Synapse

THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

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Robert N. Sobel, M.D., Editor & Syed Abdullah, M.D., Co-Editor

"YOUR DISTRICT BRANCH"

Since the last publication of Synapse, the Executive Council has met October 27th, December 1st and January 19th. In the last issue I wrote that I thought we are entering into a phase of formalizing our activities more – with membership, monies and administrative support all on our agenda, priorities I conveyed to the central office of the APA in a recent poll they took of branch presidents. Our last two meetings expanded further on these themes as well as our usual items of business.

We are beginning the process of brainstorming for a second grant proposal to the APA that will build on our successful grant of last year. We have ideas for projects that would add an email list for our communication tasks, obtain support for expanded educational activities including establishing a speakers' bureau and funding for one-on-one personal membership retention efforts. We are eager to hear other project ideas. Our goal is to prepare a proposal before 6/1/07 in time for the 6/30/07 deadline.

Andy Hornstein, MD and Alan Tuckman, MD have created a reasonably accurate and computerized list of our members. We want to now add email addresses for all those who have them. This is a far more efficient and practical method for us to communicate with you. We even discussed reducing dues for those who were willing to use email for our mailings. Call Alan at 845-354-6363 or email him (atuckman3368@yahoo.com) with your email address.

We have prepared a sizable grant proposal to Senator Morahan's office in collaboration with NAMI-Familya and the Mental Health Coalition. We are hoping this will result in funds for special projects for all three organizations.

We have learned that staff sharing with other organizations is not feasible as no organization has extra staff time to share.

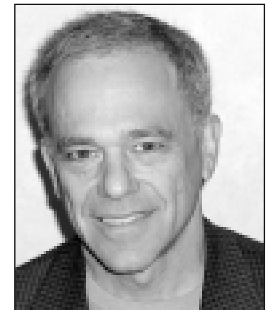
I continue to receive 3 calls weekly on the information service phone line. I anticipate revising the manual of private psychiatrists over the next several months. Look for a mailing announcing the opportunity to add your practice information to the list.

Madhu Ahluwalia, MD and Diane DiGiacomo, MD (President and incoming president, respectively) report that the Mental Health Coalition is healthy and doing very well with a robust treasury. The Public Forum in October was very successful and they are actively planning for the Public Forum 2007, now a tradition for the mental health community. They continue to provide presentations at local colleges and other projects are in the planning. They are actively soliciting psychiatrists to participate in Mental Health Coalition activities.

Our Assembly Representative, Nigel Bark, MD continues to ably represent us. Unfortunately he is unable to attend the assembly at the APA meeting next May. If you are interested in participating in the national level organization, now is your opportunity. Call Dr. Bark (845-359-7553) to discuss becoming the Deputy Representative to the APA Assembly if you are able to attend the APA meeting.

Mary Mavromatis, MD and Mona Begum, MD onc e again organized the Fall Mental Health Screening, this year at St. Thomas Aquinas College rather than at a shopping mall. 42 individuals were screened and 13 were referred for further evaluation. Jeff Newton, MD is trying to build interest and participation for DB activities among Orange, Sullivan and Delaware County psychiatrists. He has called or emailed many of you. He will be continuing this. Please call Dr. Newton if you want to discuss projects, activities, member services or anything else of interest to you. (845-294-6125)

The Women's Committee continues to meet every 6 weeks for an interesting educational discussion. 6 to 7 members are always in attendance and there is room for more. Contact Lois Kroplick (362-4215 or drkroplick @ AOL.com) or Jane Kelman (638-2626 or jek@icu.com) for details if you'd like to attend.



Dr. Tuckman reports that our dues income is expected to drop by 25% due to a drop in our membership to 125, paralleling the national trend. We have adequate reserves at present to continue our activities but must take steps in the future to retain members and encourage eligible members to join. We hypothesized that psychiatrists who are not members may not appreciate the advantages of membership. Non-members are enjoying the benefits brought to our profession by the lobbying and educational efforts of our national and state offices without having to pay dues. We'd like these psychiatrists to come into the organization and participate in all of the activities available to members.

