

# The Wisconsin Psychiatrist

Spring 2010 | Volume 50 • Number 1



## Psychosomatic Expert Headlines WPA 2010 Annual Meeting

By Claudia Reardon, MD and Jerry Halverson, MD, 2010 Annual Meeting Co-Chairs

Wisconsin psychiatrists and family physicians descended upon the American Club in Kohler, WI for this spring's WPA Annual Meeting on April 23-24, 2010. Attendees indicated via post-meeting evaluations that they thoroughly enjoyed the weekend's events and speakers. They found the mix of speakers, both local and national experts, to be polished presenters who melded well under the general theme of "where psychiatry and medicine overlap".

Headliner James Levenson, MD, perfectly illustrated that overall theme with his series of three talks. He discussed nuances of psychiatric treatment in the medically ill, breaking down this discussion by organ system in a very user-friendly and practical manner. His second talk, on the use of neuroleptics in the treatment of delirium, exemplified that you should not believe everything you read. His third presentation, delivered first thing on Saturday morning to what was likely a record-setting crowd for our Saturday 8 am time slot, addressed psychiatric legal issues; Dr. Levenson impressed with his having diligently researched Wisconsin mental health law despite his living in the far-off state of Virginia. Besides the talks he delivered, Dr. Levenson was an active audience participant during the other seminars, and also enjoyed meeting many of our state's psychiatrists at the Friday evening reception and during the lunch he had with residents and early career psychiatrists earlier that day.

To be sure, a full cast of local psychiatric experts was not to be outdone by Dr. Levenson. MCW's Tom Heinrich, MD presented an impressive review of the metabolic effects of atypical antipsychotics. Rogers Memorial Hospital's eating disorder expert, Ted Weltzin, MD, shared his wisdom on

the latest in eating disorders. UW's Ruth Benca, MD, PhD delivered a captivating update on sleep medicine. The longstanding head of college mental health services at the University of Wisconsin, Eric Heiligenstein, MD, delivered a double-header with his thought-provoking talks on treatment of nicotine dependence in the mentally ill, and a rational approach to ADHD management.

Friday's educational programming concluded with a special presentation by Olympic track and field athlete Suzy Favor Hamilton. Her dramatic presentation began with a video clip portraying her as a successful, beloved, decorated world-class athlete. She proceeded to discuss the struggles underneath the surface, though, which included her brother's suicide, her own struggles with depression, eating disorders, and compulsive exercise, and her "faked" collapse on the last lap of the Olympic final of the 1500 meter run. Suzy's was a very genuine presentation that invited many thoughtful questions from the audience.

Friday evening's events included a free reception, which was well-attended and lively as always. The students, residents, fellows, and early career psychiatrists also enjoyed a networking dinner at the Horse & Plow Restaurant.

Saturday's line-up included not only Levenson and Heiligenstein, but also an authoritative review of late-life depression by UW's Psychiatry Residency Training Director, Art Walaszek, MD. The meeting concluded with a panel of psychiatrists (Rachel Molander, MD, Claudia Reardon, MD, and Ken Robbins, MD) and family physicians (Daniel Duffy, MD

## In This Issue

WPA and WAFP Working to Improve Collaboration in Patient Care.....	3-4
Congratulations to Jerry Halverson, MD .....	4
From the President: Hallowed Ground.....	5
Involuntary Treatment for Cancer: An Ethical Case Discussion .....	7
ECP & MIT Events at WPA Annual Meeting .....	8
Maintenance of Certification is Upon Us .....	8
Legislative Update .....	9
Career Fair .....	10
Treatment of Depression in Bipolar Disorder.....	11
Green & Gold Seminar.....	12
Our Own Clarence Chou, MD is Honored .....	13

*continued on next page*

*Continued from front cover*

and Alan Schwartzstein, MD), who discussed challenges and strategies in collaboration between our two specialties. Dr. Molander moderated this enthusiastic discussion, and she describes the panel further elsewhere in this newsletter.

If you were unable to attend the meeting this year, WPA members have access to all the speakers' PowerPoint presentations on the website ([www.thewpa.org](http://www.thewpa.org)). And we sure hope you can clear your calendar for next spring's annual meeting: March 11-12, 2011 at the Kalahari Resort in Wisconsin Dells. We'll see you there for what promises to be an informative weekend of national and local experts, including Marlene Freeman, MD, Henry Emmons, MD, and David Rakel, MD, discussing integrative medicine in psychiatry. ♥



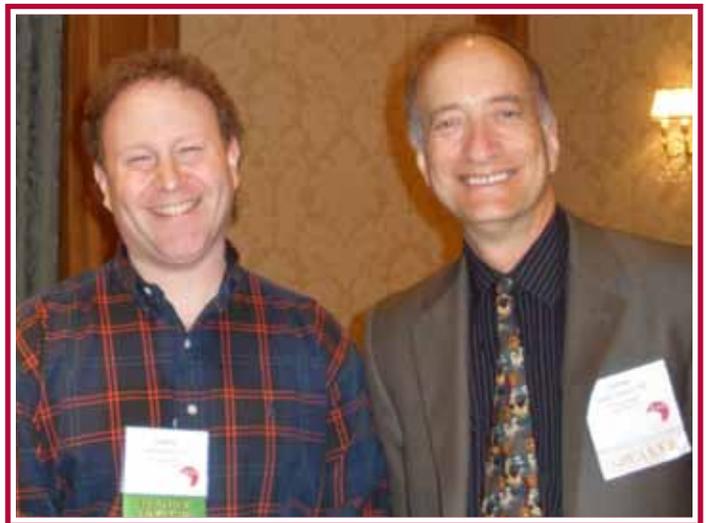
*The WPA Annual Meeting was held at the American Club in Kohler, WI April 23-24, 2010.*



*Claudia Reardon, MD (Right) and Olympic Runner Suzy Favor-Hamilton (Left) spoke at the WPA Annual Meeting*



*Annual Meeting Co-Chairs Jerry Halverson, MD & Claudia Reardon, MD with WPA President Ken Casimir, MD at the WPA Annual Meeting Luncheon*



*Jeffery Marcus, MD member of the WPA Executive Council with WPA Annual Meeting speaker James Levenson, MD*

