Dear PaPS members,

I am thrilled to start this term as president of the society. I believe we have something very special here, and I want to thank my predecessors, whose leadership has laid a strong foundation for our society. I had the honor of working closely with the past few presidents, and I hope to be able to build upon their legacy. I also want to thank our association management team, Next Wave Group, for their work and for their ongoing effort to better serve our society’s needs. I cannot thank our council and committee members enough for their time and invaluable service. I rely on their ongoing support.

We will have a busy year that starts with work on engaging more members, especially residents, fellows, and early-career psychiatrists (ECP). This has been an ongoing effort, and we will try to do even more by establishing closer communication with residency training programs to educate them on the value of membership and to bring mentoring, networking, and educational offerings to the trainees. Our residents are the future of the practice of psychiatry, and PaPS is here to serve as a resource during their training years, assisting them through the transition into early-career psychiatrists and providing valuable resources and educational opportunities throughout their career. I believe more residents and ECPs should be involved in activities, committees, and task forces in our society. Our focus is to strengthen the bond between residents and other members of our society with the hope of reducing the loss of talented professionals who move out of Pennsylvania when they graduate.

Our committees are busy as usual. The government relations committee is continuing to do crucial work. We will keep updates on their activities on our website for the members and to encourage all to get involved in advocacy. Please be attentive to special emails from PaPS, as from time to time we have a “Call to Action” when support is needed.

We are in the planning stages for the annual board retreat, which will be held on September 7th. As a member-driven organization, we are trying to make constant strides to improve the value of our programs. A survey has been sent out to the entire membership to elicit feedback, which we will use to focus our meeting on the goals that are important to our membership. We hope to hear from as many of you as possible. If you have not completed the survey, please [click here].

Maintaining financial stability cannot be underestimated, as we have gone through some turbulent times in the past. Having said this, I think we should try our best to foster growth, innovation, collaboration, and inclusivity within our community while also maintaining fiscal responsibility.

We, as a society, care about the connectedness and networking of members. We should continue to present opportunities for members to socialize. I believe we, as a society, can support them in their work and career development, but can also help fight burnout, which is becoming more common. To this extent, the “meet and greet” in NYC during the last APA meeting was successful and very well attended. We will continue to host events like this. I hope to see you at one of these future events.

Thank you again for all your support, and I hope we have a productive year together.

Sincerely,
Irakli Mania MD, DFAPA, FASAM
President, Pennsylvania Psychiatric Society
2024–2025 Pennsylvania Psychiatric Society Executive Committee

**President**
Irakli Mania, MD, DFAPA, FASAM

**President Elect**
Kavita K. Fischer, MD, DFAPA

**Vice President**
Mark Matta, DO, DFAPA

**Immediate Past President**
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**ECP Representative**
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**Publication**
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**Website Manager**
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**PaPS Organization Management**
Patricia H. Troy, M.Ed., CASE, IOM, CAE
President/CEO Next Wave Group
PaPS Calendar of Events

July 9 - DB Executive Council Meeting
July 10 - PaPS Monthly Webinar Series
July 13 - DB & Chapter Council Orientation (Virtual)
July 16 - PaPS Government Relations Committee Meeting
July 16 - PaPS Membership Committee Meeting
August 7 - PaPS Monthly Webinar Series
August 13 - DB Executive Council Meeting
August 13 - DB Women’s Committee Book Club
August 20 - PaPS Government Relations Committee Meeting
September 4 - PaPS Monthly Webinar Series
September 7 - PaPS DB Council Retreat (in-person)
September 10 - DB Executive Council Meeting
September 17 - PaPS Government Relations Committee Meeting

**Events as of July 3, 2024**

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The PaPS community is comprised of approximately 1,350 members across Pennsylvania. Members are solo practitioners, hospital/clinic based, community and group practitioners, and academia.

With the diverse backgrounds in specialty practice, career level, and expertise, PaPS offers members a wealth of shared knowledge, experience, and mentoring.

PaPS looks forward to continue to serve our members needs in 2024.
There is much to interest psychiatrists in a recent book by English writer and podcaster Carolyn Crampton, a self-described “hypochondriac cancer survivor.” She discusses years of research in *A Body Made of Glass: A Cultural History of Hypochondriasis*. Her hypochondriasis apparently was not severe, perhaps not even present, before she received chemotherapy and radiation for Hodgkin Lymphoma at age 17. A year later an enlarged neck lymph node preceded a more lastingly effective stem cell transplant and persistently troublesome fears of disease. She has mixed feelings that a history of cancer caused her new medical doubts to receive many thorough evaluations by the National Health Service.

The presentation of the history of hypochondriasis is thoughtful and clear. Readers will enjoy reviewing how the medical dogma of humors was supplanted in turn by animal spirits, vapors and nerves. She gives an interesting patient’s view of how treatment with Eye Movement Desensitization and Reprocessing helped her. Discussion of other approaches such as Cognitive Behavior Therapy, antidepressant medicines, placebo (Zeebo pills), semi-placebo (vitamins), and Pain Neuroscience Education are presented more didactically. She believes that “the crucial tension is between the patient’s experiences of their condition and the lack of an explanation from the medical authorities.” The reader may enjoy thinking about Crampton’s challenge that DSM-5 “begins to seem less like a dictionary and more like an extensive exercise in obfuscation” when it replaces Hypochondriasis with Somatic Symptom Disorder and Illness Anxiety Disorder.

Although not therapeutically helpful, she clearly enjoys finding accounts starting thousands of years ago of persons with similar problems. Readers will enjoy her reviews of what has been written by and about such figures as Darwin, Proust, and Jane Austin. The title of her book comes from several, including a king, who believed they were made of glass and might break. Stories of the Nocebo Effect and a TikTok inspired increase in Tourette’s Syndrome patients are bracketed by descriptions of her sudden episodes of blindness and deafness several times a week. No medical explanation was found for these attacks but an unnamed medicine for hypotension reduced their frequency to only a few a year. This was not discussed as a possible Functional Neurological Disorder. Like many patients Crampton’s condition may have more than one facet.

