WASHINGTON PSYCHIATRIC SOCIETY NEWS

MAR/APR 2009

WPS TASK FORCE ON GENDER IDENTITY DISORDER

INSIDE THIS ISSUE:

By Edgardo Menvielle, MD

In December 2007 , the WPS Board of Directors established a task force to issue recommendations about the diagnosis of Gender Identity Disorder (GID). I was asked to chair the group which included Drs. Dana Beyer, Ellen Feder, Michael Hendricks, Joan Kinlan, Roger Peele, Julian Redditt and Ms. Catalina Sol.

Our intention was to make recommendations regarding GID for the DSM V. One option was to advocate removing the diagnosis. The other was to generate options for revision. Revisions would aim at increasing access to appropriate mental health services, decreasing language that is unnecessarily stigmatizing, and providing clinical descriptions that accurately reflect the variety of patients' experiences in order to guide clinical care.

Very conflicting goals encumber these efforts. Eliminating any diagnosis risks impeding access to mental health and surgical/medical care for gender variant persons. Diagnostic categories dealing with gender variance could be used to restrict civil rights and/or stigmatize this population of individuals. Our report is an attempt to provide clinical descriptions that minimize stigma and that focus on the personal struggle and suffering that can be associated with it.

We wanted to move beyond a deficit model and this meant removing the diagnosis of GID which puts the emphasis inappropriately on defect of identity. We saw the identity problem as a consequence of other factors and not always even a significant problem.

We thought it helpful to separate children from sexually maturing adolescents and adults and to distinguish persons that require medical and/or surgical interventions from those that do not. We then defined three diagnostic elements:

1. A drive that compels a person to assume a gender role and/or gender identity that differs substantially from the gender role assigned at birth, socialized by the group, and/or associated with expected behaviors, thoughts, feelings, and fantasies.

2. Distress of clinical significance or functional impairment associated with the social responses to gender variant expressions or with the psychological conflict arising from internalized cultural expectations.

3. Repudiation of physical characteristics experienced as at odds with or inconsistent with one's bodily gender such as form of genitalia, breasts, etc.

This led to three diagnostic categories:

1. **Transsexualism—Axis I**
If all three elements are present. This applies to persons over 18 years of age and pubertal children under age 18.

2. **Gender Discordance—Axis I**
If only elements 1 and 2 are present. This would apply only to persons 18 years old or older.

3. **Child/Adolescent Gender Variance—V Code**
Persons under 18 years of age.

We chose Gender Variance for children and most adolescents because diagnosing children presents unique challenges. Although it may be fluid at any point in life, gender identity is particularly so in childhood. For example, although most children who manifest gender variance make statements in the early years regarding a wish to be another gender, most of them do not progress to Transsexualism, although some do. A substantial proportion of these children later declare themselves to be same-sex attracted. We felt that the higher level of prognostic uncertainty among children necessitated a V-Code diagnostic category. Children whose clinically significant gender variance persists after age 18 should be re-diagnosed as Gender Discordance or Transsexualism, as necessary. If the intensity of the distress and impairment of the gender variant child entering puberty means that the child needs to transition gender and/or receive medical interventions to slow down the progress of puberty, it is appropriate to use the diagnosis of Transsexualism before age 18.

With adults, we see that gender variance remains constant over the long term for some individuals but not for all. There may be fluctuations and a person may also move from one category to another. For example, a person may be coded as Gender Discordance initially, and later knowledge and experience may lead to a re-diagnosis as Transsexualism.

Note that the functional impairment and/or distress associated with Gender Discordance or Transsexualism may be resolved through successful transition whether this is social or

Continued on page 7.

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THE PRESIDENT'S COLUMN

HAROLD I. EIST, MD, DLFAPA, PRESIDENT, WPS, PAST PRESIDENT, APA

PSYCHIATRISTS AND MEDICAL BOARDS — HOW BAD ARE WE?