# WPA and WAFP Working to Improve Collaboration in Patient Care

By Rachel Molander, MD

In the last few months the Wisconsin Psychiatric Association (WPA) and the Wisconsin Academy of Family Physicians (WAFP) began a critical discussion on how to improve access to psychiatric care, and collaboration between psychiatrists in primary care physicians. The dialogue began with a series of "Access Webinars" organized by the WPA Access Sub-Committee (Claudia Reardon MD, Ken Robbins MD, Justin Schoen MD, Lee Greenwald MD). The Webinars were co-hosted by a psychiatrist and a family practice physician, and included the following topics

## February 9, 2010

**Point of Contact: Referrals for Care Between Psychiatrists & Family Physicians**

## March 9, 2010-

**Managing Meds: Prescribing and Monitoring Psychiatric Medications**

## April 6, 2010-

**Collaboration of Care: Developing and Maintaining Open Communication between Psychiatrists and Physicians**

The Webinars were followed by a discussion panel with both family physicians and psychiatrists at the WPA Annual Meeting held April 23-24 at the American Club in Kohler, WI. The panel included WAFP President-Elect Dr. Alan Schwartzstein and his colleague Dr. Daniel Duffy, along with three psychiatrists Dr. Kenneth Robbins, Dr. Claudia Reardon and Dr. Rachel Molander. The panel and Webinars proved to be excellent forums to share perspectives, and clarify the obstacles to improving access and collaboration.

A number of the recurrent themes and concerns that arose in these discussions are outlined below.

1. The lack of access to psychiatric referral and evaluation is a great source of frustration for our family physician colleagues. This is particularly a problem for the Medicaid population and in rural areas where there shortage of psychiatrists is striking. In the absence of referral access, family physicians end up feeling compelled to manage psychiatric disorders that they may feel are beyond their professional expertise, or resort to leaving mental health disorders untreated.
2. Family physicians and psychiatrists alike expressed disappointment with the lack of communication between providers about shared patients. All participants agreed that the failure to communicate frequently results in poor patient care, especially with respect to medication management.

Concern about confidentiality/HIPPA regulations was a frequently cited obstacle to communication throughout the Webinar series. This issue was addressed in more detail during the panel discussion thanks to Dr. Alan Schwartzstein from the WAFP. Dr. Schwartzstein presented an excellent review of the legal issues around confidentiality and sharing of mental health records. Briefly, he explained that there are basically three levels of regulation that govern communication between providers about mental health



WISCONSIN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR WISCONSIN

treatment: federal, state, and institutional level. Most frequently cited as a barrier to communication (albeit incorrectly) are federal HIPPA regulations. He clarified that in general HIPPA does not require consent to disclose information between health care providers for the purposes of treatment. The exception is that federal law *does* protect AODA treatment records from being shared with another clinician *if* the treating clinician is licensed as an AODA provider. State laws vary, and state law preempts HIPPA if the state law is more stringent. Wisconsin statute 51.30 allows limited release of records without consent to "related health care entities" and covers general information such as diagnosis, treatment, diagnostic tests and symptoms. Restrictions at the institutional level are usually much more restrictive, and often represent the greatest obstacle to communication between health care providers. The WPA audience was greatly appreciative of this clarification of legal issues around sharing of information between providers.

The other major reason for why psychiatrists and primary care doctors aren't communicating came down to the basic logistics of busy days, and different practice cultures. Family physicians complained that they don't get return calls from their psychiatric colleagues in a timely manner, and that the consultation letters they receive from psychiatrists contain information that is not helpful to them. They contrast this to their other specialty colleagues (e.g. cardiology), who they can call as needed throughout the day, and from whom they receive concise consultation reports with information on diagnosis, progress, and treatment plan. Psychiatrists expressed similar frustration with difficulties reaching busy primary care physicians, and not being informed when a PCP changes/

*continued on next page*

- stops/starts psychiatric medications in a shared patient. We all agreed that a helpful step would be to have a formal exchange of contact information, and an agreed upon set of parameters for care collaboration from the outset of the psychiatric referral.
3. There are not clear guidelines for when a primary care physician should refer for psychiatric evaluation, and when a patient should be transferred back to primary care. Furthermore, primary care physicians vary widely in their willingness and comfort level with prescribing psychiatric medications; this makes the development of explicit guidelines about referral and transfer back to PCP challenging.
  4. PCPs are currently prescribing a wide range of psychotropic medications with minimal access to curbside or formal psychiatric consultation. Between 1996 and 2001, the total # of prescriptions issued by primary care physicians for psychotropic medications increased by 48%. Approximately, 80% of all anxiolytic prescriptions, 65% of all antidepressant prescriptions, and 20% of antipsychotic prescriptions (1). In the Webinars and discussion panel, family physicians expressed a desire for more "curbside"/phone consultation to help manage patients on complex psychotropic medications.
  5. There was a lot of discussion of alternative models of care that improve collaboration such as Integrated/Co-located mental health and primary care, and care management programs for mental health disorders. A few systems have such models in place (VA, some HMOs) and there are a variety of ways to implement the models depending on staffing and funding. The model with the strongest evidence base for improved patient outcomes and cost efficacy is one in which there is a "care manager" (usually an RN or SW) who works directly with the primary care physician (+/- imbedded in the clinic vs. off site). Care managers do an initial assessment and develop a treatment plan with the patient and PCP. They then follow the patient closely (usually by phone) to check on medication compliance/side

effects, reinforce other components of treatment plan (e.g. behavioral activation), and monitor symptoms (usually with a standardized scale such as a PHQ9). Care managers then communicate back to the PCP and the medication/treatment plan is adjusted as needed. The care manager is supervised by a psychiatrist 1-2 hours per week, who also may see more complicated cases directly. The psychiatrist is usually also available prn to the PCP for curbside consultation. A good resource to learn more about an evidenced based model of integrated care is the website for the large study of collaborative care for depression in older adults out of University of Washington: IMPACT <http://impact-uw.org/>. There was also a good review of collaborative care study outcomes in 2006 (2).

6. Last, but not least, both family physicians and psychiatrists expressed respect for one another's field of medicine and expertise, and a desire to improve how we collaborate in the care of our patients.

The Webinar and panel discussions contained additional details and depth beyond the scope of this article. At the conclusion, there was consensus between WPA and WAFP participants that this dialogue should continue. As evidence that there is more to come, we received an invitation from Dr. Schwartzstein for representatives from the WPA to attend the annual WAFP meeting and possibly replicate the WPA panel discussion at their meeting.

So while this is just a beginning, the WPA and WAFP have a shared mission to improve the health of our patients, and I think we all agree that this mission will be more successful if we pursue it together.