Regarding membership, Dr. Mary Barber has been anointed a Distinguished Fellow, Dr. Peter Ferber a Life Fellow, Dr. Khin Soe a Fellow. Dr. Nauman Monsoor has resigned and Dr. Hameeda Jangda has been reinstated.

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"IME's - A Danger Zone"

Several years ago, I wrote, in this column, about psychiatrists performing evaluations in civil litigation cases, such as insurance, worker's compensation, disability, fitness for duty and other types of independent, "third-party evaluations," discussing the question of liability and that psychiatrists are protected from malpractice actions if they have not developed a "doctor-patient relationship" with the evaluee. At that time I emphasized the protections afforded psychiatrists who conduct these evaluations.

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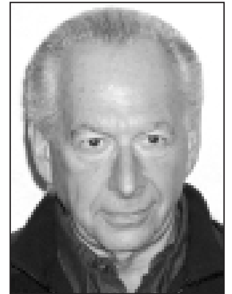
SYNAPSE designed by Lydia Dmitrieff

At this time, stimulated by several articles over the past several years regarding the dangers inherent in conducting these evaluations, I thought it would be appropriate to elaborate on this subject, since many non-forensic psychiatrists, with no training in forensic work and little understanding of its pitfalls, have been performing these evaluations periodically, but in great numbers. Most psychiatrists do believe that there is little or no liability, if they have not acted in such a manner as to have assumed the responsibility of a "treating physician." I believe we all know, currently, that it is extraordinarily easy to become someone's "treating psychiatrist," unintentionally, simply by giving a small amount of advice on the telephone to a non-patient, writing a prescription for a "friend or family member," or acting in one of many different ways which could be construed as providing medical care to a previous non-patient.

When an individual brings a malpractice action, they must prove that the psychiatrist had a **Duty** or obligation to the plaintiff, meaning that a doctor-patient relationship existed, that the psychiatrist **Departed** from that duty, providing care below a "certain standard of conduct," and that the breach of the duty caused an injury or **Damage** to the plaintiff with a **Direct** connection between the psychiatrist's "below standard" conduct and the damage that resulted. (These are the "**4-D's** of proving a medical malpractice case.)

Interestingly, some courts have interpreted the independent medical examination of a "presumed non-patient" as part of, or as tantamount to, the beginnings of a doctor-patient relationship and, thus, the first prong of the malpractice requirement has been met. In addition, since there are standards for conducting any psychiatric evaluation, whether it is for treatment or a third party, there do exist standards in conducting the evaluation process, most specifically related to not causing damage or harm to the evaluee. If the court finds that a physician-patient relationship has been established, then all of the requirements of the treating physician relationship exist. Case law has indicated that IME (Independent Medical Examination) physicians do have significant legal duties to the person being evaluated.

"To not cause injury during the examination (i.e., to follow accepted professional standards), to disclose significant findings in a reasonable manner, and to maintain confidentiality as appropriate to the situation (meaning the obligation to advise the evaluee as to who will be receiving the information acquired during the evaluation and not divulging it to others)." As a matter of fact, since there are two parties to this evaluation process, other than the evaluating psychiatrist, (the evaluee and the third party retaining the psychiatrist) a responsibility may be owed to both, and the third party may also have a cause of action against the psychiatrist for a negligent evaluation. Thus, it becomes evident that an evaluating psychiatrist may be sued for traditional malpractice (doctor-patient: when a doctor-patient relationship is determined to have occurred) and negligence in conducting an inadequate evaluation, even where a doctor-patient relationship does not exist, since agreeing to conduct an evaluation is tantamount to the creation of a contract between the psychiatrist, the evaluee and the third party requesting the evaluation. This means that even if a court determines that a doctor-patient relationship did not exist, the psychiatrist can still be held liable for a breach of the contract that was created, by performing the evaluation in a manner that was determined to have been conducted, "below the standard of care" for such evaluations.



