapaport and colleagues would like to see for the new section include the following:

- Clinical trials reporting unique interventions in challenging patient samples.

- Case series of challenging clinical scenarios that suggest a novel or effective application of psychopharmacology or somatic therapies.

- Electronic medical record evaluations of medication combinations or the effects of psychotropics on patients with complex medical status.

- Clinical applications of biomedical

testing procedures that assist in the selection or use of therapies.

- Highly compelling and convincing individual case reports of innovative treatment approaches.

- Commentaries offering original perspectives on an aspect of clinical psychopharmacology.

In an editorial in the winter issue of *Focus,* Rapaport wrote about the new section: "With the expansion of options, including somatic therapies such as deep brain stimulation and transcranial magnetic stimulation, clinicians are encountering increasing numbers of patients undertaking treatment regimens that often have not been subject to controlled studies. Other patients have multiple psychiatric or medical comorbidities—or are taking medications for other diseases—that introduce uncertainty into treatment selections. The result is that clinicians are often working with patients for whom the existing evidence base provides little guidance. … There is thus a great need for published clinical evidence that can fill the gap between the results derived from regulatory trials and psychopharmacological management as it occurs in the clinic." PN

"Introducing a New Section: The Applied Armamentarium" is posted at http://focus.psychiatryonline.org/doi/full/10.1176/appi.focus.15108. Inquiries about this section should be sent to Boadie Dunlop, M.D., M.S., at bdunlop@emory.edu. Subscription information is posted at http://apapsy.ch/FOCUS.

Psychotherapy

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• **Are you charismatic and outgoing?** If so, referrers and patients will gravitate toward you if you are responsive and competent.

• **Do you have a specialty area in demand in your community?** This can fill a practice even if you aren't a natural networker.

Clinicians with special expertise in children or adolescents, addictions, couples, borderline personality disorder, postpartum, or other areas that many clinicians find challenging will usually see their practices fill by getting the word out to referral sources about their interest area.

To spread the word about your expertise, give talks to organizations of clinicians in your community and write articles for the local medical or psychotherapy society. Interestingly, talks at national meetings can be less effective at practice building than almost anything local. Also, for practice development purposes, an article in the newsletter of the local medical, psychological, or psychiatric society can be more important than a journal article.

• **Do you have a supervisor from residency with whom you get along?** Choosing a well-connected supervisor is another good way to get referrals as the individual knows your work intimately

and can advocate with his or her network on your behalf.

If you are practicing in the same community, take the person out to lunch. He or she will almost always be happy to help you out. Affiliation with your local psychotherapy or psychoanalytic organizations as well as your psychiatric society is important. Go to talks and dinners and meet people to tell about your interest area and practice.

Also, your flexibility in seeing new patients is a key to growing your practice. Stay late. Come in on the weekends. Get those new patients seen quickly. When they are calling around, they will usually go to the first person who can fit them in.

In summary, please continue to develop your psychotherapy skills as an ECP. It will provide a valuable service to your patients and your community and you are likely to find it professionally gratifying. Get supervision at first, and consider an ongoing supervision. If you want a practice that is primarily psychotherapy, be prepared to take a pay cut or to withdraw from insurance panels and either be really personable and responsive or have an interest area that you promote locally.

I am fortunate to have a career in which I get to see patients, run groups, teach, administer, manage, and plan. Almost invariably, however, the most gratifying hours of my week are spent with psychotherapy patients. Use some of the ideas outlined above, and it can be so for you too. PN

AMA

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rating comments and criticism from the House of Delegates and from comments received online. The revised *Code* was adopted at AMA's 2016 Annual Meeting in June; each new revision by CEJA in response to the House was also placed online for comment.

The final result is a more streamlined *AMA Code* with 161 opinions (down from more than 200 in the prior Code), in 11 chapters. The chapters include opinions on the following topics:

- Patient-Physician Relationships
- Consent, Communication, and Decision-Making
- Privacy, Confidentiality, and Medical Records
- Genetics and Reproductive Medicine
- Caring for Patients at the End of Life
- Organ Procurement and Transplantation
- Research and Innovations
- Physicians and the Health of the Community
- Professional Self-Regulation
- Inter-professional Relationships
- Financing and Delivery of Healthcare

Even as the *Code* was being updated and modernized, new opinions were still being formulated and debated within the Council and the House of Delegates, such as opinions on physician stewardship of health care resources, and allocation of scarce health care resources.

Sabin, who has written extensively about the subject of ethical stewardship of finite resources, said he believes those opinions in the updated *Code* represent an important evolution in the way physicians think about their responsibility to the health of the individual patient as well as the broader public.

