

The Psychiatric Society of Virginia VIRGINIA NEWS

FALL/WINTER

A District Branch of the American Psychiatric Association

2005

Edward Goldenberg, MD, DFAPA



From the President of PSV: At the Crossroads

While I've been struggling with the issues of this column for some time, I have vacillated on whether or not to put this in print. However, over the past few months *The Virginian Pilot* has published articles about changes in medical care in the Hampton Roads / Tidewater area which beg the question:

Can We Afford to See Our Patients?

I have witnessed a troubling evolution in the insurance/managed care/public health programs over the past 14 years since I moved to Virginia. In order to treat patients, I've seen myself and my colleagues expend more hours filling out papers and utilizing clerical staff hours each year. To make the practice of psychiatry financially possible we must see more patients, do additional non-clinical work, or regrettably, consider entering another profession. I have read newspaper articles in recent months about some colleagues in internal medicine and family practice who have started moving into "Concierge Care." In this model, the patients subscribe for a fee (such as \$125 monthly, or more) to a program that allows them to be seen with less waiting and with less bureaucracy. But not everyone is willing or can pay the monthly fee, so fewer total patients are

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seen in the Concierge practice. But each receives more attention. And by the way, those doctors earn higher incomes and reportedly enjoy more job satisfaction. But wait—we didn't expect to earn high incomes when we chose to go into psychiatry. We knew that some other physicians and surgeons might earn twice, four times, or even 10 times the income of the average psychiatrist.

But even within psychiatry things have been changing. Virginia psychiatrists who don't want to lose income generally chose one of the following options: 1) they accept salaried public psychiatry positions with benefit packages; 2) they remain in private practice, but choose to not participate in insurance plans and return to the "fee for service model" of the past; or 3) they make other career choices. The public sector patient base has condensed and shifted such that many of the poorer and chronically mentally ill patients are increasingly being treated in the private practice sector by the few providers who participate with Medicaid and Medicare plans. However for private practice as well as community psychiatry providers, we face anything but a condensed bureaucracy. There have been increasing restrictions imposed by managed care plans which make it more and more difficult to see our patients and prescribe the medications our professional judgment suggest will best help them. Who benefits from this? Unfortunately, it seems unlikely that this is of any benefit to the patients, providers, nor Joe Public Taxpayer. Aside from the managed care

companies who are paid to manage/restrict services, I'm not really certain who does benefit.

Are there any remedies?

There have been various theories and indeed philosophies as to how best provide services to so many people with the limited funds available. No one answer seems to solve this dilemma. Although I'm not ready to advocate socializing our system at this time, it certainly seems that we may ultimately be pushed in that direction. In the meantime, the squeeze is being felt increasingly by psychiatrists, other physicians, and other mental health providers, while patients seem to be increasingly discontent with how many hoops they must go through to obtain care.

So, is it time to opt out?

I have not yet decided whether to get out of the managed care/insurance game. Should I stop participating with insurance plans and set up a "concierge" practice or more practically, return to fee for service, and offer whatever charity work my conscious dictates? Should I focus more on my therapeutic contracts with patients or continue to review contracts with managed care, insurance companies, and other bureaucracies? Should I just keep thinking about it and do nothing?

What do you think?

I know many of you have struggled with some of these same issues. It is not my intention here to offend or cause discomfort for anyone, but rather to open a dialogue about these issues. If you are willing to write down your thoughts, whether positive or negative, I would like to review them and possibly present them in another column or meeting. Please share your opinions or comments by sending me an email at DrEd2001@aol.com. Thanks!

Sincerely,

A handwritten signature in purple ink that reads "Edward Goldenberg MD".

Edward Goldenberg, M.D.

Outpatient Public Psychiatry in Virginia

The majority of Virginia's severely and chronically ill people are cared for in community mental health centers. In Virginia the state is divided into forty Community Services Boards (CSB) or Behavioral Health Authorities (BHA). (Here both called CSBs.) In 2004 the CSBs served about 187,000 individuals (children and adults). About 109,000 were listed as primarily having mental illness, 54,000 as primarily having substance abuse disorders and about 24,000 primarily with mental retardation.