An additional risk, in an independent medical evaluation, may occur if, during the course of the evaluation of a non-patient evaluee, the psychiatrist makes comments to the evaluee which are interpreted as "medical advice" and thus creating a doctor patient relationship, and the physician becomes an unwitting treating physician, even though there was no explicit contractual agreement to treat the patient (even if there was an explicit statement that it is not a treatment relationship).

One of the most risky situations in psychiatric malpractice liability, as I have described in previous columns, can occur

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Mental Health Screening Event

WHPS's Depression Screening Day event was first held at the Nanuet Mall (an innovation spearheaded by Dr. James Flax) and then in recent years at the Palisades Mall. Thus this year's decision to conduct our Mental Health Screening Event at the Dominican College Health Expo may have been a surprise. Our District Branch has sponsored, financed and provided the manpower (our membership) for this annual free mental health screening in the community.

We have done this in conjunction with a national non-profit organization called Screening for Mental Health, Inc. which sponsors National Depression Screening Day (and other screening programs as well: visit them at www.MentalHealthScreening.org for more information). In the past we have conducted these screenings in the mall setting on National Depression Screening Day because we found it to be the most effective way to screen members of the community in a non-threatening, natural setting. By conducting screenings in these public settings, we not only provided the service of screening individuals who might not have the opportunity or resources to be screened, but we also provided educational materials, referrals, and answered questions in a non-threatening setting. Although the screenings began as screenings for depression (15 years ago) we now also screen for anxiety, PTSD, and bipolar disorder, along with depression.

Although very successful, in terms of numbers of individuals screened in the mall locations in the past, we found that we were screening a dwindling number of individuals in the mall setting, many of whom were already in treatment! Those of us who participated also felt that at times we were chasing individuals to get them to participate. Many people walking through the mall believed that we must be "selling" something. As a result we decided to participate at the Health Expo at Domincan College which was on October 29th, not on Depression Screening Day, but during the same month.

Those of us who participated felt the screening was very successful. We screened 42 individuals and referred 4 people for treatment for depression, 5 people for treatment for generalized anxiety disorder and 4 people for treatment for post-traumatic stress disorder. We did not have to chase anyone down, although we did lure them with candy! The individuals who attended the health fair were there to receive medical information and to be screened and so were very receptive and understood that we were health professionals.

Because we switched the venue and were working in a condensed time frame, we may not have reached every member who would have been interested in participating. My apologies if that is the case. I wish to personally thank those members who participated and who made the event successful (and made it fun!!). Thanks to Diane DiGiacomo, Lois Kroplick, Jane Kelman, Rick Brand, Dom Ferro, Jim Flax (who came to the rescue at the last minute) and my co-chair Mona Begum.

I am especially grateful to those who volunteered because it was a gorgeous, weekend day when social and family duties call. But I think we all had a great time . So I look forward to next year, when we can do this again. ▲

Mary Mavromatis

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Emil Kraepelin: His Legacy Lives On in Psychiatric Annals

Kraepelin was born in 1856, the same year that Sigmund Freud was born, also in Germany not too far from each other. Both of them were destined to make lasting contributions to the field of Psychiatry. The late 19th century was a period of great excitement in the scientific understanding of physical illnesses, but the developments in psychiatry had woefully lagged behind. In 1858 Rudolf Virchow published his monumental work Cellular Pathology. By the 1870s the germ theory was well established as the etiology of infectious diseases. Vaccinations and antitoxins were being developed. The periodic table of the elements had been drawn up and the new chemistry was adding to the euphoria in scientific circles.

In the field of psychiatry, however, the debates on consciousness and volition were still going on with very little benefit to the understanding of mental illnesses. The philosophers were having a field day in endless arguments while the mentally ill languished in a limbo. The neurons had been discovered but, with only the light microscope in the hands of the researchers, their role in the causation of mental diseases remained inconclusive.