#### **Selected References:**

- IMS Health, National Prescription Audit (NPA) Plus – Moving Annual Total (MAT), 2001
- Simon Gilbody, MBChB, MRCPsych, DPhil; Peter Bower, PhD; Janine Fletcher, MSc; David Richards, PhD; Alex J. Sutton, PhD Collaborative Care for Depression A Cumulative Meta-analysis and Review of Longer-term Outcomes Arch Intern Med. 2006;166:2314-2321

## **Congratulations to Jerry Halverson, MD**

*By Justin Schoen, MD*

**W**e at the Wisconsin Psychiatric Association (WPA) would like to congratulate Dr. Halverson for recently receiving the "Forward under Forty," award by the University of Wisconsin Alumni Association. This prestigious award is given to a select group of UW graduates under age 40 who are making an impact on the world by living the Wisconsin Idea. This award can be further reviewed by looking at the website, [www.forwardunder40.com/40](http://www.forwardunder40.com/40). Dr. Halverson also received an American Medical Association Foundation 2010 leadership award for outstanding community and peer leadership as an early career physician. Dr. Halverson was also highlighted in, "The Daily Bulletin," of the APA annual meeting given his role as co-chair with Dr. Claudia Reardon for a workshop entitled, "Scope of Practice Challenges: Experiences, Successes, and Tribulations from Across the Country."

For those of us that have the pleasure of knowing and working with Dr. Halverson, this comes as no surprise. Dr. Halverson is a gifted and driven individual. He is an active member of the WPA, particularly as the legislative chair. He also has leadership roles in the Wisconsin Medical Society. He has worked in many different roles through the University of Wisconsin, Meriter Hospital, and now Rogers Memorial Hospital. He continues to provide high quality care to patients, education to students, residents, and colleagues, as well as leadership to the great psychiatric community. He does so with intensity, integrity, and intelligence while maintaining a great sense of humor. We are lucky to have such a talented member and would like to congratulate and thank Dr. Halverson one more time for all of his accomplishments.



## Hallowed Ground



This year, we celebrate the sesquicentennial of Mendota Mental Health Institute, one of Wisconsin's most significant cultural and historical landmarks. As we observe this milestone, as Medical Director of MMHI, it is my distinct honor and pleasure to share with you a brief overview of the relationship of our institute to the history of Wisconsin and to the history of psychiatry.

Long before the site was developed by the state, it was home to the Woodland tribes who were precursors of the Win-

nebago (now known as Ho-Chunk) native American tribe. Beginning around 500 B.C., the Woodland tribes began building conical earthwork mounds. By 800 A.D., more complex forms were being constructed, including linear mounds and effigy mounds. Those built later assumed the shapes of birds, deer, panthers, and other animals. The mound group located at MMHI was identified early in state history as being unusually large and highly significant. The mounds in this group likely were built over a 1,000 year period; the conical mounds were built between 0 A.D. to 500 A.D., while the effigy mounds date to the Late Woodland Stage (650 A.D. to 1200 A.D.).

Buried in the mounds are chiefs, their families, and artifacts, and so the surrounding land encompasses two districts listed on the National Register of Historic Places: the Farwell's Point Mound Group, and the Mendota State Hospital Mound Group.

Governor Leonard J. Farwell, who was in office from 1852 until 1854 set into motion a plan to establish a state hospital for the mentally ill. On March 31, 1854, the Wisconsin State Legislature established the "State Lunatic Asylum" and appointed three commissioners to oversee the process of procuring land and building the hospital. The Commission designated the Worcester (Massachusetts) Hospital for the Insane as the prototype for the Wisconsin hospital. On July 14, 1860, the doors of the Wisconsin State Hospital for the Insane opened to admit its first patients.

By 1879, the facility at Mendota covered 400 acres, and although patient capacity was set at 500, the inpatient census was 580. In 1915, Dr. W.F. Lorenz founded the Wisconsin Psychiatric Institute on the Mendota grounds, "to investigate the causes of insanity, to provide treatment for cases requiring special facilities, and to instruct and train personnel in investigating and treating insanity." The progressive approach to the care and treatment of the mentally ill at Mendota led to the state of Wisconsin entering into a partnership with the federal government following World War I.

Beginning in October, 1919, Wisconsin veterans with mental disabilities (many of them with "shell shock," as PTSD was characterized back then) were being treated at the Institute. Dr. Lorenz's approach to treatment, with its focus on occupational therapy, became the subject of a New York Times article which proclaimed this as the principal reason that "forty percent of the 200 shell-shocked soldiers treated at Mendota have been sent home cured." Consequently, in 1921, the Wisconsin Legislature appropriated \$250,000 for the erection of the Wisconsin Memorial Hospital, which was completed in 1922. Although the Wisconsin Memorial Hospital is listed on the National Register of Historic Places, and is considered significant for its architectural

quality, there remains some controversy regarding the availability of budget resources for its renovation and preservation.

Another remarkable component in Mendota's history was the establishment of the first Program of Assertive Community Treatment (PACT). During the era of deinstitutionalization (the late 1960s and early 1970s), Mendota researchers investigated new approaches to providing integrated, long-term care to persons with severe and persistent mental illness. By using their approach, which sought to aggressively mitigate obstacles to success in the community, rates of rehospitalization dropped precipitously. For this groundbreaking work, in 1974, Mendota received the American Psychiatric Association Gold Award for innovation in psychiatric treatment. In October, 1998, NAMI recognized 25 years of documented treatment success of the PACT model by announcing an initiative to bring the PACT treatment model to every state by the year 2002. PACT currently provides services to approximately 140 clients, under the leadership of medical director Dr. John Battaglia.

Today, MMHI remains an important resource for acute psychiatric treatment for the citizens of Wisconsin, as well as the site of ongoing research and teaching. Like most state psychiatric hospitals, Mendota's inpatient census reached its zenith during the late 1950s and early 1960s, when upwards of 2000 patients resided on grounds. With the advent of effective psychotropic medications and the emergence of deinstitutionalization as governmental policy, state hospitals have shrunk considerably, and Mendota is no exception. By the end of this year, bed capacity will consist of approximately 205 forensic and 60 civil beds, along with 30 beds for treatment of juvenile correctional patients at Mendota Juvenile Treatment Center. Perhaps the most important research going on Mendota is at MJTC, where innovative approaches to the treatment of conduct disorder and comorbid psychopathology are being actively investigated. In contrast to delinquent youth in juvenile detention or at state schools, rates of recidivism and reoffense for youth treated at MJTC are remarkably diminished.