One of the most attractive features of *A Body Made of Glass* is that it leaves me thinking even as it ends. Must she accept that hypochondriasis cannot be eradicated because it is based on the human propensity to doubt and fear? Is it best that she has “let go of the idea that I need to be less fragile, less breakable, less conscious of my every twinge and scrape”? Her mantra is “I am ill and I am well. I am still here.” But how is that useful? If these ideas let her function well without suffering, I am happy for her. But I still hope that more can be learned about effective diagnosis and treatment for others.

Edward C. Leonard, Jr. MD, DLFAPA
Welcome to the dog days of summer. I hope you had an enjoyable 4th of July holiday.

Congratulations to Dr. Irakli Mania on his appointment as President of the PaPS. Dr. Mania has hit the ground running and focused on meeting the mission and goals of the District Branch. Installation of new officers took place in June. See the congratulatory insert in this issue of the newsletter for all newly elected officers and directors. Members can be assured your needs and the fiduciary oversight of the Society is in great hands. If you have questions, concerns, or ideas for innovative programs, please email papsych@papsych.org.

PaPS’ District Branch Council members will be participating in its annual Council Retreat on September 7th to review its strategic plan, adjust goals based on today’s needs, and review feedback received from members through the 2024 Member Survey. If you have not taken an opportunity to submit your survey responses, please click here and submit by August 12th.

The submission window for DFAPA applications closed on July 1st with 138 APA members applying for this distinguished honor. PaPS was advised that five (5) members of the District Branch have submitted applications for DFAPA and will be moving on to the next phase of the review process.

PaPS’ monthly webinar series continues to provide members the opportunity to learn about various aspects of the specialty practice and provides 1.0 FREE CME credit hours to attendees. Sessions are recorded and uploaded to the Members’ Only portal on the website. July’s session focused on Beyond Tarasoff: Ethical Duties to Third Parties in Psychiatry and was facilitated by Dr. Jacob Appel of Icahn School of Medicine, Mount Sinai, New York City. For a complete list of the remaining session topics, please see the Calendar of Events.

As always, visit the PaPS website (papsych.org) for the latest District Branch and Chapter updates and registration information. PaPS Council meetings, whether at the District Branch or Chapter levels are open to all members. Registration is required for non-Council members.

Are your APA dues still outstanding? APA has moved your membership to “expired,” which means access to the APA and PaPS member benefits has been frozen. Fear not, there is still time to reactivate your membership. Head over to the APA website and renew your dues before August 31st to be reinstated. After September 1st, unpaid members will need to submit a new membership application.

If you have questions, concerns, or ideas for advancing the psychiatry profession for PaPS members, please reach out to me at rcook@nextwavegroup.net.

Be well,

Robbi-Ann M. Cook, CAE
Executive Director

ASSURE
The Roadmap to PaPS’ Path Forward

Advocate for the needs of patients and physicians
Support our members’ professional needs
Serve our patients and community
Uphold the highest standards of care for our patients
Respect diversity
Educate the public about mental illness

Mission & Goal of PaPS

Empowering Quality Psychiatric Care in Pennsylvania

Be part of the renewed energy and engagement. Get involved. Be engaged!
Congratulations to PaPS’ District Branch and Chapter Council members who were installed in June during the Annual Business Meetings. Visit the PaPS website (papsych.org) for a complete list of all elected officials.

**2024-2025 PaPS District Branch Council**

President—Irakli Mania, MD, DFAPA, FASAM  
President Elect—Kavita Fischer, MD, DFAPA  
Vice President—Mark Matta, DO, DFAPA  
Treasurer—Indranil Chakrabarti, MD, FAPA  
Secretary—Aileen Oandasan, MD, FAPA  
Immediate Past President—Usman Hameed, MD, DFAPA, DFAACAP

**Central Chapter Council**
President - Pradipta Majumder, MD, FAPA  
President Elect - Luke Piper, MD  
Treasurer/Secretary-  
   Yassir Mahgoub, MD, FAPA  
Immediate Past President  
   Zeeshan Faruqui, MD, DFAPA

**Lehigh Chapter Council**
President - Howard Levin, MD, FAPA  
President Elect - Elizabeth Mutter, DO  
Treasurer/Secretary-  
   John-Paul Gomez, MD, FAPA  
Immediate Past President-  
   Katherine B. Martin, MD

**Northeast Chapter Council**
President -  
   Sanjay Chandragiri, MD, DFAPA  
President Elect -  
   Dominic Mazza, MD, DLFAPA  
Treasurer/Secretary -  
   Immediate Past President -  
   Richard E. Fischbein, MD, DLFAPA

**Philadelphia Chapter Council**
President - Kenneth Weiss, MD, DLFAPA  
President Elect -  
   Heather V. John, MD, PhD, FAPA  
Vice President - Kristin Van Zant, MD  
Treasurer -  
   Frederick “Rick” Stoddard, MD, PhD  
Secretary - Sudha Nair, MD, MPH  
Immediate Past President -  
   Ellen Davis Conroy, DO, FAPA, FASAM

**Pittsburgh Chapter Council**
President - Mayank Gupta, MD, FAPA  
President Elect - Nicola S. Gray, MD, FAPA  
Treasurer - Tania Kannadan, MD  
Secretary - Santiago Almanzar, MD, FAPA  
Immediate Past President -  
   Aileen Oandasan, MD, FAPA

**Western Chapter Council**
President - Benjamin Gangewere, DO  
President Elect -  
   Treasurer/Secretary -  
   Allen D’Souza, MD, FAPA  
Immediate Past President -  
   Elizabeth Ramsey, DO, FAPA
As I write this (July 9), the legislature is in heavy discussion about the budget, which was supposed to have been passed by June 30 according to the state constitution. Going forward without a budget is mainly a problem for some agencies (like many in the behavioral health world) that rely on state grants, which are held up until the budget is passed. If it goes on too long, agencies and counties have had to borrow money to keep things going, which increases costs.