Emil Kraepelin studied medicine in Leipzig; one of his teachers was Wilhelm Wundt the "father of psychology." Wundt had pioneered experimental studies in the field of psychology which left a lasting impression on the mind of young Kraepelin. He chose to study psychosis hoping that such gross mental disturbances will show some physiological abnormalities in the brain. The syphilitic origin of some of the paralytic dementia, and mental effects of brain trauma and cerebrovascular damage were pointers to the etiological concomitants to certain mental changes.

But the search of lesions in the brain in the case of the psychoses drew negative results. Search for toxins also did not reveal the etiology of the major mental illnesses.

Finally Kraepelin took up the task of systematically studying the psychoses which he observed in the hospitals and the clinics. With meticulous observation and follow up studies he gradually built up the nosology of the psychoses. His first category was dementia praecox which he defined as the 'sub-acute development of a peculiar simple condition of mental weakness occurring at a youthful age.' He postulated that this condition had a relentless course with poor prognosis. He explained that it was an endogenous form of psychosis in contrast to Manic Depression which was caused by exogenous factors and was therefore treatable and had a better prognosis. Later Eugene Bleuler changed the name dementia praecox to Schizophrenia.

Kraepelin noted that any one symptom could be shared by other categories of psychosis. Therefore no symptom was pathognomonic to any one condition. Rather it was the pattern of symptoms and their course, that distinguished each malady. He also observed on the genetic pattern of the illnesses. For example, he postulated that there seemed to be more persons with dementia praecox among the relatives of the patient than in the general population, and that the same was true about manic depression. He thereby set in motion the genetic study of mental illness which has mushroomed into a vast field of study and continues to occupy much energy and resources of the research community.

It is to be noted that Alois Alzheimer, working in Kraepelin's lab discovered the pathological basis of a form of dementia that later came to be known Alzheimer's disease. Kraepelin was confident that one day the pathological basis of all the psychosis will be determined.

He wrote the text book of Psychiatry which remained a source of reference in Europe for about forty-five years. The book went through nine editions with new additions to the list of diagnoses. While working on the ninth edition of the book Lehrbuch der Psychiatrie Kraepelin passed away on October 7, 1926. The book had one translation in English.

While Freud and Kraepelin lived in the same times and worked in the same field, spoke the same language, they never communicated with each other or made any reference to each other. Freud moved away from the study of the psychoses as he felt that psychoanalysis was not the proper approach to their treatment. Freud got busy building his movement into a world wide fellowship as many flocked to his fold. As is well known, he did not tolerate any deviation from his teachings even by his senior disciples. His focus remained on the neuroses while Kraepelin confined his work to the understanding of the psychoses.

In 1909, on the occasion of the Clark University's 20th anniversary, Freud, Jung and Ferenczi were invited to the USA and honored as dignitaries of modern psychiatric movement. Kraepelin was excluded from that honor. His great contribution in discovering schizophrenia and manic-depression remains largely unknown to the general public. His writing, which lacked the literary power of Freud, is little read outside scholarly circles. However, his views now dominate psychiatric research and academic psychiatry. Today the published literature in the field is overwhelmingly biological in its orientation. His fundamental theories on the etiology and diagnosis of psychiatric disorders form the basis of all major diagnostic systems in use today. The American Psychiatric Association's DSM-IV and the World Health Organization's ICD (International Classification of Diseases) are based on Kraepelin's findings and classifications. ▲

Syed Abdullah, M.D.

District Branch Representative's Report: NYSPA's Annual Fall Meeting

My previous two reports were on meetings of the Assembly (of District Branches of the APA, to give it its full name). This one will be mainly about the New York State Psychiatric Association's (NYSPA) fall meeting because it is clear to me that NYSPA is doing some very important things for psychiatrists and for their patients.