In the year 2000, an estranged husband made a false, unsworn, complaint to the Maryland Board of Physicians regarding my treatment of a woman and her two children. This type of complaint is not uncommon in bitter, contested, highly emotional divorce and custody proceedings.

It was this experience that led to my learning of a serious flaw in a section of the Maryland law.

As legislators will freely admit there is no perfect legislation and when problems are discovered they need to be fixed.

This accords with our ethics, which require that we obey the law; but if the law is a bad law, we attempt to change it. This is not an easy process. According to the AMA House Policy: "A physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition..."

Maryland law allows people the right to protect their privacy by going to court to quash subpoenas seeking their personal information, to raise their objections, or to seek a protective order.

However, in the legislation empowering disciplinary board action, the administrative board was given broad discretion to get patient records in the face of a third party complaint without the patients' knowledge or consent.

Clearly, if the patients were not notified that their records were being sought, they could not exercise their constitutional and legal rights to protect their privacy.

In five court hearings and in testimony before the Senate and House of the Maryland Legislature, members of the Medical Board staff insisted that the blanket disclosure policy, which entitled them to get patient information without notification, was essential because they alleged that psychiatrists are two times more likely than any other medical specialty to be the subject of Board disciplinary action. They quoted a 2001 AJP study of 300 California physicians censured by the California board to back them up. The same paper included mention of a Georgia study of 1000 impaired physicians that did not show an excess of psychiatrist misbehavior.

Obviously, physician misbehavior is complex and involves many variables that begin even before medical school. Study of this issue is difficult and there has been little definitive data to date.

In the December 22, 2005, NEJM, Papadakis et al concluded that disciplinary action among practicing physicians by medical boards was strongly associated with unprofessional behavior in medical school. In this paper, 4.9% of medical students exhibiting unprofessional behavior went into psychiatry and 4.2% of disciplined physicians from 3 medical schools were psychiatrists- 8th on a list of 13 medical specialties.

My counting of disciplinary actions against psychiatrists in Maryland from 2002-2008 indicated that psychiatrists account for 6.8% of Board disciplinary actions, some of them for minimal infractions such as late payment of licensure fees. Psychiatrists are 10-12% of practicing specialists in the state and were less frequently disciplined than 6 other specialties.

The small change in the Maryland law that was sought by a Maryland psychiatrist requires notification of patients that the Board is seeking their records and spells out remedies they may seek which are already part of State law.

The attacks on physicians, in general, and psychiatrists, in particular, are not germane to the issue of the patient notification bill, which seeks to protect patient care, not alleged care violators. However, these public attacks attest to continuing stigma.

I regret to report that we are not yet good enough. There are care violators who engage in unethical behavior and we need to work on improvement. This work has to begin in medical school and continue through residency education, and into the years of physician practice. The literature supports the fact that involvement in professional society activities reduces both isolation and incidents of Board discipline.

SINGLE PAYER SYSTEM IS THE ONLY OPTION

By Robert Kiesling, MD, FAPA

I believe that the single payer system is the only option that will control health care costs and provide universal coverage. There are now several dozen countries whose populations live longer than we do and who spend half as much money on health care. We are spending over $8000 per person each year. Letting the market regulate itself has not worked on Wall Street and will not work in health care. Footballers don't play without referees. There are Bernie Madoffs out there everywhere.

Only 2% of medical students in the USA are going into internal medicine. In my day 10-15% of the class did. The average medical student at Georgetown has $260,000 in debt upon graduation. Only 30% of the doctors in the US are in primary care: compare that to 50% in Canada. Are we headed for a system where everyone gets an MRI but no one can find a primary care doctor?

We have been dancing around for 16 years since the collapse of the Clinton plan. We are spending one third of the Medicare dollar in the last year of life. Huge amounts of money are going into unnecessary surgical and radiological procedures as well as administrative costs.

When I hear about psychiatrists who charge $350 per visit and don't take insurance, I think about the guys on Wall Street. They thought those financial institutions were for their personal benefit instead of the benefit of the public. The public will turn on us like they did on Wall Street, the banks and the auto industry unless we get back to our roots.