The Institute continues to be a training site for medical students and residents from the University of Wisconsin School of Medicine, and for forensic psychiatry fellows from Medical College of Wisconsin. Students and residents invariably appreciate the opportunity to learn about the assessment and treatment of patients presenting with florid psychopathology which is rarely encountered any more in this era of managed care and short hospital stays.

Nestled among the ancient effigy mounds on the shores of the lake whose name it shares, Mendota Mental Health Institute has occupied a prominent place in the history of our state, as well as the history of our field. Thanks to the vision of founders early in Wisconsin's history, and the hard work and dedication of multiple generations of mental health professionals and support staff, MMHI has evolved and continues to thrive. We celebrate 150 years of service to Wisconsin's psychiatric patients and their families, and consistent with our state motto, we look...forward.

A handwritten signature in black ink that reads "Casimir MD". The signature is written in a cursive, flowing style.

Kenneth C. Casimir, MD  
WPA President

## Welcome to 2010!



**It has been a busy 2010 so far! WPA has several exciting events planned for this year.**

### **WPA Annual Meeting**

Thank you to all the attendees, speakers and exhibitors at the April 23-24, 2010 WPA annual meeting, "Where Psychiatry and Medicine Overlap: Seeing the Big Picture of our Patients' Health" will be held at the American Club, Kohler. Special thanks to meeting Co-Chairs Jerry Halverson, MD and Claudia Rear-

don, MD for an outstanding program.

The 2011 Annual Meeting planning has already begun and the meeting will be March 11-12, 2011 at the Kahalari Resort in the Wisconsin Dells. Be sure to put the date on your calendar now.

### **WPA Career Fair**

WPA is planning a Career Fair on Saturday, August 28, 2010 at Rogers Memorial Hospital in Oconomowoc. The program will feature presentations by practicing Wisconsin psychiatrists on many issues facing early career psychiatrists. All residents in training in Wisconsin, medical students with interest in psychiatry and psychiatrists in practice for less than five years are invited to attend.

### **WPA – Wisconsin Academy of Family Physicians Webinars**

The last of three one-hour webinars was held April 1, 2010 to discuss topics concerning collaboration and communication between primary care physicians and psychiatrists. The webinars were well attended by members of both organizations. The discussions held during these webinars was the basis of a panel discussion at the WPA annual meeting in April - "Access to Psychiatric Care: A Panel Discussion of Wisconsin Psychiatrists & Family Physicians". The panel was co-presented by members of both organizations.

### **WPA Green and Gold Fall Event!**

Prepare yourself to experience the rich history of Wisconsin football at the legendary Lambeau Field in Green Bay, home of the Green Bay Packers. WPA is planning a half-day CME program and tailgate dinner on Friday, October 1, 2010. Watch for details in the coming months.

**Jane A. Svinicki, CAE**  
Executive Director

Everyone has questions  
about mental illnesses.

Now, for some answers.

Are you among the 44 percent of Americans who reported knowing only a little or almost nothing at all about mental illnesses? If so, here are some facts you ought to know:

Mental illnesses are common. One out of five Americans suffers from a diagnosable mental disorder during any given year. Severe and persistent mental illnesses are less common, but still afflict 3 percent of the population.

Research shows that mental illnesses are caused by genetic and environmental factors, traumatic events and other physical illnesses and injuries. And according to the National Institute of Mental Health, the rate of successful treatment for depression (70 to 80 percent) is much higher than the rate for other chronic illnesses such as heart disease (45 to 50 percent).

Learn more facts about mental health by visiting [www.HealthyMinds.org](http://www.HealthyMinds.org). You may be able to help yourself or someone you know lead a healthier, happier life.



# Involuntary Treatment for Cancer: An Ethical Case Discussion

By Mark Komrad, MD and Debbie Weaver, MD

Mr. V, an 80 year old man with schizophrenia, refused treatment of an orbital lymphoma. Despite being delusional for decades, he never received psychiatric treatment until he was certified to a state hospital from 1987-90. He lived with his mother and sister until they died, after which he lived reclusively until savings ran out and neighbors called police because of his bizarre behavior. He was diagnosed with Paranoid Schizophrenia and was treated with antipsychotics, but never developed insight into his illness. Psychological testing revealed his rigidity, lack of insight, and denial of all symptoms, problems, or feelings he considered unacceptable.

This denial has persisted throughout his treatment. Although he acknowledges his three year hospitalization, he insists his doctors decided that he didn't have schizophrenia and that his only problem was lack of housing. He has lived in supervised housing since 1990, and has come to regard his providers as surrogate family. He rarely deviates from a rigid routine, but he is socially appropriate, never exhibits overt psychotic symptoms and has shown good decision-making capacity in most domains.

After his orbital lymphoma was diagnosed, his doctors told him that a brief course of radiation therapy offered a 90% chance of a cure. Without treatment he was likely to die within four years. He told his doctors he understood the facts, but, at 80, he had lived a full life and did not want radiation. However when questioned in greater depth, he stated he did not believe he had cancer and did not believe he would die without treatment. His denial that he had cancer resembled his chronic denial about his mental illness. Attempts to treat this psychotic denial with medication changes were unsuccessful.

The treatment team determined that he lacked capacity based on a delusional denial of his cancer, and they considered pursuing guardianship in hopes of compelling treatment to save his life. However, many of those clinicians who were most closely involved in his care believed forcing treatment would cause greater suffering than honoring his wishes to refuse treatment. An ethics consultation was requested by his psychiatrist.

## Discussion:

In any ethical dilemma it is useful to take beneficence as the point of departure: what moral benefit can the clinician provide to the patient? In this case, we have two potential goods, the sanctity of life and the right of self-determination. To push towards one diminishes the other. The more we work to preserve this man's life and to reduce the suffering cancer can cause, the more we have to diminish his exercise of self-determination, and vice-versa.

This particular reciprocal coupling is a common one. It is the infamous, "whose life is it, anyway?" scenario. The ethos of the medical profession is generally weighted towards the sanctity of life, with its associated emphasis on preservation of well-being. However, our larger, individualistic culture is weighted towards the right of self-determination. So, this contemporary tension (a very modern one, not present prior to the Enlightenment), demonstrates how ethical conflicts create tensions for physicians today.