Having attended three Assembly meetings and two NYSPA meetings I see their importance in deciding the policy and actions of the APA. And the West Hudson Psychiatric Society with its prize winning Newsletter and pioneering coalition building should be contributing to these. This is how your views, opinions, gripes and ideas may become APA policy and actions.

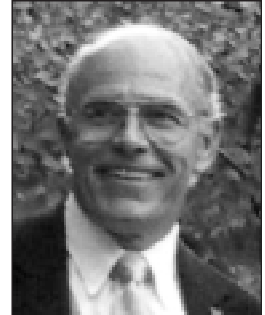
We are the only district branch that does not have a Deputy Representative to the Assembly and we should have one. Any volunteers? And next May I am not going to be able to attend the Assembly so if anyone going to the APA in San Diego would like to go a couple of days earlier and be our Rep please let Jim Flax or me know. It is interesting and very social.

The fall meeting of the Assembly dealt with 22 action papers (on medical marijuana, Medicare part D, Suppression of Free Intellectual Exchange, Practice Guidelines etc). It heard: reports from APA officers and committees, tributes to Wayne Fenton and Lawrence Kolb, of issues to improve Psychiatry–Primary Care Collaboration and the related Access to Care in Rural Areas (a solution to which might lessen the pressure for psychologist prescribing), of Psychiatric Care for Military Members and their Families (most do not have VA services nearby) and an inspiring talk and plea for collaboration from Suzanne Vogel-Scibilia the psychiatrist President (and 'consumer') of the newly renamed National Association for Mental Illness (to emphasize the person first).

But NYSPA is doing some important things that I learned about at its fall meeting (technically the AREA II Council Meeting) at the LaGuardia Marriott. (Incidentally all members are welcome at these one-day meetings, on a Saturday in the Fall and Spring, and at the Committee meetings which are from 9 to 10am.) I attended the Public Psychiatry Committee, re-energized by its Chair, Ed Amyot. There are clearly major Public Psychiatry issues that NYSPA can and should do something about (and if more of the psychiatrists in State Hospitals and County Services were members they would have a stronger voice.) These include pay, to overcome the shortage of psychiatrists in State Hospitals, emergency services for children, co-ordination with OMRDD, the solitary confinement of prisoners with mental illness, the retention of sex offenders in State Hospitals, the paradox of reducing the census when there is a constant enormous waiting list for admission, and the need for general improvement in Community Services. NYSPA is working closely with NYSMA (NY AMA) to have a joint approach to the legislature on several of these issues and is lobbying directly on others.

A new NYSPA committee, chaired by Glenn Martin, is Information Technology where there are major issues of liability, confidentiality, policy, tele-psychiatry. Anyone with expertise or interest would be very welcome.

NYSPA has been working very hard and long for Parity. Timothy's Law is the bill that has been basically negotiated by our Legislative Advocate in Albany, Richard Gallo who was able to reconcile the different priorities of the Senate and Assembly, working closely with for example Senator Spano, a great advocate for the mentally ill and psychiatry who will be missed in Albany and another great advocate Senator Morahan who fortunately is still there. It was passed by the Senate and by the Assembly and signed by Governor Pataki just before he left office. It is inevitably a compromise bill, not including alcohol and substance abuse, but requiring all group health plans to cover at least 30 inpatient days and 20 outpatient days of treatment for all mental illness and large companies to provide full coverage for certain serious mental illnesses. The State covers the cost of coverage for employers with less than 50 employees.



The Governor vetoed the SHU bill that would end solitary confinement of mentally ill prisoners but it will be back next year.

NYSPA was able to ensure that $2 million has been set aside for the Medicaid/Medicare crossover restoration payments for outpatient psychiatric services that are paid at 50% and this will be paid at the end of the year on a pro-rata basis. This is six times the NYSPA dues!

Seth Stein, the extremely knowledgeable and effective Executive Director of NYSPA, reported that CMS has enhanced the value of the Evaluation and Management Codes (eg 99214) and has drafted a memo explaining when they can be used and the documentation required.