Show Me theEvidence!

What is "Number Needed to Treat" Anyway?

Understanding and Using Evidence-Based Medicine in Clinical Practice

presentation by **Leslie Citrome, M.D.**
Professor, Dept. of Psychiatry, New York, University School of Medicine, NYC

April 30, 2009

HEAVY HORS D'OEUVRES 6:30 PM - 7:30 PM • PRESENTATION 7:30 PM - 9:30 PM

PROGRAM

Evidence-based medicine emerged as a way to improve and evaluate patient care. It involves the thoughtful clinician incorporating the best available research evidence into an individualized treatment plan, taking into account clinical experience and patient preferences. Dr. Citrome's presentation will inform us how putting theory into practice necessitates the use of special tools to appraise the research evidence that we encounter. One important and intuitive tool is number needed to treat (NNT), which can be used to calculate the clinical significance of a statistically significant result. Dr. Citrome will present for discussion the results from recent large effectiveness trials and examine the balance between efficacy, tolerability, and adherence, using the concept of NNT, its analogue, number needed to harm (NNH), and introduce the concept of likelihood to be helped or harmed (LHH).

OBJECTIVES:

- Outline the steps involved in practicing Evidence-Based Medicine (EBM)
- Quantify clinical significance using Number Needed to Treat (NNT)
- Apply EBM and NNT to clinical practice

ABOUT LESLIE CITROME, M.D.

Dr. Citrome is Director of the Clinical Research and Evaluation Facility at the Nathan S. Kline Institute for Psychiatric Research. He is Professor of Psychiatry at the New York University School of Medicine, where he also did his Residency and Chief Residency in Psychiatry. He received his medical degree from McGill University and his masters in public health from Columbia University. Dr. Citrome leads and collaborates on a number of studies on schizophrenia and the management of aggressive and violent behavior. He is a member of the Medication Utilization and Outcomes Research Program of the New York State Office of Mental Health. He has authored over 250 papers and has lectured extensively throughout the world. He has served as section editor, guest editor and is a peer reviewer for over 25 journals.

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For additional information and to apply, visit: **www.cia.gov**

THE WORK OF A NATION. THE CENTER OF INTELLIGENCE.

CME COMMITTEE CONFERENCE ON LEGAL MANAGEMENT FOR PSYCHIATRISTS

By Judith Nowak, MD, Editor

A conference entitled "Minimal Risk with Minimal Effort" on Legal Risk Management for Psychiatrists was presented on February 7, 2009 by WPS. This excellent course was given by Dan Tennenhouse, MD, JD. Dr. Tennenhouse is a graduate of the University of Michigan School of Medicine and the University of California Hastings College of the Law, San Francisco, California. Both a lawyer and a physician, he is a well-known lecturer on legal medicine and risk management for physicians, nurses, and other health care professionals.

DAN TENNENHOUSE, MD, JD

Dr. Tennenhouse addressed the issue of informed consent and warnings. He noted that proper disclosure prevented surprise, improved rapport and compliance and provided the opportunity for appropriate warnings. Medication warnings can be listed in a patient hand-out or documented as a note of your verbal disclosure. He tended to discourage documents signed by patients, noting that juries tend to view these negatively as purely defensive. The exception are documents permitting disclosure to third parties which should always be signed.

Other issues covered by Dr. Tennenhouse included risk management measures for suicide, non-compliant patients, and collaborative care.

His comments on dealing with adverse outcomes were helpful and reassuring. He said that we must remember that adverse outcomes are often unavoidable and that barriers to a lawsuit are good communication and effective record keeping. In the case of an adverse outcome, it is important that one communicate with the patient and the family but always get advice before admitting a mistake or explaining a "reasonable error of clinical judgment." He advised us not to appear negligent when there is no negligence. He also advised us not to blame others.

Dr. Tennenhouse recommended we remember that the content of the medical record should be for good continuity of patient care, for communicating with the health care team, and for satisfying billing requirements. He advised us to avoid record keeping that is only defensive.