Even small CSBs are relatively large and varied organizations. In the forty CSBs there are about 12,000 employees including about 225 full-time or part-time psychiatrists. Some cover large geographic areas but have relatively small budgets and staff, such as Mount Rogers CSB in southwestern Virginia or Mid-Peninsula Northern Neck CSB on the coast. Others are small, geographically speaking, but have very large budgets and staff such as Fairfax-Falls Church CSB or Norfolk CSB.

To give a size comparison, Valley CSB, where I work in Staunton, is considered a mid-size rural CSB. Yet our annual budget is about \$15,000,000 with a staff of about 250 including five psychiatrists providing the equivalent of 3.5 full-time doctors. A variety of treatment programs occupy six offices totaling roughly 60,000 sq. feet.

Work in a CSB can be challenging and fulfilling due to the degree of patient pathology, diagnostic variety as well as the benefit of working with many non-physician team members to provide care. Before coming to Valley CSB I enjoyed hospital work in the public and then private setting and eventually work in a solo outpatient practice. In my outpatient private practice I liked the longer exposure to those in my care compared to the increasingly brief exposure in the hospital work, but I missed the team work I enjoyed in the hospital setting. When I moved to the CSB I found the best of both worlds, outpatient longer-term work and teamwork to serve them.

Virginia's CSBs were created by the Code of Virginia in 1968 as local government agencies not a part of the State Government. Some of Virginia's CSBs are part of the local county or city and others are separate public agencies. Each CSB is administratively distinct just like local school boards or police departments. This is different from some states, such as Texas and Pennsylvania, in which the state hospitals and the community mental health centers are all run by the same state agency.

The overall relationship between the CSBs and the DMHMRSAS has at times been fairly adversarial. However, during these past several years since Jim Reinhard, M.D. has been Commissioner, the relationship has been increasingly cooperative. It is worthy of note that Dr. Reinhard is the first psychiatrist to head this very large department for many years. He is a true team builder and one aspect of his tenure has been to forge a strong working relationship with the Virginia Association of Community Services Boards (VACSB).

The VACSB, formed in the late 1980s, currently has a staff of four and represents thirty-nine of the forty CSBs in Virginia. Mary Ann Bergeron is the Executive Director of this organization which represents the CSBs in state and federal public policy matters, including state and federal funding. The VACSB works to build consensus on policy, administrative, and operational issues of CSBs and to represent those issues and solutions to the state agencies who most



relate and to the Virginia General Assembly. The VACSB is currently the strongest and best organized advocacy organization in Virginia to promote the needs of people with mental illness and mental retardation and their efforts are undertaken with impressive collaboration with other advocacy organizations including the PSV.

In my work with the Virginia Association of Community Psychiatrists (VACP) I have had considerable contact with individuals working within the VACSB, the various CSBs and the DMHMRSAS and I am regularly impressed with the degree of dedication, competence and compassion in these various teams. I have been proud and grateful to work with them. Obviously much improvement is needed in the provision of care for those with psychiatric illness in the United States. In Virginia we have the foundation of people and public organizations that can grow into more completely providing that care. Yes we need more money, but we will also need flexibility along with a willingness to try new approaches and always team work with non-psychiatrists.

For an excellent description of the current trends and the plans for the CSBs and State Hospitals see the draft copy of the Comprehensive State Plan placed on the Department's web site www.dmhmsas.virginia.gov. This draft plan builds on the work of the Department's restructuring efforts and is the future direction outlined in the Integrated Strategic Plan. It proposes specific actions for addressing critical issues facing the Commonwealth and includes a summary of resource requirements identified by the Department.