I am glad to say that members from New York State hold a disproportionate (to the membership) number of offices in the APA and contribute a disproportionate number of action papers to the Assembly. The current speaker of the Assembly, Michael Blumenfield (from Westchester), is encouraging more grass roots contributions through the District Branches; suggesting that each hold a 'hearing' on some important topic with local leaders or coalition partners, for public relations and or to develop an action paper to influence APA policy. The topics he suggested include mental health of returning veterans, access to care, stigmatization, the relationship with Pharma etc.

Less formally, anyone with strong views is encouraged to share them with the District Branch executive committee (everyone is welcome at its meetings) and the NYSPA meetings. As your District Branch Representative to the Assembly I will be glad to pass on your views and if appropriate help prepare an action paper. ▲

Nigel Bark , M.D.

A Night At The Phallus

On, Friday, October 27, The West Hudson Psychiatric Society was treated to an intimate dinner discussion led by Leon Balter, MD, addressing the cult of the male musical entertainer and it's origins in the myth of Orpheus, which Balter argues is the standard for appreciation of the symbolism of an ongoing cultural phenomenon.

First, the myth. The very earliest musicians were gods. Athena invented the flute, but never played it. Hermes made the lyre and gave it to Apollo, whose playing made the Olympian immortals forget all else. Hermes made for himself a pipe. Pan also played the pipes. The Muses played no instruments, but their voices were lovely beyond compare.

After the gods came the mortals, some of whose performances rivaled the gods, but none so great as Orpheus. On his mother's side, he was more than mortal. He was the son of a Muse. His mother gave him the gift of music. He had no rivals even among the Thracians, Greece's greatest musicians. When he played and sang, no one and nothing could resist him.

Things animate and inanimate followed him. He moved the rocks on the hillside and turned the courses of rivers. His power was witnessed with Jason on the Argo, when his singing and playing the lyre saved the crew from the Sirens.

When Orpheus met Eurydice, they married, but their joy was brief. As Eurydice walked into the meadow with her bridesmaids, she was bitten by a viper and died. Orpheus's grief was overwhelming and he dared the greatest journey for his love, to retrieve her from the underworld.

With his lyre, he charmed all to stillness. Cerberus the dog relaxed his guard; the wheel of Ixion stood motionless; Sisyphus sat at rest, Tantalus ignored his thirst, and even the eyes of the dread Furies were wet with tears. The ruler of Hades drew near to listen with his queen. No one under the spell of his voice could refuse Orpheus anything. Not even Hades.

They summoned Eurydice for Orpheus, but with one condition: He must not look back at her as she followed him until they reached the Upper World. He longed to look back, but waited until he broke into the daylight, and then glanced back. It was too soon, as Eurydice was still in darkness, and, as he put his arms around her, she slipped back away from him. He tried to follow, but the gods would not consent to a second journey into the world of the dead.

Utterly desolate, inconsolable, he wandered aimlessly, always playing the lyre, avoiding the world of men. Finally he encountered a band of Maenads, as frenzied as those who killed Pentheus so horribly. They tore Orpheus limb from limb, and flung his severed head into the swift river Hebrus. It was borne by water to the Lesbian shore, and found by the Muses, still singing. They gathered his limbs and placed them in a tomb at the foot of Mount Olympus, where, to this day, the nightingales sing the most sweetly.

Central to Balter's theme is that Orpheus is an atypical male hero, and, most importantly, a feminized male. Instead of the sword, he carries a lyre. He sings of peace, of themes central to the service of civilization, not of the destruction and conquest of enemies. Orpheus lived an ascetic existence. He did not eat meat. He is rumored to have liked quiche and broccoli pate.