ON BEING A MEMBER OF WPS

William Lawson, MD, PhD, DFAPA
President-Elect of the Washington Psychiatric Society

"I see tremendous opportunities for the WPS to provide local and national leadership."

The Washington Psychiatric Society is one of the largest and most influential District branches in the nation. In spite of its size, it has engendered feelings of family that allow members fellowship and support for each other. In the current economic downturn and with changes proposed in health care delivery I see tremendous opportunities for the WPS to provide local and national leadership.

I look forward to assuming the presidency and I intend to address issues of visibility and political clout, closer ties to the rest of the medical community, emphasis on psychiatrists as the professional leaders in mental health, improving access to all evidence based treatments for our patients, and developing a new generation of psychiatrists. I encourage you to join the WPS and to actively participate in its dynamic committees. I am Director of the Mood Disorders Program and Professor and Chair of the Department of Psychiatry and Behavior Sciences at Howard University College of Medicine and Hospital. My voice mail is 202-865-6611 and my fax is 202-865-3068.

Election 2009

APA Election Results Announced

The Committee of Tellers met on February 20, 2009 and reviewed the results of the 2009 APA National Elections. The winners were as follows:

President-Elect
Carol A. Bernstein, MD, 51% (3-way race)

Vice President
Jeffrey Geller, MD, MPH, 55% (3-way race)

ECP Trustee-at-Large
Joyce Spurgeon, MD, 57% (2-way race)

MIT Trustee-Elect
Kayla Pope, MD, JD, 53% (3-way race)

Area 1 Trustee
Frederick J. Stoddard, Jr., MD, 55% (2-way race)

Area 4 Trustee
John J. Wernert, MD, 64% (2-way race)

Area 7 Trustee
William Womack, MD, 51% (2-way race)

We are sorry that our man, Dr. Roger Peele, was not elected but he ran a great race! Good luck to our new APA Officers.

Obituary

By Miltiadis Zapharopoulos, MD of the American Academy of Psychoanalysis and Dynamic Psychotherapy

Leon Salzman

Leon Salzman, MD, age 93, died February 28, 2009 at his home in Bethesda, MD of complications from a stroke. He was born July 10, 1915 in Brooklyn , NY—one of 11 children.

Dr. Salzman graduated from City College of New York in 1935 and from the Royal College of Physicians and Surgeons of Edinburgh, Scotland, in 1940. He served in the U.S. Public Health Service from 1941 to 1943 and his training in psychoanalysis was at the Washington Psychoanalytic Institute. He was a member of the Washington Psychoanalytic Society and the American Psychoanalytic Association.

In 1956 Dr. Salzman became a Founding (Charter) Fellow of the American Academy of Psychoanalysis—now the American Academy of Psychoanalysis and Dynamic Psychiatry. He was its first Treasurer and served as its President from 1964 to 1965. In 1962 he was a stalwart representative of the Academy at the formation of the International Federation of Psychoanalytic Societies and in his peripatetic peregrinations he served on the faculties of Georgetown University School of Medicine, Catholic University, The Medical College of Virginia, Tulane University Medical School and New York Medical College. His books on Obsessive Personality and its treatment became standards in the field.

In the words of another President of the Academy, Dr. Salzman was known to many members, whose ranks are unfortunately dwindling, as a most lively, gracious and generous friend, and a raconteur of note. Along with his wife Anne, who predeceased him, he was a delightful and considerate host, whether in Washington, New York, or Cape Cod. He is survived by four daughters: Dr. Carol Salzman and Susan Braverman of Bethesda, Terry Rusinow of Portland, OR, and Sara Salzman of Kerrville, TX, and by eight grandchildren and four great-grandchildren.

We have lost a rare man and we shall go on remembering him well.

Continued from page 1.

physical transition. In such cases, the full diagnostic criteria are no longer met and there is no coding of a gender related disorder. There is no diagnosis.

