Our 2014 PSV spring meeting is now behind us. Congratulations to the planning committee on yet another fantastic program! The conference was well attended and attracted sponsorship from a large group of vendors and exhibitors, all of whom help to make our meetings financially possible. Almost 100 psychiatrists attended the meeting to hear about the future of psychiatry and the therapeutic relationship and I doubt any were disappointed with what they heard.

On Friday afternoon the board met, as usual, in a called session. Later board members and meeting attendees were treated to a reception featuring the presentation of a number of yearly awards including the annual legislator of the year award. This year we were honored to present that award to Senator Creigh Deeds who addressed the crowd expressing his gratitude as well as his intent to continue to press forward with needed mental health reforms. The reception was also attended by Dr. Sterling Ransone Jr., president of the Medical Society of Virginia. The reception afforded the attendees a great opportunity to visit with members from other parts of the state as well as to meet new members, guests and students in attendance.

We started Saturday’s scientific session with an address during breakfast by Dr. William Hazel, Virginia Secretary for Health and Human Services. Bill is well known to a majority of our membership and gave a nice overview of the upcoming changes in the Virginia system. Following breakfast, we started the scientific program with warm welcome remarks by then president Dr. Rizwan Ali and proceeded with the program. Our key note lecture was delivered by Dr. Nigel Garth on “The Affordable Care Act: Current and Future Trends”. The audience received a thorough overview of the ACA and its implications for psychiatric practice followed by ample opportunity for questions. Dr. Garth’s...
A MESSAGE FROM THE EDITOR

Are you “Placebo enhancing?”

By Kathleen M. Stack, MD, DFAPA
PSV Newsletter Editor

It was with great interest that I read the February 2014 Psychiatric Annals titled “Frontiers in Placebo Effects”. The journal divided the reports into five articles.

The first was Report the Neuronal Mechanism of Placebo Effects. Second was, Psycho-social Mediators of Placebo Effects. The third was, Lessons Learned from Placebo Arm “Wrestle” in Clinical Research. The fourth addressed the Ethical Dilemmas of Placebos. Fifth, and to me surprisingly was, Enhancing Placebo Effects in Clinical Care. Each was interesting with an emphasis on different aspects of the placebo response.

I was not aware that there has been a steady decline in the effectiveness of new pharmacotherapy agents during the last 25 years with an increase in placebo response of 7% per decade. The complexity of why this is so exceeds my ability to summarize so I refer you to the journal.

I was intrigued and initially a little annoyed by the title of the fifth article, Enhancing the Placebo Effect in Clinical Care.

In summary, The placebo effect of clinical care is the therapeutic relationship. This was a new way to conceptualize the doctor-patient relationship for me. I was surprised by the meta-analysis of placebo controlled antidepressant studies which showed that 25% of the response was due to the drug and 50% was the placebo component (Kirsch et al). The article referenced a NIMH study that provided empirical evidence that being an effective psychopharmacologist is not just about which medication is chosen, but the therapeutic alliance. McKay et al analyzed data from 112 patients treated by 18 psychiatrists (50% drug arm and 50% placebo) and found that the therapeutic alliance was the largest contribution to improvement in depression.

Also no unique features were identified in the “placebo responders”. So the focus on the difference is in the provider.

The “placebo-enhancing” practitioners were described as working to develop a “sustained partnership” with patients using some or all of the following qualities (Brody)
- Caring, empathy and sensitivity
- Ability to adapt medical care goals to the patient’s needs and values
- Encouragement of the patient to participate fully in the decision-making
- Confidence, enthusiasm, affability and willingness to be reassuring
- Perception as warm and friendly, trustworthy and reliable by patients

Most of these points seem very familiar to me from my training, the behavior of those I tried to emulate or the physicians I have sought to provide my own medical care.

If this is what is referred to as “placebo enhancing” psychiatrists, I hope I can be one.

References

Become an APA Fellow. It’s Now Easier to Apply!
Are you ready to take the next step in your professional career?
The deadline for submitting a Fellowship application is September 1st. Visit http://www.psychiatry.org/join-participate/member-benefits/becoming-a-fellow to apply.
presentation was well received and set the stage nicely for the rest of the day’s presentations.