Balter contends that, when Eurydice died the second time, it was an Oedipal defeat for Orpheus, and that his looking back for her was an act of ambivalence about wanting her, and possibly masochism. When the women savagely attacked Orpheus, the trophies of his head, lyre and limbs bestowed on them some of his magical power, and the submission of a feminized male is an ideal for the phallic woman. The defeat and incorporation of Orpheus satisfies the ideal fantasy to defend against depression and anxiety that is the lot of the female.

Having laid the groundwork for a thesis of the origin and symbolic meaning of the male entertainer, Balter treated us to a Who's Who of popular culture, beginning in Europe with the troubadors, who invented lyrical poetry and to the jousting festivals, where men maimed each other for the benefit of women, permitting, symbolically, the cannibalization of men.

He then barnstormed through the modern era. The first 'crooner' was Rudy Vallee, followed by a succession including Bing Crosby, Frank Sinatra, Elvis Presley and The Beatles, always addressing the feminized character of the artists. He included the actors Marlon Brando and Clint Eastwood as further examples of feminized men.

One hallmark of the modern artist is represented by his need for a microphone, a phallic prosthesis, required because of the modern male entertainer's lack of power. Weak men need a mike, so that their voices may be soft and intimate (feminine), and still may be heard.

Why did this phenomenon become so important here and now? First, we are a democracy, and the mike made possible the predominance and intimacy of the common man. Next, inventions like the radio and phonograph made possible the mass marketing of musical entertainment.

Balter sees fan clubs as an extension of the Orpheus phenomenon, wherein groups of women form a collective to acquire (cannibalize) trophies of their favorite feminized male cult icon. "Real men" says Balter, "do not ask women to 'Love Me Tender.'" ▲

Richard Brand, M.D.

Timothy's Law Implementation

Timothy's Law became effective January 1, 2007. However, the law does not become effective for patients until either their current health plan reaches its annual renewal date or they obtain a new health plan after January 1, 2007. Therefore, it is possible that for individual patients, Timothy's Law may become effective at different dates throughout the year. NYSPA is interested in learning about any problems that psychiatrists and their patients encounter with Timothy's Law implementation.

Please contact the NYSPA Central Office by email (centraloffice @nyspsych.org) or telephone (516-542- 0077) with any problems or questions.

As a reminder, here are the new Timothy's Law benefits:

- Every person covered by group health insurance or a group HMO plan has a minimum of 20 outpatient visits for mental illness and 30 inpatient treatment days a year.
- The state will pick up the cost of providing the 20/30 benefit for businesses with 50 or fewer employees.
- The 20/30 benefit covers all diagnoses covered by the state employees health benefit plan which cover members of the Legislature and their families.
- Larger employers have to provide an additional layer of coverage. It includes unlimited treatment for adults with schizophrenia/psychotic disorders, major depression, bipolar disorder, obsessive- compulsive disorder, delusional disorders, panic disorder, bulimia and anorexia. The level of coverage also applies to children under 18 for those illnesses plus "serious emotional disturbances," (SED) defined as attention deficit/hyperactivity disorders, disruptive behavior disorders and pervasive developmental disorders, where the child is at risk for suicide, serious self- destructive behavior, significant property damage or removal from the home.
- Smaller employers can opt into the expanded coverage.
- Deductibles and co-insurance for any covered mental health service must mirror those imposed for other benefits under the policy or plan. "Specialty copayments" will apply where policies impose a different co-payment for specialty services. The law does not affect utilization review requirements or out- of-network differentials, except that such differential must mirror those imposed on other covered illnesses in the policy. However, networks must demonstrate an adequate number of participating providers as will be necessary to accommodate the additional number of insured persons and added coverage.
- The law is in effect for three years. During that time, the state has to analyze the cost and effect of the law.
- The law does not affect coverage under the Child Health Plus, Family Health Plus or Healthy New York programs nor does it affect self-insurance plans which are exempt from state insurance law requirements by federal law (ERISA).▲

A Mentally Healthy Workforce? It's Good for Business

Posted at the request of the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation.