VIRGINIA NEWS

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*We welcome letters to the editor
and editorial contributions.*

Area V Council Meeting & APA Assembly Meeting

The Area V Council Meeting was held just prior to the Assembly meeting in Washington because the meeting had been scheduled to occur in New Orleans. Obviously all of the District Branches affected by hurricanes Katrina and Rita are in Area V. The Assembly representatives from these areas shared reports and pictures of the devastation, including the severe disruption to medical and psychiatric services. Several of the representatives had significant personal losses as well.

As usual, the agenda was lengthy and fast-paced, and Ram and I were kept busy. I am currently serving as Chair of the Reference Committee on Enhancing the Scientific Basis of Psychiatric Care and Governance Issues, and am on the Rules Committee, as well as on the Steering Committee for the APA Practice Guidelines, all of which have required a lot of time both at the meetings and between meetings, but all of which have had the pay back of being “growth experiences.” Ram, who has served on the Nominating and Awards Committee, is currently sitting on the Reference Committee Supporting Education/Training/Career Development.

As always, there is good news and less than good news to report. We did hear a lot about Medicare Part D, which will affect 35 million Medicare beneficiaries including the elderly and the disabled. There may be five people in the country who understand this program—but none of them seem to work for the federal government. As you may be aware, there are currently approximately 134 insurance entities that will be offering variations of Part D benefits at various cost levels. Each insurance entity can

have its own formulary, its own tier system, its own pre-approval requirements, and its own appeals system. Each can change any of these variables at any time with 60 days notice. Once a Medicare recipient has signed up for a given “product” the recipient cannot change plans for a year despite any changes the plan makes—a very one-sided contract. Apparently about 45 of these plans will be available in the Charlottesville area. You can find how many will be available in other areas of the state by entering the zip code on the www.medicare.gov website. Another reportedly more helpful website is www.mentalhealthpartd.org. This latter website is cosponsored by a number of organizations, including the APA. It may be worth alerting your patients that some of the insurance entities, once they have the recipient on the phone to sign up for Part D benefits, will be trying to enroll them in Medicare HMO’s, which could have serious implications on the access options they will have for all healthcare.

- It was warned that there is the potential for a lot of new federal bureaucracy on the horizon around the issue of “pay for performance.” We may be facing having to complete more forms, and generate more records, with no new reimbursement.
- There is scheduled to be a 4.4 percent decrease in Medicare reimbursement in January 2006. There is a bill before Congress to void this decrease and mandate a 1 percent increase. It remains to be seen if the cost of the Iraq war and the Gulf Area damage will derail this bill.
- There was discussion about ongoing problems with Medicaid, especially in “First Health” programs in several states under which it is mandated, for example, that despite how many illnesses a patient has, the program will only cover four medications, only two of which can be brand medications. It is left to the patients and their doctors to decide which ones. It remains to be seen if these types of policies begin to invade Medicare Part D over time. On the other hand, since Medicaid recipients who also have Medicare coverage will all go into the Medicare Part D program, there may be benefit to them from the ripple effect of AARP monitoring and advocacy.
- For those who were in the past covered by Legion Insurance, a Pennsylvania judge has released the escrow funds to allow their use for the settlement of claims.
- There is something of a current truce between the Texas Society of Psychiatric Physicians and the APA Board of Directors over the issue of dual membership.
- Medicaid cuts by Congress will disproportionately hurt psychiatric patients.

The APA remains on solid financial ground. Revenues for last year were 55.5 M with expenses of 51.5 M. From 1999 to 2004, APA revenues grew 41 percent, while expenses grew only five percent. It is noted that member dues make up only about 17 percent of revenues. Most revenues come from APPI publishing and from the annual meeting. Essentially all of the APPI profit comes from the DSM. All other publishing barely breaks even. Revenues from Atlanta, despite the relatively low turnout, were better than expected due to lower costs and the mix of registrants. The APA currently has 35.9 M in investments. It is noted that the APA does not invest

Continued on page 7

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How Many Psychiatric Hospital Beds are Needed?