While the budget is being wrestled with, the legislature is in session, so other things can happen, but they rarely do. This year, that includes things like HB1000, authorizing psychologist prescribing.

We need to really thank the members of the psychiatric society who answered the call to fight the patient safety battle this month. Thanks to a lot of work by members of our committee, DB and chapter leaders, and many of our general members, the Professional Licensure Committee did not hold a vote on HB1000. We got late notice of a premeeting to be held on June 20, with a vote scheduled for June 26. A call went out to all members, with an emphasis on the constituents of the members of the Prof. Lic committee. It seems to have worked. The chair appears not to have had the votes, thanks to the lobbying done by our members. The bill remains in committee and can be acted upon at any time. We expect that nothing will happen over the summer recess, and the pre-election time does not generally take up such potentially controversial issues. The lame duck session after the election, if there is one, remains a potentially active time. Every bill dies on November 20, 2024, though we can expect it to be introduced in the next session.

We have made contacts with several legislators about getting state funding for psychiatry residency slots to help with access in a safer way than expanding scope. A survey of residencies in the state shows that 50–75% of residents trained here stay here. While there is a lot of support, time seems to have run out for this session. We will try to get it into the budget for next year. The cost to add one additional resident spot for each of the Commonwealth’s 14 residencies for four years would be approximately $7 million.

In the current budget negotiations, there is some hope that there will be money set aside for collaborative care support. As some will remember, this had been approved last year as part of a $100 million investment in behavioral health infrastructure (a response to mass shootings the year before, to answer gun violence, avoiding any gun restrictions). The $100 million was shifted to pay for a MH counselor in every school. We’re hoping for $10 million to support startup costs for primary care practices to develop electronic health records, hire behavioral health workers, and form relationships with psychiatrists.

Outpatient psychiatric clinic regulations are being reworked. There is an effort being put forward by the Rehabilitation and Community Providers Association (RCPA) and the Department of Human Services to amend current state regulations, which require outpatient psychiatric clinics to provide two hours of on-site psychiatric time per week for each full-time employee. Psychiatrists must be physically present for at least 50% of that time, with the remaining time covered by a psychiatrist or an advanced practice professional. COVID waivers relaxed the in-person requirement, but as those waivers run out, there is now a plan to allow the mandatory time to be done remotely and by either a psychiatrist or an advanced practice professional. The current regulations are ambiguous and confusing, especially concerning whether the time is to be spent in direct care, supervision, or administratively, so it appears something must be done. The push to equate APPs and psychiatrists is alarming, however. No legislation has been introduced yet, but possible wording has been floated, which we have commented on. OMHSAS and RCPA did not like our comments much. This is again being done in the name of access and the difficulty some clinics are finding when trying to hire psychiatrists.

We are also looking for ways to help with the rising number of people in the Commonwealth who are running into problems with gambling, as was predicted as access to online gambling became available. A bill to bar the use of credit cards for this purpose has been introduced but is unlikely to go anywhere due to the strength of the gaming lobby and the amount of money it generates for the state. Other approaches might pass muster, such as giving teeth to self-imposed bans and making it illegal for a person to gamble once they have asked to be excluded. Another method to limit problem gambling would be to bar the gaming industry from offering free credit extensions or other inducements to someone who has asked to be excluded.

Again, heartfelt thanks to all our members who contacted their legislators about psychologist prescribing and other matters. Unless we engage with our elected representatives, they will not know how important certain issues are to us. Even when there is nothing pending, it is vital for knowledgeable professionals like us to make our voices heard.

Thanks also to our strong partners at APA central offices who developed the action alert, which went to all Pa Psychiatric Society members very quickly, despite the Juneteenth holiday.

If any member has an issue with a potential legislative or regulatory move on the part of the administration or legislature or something that they believe should be addressed, please contact our executive director, Robbi Cook, or me directly.
Dry and monotonous as the law may be, practitioners in Pennsylvania, particularly psychiatrists and emergency physicians, are well-served by an understanding of Pennsylvania’s Mental Health Procedures Act (MHPA). This act comprises chapter 15 (sections 7101-7503) of PA’s Title 50. Written in 1976 (and surviving largely intact even to this day), the key functions of this law involve defining the legal basis and mechanisms for voluntary inpatient psychiatric hospitalization, as well as involuntary inpatient (and in some cases, outpatient) treatment. The colloquial shorthand of ‘201,’ ‘302,’ and so on comes from the respective sections of this law (e.g., section 7201, and section 7302). Importantly, the MHPA defines the “how” of inpatient mental health treatment (i.e., the legal procedures involved), as well as the “why” (i.e., what facts warrant consideration of treatment treatment); these are essential topics for PA physicians to understand, especially emergency physicians and psychiatrists who are most likely to field patient presentations that warrant psychiatric hospitalization.

My writing this quarter intends to highlight what I view as a more subtle feature of the MHPA, but a critically important one that physicians ought to be aware of. It comes from section 114 and reads as follows:

Section 114. Immunity from Civil and Criminal Liability.—(a) In the absence of willful misconduct or gross negligence, a county administrator, a director of a facility, a physician, a peace officer or any other authorized person who participates in a decision that a person be examined or treated under this act, or that a person be discharged, or placed under partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise reduced, or a county administrator or other authorized person who denies an application for voluntary treatment or for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

This is the MHPA’s limited immunity provision for physicians acting under its purview, as well as other individuals who may be involved in the Act’s procedures (e.g., the police officer who brings a patient in for evaluation under a 302 petition).

For our purposes, what this essentially states is that a physician who acts in accordance with the MHPA (for example, petitioning a 302, upholding/denying a 302, treating a hospitalized patient, or discharging a patient treated under the act) is immunized from civil or criminal liability unless they acted with “willful misconduct or gross negligence.”