Psychiatrists typically enter into this tug-of-war with an added feature in the mix, as in this case. This patient's mental condition renders him less capable of authentic decision-making. It is not that he is making a foolish decision by refusing treatment (indeed, many people without psychiatric disorders might refuse this treatment). Rather, this man's decision-making abilities are impaired. In the "whose life is it" argument, because of psychotic denial- this man doesn't understand that his very life is at stake. His diminished autonomy lightens the weight of self-determination as a compelling ethical force, in comparison to the sanctity of life. In other words, it moves the ethical argument towards paternalism. Psychiatrists are more familiar and comfortable than other specialists with the exercise of paternalism, and with overriding a patient's refusal. It is no surprise to learn that it was the psychiatrist who seriously pursued the ethical question of involuntary cancer treatment and who called for an ethics consultation.

There is a strong risk for maleficence, if this patient's life is forcibly saved. Forcible radiation therapy is highly intrusive, complex, and extended, starting with the appointment of a guardian, followed by forced anesthesia and restraints in the radiation machine. Moreover, this man currently denies any suffering. So, to force treatment would be to introduce this fragile personality to both physical, and certainly emotional suffering, and associated indignities, before Nature itself brings on that affliction through his cancer's progression.

Interestingly, we psychiatrists are not only experienced with involuntary treatment, but also with ordering highly intrusive and complex procedures for refusing patients. For example, we sometimes initiate guardianship in order to proceed with involuntary ECT. However, there is an important difference. Involuntary ECT is used in clinical situations where the paternalism of overriding refusal can be an autonomy-restoring procedure. We hope and expect the very disorder which is powering the refusal (e.g. catatonia) to resolve, thanks to that procedure, leading to a less vulnerable and more rational patient. By contrast, in this case, the intrusive and complex radiation intervention is irrelevant to improving the patient's autonomy, other than for the tautological point that, in death from cancer, there is no autonomy. [This point is important, otherwise, we'd be justified in involuntary treatment for any behavior that might lead to death--like smoking].

Unlike ECT, the radiation treatment itself will not restore or even improve his autonomy. For this patient, the interventions are so severe, and he is such a fragile person that overriding his refusal may be quite traumatizing to him, a trauma from which his treatment team does not expect he could recover. So, rather than improving his autonomy, this course may permanently diminish it. Moreover, it would scar his trust in his entire community of clinicians, who also effectively function as his "family." This would be an outcome that is both clinically and ethically undesirable.

The radiation oncologists who would perform the procedure, have little experience with patients who deny their own illness. They may be quite uncomfortable with the whole scenario. Thus, the patient may be exposed to negative feel-

*continued on next page*

ings and perhaps hostility which may diminish the healing and supportive atmosphere that typically optimizes clinical outcome. There would be a rift between those clinicians who are strongly opposed to involuntary treatment (of whom there are more than a few in this case) and those who support it. This may interfere in their ongoing medical collaboration for this permanently dependent and disabled man.

So, the precept of a previous column (The Maryland Psychiatrist, Fall 2008, Vol. 35, #2), that only autonomy-enhancing (or at least “preserving”) paternalism is justified, is simply not met in this case. In this case, forced treatment might actually crimp what limited autonomy the patient has, and also offend his clinicians, so as to diminish their capacity for benevolence.

This case shows how clinical ethics cannot be formulistic or generic, and therefore should not be legislated. Ethics must be pursued on a case-by-case basis, argued with the tools of principle, but improvised to fit the particular case. In this sense, medical ethics is more like jazz than it is like engineering. ♣

Reprinted with the permission of the Maryland Psychiatric Society.

## Residents Forum

### MIT & ECP Events at WPA Annual Meeting

By Travis Fisher, MD

On April 23<sup>rd</sup>, 2010, psychiatrists came from all across the state of Wisconsin to attend the WPA spring conference, seeking to enhance their clinical care by improving their knowledge of the interface between medicine and psychiatry. A chance to earn some CME, stay at the American Club and golf at Whistling Straits probably helped convince a few people as well. For residents and early career psychiatrists, however, the chance to network with other trainees and future colleagues was a greater draw. To help facilitate this, the WPA organized a dinner on Thursday night specifically for them.

At the Horse and Plow Restaurant, trainees and young psychiatrists from Madison, Milwaukee and Marshfield all met to discuss their current situations, future plans, and other topics in a more relaxed, informal atmosphere. Residents had the chance to discuss with early career colleagues how they made the transition, “dos and don’ts,” and other helpful tips in job hunting. It wasn’t all business, fortunately—football, politics, food, philosophy and the merits of the hotel hot tub all ended up on the table as well. Ending with a round of dessert and a surprise visit by President Ken Casimir, the evening was enjoyed by all. Too often it is easy for a trainee to be consumed by the demands of their residency, or a young psychiatrist to be buried under the work of establishing themselves. Here’s hoping that the chance to put it all aside and socialize is on the annual meeting schedule for years to come.

## Maintenance of Certification is Upon Us

By Art Walaszek, MD

Though only about two-thirds of practicing psychiatrists have obtained board certification through the American Board of Psychiatry and Neurology (ABPN), it is likely that the pressure to become board certified will grow. Employers and credentialing bodies are increasingly asking that physicians be board certified; eventually, obtaining and maintaining a license to practice medicine may be contingent on certification.

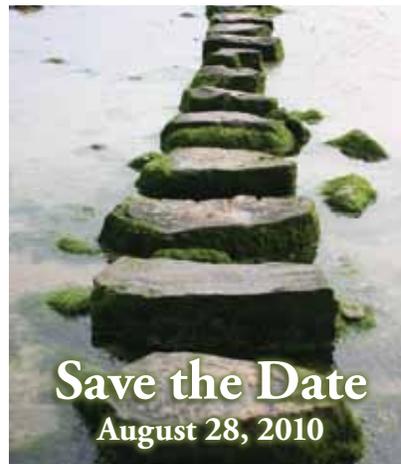
ABPN has completely redesigned initial certification. Beginning with the graduating Psychiatry residency class of 2011, candidates must have completed three oral examinations in residency (in lieu of the soon to be mothballed Part II oral exam) and must pass a new cognitive examination that includes a computerized patient simulation.

In addition to a written exam every 10 years, maintenance of certification (MOC) now requires evidence of life-long learning in the form of: CME credits (30 per year), self-assessment (SA) activities (twice in 10 years), and performance-in-practices (PIP) modules up to three times in 10 years. The exact requirements depend on the year of initial certification or most recent recertification (see [http://www.abpn.com/moc\\_psychiatry.htm](http://www.abpn.com/moc_psychiatry.htm) for details). It is unclear yet how these changes will affect psychiatrists with life certificates.