This past summer there was a discussion on the VACP email discussion group about how many psychiatric hospital beds are needed in our state. This conversation emerged from a very thoughtful forwarded note from Mike Hogan, the Commissioner from Ohio, who also chaired the President's New Freedom Commission. Two responses that are especially apt are included below.

Ed Kantor, M.D. of UVA wrote:

"I think that any consideration of state hospital beds needs to occur in concert with the availability and access to community/university hospital beds. As the traditional public system shifts its orientation to community care, some realistic mechanism of coordinated planning with the newest partners—community and university psychiatry units/systems should be undertaken. In order for the 'fee for service' mode to work with SPMI clients, I believe there has to be an expectation of joint planning and ownership of the situation.

Intermediate to long term hospitalization in the current acute inpatient unit model often creates a mismatch of expectations. Longer term psychosocial rehab, reasonable reimbursement to the providers and the facility, solid methods of case management and interagency coordination should all be built into the planning. The model of contracting for 'beds' forces a fragmented "it's your problem now" model rather than a joint ownership model from both sides. Institutions rarely have enough of a conscience to do the right thing over time when faced with significant financial losses.

I think that the series of closures of both for-profit and not-for-profit psychiatry units over the past 6-8 years suggests that it's time for a new approach to community planning, funding and cooperative relationships between agencies that are no longer of the same ilk as 10-15 years ago. If CSBs and community/university providers are all in the fee-for-service model, serving the same clients/patients are there really different systems or just different budgets?"

Ananda Pandurangi, M.D. of MCV responded with the following:

"In my role as Chair of the division of inpatient psychiatry for 15 years at MCV Hospitals—which provides academic programs, tertiary care programs and general care for an inner city population, I would like to outline four observations/suggestions on this topic.

- (1) There is a need for an umbrella organization within each region of the State with authority to achieve among other things a higher order of case management. For example an "authority" a la transportation authority, sports complex authority etc. This would need to be achieved legislatively. Public, private and charitable organizations will need to be represented on this and agree to pull in the same direction. Sufficient incentives have to be built in for all to agree. Without a central authority, at this time the field is too disparate with too many players and inertia. Hospitals, clinicians, CSBs etc will not by themselves give up any degree of control to others nor agree to work for someone else's goals—yet the coordination that Hogan and Kantor mention cannot be achieved without give and take on everybody's part and sufficient incentives to do so.
- (2) To marshal the required database for the creation of such an authority, and then to process, negotiate and develop specific organizational structure, mission/objectives, policies and procedures, risk management strategies and legal immunity, outcome and satisfaction analysis etc, a study group or commission is necessary—along the lines of the Hammond Commission or the Mental Health Commission (under the JLARC), led by senior legislators from the two parties and participation by all players.
- (3) Continuum of Care. In Virginia, several study groups, task forces, and committees have emphasized this over the years. We all know what it takes—acute care, step down care, outpatient clinics, residential rehab, community rehab, crisis intervention, emergency access, PACT, housing etc. Attempts at creating such a

continuum have been feeble and fragmented. In part, this is a function of:

Turnover in the Central office of MH/MR and the Governor every four years. No Commissioner however good and interested he might be can generate the synergy needed between political, financial, provider/professional and consumer groups to achieve this in 4 years.

Lack of interest and lack of incentive for the private sector.

Lack of funding. In our field we are always robbing Peter to pay Paul. Cancer and Heart Disease do not do this. They raise new funds. As a field Mental Health is severely under funded. There is no way around this. There is no one to energize us to commit ourselves to this. NAMI is a lone voice. VHME did what it could but is not into fund raising. Academicians are busy with clinical service or core research. Clinicians are overwhelmed as it is. MH/MR could/should take the lead but they would need very significant help from the field. A small investment may reap big benefits in this area.