In addition to the main Gender Variant diagnosis, secondary associated or other diagnoses should be used, such as depression, anxiety or adjustment disorder. V Codes may also be appropriate such as 313.82, Identity Problem, and V62.89, Phase of Life Problem. Sexual orientation is irrelevant and does not need to be factored into the diagnosis.

We fully appreciate that gender concepts are not independent of cultural, societal, and historical factors even though biology may underlie gender. Therefore, acknowledging that we are inevitably biased by our current views is critical to minimizing such bias when developing our clinical formulations.

Editor's Note: Plans are being made for a WPS CME event in June, 2009 on the topic of Gender Identity Disorders: Issues in Diagnosis, Treatment and Prognosis. The date, time and place are still to be announced.

DISTINGUISHED FELLOW NOMINATIONS

We invite those eligible for designation of Distinguished Fellow to apply through WPS as soon as possible. Completed paperwork is due to the WPS office by June 1, 2009.

Please contact Jane Martin, Director of Member Services, at janemartinso@yahoo.com or 410.626.1182, for more information.

Classified Ads

Office Space Available

DC Office Condominium For Sale: Available July 1,2009. In small attractive office building at 2112 F Street, NW. Very accessible to downtown offices, Virginia, and Maryland, near GW metro, GW campus, World Bank, and State Department. Parking in the building or on the street for patients. 656 square foot space ideal for a psychiatrist or psychotherapist. It has an entrance to waiting room and a separate exit from a large 15 x 15 foot consulting room with much light from front wall of big windows overlooking quiet street. Waiting room with bathroom for patients. Hallway with separate bathroom including a shower and closet. $270,000, financing available via banks or the seller. Call David Levi at 202-293-9138.

Foggy Bottom Office: Share a 4 office suite with 3 mental health professionals. Newly renovated 280 sq. ft. office in a large medical office building, 2440 M Street, NW. 7th Floor, 17 ft. of windows, in-suite bathroom, kitchen and private entrance. Parking in the building. $1700/month. Call 202-293-5482.

Attractive office in Connecticut Ave. townhouse at Red Line Woodley Pk Metro. All tenants therapists. 270 sf plus restroom and storage area. Beautiful wood floors. Excellent location. Great natural light. Security door with dedicated intercom. Contact Marc: 202-686-7691 or mrqwin@aol.com $825mo

Positions Available

The Department of Psychiatry and Behavioral Sciences at The George Washington University Medical Faculty Associates, an independent non-profit clinical practice group affiliated with The George Washington University, is seeking a **psychiatrist** for a full time appointment. This academic hospitalist position will include: 1) attending on the GWU Hospital inpatient psychiatric unit and consulting to the GWU Hospital emergency room; and,
2) opportunities for additional medical student and resident education and clinical research. Basic Qualifications: Applicants must be license eligible in the District of Columbia and be Board Certified or Board Eligible in General Psychiatry. Academic rank and salary will be commensurate with qualifications.

Review of applications begins March 6, 2009, and will continue until the position is filled. Application procedure: To be considered, interested applicants should send a letter of interest, curriculum vitae and two letters of recommendation to:

Jeffrey S. Akman, MD
Leon Yochelson, Professor & Chair
Department of Psychiatry and Behavioral Sciences
2150 Pennsylvania Avenue, NW
Washington, DC 20037

Only completed applications will be considered.

The George Washington University Medical Faculty Associates is an Equal Opportunity/ Affirmative Action Employer.

The Department of Psychiatry and Behavioral Sciences at The George Washington University Medical Faculty Associates, an independent non-profit clinical practice group affiliated with The George Washington University, is seeking a **consultation-liaison psychiatrist** for a full time appointment. The position will include: 1) attending on the psychiatric consultation service in the GWU Hospital; 2) outpatient clinical work; 3) opportunities for additional medical student and resident education and clinical research. Basic Qualifications: Applicants must be license eligible in the District of Columbia and be Board Certified or Board Eligible in General Psychiatry and Psychosomatic Medicine. Academic rank and salary will be commensurate with qualifications. Preferred Qualifications: Psychosomatic Medicine and/or Consultation Liaison Psychiatry fellowship training.