Sabin said the lengthy process of updating the *Code* is one psychiatrists should admire. "I have been very impressed with the process of code modernization at the AMA," he said. "It relied on dialogue within a large organization engaging a lot of different parties and voices, and a process of give and take with which we in psychiatry are very familiar." PN

The full text of *The Code of Medical Ethics* can be downloaded at no cost at https://www.ama-assn.org/about-us/code-medical-ethics. A print copy of *The Code of Medical Ethics* can be purchased from the AMA.

Confidentiality

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stance use treatment once it is uploaded into an electronic health record system. Misidentified data may then be transmitted in countless ways, making it nearly impossible to track how different electronic health record systems store, retrieve, and transmit the information. APA is working with a coalition to promote legislation that will harmonize the updated rule with HIPAA regulations.

Psychiatric News will provide further updates on implementation of the final rule. PN

APA members with questions about the rule should contact Michelle Dirst at mdirst@psych.org. Information about the rule is posted at www.psychiatry.org/CFR42.

Mergers

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sued aggressive expansion in Medicare Advantage, doubling its Medicare Advantage footprint over the past four years. The DOJ also argued that Aetna's purchase of Humana would substantially reduce competition to sell commercial health insurance to individuals and families on the public exchanges in 17 counties in Florida, Georgia, and Missouri, affecting more than 700,000 people.

DOJ said the proposed merger of Anthem and Cigna would substantially reduce competition for millions of consumers who receive commercial health insurance coverage from national employers throughout the United States. The department said consumers receiving insurance through large-group employers in at least 35 metropolitan areas, including Denver, Indianapolis, Los Angeles, New York, and San Francisco, and from public exchanges created by the Affordable Care Act in Denver and St. Louis would be most affected (*Psychiatric News,* August 19, 2016).

The courts agreed. APA has worked to educate DOJ about the dangers of the proposed mergers, arguing that they would be detrimental to health care generally, but could especially be harmful to patients with mental illness because the mergers would diminish competition in setting rates and determining conditions of psychiatrist participation in health networks. Also, existing violations of the federal Mental Health Parity and Addiction Equity Act could be exacerbated because patients would have fewer choices among insurance providers.

APA leaders hailed the court decisions. "The trend toward consolidation in the insurance market is a troubling one that threatens patient choice, which is critical in our health care system," said APA President Maria A. Oquendo, M.D., Ph.D. "We are pleased that the court sided with the Justice Department and agreed that these mergers would reduce competition and limit patients' coverage options."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., concurred. "We applaud these two rulings, which preserve competition in the health insurance market and prevent insurers from acquiring unprecedented market power," Levin said. "APA will continue to advocate on behalf of patients and physicians to foster more competitive health insurance markets."

At press time, Aetna and Humana announced that they would not appeal the decision.

Anthem executive Joseph Swedish indicated in a statement it was likely the company would appeal. "If not overturned, the consequences of the decision are far reaching and will hurt American consumers by limiting their access to high-quality, affordable care, slowing the industry's shift to value-based care and improved outcomes for patients, and restricting innovation, which is critical to meeting the evolving needs of health care consumers," he said.

But on February 14 Cigna announced it would terminate the proposed merger agreement with Anthem. In a statement on the Cigna website, the company said: "Cigna believes that the transaction cannot and will not achieve regulatory approval and that terminating the agreement is in the best interest of Cigna's shareholders. To effect this termination, Cigna has filed suit against Anthem in the Delaware Court of Chancery. The suit seeks declaratory judgment that Cigna has lawfully terminated the merger agreement and that Anthem is not permitted to extend the termination date. The complaint seeks payment by Anthem of the $1.85 billion reverse termination fee contemplated in the merger agreement, as well as additional damages in an amount exceeding $13 billion. These additional damages include the amount of premium that Cigna shareholders did not realize as a result of the failed merger process." PN

Election Results

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the changing political climate nationally."

In the race for secretary, Philip R. Muskin, M.D., M.A., of New York City emerged the winner. His opponents were Gail Robinson, M.D., of Toronto, Ontario and Robert Roca, M.D., M.P.H., of Baltimore.

In the race for minority/underrepresented representative (M/UR) trustee, Ramaswamy Viswanathan, M.D., D.Sc., of Brooklyn, N.Y., defeated David Scasta, M.D., of Milford, Pa.

In the race for Area 2 trustee, Vivian Pender, M.D., of New York City won over Ravi N. Shah, M.D., M.B.A., of New York City.