- (4) Special or niche populations. In the last 100 years, society and the mental health field have changed dramatically. Yet there is hardly any recognition for specialization and the unique needs of individuals. We seem to hold on a "one size fits all" approach. On the inpatient side it is very evident we need specialized units and programs for the MR-MI, S.Ab-MI, Criminal-MI, SPMI, (severe) PD-MI etc populations. A well know fact is that most recently the bed crunch in the regions is coming from lack of beds for such populations. As Ed points out the LOS for such patients does not match with the average LOS for other acute patients and what third party payers including Medicare will pay for. Thus there is no clinical or financial incentive to admit such patients (and risk complications, injuries and law suits). This is one problem the State should and can play a leadership role in right now. It needs seed monies, grants and contracts to get these going and to be successful."



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PSV Advocacy Report

Cal Whitehead can be reached at 804-644-4424 or by e-mail at: cwhitehead@whiteheadconsulting.net

Organized Psychiatry Active in Policy Development and Politics

Virginia psychiatrists have been busy this fall advocating for their profession and patients in the policy and political arenas. Psychiatrists from many practice settings across the state have served on government workgroups and in advisory roles. Strong support for PsychMD-PAC has provided psychiatrists with visibility during the recent campaign season which saw the election of Tim Kaine (D-Governor), Bill Bolling (R-Lieutenant Governor) and Bob McDonnell (R-Attorney General). As always, for information about your elected officials, visit "Who's My Legislator?" at <http://conview.state.va.us/whosmy.nsf/main?openform>. Below is a summary of some of our recent advocacy activities.

Expert Witness (psychologists)

The Virginia Psychological Association (VPA) is proposing legislation that would require judges to recognize psychologists (and, they offered, psychiatrists) as expert witnesses in cases addressing causation of a neuro-psychological condition. This was described using a condition caused by an auto accident. Some neuro-psychologists have been told that only a neurologist is qualified to be experts in such cases. Current case law provides that only physicians can testify on causation. Unanimous feedback from organized psychiatry leaders has been in opposition. PSV President Dr. Goldenberg has formally communicated this to the VPA. The MSV and the Virginia Association of Defense Attorneys (VADA) also oppose this proposal.

Assignment of Benefits (AOB) for Emergency Care

A group of private emergency medical practices and the Virginia College of Emergency Physicians (VACEP) are proposing legislation that would require insurance companies to honor patient assignment of benefits (AOB) to out-of-network providers for care provided under EMTALA. This would mean the reimbursement would go directly to the physician rather than the patient. Anthem-Wellpoint and the Virginia Association of Health Plans strongly oppose this concept. The Psychiatric Society of Virginia, Virginia Orthopaedic Society and Virginia Chapter American College of Cardiology support this effort.

Call Coverage for CSB Patients

There are ongoing discussions about lack of, or insufficient, physician coverage for after hours care of CSB patients. Private hospital emergency departments and on-call physicians have complained about not being able to reach prescribing or treating doctors after hours. Exploration of ethical, regulatory, and legal requirements for call coverage is being suggested.

Behavioral Health Subcommittee, Joint Commission on Health Care Not Guilty By Reason of Insanity

PSV-WPS has provided the Joint Commission on Health Care (JCHC) substantial feedback on current NGRI law. Many of our comments have been incorporated into the proposed reforms including:

- Legislation to clarify that voluntary admissions to State hospitals do not have to result in revocation of conditional release for NGRI acquittees.
- Legislation to remove language prohibiting psychiatrists and clinical psychologists who are employed by the Commonwealth from being paid for completing evaluations.

- Legislation to amend the *Code of Virginia*, Title 19.2 Chapter 11.1 so that consideration of violations of conditional release may be considered by the Court on an expedited basis.
- Continued support of initiatives designed to divert individuals with behavioral health care needs from the criminal justice system and to provide treatment for individuals who are not diverted and legal requirements for call coverage is being suggested.