One of my previous articles for Pennsylvania Psychiatrist described the pillars of medical malpractice, where ordinarily the standard for civil liability is ordinary negligence (basically, that some action fell below a certain standard of care, even in the context of generally well-intentioned care). Section 114 serves as a liability protection for PA psychiatrists because it insists upon a “gross negligence” standard. Cornell Law School’s Legal Information Institute describes gross negligence as “representing an extreme departure from the ordinary standard of care,” and “willful, wanton, and reckless conduct” that “implies a thoughtless disregard of the consequences” and a “failure to use even slight care” to avert those consequences. PA case law generally accords with this view, calling it “[behavior that is] flagrant, grossly deviating from the ordinary standard of care” (Albright v. Abington Memorial Hospital, decided 1997) or “[wanting] of even scant care…an ‘extreme departure’ from ordinary care” (Feleccia v. Lackawanna College, decided 2019).

Hopefully, the difference is apparent on its face. The practical import of this is that gross negligence is much more challenging to establish (both in terms of a legal complaint that could survive a dismissal motion, and in terms of an actual civil trial). As a result, physicians who demonstrate well-meaning efforts to take care of patients under the MHPA – even if not perfect – are heavily insulated from liability under section 114. For example, even if a bad outcome resulted from a patient’s being discharged from treatment under the MHPA, a plaintiff would have to go further than alleging ordinary negligence (e.g., a mistake in the suicide risk assessment or treatment plan) and would instead have to show that the discharging psychiatrist was, to paraphrase PA case law, “wanting of even scant care” in their decision-making.

The Pennsylvania State Legislature was deliberate in its decision to craft this immunity provision. The MHPA’s policy statement (section 102) notes the desire of the legislature to “assure the availability of adequate treatment to persons who are mentally ill,” and likewise notes that “treatment on a voluntary basis shall be preferred to involuntary treatment; and in every case, the least restrictions consistent with adequate treatment shall be employed.” The Legislature recognized challenges physicians would face (and which many of us can relate to) in balancing patient autonomy with the sometimes serious and acute safety risks brought to bear by their mental illness.
Absent an immunity provision, it’s easily conceivable that psychiatrists, emergency physicians, and others would hesitate to offer help to patients in desperate need of psychiatric care (and take on the consequent liability risks), violating the MHPA’s goal of ensuring availability of such care. Additionally, facing the ordinary negligence standard in a high-risk arena of emergency psychiatry, physicians would be incentivized to seek more restrictive treatment to minimize liability exposure upon themselves, violating the MHPA’s favor toward less-restrictive alternatives.

To be sure, MHPA section 114 is not license for psychiatrists, emergency physicians, and others to act callously, impulsively, punitively, or without the patient’s best interests in mind (hence why the section still allows for liability in cases of gross negligence or willful misconduct). In fact, PA case law has held that in the presence of such conduct, the MHPA implicitly allows plaintiffs to bring suit (Goryeb v. Commonwealth, Department of Public Welfare, decided 1990). But it does offer reassurance that well-meaning care efforts under the MHPA are heavily insulated from malpractice liability, and offers us respite against the ravages of defensive medicine (which can be especially troubling when considering options such as involuntary commitment). Psychiatrists in Pennsylvania, whether early-career psychiatrists or seasoned practitioners, are wise to keep this in mind, both in respect to considering work in emergency psychiatric settings, and with respect to treatment and disposition decisions. Wrestling against defensive instincts has been a perennial challenge in my early years as an attending; I take section 114 as reassurance that when working with patients under the MHPA, I can focus on what is in my patient’s and society’s best interests, and not simply what most insulates me from liability.
July is my favorite time of year when it comes to academic medicine. Many occupations abide by the calendar year or a fiscal year, but medicine follows the academic year, and we turn over a new leaf every July 1st. The long-awaited achievement of graduating trainees heralds the entrance of newly minted physicians eager to leave behind their short white coats. As one class passes the baton to the next, those still running in the marathon of clinical training advance in their supervisory roles. This hierarchical structure of medical education is partly what fosters camaraderie and our sense of community, in addition to organized efforts like the American Psychiatric Association and our own Pennsylvania Psychiatric Society.

One of the things I appreciate about PaPS is how easy it was for me to get involved shortly after relocating to Pennsylvania for residency. Previously, I lived and trained in the South from high school up to the completion of my internal medicine year during the pandemic. While there, I was involved in advocacy work at the local and state levels. So, when I moved to Philadelphia, I knew I wanted to join the Government Relations Committee which led to my joining the Workforce Shortage Task Force. These groups allowed me to quickly gain insight into the issues my new city, state, and specialty were facing at the legislative level.

While honing one’s clinical craft should be the major focus of residency, it is also important to consider one’s career with a long-term view involving various stakeholders. Relative to other specialties, our patients disproportionately experience barriers that hinder their access to reliable high-quality mental healthcare. To ensure that we are delivering the highest standard of psychiatric care as interns, residents, fellows, and attendings, we must protect our patients by safeguarding our training.

In the next issue, I will explore some of the efforts going on behind the scenes and on the frontlines so that we can continue to usher in future generations of psychiatrists to our Commonwealth. Until then, stay cool and safe this summer and enjoy the thrill of newness that only a new academic year can bring!

If you have a program activity or residency endeavor that you would like to highlight, feel free to email me at gracecho.einstein@gmail.com. I’d love to collaborate with you in shaping a brighter future for our specialty.

Yours in service,
Grace Cho, MD

Dr. Cho is a PGY-4 psychiatry resident and administrative chief resident at Jefferson Einstein Philadelphia Hospital, as well as an APA/APAF Leadership Fellow currently pursuing a fellowship in forensic psychiatry. She is the new resident-fellow representative for the state.
Since former Chapter President, Ellen Davis Conroy, reported on the annual Colloquium of Scholars in the last issue, we enjoyed a Spring dotted with education, social, and charitable events.