Examples of self-assessments include the Psychiatrists In-Practice Examination (PIPE) and the APA journal, *Focus*. The University of Wisconsin School of Medicine and Public Health offers “Cease Smoking Today,” a web-based product that will help clinicians address tobacco dependence among their patients and that will count towards either the SA or PIP requirements. Psychiatrists in group-based practice may participate in institutional quality improvement projects that could fulfill the PIP requirement.

The WPA will devote part of its Fall 2011 meeting to discussing MOC. In the mean time, please make sure to keep up on the topic by checking the ABPN website regularly and talking with local CME experts.

More information on page 10.



**Save the Date**  
August 28, 2010

Free Seminar For:  
Psychiatry Residents & Fellows  
Early Career Psychiatrists  
Medical Students with an Interest in Psychiatry

## WPA Hires New Lobbyist

In January, WPA hired Eric Jensen of Jensen Government Relations, to be our lobbyist in Madison. Eric is an attorney by training and spent 3.5 years as a lobbyist for the Wisconsin Medical Society before striking out on his own. He continues to enjoy a close relationship with WMS, and in addition to WPA also represents among his clients the Anesthesiologists, Emergency Physicians and Physician Assistants providing him regular interaction with the Legislature's health-related committees.

## 2009-2010 Legislative Session Comes to a Close: What's Next?

In the early morning hours of April 23<sup>rd</sup>, the State Assembly adjourned bringing the 2009-2010 Session to a close. A Session that began with great fanfare as Democrats won the Assembly majority and took control of both houses and the Governor's office for the first time in a generation, ended with press accounts citing a variety of significant policy issues unresolved and many question marks about which party will control what when Legislators return next January.

To date, more than 20 legislators from both parties and both houses of the State Legislature have announced they will not seek re-election. Combined with slim Democrat majorities in both houses (18-15 in the Senate, and 52-46-1 in the Assembly), a frustrated electorate, and a Governor's race that doesn't include an incumbent candidate for the first time in more than two decades the November elections hold the potential to return a very different looking State Government to Madison in January.

## High Notes for WPA: Autism Coverage, Mental Health Parity and Psychologist Prescribing

The 2009-2010 Session began on a high note as years of effort culminated as a provision in the State Budget required insurers to provide coverage of Autism Spectrum Disorders.



Since then, the Office of the Commissioner of Insurance has been working on the Administrative Rules that will carry out this requirement, periodically seeking WPA's input.

As the end of the Session approached, two significant victories on "stand alone" legislation for WPA: passage of the long awaited Mental Health Parity legislation, and the non-passage of legislation to give psychologists prescribing privileges. Rep. Sandy Pasch (D-Whitefish Bay) and Senator Dave Hansen (D-Green Bay) successfully navigated the legislative gauntlet to push through Mental Health Parity legislation (SB 362) after more than a decade of effort by many advocates and legislators, and Governor Doyle signed Parity into law on April 29<sup>th</sup> (Act 218). Meanwhile, Senate Bill 180, authored by retiring Senator Judy Robson (D-Beloit), which would have provided prescriptive authority to psychologists failed to pass and will need to be reintroduced in later sessions to have any chance of becoming law in Wisconsin.

## Finally, a couple of additional items of note:

1. The so-called Family Justice Bill (SB 203) which would allow parents of adult children or adult children of parents injured by medical negligence to recover damages for loss of society and companionship failed to pass. SB 203 was a priority for the trial bar, but opposition from organized medicine and others helped defeat it in the dying days of the Session.
2. Governor Doyle's Badger Care Plus Core program (coverage for low income adults without children) got rolling, and very soon after had reached program capacity. The Badger Care Plus Basic program was quickly created to provide limited coverage to those on the Core program waiting list. After much debate on coverage, both will include coverage of mental health services provided by psychiatrists. 🍷



## WPA Fall Green and Gold CME Seminar

Friday, October 1st

Visit Lambeau Field, Home of the Green Bay Packers, and attend a WPA educational program at the Stadium. Families and friends are invited for a tailgate following the seminar.

Visit [www.thewpa.org](http://www.thewpa.org) for more information.

# WPA to Hold 2010 MIT and ECP Career Fair August 28 at Delafield Hotel

By Jerry L. Halverson, MD, Program Chair



The Wisconsin Psychiatric Association is holding its triennial member in training and early career psychiatrists career fair once again this year on Saturday August 28, 2010 at The Delafield Hotel in Delafield, WI (<http://thedelafieldhotel.com>). This is an event that was last held in the fall of 2007 and was very well received by the attendees and recruiters alike. The Executive Council decided to continue to support the career fair, but that it would be best to repeat it every 3<sup>rd</sup> year and continue

to hold it between the two training programs in Madison and Milwaukee. As was true in 2007, this will be a free event with free, good food and excellent speakers that is aimed at medical students, residents and early career psychiatrists.

Our goal with the WPA Career Fair is to help the “young” psychiatrist have a better idea of what is out there for them after graduation, or maybe after that first job doesn’t work out as expected. We will accomplish that by hooking them up with recruiters from hospitals and healthcare employers from across the state as well as having psychiatrists that have “been there and done that”, to give them a better idea of what is available and really going in Wisconsin Psychiatry. We will also have other speakers that we feel will be of interest regarding the issues that they will face entering the physician workforce.

All medical students with a psychiatric interest, members in training (as well as “non members” in training) and early career psychiatrists (first 8 years of practice) are encouraged to attend. All that we ask is that you RSVP on the website ([www.thewpa.org](http://www.thewpa.org)), so that we have an idea of how much food is needed. By the way, not so early career psychiatrists are also invited, but may be charged a nominal tuition fee (which will be on the website) or will be put to work on a panel. We expect that many of our members might find this a useful event whether they are early in their career or not. Contact me or the WPA office with questions.

We will have a limited number of rooms available at a discount at the Delafield Hotel (<http://thedelafieldhotel.com>). Do yourself and your significant other a favor and stay over. It’s a hotel that you’ll be happy that you “discovered”!

Please save the date on your calendar and see you there!