Review of applications begins March 6, 2009, and will continue until the position is filled. Application procedure: To be considered, interested applicants should send a letter of interest, curriculum vitae and two letters of recommendation (including one from the Fellowship Director, if applicable) to:

Jeffrey S. Akman, MD
Leon Yochelson, Professor and Chair
Department of Psychiatry and Behavioral Sciences
2150 Pennsylvania Avenue, NW
Washington, DC 20037

Only complete applications will be considered.

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Wanted - **Psychiatrist** to work pro bono 3 hours per month at psychopharmacology clinic for the Homeless. Good For The Soul. Patients do not adhere to dress code. Call Dr Goldberg at 301-509-3675.

Conferences of Interest

CAPTURING THE IMAGE OF MOTHER-INFANT INTERACTION: LINKS TO THE CLINICAL ENCOUNTER

with Beatrice Beebe, PhD., presented by The Institute for Contemporary Psychotherapy and Psychoanalysis (ICP&P)

Saturday, May 2, 2009, 8:30 am to 4:30 pm

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Non-Members: Early fee (due 4/15/09) $170; Regular fee $185

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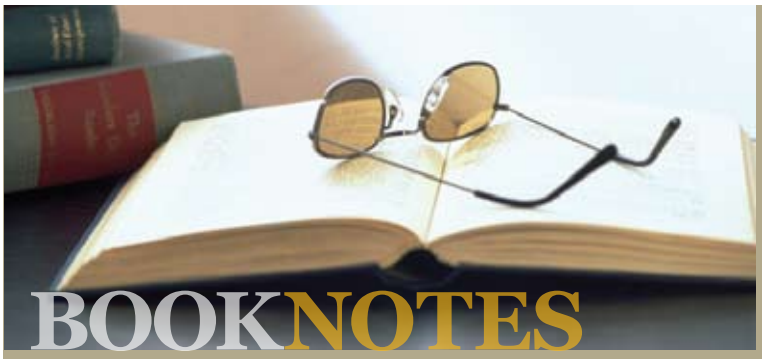

Changing American Psychiatry, A Personal Perspective

By Melvin Sabshin, MD; Reviewed by Harold I. Eist, MD, DLFAPA

Mel Sabshin's book *Changing American Psychiatry, A Personal Perspective*, was released at the 2008 APA Annual Meeting. I could hardly wait to get it and read it, hoping that it would be full of titillating, tell-it-all gossip. True to his style, Dr. Sabshin painted in broad strokes and avoided the petty.

Dr. Sabshin's influence and range of activitities were legion. As Medical Director of the American Psychiatric Association, he presided over the growth of the APA until 80% of psychiatrists were members, a higher percentage of the field than any other medical specialty organization. Since his departure, APA membership has declined by at least 10,000.

His vision in a time of change was to unite the field by skillfully bringing together ideologues: a difficult, political task. He recognized the value of both clinical wisdom and scientific research and understood the limitations of each and the necessity of their integration.

It is clear that Dr. Sabshin valued the progressive integration and respect psychiatry earned during his tenure and continues to earn in the house of medicine. This was reflected in his naming leaders from academia and research and from the directors of large delivery systems.

Just as he worked to raise the bar in American Psychiatry, he worked to raise the bar in World Psychiatry where he was a driving force for improvement in many areas including ethics.

Dr. Melvin Sabshin

He deserves major credit for the DSM's, which have had a profound impact on focusing diagnoses and research. As our field and our knowledge expands world-wide, our classification systems will change. The historic importance of the DSM III and IV, however, should not be forgotten.

This review is not simply a paean to Mel Sabshin. As he said in his book, he made mistakes. Nevertheless, he should be remembered for his accomplishments during nearly a quarter century of major growth and change while at the helm of the APA. This book is written in a clear, expository style. It deserves to be read.