On April 13, the Chapter held its Women’s Committee education event at the Inn at Swarthmore. The topic was unusual and timely: Autism Spectrum Diagnosis. Dr. Cecelia Johnson-Dunlap spoke on the presentation of ASD in female patients, a theme amplified by Drs. Julia Parrish-Morris and Wendy Ross. Psychologist Jamie N. Pearson introduced the FACES program of advocacy to support Black families with ASD members. The program was a great success with impressive attendance on a Saturday morning.

In May, following the Convocation of Fellows at the APA’s annual meeting in New York City, the PaPS held a social meet-and-greet event that was well attended by Chapter members. It was great to interact with PaPS members from outside the Philadelphia area as well as to see familiar colleagues in an informal setting. It left everyone with a positive feeling about not only Pennsylvania psychiatry but with enthusiasm for our profession.

June was also an active time for the Chapter. Several Chapter members participated in PaPS’s Fireside Chat on June 13, and evening program entitled “Women in Psychiatric Society Leadership: Lessons Learned and Lessons to Share.” Moderated by Drs. Aileen Oandasan and Andrea Bowen, the session included panelists Drs. Mary Anne Albaugh, Ellen Davis Conroy, Hope Selarnick, and Kristin Van Zant.

At the final Chapter event, the Annual Meeting, we had the changing of the guard. Dr. Conroy recounted the year’s activities and conveyed inspiration about our profession before handing the reins to yours truly. I’m so indebted to her and to Roy Harker from Next Wave Group for paving the way for me. I’ve started my presidential year not only with a lot of momentum but also with a great roster of Executive Committee officers, representatives, and committee members. There’s a lot to look forward to!

Looking to the calendar of events, our major event, the annual Awards Gala, will take place at the College of Physicians of Philadelphia on the evening of November 16. The awardees will be announced in the next issue. Meanwhile, we have a stellar Education Committee headed by Dr. Rama Rao Gogineni. They are working on details for our 2025 Colloquium of Scholars in March. There will be other educational and social events throughout the year. I’m delighted to be part of a vibrant community of professionals.
Support the Advocacy Efforts of the Pennsylvania Psychiatric Society Today

The PaPS PAC Online Donation Portal Is Now Live

PaPS PAC Mission: The PaPS PAC represents the interests of Pennsylvania psychiatrists and our patients. Contributions are used to show bipartisan support to our friends in the Pennsylvania legislature who champion the causes and concerns important to psychiatry and medicine in our state.

Make Checks Payable & Mail To:
Pennsylvania Psychiatric Society - PAC
PO Box 61634
Harrisburg, PA 17106

*Contributions are not tax-deductible, are voluntary and open to U.S. Citizens only. PA Campaign Finance Reporting Law prohibits corporate contributions.*

PaPS EDUCATIONAL SERIES
Monthly Educational Sessions geared for all career levels.
Held the 1st Wednesday of Each Month | 6:30 PM to 7:30 PM | Virtual Format

September 4, 2024
Minors’ Claim Review

Facilitator: C. David Cash, JD, LLM
Planner, Content Developer, Speaker
Professional Risk Management Services, Inc. (PRMS)

1.0 CME Credit Hour Available
Registration Required
PaPS Members Free | Non-Members: $35/Session
The Pittsburgh Chapter will again host the **Resident Research and Awards Night**.

Plan to attend and meet/network with your colleagues to support and promote mental health together.

**Registration will open in late September!**

Questions?

Email PaPS Western Regional Director Judy Lyle at jlyle@nextwavegroup.net
At the last council meeting of the Pittsburgh chapter of the Pennsylvania Psychiatric Society, I had the honor of assuming the role of president, succeeding the highly esteemed Dr. Aileen Oandasan. Dr. Oandasan has been a remarkable leader, bringing a wealth of diversity and enthusiasm to our chapter through her inclusive leadership style. Under her guidance, our chapter has flourished, addressing many critical issues and setting a commendable example for all of us. Her initiatives, such as the highly successful Resident Night and the Spring Symposium, have been instrumental in fostering community and professional growth within our chapter. We extend our deepest gratitude to Dr. Oandasan for her outstanding contributions and wish her continued success in her central leadership role on the governing board and council.

Since taking on the presidency, we have held one general council meeting where several actionable points were discussed. One of the most pressing issues addressed was the recent legislative action opposing psychologists prescribing privileges. Recognizing the importance of this matter, the Pittsburgh chapter has made a concerted effort to reach out to local legislators. In response, the council has agreed to form a dedicated committee, led by some of our esteemed members, to work directly on government relations. This committee will not only focus on this issue but will also encourage more active participation from our chapter in legislative actions and government relations. This initiative aims to ensure that our voices are heard and that we continue to advocate for the best interests of our profession and our patients.

In addition to the government relations committee, we have also established a Resident Engagement Committee. This new committee, led by one of our young and dynamic council members, aims to promote organized psychiatry among residents and address the various challenges that lie ahead. By fostering greater engagement and participation from our resident members, we hope to cultivate a strong foundation for the future of our chapter and the broader psychiatric community.

Looking ahead, we have several exciting plans and initiatives on the horizon. We are organizing a series of fireside chats, which will provide an informal yet informative platform for members to discuss pertinent issues and share insights. Furthermore, our council is diligently preparing for the presentation of lifetime achievement awards and early career awards. In recognition of the contributions made by mid-career psychiatrists, we are also in the process of creating a new award category specifically for them.

Our plans for the year include enhancing the Resident Night, making it even more comprehensive and engaging, and developing an impressive lineup for the Spring Symposium. These events are not only opportunities for professional development but also for strengthening the bonds within our community.