The following lecture was presented by Caitlin Feller and Dr. Stephen Horan on “Population Health Management and the Patient Centered Medical Home Model”. I doubt any of our membership has escaped the buzz surrounding the medical home concept and this presentation was particularly informative and enlightening regarding psychiatry’s role in the development of the model. Again, questions were entertained at the end of the presentation and several attendees took advantage of the opportunity to further clarify the topic.

After a brief break to visit the exhibits and have some coffee, the attendees returned to the conference room to finish the morning session with a discussion of the future of Telepsychiatry entitled “Telepsychiatry and Current Application and Future Implications” by our very own Dr. Varun Choudhary. A panel discussion followed his presentation regarding the future of psychiatry featuring the morning presenters, moderated by Dr. Choudhary. Again, there was lively discussion and, no doubt, significant advances in our knowledge as a group about changes taking place in our profession and the delivery of psychiatric care.

During our lunch business meeting we heard from Dr. Melinda Young, current speaker of the APA assembly, regarding updates on the APA and its interests and actions, a topic that many of our membership were intensely interested in given changes in the medical landscape discussed during the morning session. Also at lunch the 2014-15 slate of officers was introduced and the presidential gavel was officially passed from Dr. Rizwan Ali to Dr. Brian Wood. Dr. Ali thanked the membership for a great year and wished the new officers well. Dr. Wood spoke briefly about his personal journey within PSV and why all of us need to be involved with our professional organizations at this critical time in medical history.

Well satiated from a delicious meal and hopeful discussion, we returned to the conference room for the afternoon session while the trainees in attendance had the opportunity to attend a special breakout session on “Managing Your Debt” presented by UBS representatives.

In the afternoon session, attendees were enlightened first by a presentation on “Education and Psychiatry’s Future”. Educators from several schools took part in the presentation including one of PSVs members-in-training, Dr. Stephanie Peglow who is currently Chief Resident at EVMS. Next, our final faculty for the conference, Dr. Anita Everett presented, “The Crystal Ball: Psychiatry and the Management of Multiple Chronic Conditions”. Both presentations were well received by the membership, many of whom work in academic and public psychiatry positions.

In the final session of the afternoon, presenters from both of the afternoon lectures returned to the stage to entertain questions and engage in discussion with attendees. There was, once again, lively discussion right up until the scheduled 4 pm close of the meeting arrived. As discussion was concluded, Dr. Wood thanked the speakers, committee, staff and sponsors and invited everyone to the PSV fall meeting on September 20th and 21st in Chantilly, Virginia.

At the end of every conference we are reminded to please turn in our evaluations including suggestions for topics in future meetings. Like others, this spring meeting was based on the suggestions of our members and was once again a professional and financial success for PSV. So, keep those suggestions coming! We greatly appreciate everyone’s support and effort in planning the meetings including our staff, members of the planning committees, officers and board members of PSV, meeting attendees and very importantly our industry sponsors. We look forward to seeing everyone in Chantilly in September where we will address the state and future of sub-specialization in Psychiatry. I’ll look forward to seeing you all there.

Visit www.psva.org for the latest society information
Key Policy Makers and Important Guests Attend Spring Meeting Reception

Special Meeting Recap

By Ralston King
PSV Lobbyist

The Psychiatric Society of Virginia Spring Meeting was filled with key policy-makers and important guests from the Virginia Executive Branch, Legislature and the Department of Behavioral Health and Developmental Services (DBHDS). On Friday evening at the Board Meeting, the PSV Board welcomed Dr. Jack Barber, the Medical Director of the DBHDS. Dr. Barber briefed the Board on legislation regarding the new acute bed registry, potential funding through legislative changes and the emergency involuntary commitment law reform.

On Friday evening, the PSV welcomed to the annual reception: Delegate Betsy Carr (D - Richmond), a long time mental health advocate at the General Assembly, Medical Society of Virginia (MSV) President Sterling Ransone, MD and his wife Karen Ransone, MD, MSV Director of Government Affairs Matt Mansell and National Alliance on Mental Illness (NAMI) Executive Director Mira Signer. Most notably, the PSV was deeply honored and moved to have Senator Creigh Deeds (D - Charlottesville) and his wife Siobhan join the PSV. The PSV Board selected Senator Deeds to receive the 2014 PSV Legislator of the Year Award for his efforts on SB 260 that passed during the 2014 General Assembly Session.