DMHMRSAS Services for Children and Adolescents

- \$1.7 million budget amendment to fund 4 two-year child psychiatry fellowships and 4 one-year child psychology fellowships; training for primary care providers
- Funding for two demonstration projects and provide funding for 6 additional projects to serve "youth with juvenile justice involvement, and/or those with co-occurring mental health, mental retardation"
- Funding for MH treatment for detention centers (only 7 of 25 centers currently have service programs)
- Provide funding to establish 20 Mental Health/School-Based Demonstration Projects for middle-school students "who experience educational difficulties as a result of psychiatric and/or substance abuse problems."

Free Clinic and Community Health Center funding for MH service Medicaid Reimbursement Increases

MSV and specialty societies will again seek across-the-board reimbursement increases for physicians.

Virginia Association of Free Clinics (VAFC)

PSV-WPS helped them secure several psychiatrists to lecture at their Annual Conference.

PsychMD PAC

We have maintained our strong participation in this year's House of Delegate and statewide races. Through PsychMD PAC, psychiatrists have been visible at recent events for gubernatorial candidate Tim Kaine, Speaker Bill Howell, and House Majority Leader Morgan Griffith.

Here are 2005 PsychMD PAC contributors... Thank you!

| | | |
|----------------------|----------------------|---------------------|
| Agarwal, Ramesh | Friedel, S.W. | Morse, Jeffrey |
| Arons, Michael | Goldenberg, Edward | O'Keefe, Dorothy |
| Brasington, Steve | Gorman, Barry | Pizzani, Miriam |
| Brodie, Owen | Greco, Philip | Pushkin, Yaacov |
| Buyse-White, Valerie | Issa, Fuad | Royal, Orren |
| Carter, Wesley B. | Jacobs, Erwin | Schloff, Lizann |
| Choudhary, Varun | Jennings, Stan | Shemo, John |
| Chun, Kelly | Jones, Cheryl W. | Shemo, Mary |
| Connell, Larry | Koduru, Banerje | Silver, David |
| Davies, John | Krag, James | Silverman, Joel |
| Dee, James | Lindsay, Rebecca | Spanier, Elliott J. |
| Evani, Renuka | Luisada, Paul | Steckler, Eric |
| Fernandez, Anthony | Mansheim, Paul | Walton, Ruth |
| Fisher, Gregory | Markowitz, David | Wouters, L. Marian |
| Foster, Helen | Mirmirani, Nooreddin | |

What ABIL Offers

ABIL's mission is to "provide hope, support and advocacy for people suffering from debilitating phobias, panic attacks, and/or agoraphobia..."

What exactly is ABIL? What can ABIL offer to individuals and health care providers?

Founded in Richmond with one support group and three members in 1986 by the late Shirley Ford Green, Agoraphobics Building Independent Lives (ABIL) has grown to establish and maintain self-help support groups and offers educational programs throughout the Commonwealth. ABIL also works to provide information and advocacy on rights related issues. Our goal is to improve the quality of treatment and the overall quality of life for anxiety sufferers. Simply put, we are a non-profit organization for the education and support of those who suffer with anxiety and panic disorders.

Those who have or are recovered from anxiety illness, or have a family member who suffers, facilitate ABIL's support groups. Groups are

a safe place to come together with others who have similar problems; a place to learn they are not alone; a place where members can feel free, even if they feel anxious; a place for support and encouragement; a place for sharing successes and learning how to deal with setbacks.

ABIL publishes a quarterly newsletter, with pen pal opportunities available. ABIL also provides a Speaker's Bureau, members of which are available for public lectures, small group informational talks, school classroom presentations, staff in-services and similar venues. Our web site at www.anxietysupport.org has won a local award and we encourage you to visit.