The Pittsburgh chapter is deeply aligned with the overarching vision of the District Branch (Pennsylvania Psychiatric Society). By working closely with the central leadership, we aim to bring issues to our members from the ground up and foster effective communication and collaboration. Our commitment to these goals ensures that we remain a vibrant and dynamic chapter, dedicated to advancing the field of psychiatry and serving our community with excellence.
The Western Chapter held its annual business meeting on May 24th. We are very excited to have new members participating in leadership this year, and we are very much looking forward to planning future activities for the Western Chapter.

WE ARE ALWAYS LOOKING FOR NEW WAYS TO ADD “SPICE” TO OUR NEWSLETTER.

Feeling the urge to write an article or share a story you found interesting?

We’d love to hear from you!

Please contact Bev Dupuis, at bdupuis@nextwavegroup.com

DEADLINES FOR FUTURE NEWSLETTERS:

Fall Newsletter: September 5, 2024
Did You Miss This in the APA News?

LIFESTYLE AND GLOBAL PSYCHIATRY
Ramaswamy Viswanathan, M.D., Dr.Med.Sc.

As I begin my APA presidency, I would like to thank you for giving me the opportunity to make an impact on mental health on a large scale. One of the areas on which I will focus during my presidency and beyond is improving the lifestyle of our members, our patients, and the community at large, to enhance their mental and physical functioning, prevent illnesses, and ameliorate existing illnesses.

AMERICANS, PSYCHIATRISTS AGREE: SPORTS CAN BE GOOD FOR MENTAL HEALTH

As the Olympics kick off in Paris later this month, 84% of Americans who participate in sports—whether on a competitive or recreational level—say it benefits their mental health, according to a new poll. A majority (57%) of American adults say they participate in sports, with men (67%) more likely than women (48%), and non-white individuals (69%) more likely than white (non-Hispanic) individuals (50%) to say so.

JULY ISSUES OF APA JOURNALS COVER NEW RESEARCH


The latest issues of four American Psychiatric Association journals, The American Journal of Psychiatry, Psychiatric Services, American Journal of Psychotherapy and Psychiatric Research and Clinical Practice are now available online.

REGISTRATION NOW OPEN FOR THE 2024 MENTAL HEALTH SERVICES CONFERENCE

Join us in Baltimore, MD, Sept. 26-28, 2024, at the Hilton Baltimore Inner Harbor hotel to collaborate on practical advice to influence systems-level change for patients.

NOMINATIONS INVITED FOR APA BOARD POSITIONS

APA’s continued success hinges on the knowledge and input of its members. Nominate yourself or a colleague for one of six open Board of Trustees positions in 2025 including president-elect, secretary, and minority/underrepresented (M/UR) trustee. The nomination deadline is September 1, 2024.

RECEIVED EMAIL REQUESTS FROM MATHEMATICA ON BEHALF OF AMA?

If so, please respond. APA encourages members to complete the AMA Physician Practice Information Survey (PPIS). The data collected by the PPIS, which impacts physician payments, has not been updated in more than 15 years. Psychiatry needs more responses to accurately estimate psychiatry practice costs. If you want to check whether your practice should have received the survey or have other inquiries, please email Christy Buranaamorn.

APA FOUNDATION AWARDS

The APA Foundation’s annual awards recognize individuals and organizations who are innovating efforts to increase access to mental health care and improve the lives of community members with mental health concerns. For example:

The Chester M. Pierce Human Rights Award recognizes the extraordinary efforts of individuals to promote the human rights of populations with mental health needs by bringing attention to their work.

The O’Leary Award for Innovation in Psychiatry provides seed money to launch innovative ideas in the field of mental and behavioral health.

To nominate a colleague or peer organization for one of our awards, please click here: apply.psychiatry.org. The application deadline is August 15, 2024. If you have any questions, please email APA Foundation Awards (apafawards@psych.org).

Continued on next page >
APA STATE ADVOCACY CONFERENCE COMING IN SEPTEMBER

The 2024 State Advocacy Conference will take place September 21-22 at the Sheraton Pentagon City Hotel in Arlington, Va. This event is designed to help psychiatrists develop effective strategies and tactics to engage legislators on the many challenges facing psychiatry and mental health at the state level.

LEARN MORE

LATEST ADVOCACY NEWSLETTER NOW AVAILABLE

From hosting Congressional briefings to providing input on health care technologies, APA members and staff have been busy advocating on behalf of psychiatrists and their patients. Learn about recent events and accomplishments in the June Advocacy Update.

LEARN MORE

LOOKING TO HIRE A PSYCHIATRIST?

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About 2 - 4% of Multiple Sclerosis (MS) patients will develop psychosis, which may present prior to the initial diagnosis of MS, and will respond to corticosteroid treatment.\(^1\)

**TL; DR:** MS effects the brain through autoimmune & inflammatory factors, along with lesions that can occur in the periventricular areas; all being related to psychosis symptoms.

A 37-year-old male presented to the ED 2 weeks prior to his psychosis symptoms with a left facial droop, upper extremity weakness, paresthesias and dysarthria. On the current visit to the ED, his drug and alcohol screens were negative; and he was suffering from auditory hallucinations and delusions. No mood symptoms were present and his MMSE was 28 of 30. MRI results identified lesions in the periventricular, posterior right frontal and central pontine areas. CSF evaluation found oligoclonal bands and elevated myelin basic protein. The patient responded to a 5-day course of methylprednisolone 1000 mg/day, with remission of psychosis symptoms on day #4. Only about 20% of MS patients who present with mental health symptoms will have already discovered their illness. Keeping a high index of suspicion and ordering rapid assessment can help us choose a more effective treatment with corticosteroids (vs. antipsychotics) in these patients.

Obese patients can lose up to 15% of their body weight using semaglutide 2.4 mg weekly, but the effect plateaus by 18 months and most do not continue it.\(^2,3,4\)

**TL; DR:** Semaglutide 2.4 mg creates dramatic weight loss in patients, but 73% of patients stop it at 1 year due to high cost & adverse effects – then, lost weight is soon regained.