The career fair will start at 8 am and will wrap up by 3 pm. The career fair will include meals, recruiter contacts and the following speakers/ topics:

- Fellowship panel- Is a fellowship right for you? We will have psychiatrists that have done the Child and Adolescent, Geriatric, Forensic, Psychosomatic, Addiction, Research and Sleep fellowships (not all the same person!) there to answer your questions and speak about their experiences.

- Career Panel: We will have psychiatrists with different practices that practice in different venues speak about their experiences and be there to answer questions. We will have psychiatrists employed by hospitals/ multispecialty groups and those from private practice. We will have psychiatrists that are hospital based and those that are outpatient based. We will have academicians, psychotherapists, researchers and whatever other kind of practice that we can find.
- Finances- Building a career, a practice and a retirement: Well known CPA Mike Arnow will speak to the group in his interactive and humorous style about all of the important financial things that you need to know (but nobody will tell you) when starting a career. He specializes in Medical Practices and probably advises one of your mentors.
- State Senator Jon Erp enbach will discuss the future of health care, from a politicians point of view.
- Advocating for Your Patients and Your Profession: Mark Grapentine, JD from The Wisconsin Medical Society will give his humorous and spot-on assessment of the politics of the moment and how they will affect your practice.
- Pulling it all together- charting your own path / what to consider when choosing a career: Ken Robbins, MD.

## Tentative Agenda

<b>730-830</b>	Coffee, Continental Breakfast/ Recruiters
<b>830-930</b>	Plenary- Mike Arnow Finances now and in the future
<b>930-1000</b>	Recruiters
<b>1000-1045</b>	Breakouts 1: Fellowship Panel/ Career Panel
<b>1045-1100</b>	Recruiters
<b>11-1200</b>	Breakouts 2: Fellowship Panel/ Career Panel
<b>12-1230</b>	Sen Jon Erpenbach
<b>1230-1315</b>	Mark Grapentine
<b>1315-1330</b>	Recruiter visits
<b>1330-1430</b>	Ken Robbins: Pulling it all together- charting your own path or what to consider when choosing a career

## The Treatment of Depression in Bipolar Disorder

Let me start this column with sharing a recent case that reflects the complexity or “ignorance” of how we understand the treatment of depression in someone with bipolar disorder.

Case: A 52 y/o woman was admitted to the inpatient psychiatry service giving a history of two months of increasing depression, irritability, attentional problems and more recently suicidal ideation. Sleep has become more difficult recently.

She carries a diagnosis of bipolar disorder and the history is clear with manic episodes with grandiosity and similar grandiose behavior. She is medication compliant, no new psychosocial stressors and no problems with substance abuse. She stated that depression occurs occasionally but has not been as severe as it had seemed recently for many years.

MSE: mildly distressed, irritable, affect constricted with no thought disorder. Speech normal rate and complaints of “depression” and “anxiety.” No grandiosity or hyperactivity.

She has not seen a psychiatrist in the last few years and her medications were continued by her primary care physician.

### Medications:

- Lamotrigine 200 mgs per day
- Clonazepam 1 mg BID
- Fluoxetine 90 mg per day

### Hospital Course:

Because of the concern about the dose of fluoxetine it was stopped on a Thursday, the day of admission. No other medication changes were made. The weekend covering MD also did not make any changes. By Monday she was feeling better less depressed, more focused in thinking. Her mood and affect seemed close to normal. No medication changes were made. Four days later she was discharged home. She had no further complaints of depression, SI, attentional difficulties or sleep problems. Clinically she appeared euthymic without any symptoms of a mood disorder.

So what about this case caught my interest? This case is not how I would normally approach a case of bipolar depression on antidepressants but perhaps it should be an example. Several years ago the WPA sponsored Frederick Goodwin MD at our conference held at the Medical College where I was acting as the “moderator.” Dr Goodwin presented about a dozen studies all with the same general findings: antidepressants are not useful drugs for long term treatment in bipolar disorder. These studies all show problems with antidepressants such as general lack of efficacy, switching patients to mania and accelerating mood cycling. So as an inpatient physician having patients referred for admission by their psychiatrists, why are so many people with bipolar disorder on antidepressants?

In the case presented my belief is that the patient was in a “mixed state” pushed by a large dose of fluoxetine. It was removed and she returned to her normal affective state.

Let me summarize a few studies presented by Dr Goodwin.

The initial prescriptions, in the United States, for about 8,000 patients with bipolar disorder were antidepressants in 50% of cases. Recovery rate in the STEP-BD study for acute bipolar depression was the same for individuals on antidepressants or placebo.

Rapid cycling was associated with TCAs in 30 to 50% of patients. Long term destabilization of mood by imipramine (rapid cycling or increase in depressive events) was not prevented by the addition of lithium. In bipolar II patients the STEP-BD study showed better mood stability in patients not on antidepressants.

So what is available or a possible approach in patients with depression who have bipolar disorder? The FDA has approved two agents for the treatment of bipolar depression. These are Seroquel XR and the olanzapine-fluoxetine combination for bipolar depression – these agents showed statistical significant improvement compared to no treatment (placebo). The pharmaceutical critical individuals among us would ask is this a “Parma hype”?

I was part of a multicenter placebo controlled trial of ziprazidone in bipolar depression. I felt this drug should work – ziprazidone has reuptake properties in addition to many of the other properties of atypical antipsychotics. Results from two multicenter trials were that ziprazidone did not separate from placebo. I would never have predicted that result. Aripirazole also had two large placebo controlled trials in bipolar depression and it showed a trend but did not statistically separate from placebo.

What about lamotrigine in bipolar disorder. It has been accepted by the FDA to reduce the number of depressive episodes and manic episodes in bipolar disorder in maintenance treatment.

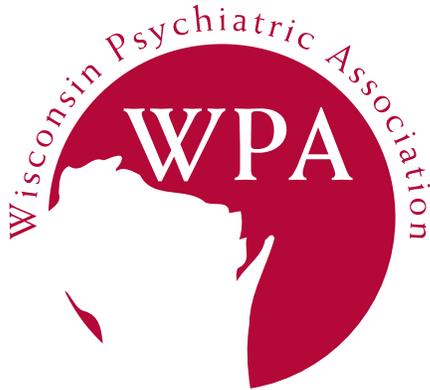
In the latest review of lamotrigine studies in the acute treatment of bipolar depression the results are less than convincing. Let me summarize the first reference below from Calabrese, et al. When looking at all five studies of lamotrigine in bipolar depression there was no statistical difference in the primary depression rating between drug and placebo. In sub analyses of studies, lamotrigine did show that the more severely depressed bipolar patients showed some statistically significant improvement compared to placebo.