Our Board of Directors is made up of mental health professionals, business people, and consumers. We seek the involvement of mental health consumers on various levels, as we are a grass roots, consumer-run organization. We continuously look for new ways to reach out to the professional community and the community at large. We have published a new brochure and a bookmark entitled "Un-Stress

Tips", which are available for distribution to physicians' offices. In the fall and winter 2004-2005, we offered a workshop entitled, "IS IT STRESS OR IS IT ANXIETY? How to tell the difference and live a healthy life" which was open to the public and well attended. It proved to us that the community wants more of this type of program, so in September and October of 2005 we are presenting "What Worries You? Problems with Anxiety, Fear, and Panic", an educational seminar on anxiety problems and their treatment. This seminar is being offered at several locations throughout the Richmond area, and presented by different mental health professionals in our community.

We encourage you to become a professional member of ABIL! Your support will enable us to continue our mission, serving anxiety sufferers and their families in the Commonwealth of Virginia. **For more information, contact Yolande Long, MSW, Executive Director, ABIL, Inc.: 804-353-3964 or abil1996@yahoo.com.**

Meeting Update continued from page 3

in pharmaceutical companies to avoid any appearance of a conflict of interest. The largest use of the APA's discretionary budget is for patient advocacy. A recent independent audit of the APA was graded "A," putting the APA in the top five percent of nonprofit organizations for financial health. The APA has a current assets/current liabilities ratio of 1.72, while the average for nonprofits is 1.40.

As a new APA member benefit, 20 hours of APA annual meeting based CME can be gotten on the APA website—www.psych.org. This is free to those who went to the APA annual scientific meeting and \$65 for those who did not go. A variety of action papers were considered and debated:

- One addressed the problem of pharmacists refusing to fill patient prescriptions by citing the pharmacist's moral or religious objections to the prescribed medication, and calling for legislation to make it

the pharmacy's legal responsibility to find in a timely manner another pharmacist or facility that will fill the prescription.

- Another addressed the problem of committed non-offenders being held in jails pending the availability of a hospital bed.
- Another action paper directs the APA to study creating a "gold standard" of an APA-sponsored, universal, internet based, continuously up-datable listing of psychiatrist availability to accept patient referrals.
- Another aims at rewarding residents in the "100 percent programs" with a waiver of the \$65 charge for access to the online library of the APA annual scientific meeting.
- Three action papers addressed issues related to the relationship between the APA and the pharmaceutical industry, both to insure transparency in the relationship and to expand access to psychiatric care and treatment, including non-pharmaceutical treatment.
- An action paper was proposed by the Military District Branch, which is in our Area V, which

addressed the formulation of an APA position statement on psychiatrist participation in the interrogation of detainees. It was very carefully and thoughtfully written. This was passed on November 11th. On November 12th, the *New York Times* published a report contrasting the APA position with one passed by the psychologists which was much more tolerant of psychologist involvement in this process. The *New York Times* story pointed out specifically that psychiatrists are physicians and that the APA position was guided by the physician ethical imperative to "do no harm."

Finally, Ram and I do encourage all PSV members to encourage their non-member colleagues to join and become active. To paraphrase Benjamin Franklin's address to the Continental Congress during the American Revolution—"if we don't hang together, we will surely all hang separately."

As always, both Ram and I remain available to discuss issues that PSV members want brought to the attention of the APA Assembly.



PSV IN THE NEWS

RICHMOND PSYCHIATRIC SOCIETY SCHEDULE OF EVENTS 2006

Mark your calendar for the following meetings held at the Willow Oaks County Club, 6228 Forest Hill Ave., Richmond—804.272.1451

6:30 pm Cocktails
7 pm Business Meeting and Dinner
7:30 – 9 pm Lecture/Q&A

FRIDAY, JANUARY 27 –

Asha S, Mishra, MD

“Efficiency, Tolerability and Side Effects: Balancing Issues When Treating Schizophrenia in the Community”

Also special guest: Jointly sponsored by the Indo-American psychiatric Society; Pedro Ruiz, M.D., University of Texas, President-Elect of the APA

“Psychiatry in the XXI Century: Future Perspectives”

FEBRUARY – No Meeting Scheduled

MARCH 2 –

Fredrick Goodwin, M.D., George Washington University

“Integrating the ‘Tried and True’ with the new in the Management of Bipolar Disorder”