GLP-1 agonists are dramatically shifting the treatment of obesity, producing a loss of 5-15% of patient body weight that has been persistent at 68 weeks of continued use. 78% of patients taking semaglutide (vs. 36% with placebo) lost at least 5% of their body weight; 61% (vs. 16%) lost at least 10%; and 42% (vs. 7%) lost at least 15%. Yet, each weekly dose costs $1300; limiting ongoing use for most patients. The most common adverse effect is increased heart rate (+10-19 BPM in 41% of patients). Further, serious adverse effects have also been identified: x9 greater risk of pancreatitis, x4 greater risk of bowel obstruction, x3 greater risk of gastroparesis. To avoid aspiration during anesthesia, semaglutide should not be used 7 days prior to surgery. There have been reports of depression and suicidality, as well. For these reasons only about 27% of patients continue GLP-1 agonists at 1 year. When your patient is using semaglutide, consider their history of (and monitor their) depression and suicidality.

While QTc prolongation is a concern when using haloperidol or ziprasidone, this study of 382 ICU patients did not find significant ECG changes using twice daily dosing.\(^5\)

**TL; DR:** It is reassuring that for 382 ICU patients treated for delirium with haloperidol or ziprasidone, there was no significant difference in ECG measured QTc compared to placebo.

In a randomized clinical trial at 16 US medical center ICUs, N=566 patients were given either haloperidol (n=192), ziprasidone (n=190) or placebo (n=184). Pretreatment median QTc intervals across the groups were similar: haloperidol 458 msec, ziprasidone 451 msec and placebo 452 msec. The maximum haloperidol dose was 20 mg/day IV, while the maximum ziprasidone dose was 40 mg/day IV. Compared with placebo neither haloperidol (OR, 0.95; P = .78) or ziprasidone (OR, 1.09; P = .78) was associated with prolonged a QTc when comparing measurements over the first 48 hours of treatment. The median QTc interval changes were -1.0 msec for haloperidol, 0 msec for ziprasidone and -3.5 msec for placebo. These data provide support that when using haloperidol or ziprasidone in the treatment of ICU patients, cardiac rhythm changes appear to be negligible.

Long term use of Attention Deficit Hyperactivity Disorder (ADHD) medications was associated with an increased risk for hypertension and arterial disease in all age groups.\(^6\)

**TL; DR:** A 14-year study of 278K ADHD patients (ages 6-64 years) found that long-term drug treatment led to a yearly 4% increased risk for cardiovascular disease (CVD).

Prior long-term follow-up studies of ADHD drug treatment have been no longer than 2 years. In this case-control study of 278K ADHD patients treated between 2007 and 2020, 10 388 cohort patients who developed CVD were compared to 51 672 cohort patients who did not. The study found that regardless of age, each 1-year addition of ADHD treatment was associated with a 4% increased risk of hypertension or arterial disease. Longer cumulative ADHD drug use showed an increased risk for hypertension: 3 to <5 years, AOR 1.72; >5 years, AOR 1.80. For arterial disease, the increased risk was: 3 to <5 years, AOR 1.65; >5 years, AOR 1.49. No increased risks for arrhythmias, heart failure, ischemic heart disease, thromboembolic disease or cerebrovascular disease were found. Overall, a 23% increased CVD risk was identified in patients treated for >5 years with ADHD medication compared with nonuse. These data encourage us to be vigilant for cardiovascular signs and symptoms for all of our ADHD patients.

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SAMHSA
July 8, 2024
Biden-Harris Administration Announces $27.5 Million in Funding Opportunities Enhancing Women’s Behavioral Health

NIMH
Collaborative Care Could Help Reduce Disparities in Mental Health Treatment
In an NIMH-funded study, a comprehensive collaborative care intervention significantly reduced post-traumatic stress disorder (PTSD) symptoms among trauma patients from racial and ethnic minority backgrounds.

Upcoming Events
• July 11–12, 2024 Virtual
  Placebo Workshop: Translational Research Domains, and Key Questions

• August 8, 2024 Virtual
  Office for Disparities Research and Workforce Diversity’s Disability, Equity, and Mental Health Research Webinar Series: Transforming Mental Health Disability Research Through Lived Experience Leadership and Co-Production

• August 30, 2024 Virtual
  Information Session: NIMH Intramural Research Program Training Opportunities (August)

CMS.GOV
Biden Harris Administration Reaffirms Commitment to EMTALA Enforcement
Following the Supreme Court’s decision in Moyle v. United States, U.S. Department of Health and Human Services Secretary Xavier Becerra and the Centers for Medicare & Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure sent a letter to hospital and provider associations across the country today reminding them that it is a hospital’s legal duty to offer necessary stabilizing medical treatment (or transfer, if appropriate) to all patients in Medicare-participating hospitals who are found to have an emergency medical condition. CMS also announced that the investigation of EMTALA complaints would proceed in Idaho while litigation continues in the lower courts.

HHS authorizes five states provide historic health care coverage people transitioning out
Illinois, Kentucky, Oregon, Utah, and Vermont to provide better continuity of Medicaid and CHIP coverage for incarcerated people, whose health care needs — from substance-use disorder treatment to chronic physical health conditions — have historically gone overlooked.
Next Wave Group is pleased to offer this program to its client District Branches. APA works every day with policymakers on Capitol Hill, in the Administration, and at the state level to shape legislation and regulations to advance psychiatry and promote the highest quality of care for our patients and their families. As an APA member, you play a critical role in furthering our advocacy priorities and policy agenda.

Come join the Division of Advocacy on Thursday, October 10, 2024 at noon ET, in an interactive setting to learn more about our advocacy agenda, the current state of play, ask your questions, and begin your journey as an advocate.

October 10, 2024
12:00 PM ET
THIS IS VIRTUAL
Click here to register.
CASE OF THE QUARTER:
SWALLOWING A BITTER PILL

Written by
Claims Department
Professional Risk Management Services® (PRMS®)

The “Case of the Quarter” column is a sample case study that highlights best practices in actual scenarios encountered through PRMS’ extensive experience in litigation and claims management. Specific names and references have been altered to protect clients’ interests. This discussion is for informational and education purposes only and should not be relied upon as legal advice.