Most employers know that a mentally healthy workforce is linked to lower medical costs, as well as less absenteeism and presenteeism. What employers may not know, however, is how to get from A to B: How does a company change a mentally unhealthy workplace or a marginally healthy one to a healthy workplace? Where does it start?

The Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation, provides some insight into that question with its just-released publication, *A Mentally Healthy Workforce: It's Good for Business*. The document is unique because it weaves together stories from the workplace world with research findings to build a coherent picture of workplace mental health. Visit www.workplacementalhealth.org to download a copy of the publication.

We encourage you to share this email announcement with your members, as well as businesses and policymakers in your community. Also, as an APA District Branch, we would be happy to mail your office print copies of the publication for distribution. To obtain print copies, please email Mary Claire Leftwich at mleftwich@psych.org with the requested number of copies. You may also contact her at 703-907-8561.

P.S. We also remind you to take advantage of APA's newsletter for businesses, Mental HealthWorks. If you are not already receiving Mental HealthWorks, you can sign up and view back issues at www.workplacementalhealth.org. We have heard from many of you that Mental HealthWorks has been useful in efforts to educate businesses and policymakers about the value of mental health benefits and encourage you to include it in your outreach programs. ▲

Your District Branch, cont'd.

Finally, Drs. Kroplick and Kelman are responsible for our Spring Educational Meeting to be held on the evening of Friday 5/4/07 or 5/11/07 at a location yet to be determined. The topic is going to be Sleep Disorders presented by Drs. Horng and Brack of the Sleep Disorders Center at Good Samaritan Hospital. Look for an announcement in your mail.

Again, I welcome your interest and participation. Please call me at 845-362-2557 or email (DrFlax@aol.com) if you would like to discuss any district branch activities, attend an executive council meeting or volunteer to participate. I encourage any members or prospective members to join us for our Friday lunch meetings. You'll get to see what we talk about, to network with your colleagues, and to hear about matters of relevance to psychiatrists from different geographic areas and from different institutions or private practice. Beware, we will try to seduce you into involvement in district branch activities.

On a clinical note, I have learned a great deal about record keeping in my relatively new role as a consultant for a disability insurance company, reviewing the medical records of my colleagues from all over the country. Poor record keeping can have dire consequences for you if you are sued. Poor record keeping can complicate your patients' receiving disability insurance benefits. Two tips for you.

1. Make sure your notes are legible. Illegible records are no better than no records.

2. When you write your notes, think about how someone will make sense of the case if they are to read your record. Does the diagnosis make sense from the history and objective findings? Does the treatment make sense given the evaluation, the diagnosis and the course?

Practicing psychiatry continues to be a joy and privilege. ▲

James Flax, MD, President

IME's, cont'd.

when a treating psychiatrist agrees to perform a "forensic evaluation" on his/her patient and then testifies in court. In this situation, "besides potential ethical problems, the third-party evaluation may destroy the treatment relationship and expose the psychiatrist to claims of both medical and forensic malpractice".

A final note with regard to courtroom testimony following independent medical examinations: If it can be determined that a psychiatrist provided purposely false, inaccurate or negligent information during testimony, that psychiatrist may be subject to various ethical, legal and licensing sanctions.

In summary, while non-forensic psychiatrists certainly may provide these evaluations when called upon, it is incumbent upon the psychiatrist to, at least, learn about the legal, ethical and professional requirements in conducting these evaluations and the risks inherent in providing them. I am reminded of a situation some years back when a relative of mine, recently having acquired his Ph.D. in Psychology, awaiting approval from various managed care panels, called me to suggest that he would like to conduct "some forensic evaluations," and asked for advice in getting referrals. When I suggested that before he looked for the referrals, he acquire some training in forensic work, he was perplexed, not understanding that a large body of literature, standards and ethical guidelines exists for these evaluations separate and apart from the standards that he already understood for his profession. He, wisely, decided to wait for his managed care treatment approval. As the old saying goes, "Caveat emptor." ▲

Alan J. Tuckman, M.D.

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