Nationally, there are two schools of thought of how psychiatrists should approach the treatment of bipolar depression: one school would recommend the addition of a second or third mood stabilizer as a treatment attempt, the second group would recommend an antidepressant approach for the short term (months) and discontinue when euthymic.

Please submit your own case or question for the next Wisconsin Psychiatrist.

### Selected References:

- Calabrese JR, Huffman RF, White RL et al. “Lamotrigine in the acute treatment of bipolar depression: Results of five double blind, placebo-controlled clinical trials.” *Bipolar Disorders*. 2008; 10:323-323.
- Tohen M, Vieta E, Calabrese JR, et al. “Efficacy of olanzapine and olanzapine-fluoxetine combination in the treatment of bipolar I depression.” *Arch Gen Psych*. 2003;60:1079-88.
- Sachs GS, Nierenberg AA, Calabrese JR, et al. “Effectiveness of adjunctive antidepressant treatment for bipolar disorder (The SEP-BP study).” *NEJM* 2007;356:1711-22.



## **WPA Fall Green and Gold CME Seminar**

*By Carl Chan, MD, Fall Meeting Co-Chair*

Mark your calendars! The 2010 WPA Fall Meeting will take place over a half day at historic Lambeau Field in Green Bay on Friday, October 1. Our confirmed speakers will include Ann C McKee, MD, Stephen M. Taylor, MD, MPH, and Michael M. Miller MD.

Dr. McKee is Associate Professor of Neurology and Pathology at Boston University School of Medicine and Co-Director, Center for the Study of Traumatic Encephalopathy at Bedford VA Hospital. Dr. McKee recently testified before Congress on the relationship between concussions and dementia in NFL football players. Dr. Taylor is a General, Child/Adolescent and Addiction Psychiatrist and also Medical Director of the National Basketball Association/National Basketball Players Association Player Assistance/Anti-Drug Program. Dr. Miller is an Addiction Psychiatrist from Madison WI.

This meeting will provide an opportunity to network with our Northern Chapter colleagues while visiting a Wisconsin institution. The tentative schedule calls for Drs. Taylor and Miller to speak from 1 to 3 pm on Friday. We will then take a two and a half hour break so that participants can either tour Lambeau Field or visit the Packer Hall of Fame. We will reconvene at 5:30 pm for a social hour followed by an indoor tailgate dinner and to hear Dr. McKee's dinner address. Family members will be welcome to participate in the break activities and dinner for a small fee (to cover expenses). Please plan to join us for a truly unique WPA event. The meeting planning committee includes Jerry Halverson, Carlyle Chan and Susan Jacquez-Dean.

# Our Own Clarence Chou, MD is Honored

By Ed Krall, MD

Clarence Chou, MD, of Mequon received the Wisconsin Medical Society's prestigious Director's Award – the organization's highest honor. He accepted the award during the Society's Annual Meeting April 16-17 in Madison. The Director's Award was established in 1928 to recognize "those who have served the art and science of medicine, their fellow physicians and the public with distinction."

No one epitomizes the spirit of this award more than Dr. Chou who is board-certified in general psychiatry and child and adolescent psychiatry, is a full-time psychiatrist at the Psychiatric Crisis Service of Milwaukee County and is also an associate clinical professor in the Department of Psychiatry and Behavioral Health at the Medical College of Wisconsin. He is known to the Wisconsin Psychiatric Association for his many years of service on the WPA Council where he has been Secretary/Treasurer and APA Legislative Representative.

However, Doctor Chou is more widely known for his community involvement in the city of Milwaukee and around the state. He has served in numerous leadership roles throughout his career and has been very active in the Wisconsin Medical Society, advocating for the medical profession and for patients. He served as Society president, as vice-chair and chair of the Society's Board of Directors, and as a member of Wisconsin's American Medical Association delegation. He is also current president-elect of the Medical Society of Milwaukee County and has served as a board member, among his many leadership roles.



## Wisconsin Medical Society

Your Doctor. Your Health.

In addition to his involvement in the Society, Dr. Chou is a longtime financial supporter of the Wisconsin Medical Society Foundation and has served on the boards of the Planning Council for Health and Human Services in Southeastern Wisconsin and the National Alliance on Mental Illness of Greater Milwaukee.

"Doctor Chou's contributions to the art and science of medicine are numerous," said George Lange, MD, outgoing chair of the Society's Board of Directors during the award presentation. "He strives for excellence not only in caring for patients, but also in service to the medical profession as a leader and a mentor."

Dr. Chou humbly added "If I had more, I'd give more," Dr. Chou has said. "I believe every physician needs to contribute in some way, whether it's financially or with time or expertise."

Dr. Chou brings honor and credit to himself, the WPA and to all of psychiatry with his self-less, distinguished service to medicine. Clarence, congratulations on a award well deserved, and thank you.

## Job Posting

### Luther Midelfort *Mayo Health System*

**Eau Claire, Wisconsin:** Luther Midelfort – Mayo Health System, is seeking a **BC/BE Adult Psychiatrist** with interest in inpatient and outpatient work. We require a physician who is collaborative in his/her approach and engages the non-physician team and patient in a collegial manner. Call of 1:6. Outpatient unit is attached to a newly renovated inpatient unit. Luther Midelfort – Mayo Health System is a vertically integrated, physician directed hospital and multi-specialty clinic of 240 physicians owned by Mayo Clinic. Our physicians practice evidence-based, protocol-driven medicine. Eau Claire is a university community with a metro area of 95,000, located 90 minutes east of Minneapolis. *Business Week* ranked Eau Claire as the best place to raise your kids in the State of Wisconsin for 2009. Eau Claire was also ranked one of the safest small cities in US (12/09). Outstanding schools, a family oriented community, a state with a favorable malpractice climate, and a strong compensation and benefits package may be expected. For more information, contact Cyndi Edwards 800-573-2580, fax 715-838-6192, or e-mail [edwards.cyndi@mayo.edu](mailto:edwards.cyndi@mayo.edu). You may also visit our website at [www.luthermidelfort.org](http://www.luthermidelfort.org). EOE.

## Call For Content:

The Wisconsin Psychiatric Association encourages submissions from members and non-members for publishing in the quartly newsletter.

Please send to [info@thewpa.org](mailto:info@thewpa.org).

Content is reviewed by the Editorial Board prior to printing. Authors will be notified in the event an article has been selected for publishing.