FACTS:

For three years, Dr. Smith has treated Mrs. Jones for major depressive disorder. Mrs. Jones is 38 years old, married, and has three minor children under the age of six. Mrs. Jones is a wealth management advisor and earns $500,000 plus per year. Her husband takes care of the children and does freelance writing, but Mrs. Jones is the main wage earner.

Mrs. Jones’ primary care physician referred her to Dr. Smith for treatment of her depression. Dr. Smith obtained records from the primary care physician and found that he had prescribed Lexapro for six months prior to the referral with minimal improvement. Dr. Smith noted her review of prior records and what she found to be significant. Over the course of treatment, Dr. Smith prescribed two antidepressants before prescribing Zoloft. Mrs. Jones reported feeling best on the Zoloft and had been stable on the same dose for eight months. Each time she changed the medication, Dr. Smith documented the patient’s report of effectiveness and the reasons for the change. At each visit, Dr. Smith performed and documented a suicide risk assessment using a rating scale that met the standard of care. Her notes indicated that Mrs. Jones did not have a history of suicidal gestures, attempts, or reported ideation. Dr. Smith documented her referral to a therapist and that Mrs. Jones was meeting with him regularly. Further, she documented that she had spoken to the therapist and asked for a call if the therapist had any concerns about Mrs. Jones’ mental health.

Three days after the last visit with Dr. Smith, Mrs. Jones checked into a hotel and hung herself.

ALLEGATION:

Mr. Jones filed a wrongful death action against Dr. Smith. He alleged that she failed to adequately assess his wife’s suicide risk and failed to appropriately monitor her medications thereby causing her death.

DEFENSE:

Dr. Smith’s documentation was so thorough that finding a well-credentialed expert to support her care was easy. Dr. Smith made an excellent witness during her deposition. Mr. Jones was also an excellent and sympathetic witness. He testified of their loving relationship and the devastation his children felt at losing their mother. He also testified that his wife was crying and sleeping more in the last two weeks of her life. Neither Mr. or Mrs. Jones reported this to Dr. Smith or the therapist. Dr. Smith’s attorney felt the case was very defensible on liability but had concerns about the potential damages. Defense counsel explained that the case would be tried in a liberal jurisdiction that would want to award this widower and his three young children a lot of money. He also said that the economic damages could be over $10 million dollars given her high earnings. Such an award would exceed Dr. Smith’s policy limit of $1 million dollars.
and expose her personal assets. Because of the potential exposure to Dr. Smith's personal assets and the liberal venue, defense counsel and the claims examiner advised Dr. Smith to consent to settling the case and suggested she was free to consult with personal counsel at her own expense, if desired. However, they also advised Dr. Smith that because the policy required her consent to settle, if she wanted to try the case, they would support her decision and do their best to win a defense verdict.

OUTCOME:

Dr. Smith felt she met the standard of care. The record and the expert supported that position. Defense counsel and the claims examiner felt the case was defensible; however, they knew that a trial always brings with it uncertainty. If the jury found for the plaintiff, an award would likely exceed the policy limits. As much as she wanted her day in court, Dr. Smith consented to settling the case thereby choosing the certainty of knowing her personal assets would not be exposed. The policy limit was offered and Mr. Jones accepted it.

TAKEAWAY:

Meeting the standard of care and documenting that care meticulously strengthen the ability to defend a provider. Consenting to settle in such situations is akin to swallowing a bitter pill. However, sometimes the potential damages or award, make settling the difficult, but prudent path to take. Defense counsel and the claims examiner consider many factors when advising an insured on settlement versus trial. Such factors may include the venue (plaintiff- or defense-friendly), recent awards in similar cases, the strength of expert support for the insured’s care, and the insured’s preference for the certainty of settlement versus the uncertainty of trial. Protecting an insured’s personal assets is always a priority. Perhaps most important to note is that Dr. Smith retained control over the course of her case because her policy included a clause requiring her consent to settle. Further, she had a defense team ready to support her in whichever path she chose.
WHY BECOME A FELLOW?

• Fellow status is an honor that reflects your dedication to the work of the APA and signifies your allegiance to the psychiatric profession.
• You are recognized by your colleagues in the Association as a member of a very select group.
• All newly appointed Fellows are publicly recognized at the Convocation of Distinguished Fellows, which is held every year during APA’s Annual Meeting.
• You receive a lapel pin in recognition of your status.
• Annual dues rates for General Members and Fellows are the same.

WHAT ARE THE GUIDELINES AND CRITERIA FOR ELIGIBILITY?

To become a Fellow, a member must have at least two of the following:

• Must be a current APA General Member or Life Member in good standing for at least three years.
• Served in a psychiatric leadership position on a national, district branch or international psychiatric association for over five years.
• Is certified by the American Board of Psychiatry and Neurology, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Association.

There is a 30-day review period for the district branch to offer comments about the Fellowship candidate. Approval by the APA Membership Committee takes place in the fall, and approval by the APA Board of Trustees takes place in December.

HOW DO I APPLY?

Fellow applications must be submitted by September 1.

Fellow applicants may apply by:

• Downloading and completing the application, or
• Submitting an online application
Psychiatrists

- 3+ months availability
- Certified psychiatrist with current valid license
- 2+ years clinical experience in a multi-disciplinary setting treating patients with psychotherapeutic and/or counselling methods
- At least 6 months of clinical practice within the last two years
- Experience managing or training staff
- Ability to work with and live in with a diverse team
- Assets: French language skills

MSF-USA is committed to the principles of equity, inclusion, and respect of diversity. As core principles inextricably linked to our success; equity, inclusion, and respect of diversity allow us to carry out our social mission and serve our patients.

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For more information and to apply:
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