APRIL 6 –

David N. Neubauer, M.D., Johns Hopkins University

“Update on Sleep Disorders”

MAY 4 & JUNE 1 – TBA

For more information contact Renuka Evani, M.D. at 804.819.4136 or e-mail at: richmondpsych@yahoo.com



Congratulations to Dr. James Levenson



Congratulations to Dr. James Levenson who was just elected MCV/VCU's Physicians' **Distinguished Clinician of the Year**. This is the highest accolade from the Practice Plan for outstanding clinical service. It is recognition for the clinician faculty at large and it therefore reflects respect and value for Dr. Levenson's work from his colleagues at MCV/VCU.

Virginia Association of Community Psychiatrists (VACP) Fall Meeting

The VACP fall meeting on 11/5/05 was well attended by psychiatrists from all regions of the State and included psychiatrists from CSBs and State Hospitals

David Moody, M.D., President of the VACP led the discussion and along with **Jim Evans, M.D.** Medical Director, DMHMRSAS discussed some of the changes in the Community Pharmacy (previously called Aftercare Pharmacy), various issues from around the state involving the interaction of CSBs and State Hospitals and **Medicare Part D**. Tony Graham, M.D. noted that the Virginia Insurance Counseling and Assistance Project has a toll free number to help our patients better deal with Part D at 800-552-3402.

Jim Reinhard, M.D. discussed lessons he's learned these past four years as Commissioner. He also discussed some of the restructuring initiatives and the Integrated Strategic Plan in progress. (see at www.dmhmrzas.virginia.gov)

Bob Gardella, M.D. presented and led a discussion about the CATIE study and summarized “What's New” in pharmacological treatment for 2005.



Paulette Chessen and Dr. Ramesh Koduri, winner of the basket for the PSV Foundation at the PSV Fall meeting held in Norfolk this past October.

Highlights from the PSV Fall meeting held at the Norfolk Marriott Waterside on October 14-15.



2005 - 2006 Board of Directors



Angie Bezik (from Delegate Terrie Suit's office), Delegate Ken Alexander, Dr. Charles Devitt, Dr. Wesley Carter, and Dan Haworth (from Senator Nick Rerras' office)



Dr. Cheryl Jones with Senator Yvonne Miller (D-Norfolk); and Dr. Jones' mother.



Delegate Paula Miller (D-Norfolk) with PSV President, Dr. Edward Goldenberg.



Dr. Doug Chessen and his wife Paulette Chessen with Delegate Algie Howell (D-Norfolk).

Congratulations to the following PSV members who have achieved Life Status as of January 1, 2006:

Distinguished Fellow Life Eligible:
Conrad H. Daum

General Member Life Eligible:
Patricia H. Brown
John J. Lee
Richard W. Oliver
James L. Reif

New officers elected for Southwest Virginia Psychiatric Society in October, 2005

Rizwan Ali, M.D., President
Manjit Vohra, M.D., Vice President
Brian Bladykas, M.D., Secretary-Treasurer

Mark Your Calendar for the PSV SPRING MEETING "Controversial Issues in Psychiatry" scheduled for Friday & Saturday, March 24-25 at the Richmond Marriott West.

VIRGINIA NEWS

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SPRING MEETING

*Mark the Date
March 24-25*

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CONFERENCE SPEAKERS:

Philip Ninan, M.D., Emory University School of Medicine

John Rush, M.D., University of Texas Southwestern Medical Center

Thursday, Apr 20, 5-9 p.m. & Friday, Apr 21, 8 a.m. to 4:30 p.m.

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This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Medical Society of Virginia through joint sponsorship of Carilion Health System CME Program and Carilion Saint Albans Behavioral Health. Carilion Health System is accredited by The Medical Society of Virginia to provide continuing medical education for physicians. Carilion Health System designates this educational activity for a maximum of eight Category 1 credits towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.