In the race for Area 5 trustee, Jenny Boyer, M.D., Ph.D., J.D., defeated R. Scott Benson, M.D.

Each year the Association's resident-fellow members elect a resident-fellow member trustee-elect, who the following year rotates into the position of resident-fellow member trustee. The winner of this year's race is Tanuja Gandhi, M.D., a forensic fellow at Yale University. His opponents were Sarah Kauffman, M.D., a PGY-2 at Columbia University, and Benjamin Solomon, M.D., M.B.A., a PGY-2 at NYU Langone Medical Center.

Election results were approved by the Tellers Committee in February, but the results will not be official until after the Board of Trustees reviews them at its meeting this month. All of the winning candidates will assume their positions on the Board at the close of the Annual Meeting in May. PN

Results of APA's 2017 Election

President-Elect

Secretary**

FIRST ROUND

SECOND ROUND

THIRD ROUND

Minority/Underrepresented Representative (M/UR) Trustee

Area 2 Trustee

Area 5 Trustee

Resident-Fellow Member Trustee-Elect (RFMTE)*

FIRST ROUND

SECOND ROUND

* A majority vote (>50%) is necessary in a three way contest. If a majority does not exist after tallying all first-choice votes, voters' second-choice votes for the candidate with the least amount of first-choice votes are tallied and added to the remaining candidates' tallies.

**A majority vote (>50%) is necessary in a four way contest. If a majority does not exist after tallying all first-choice votes, voters' second-choice votes for the candidate with the least amount of first-choice votes are tallied and added to the remaining candidates' tallies. If there is still no majority winner, an additional round is necessary. Voters' third-choice votes for the candidate with the least amount of first and second choice votes are tallied and added to the remaining candidate's tallies.

Ethics Corner

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from this stage include volunteering to serve in human rights organizations, participation in civil disobedience for a noble cause, or similar selfless acts designed to help others and that confer no benefit to the person taking the action. A physician operating at the level of Universal Ethical Principles practices medicine according to his or her conscience about what is best for the patient, the health of the public, and the needs of the profession. An example of this is the pediatrician working who is working with an undocumented immigrant with a congenital heart defect and devotes uncompensated hours to identify a hospital willing to provide pro-bono surgical treatment to the child.

The pressures and standards of physicians' professional roles tend to push us toward greater moral development. The burden of being held to a higher standard is also a privilege. Because we are forced to think about public health and allocation of scarce resources, for example, we are encouraged to think beyond the Conventional level of morality. However, even as we aspire to make our decisions from a principled level of morality, many of us are vulnerable to moving back and forth among the stages, particularly if our personal and professional moralities are not in alignment.

As we observe what happens on the political stage, let us be reminded to be morally exacting of ourselves to maintain the highest ethical ideals and behavior. PN

Med Check

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substances from distribution centers in Colorado, Florida, Michigan, and Ohio for several years.

In 2008, McKesson paid a $13.25 million civil penalty over similar violations.

"In this case, the government alleged again that McKesson failed to design and implement an effective system to detect and report 'suspicious orders' for controlled substances distributed to its independent and small chain pharmacy customers—i.e., orders that are unusual in their frequency, size, or other patterns," a DOJ release stated. "From 2008 until 2013, McKesson supplied various U.S. pharmacies an increasing amount of oxycodone and hydrocodone pills, frequently misused products that are part of the current opioid epidemic."

In response to the news, McKesson Chair and CEO John H. Hammergren stated in a press release, "Pharmaceutical distributors play an important role in identifying and combating prescription drug diversion and abuse. We continue to significantly enhance the procedures and safeguards across our distribution network to help curtail prescription drug diversion while ensuring patient access to needed medications."

Lundbeck, Ossainix Hope To Improve Delivery of Medications Across BBB

H. Lundbeck A/S announced in January that it had secured a license to develop multiple CNS products using Ossainix's ***variable new antigen receptor*** (***VNAR***) antibody technology.

VNAR is a shark-derived antibody that binds to the blood-brain barrier transferrin receptor. By fusing therapeutic agents targeting molecules in the brain to the VNAR, therapies can be shuttled across the blood-brain barrier. The technology has been successfully tested in mice.

"This new technology may pave the way for many new and better treatments of brain diseases, even some that can't be treated today due to the BBB keeping therapeutic drugs from entering the brain," Lundbeck reported on its website. "However, as the research is still in a quite early phase, there is a risk that it may not be applicable for use in humans. We will now refine the Ossianix technology with the aim of hopefully testing it in humans." PN