Bright and early on Saturday morning, Virginia Secretary of Health and Human Resources Bill Hazel, MD attended breakfast and spoke regarding the mental health system and Medicaid expansion. Secretary Hazel stressed the importance of expansion as to help fund new priorities in the mental health system. Secretary Hazel has been tasked by Governor McAuliffe to provide Healthcare Town Hall meetings throughout the Commonwealth on losing the coverage gap for Medicaid.

Community Health Solutions Offers Innovative Support

By Caitlin Feller

At the PSV Spring Meeting, we heard Caitlin Feller and Steve Horan of Community Health Solutions outline a vision for how psychiatric clinicians can play a leading role in defining effective systems of care for populations with behavioral health needs. Community Health Solutions is offering an innovative support service for behavioral health practices interested in optimizing their capabilities for patient-centered care and population health management. Community Health Solutions uses a proven support model to help practices define objectives, design strategies, build internal capabilities, and execute for results. In addition, Community Health Solutions provides an online learning network where clients can continuously learn about new developments in population health research, policy, and practice. This combination of consulting and learning support helps organizations solve their immediate challenges while building a sustainable capacity for excellence. Contact Caitlin Feller (cfeller@chsresults.com, 804.673.0166) for additional questions.

Learn more about this innovative support service at www.PopulationNetwork.com
A Quick Update On Risk Management

By J. Edwin Nieves, MD, DFAPA
PSV Editor

How many times have you read an article, and said to yourself, “that makes a lot of sense”. I had that thought the other day while reading one of our sponsors flyers. The Professional Risks Management Services Inc. (PRMS) distributed during our last board meeting is an easy to read flyer on risk management titled: “Six Things You Can Do Now to Avoid Being Successfully Sued Later”.

The flyer contains six basic principles that could easily be a primer for any practicing physician not just psychiatrists. These are up there with other “golden rules” like: “bad feelings and bad outcomes”, “do not copy and paste”, etc.

The 6 basic principles listed are:

1. Practice Good Medicine: Now you may say to yourself, “of course you should practice good medicine” but good general practice suggestions are often hard to come by. Most physicians I know have picked up good habits over time by watching other physician mentors during their training. Others are really enforced by licensing boards or current discipline practice guidelines for mental health diagnosis, like DoD/VHA2. Here are a few items listed under this heading:

   a) Know policies and procedures: this is a good one, many times we do not think about what are the current policies & procedures of whatever institution we are practicing in. Are there any limits on the number of pills, tablets or refills you can prescribe? Is it a 30 day supply and 2 refills? Do you know the local no show policy? Does it mean you should call a no show patient yourself? Or is that the responsibility of the clerical staff?

   b) Stay current in your field: Each licensing board, and institution will require proof of continued medical education. That usually provides enough incentive to complete formal education CME credit, but there are other ways too. When you attend both national and local meetings, like our spring and fall meeting, you are not only learning formally, but also informally. Part of the natural exchange of meeting colleagues on these meetings is the sharing of practice patterns, habits and anecdotal experiences that have not worked their way into the literature as of yet. There are others that as I said earlier “are not in a book”. When I was a resident at MCV doing C/L afternoon rounds with Dr. Levenson, we were waiting for an elevator in the lobby of main hospital, after a few minutes Dr Levenson said: “do you know that if you carry with you a journal every day you can read an article a day more/or less while waiting for elevators?”. Prophetic words, since then, I always carry with me a green journal or periodical in my briefcase, back pack or under my arm and I read one or two papers every week.

   c) Do not prescribe for non patients: This is old, old, old, but every so often I see this happen. “Enough said”

2. Document: We all have heard, “if it is not written-it did not happen”, for psychiatrists who do not do procedures, the electronic medical record system (EMR) may present other problems. As you all know every patient is different, therefore the clinical symptoms and impact of mental health disease is different. Make sure that you document, patients’ capacity & consent to treatment, danger to self/others, pregnancy, etc. Avoid the temptation to paste your last note. How many times have you guys been called to see a patient on the note? Your note should reflect the treatment provided and your decision making behind it. It should also contain relevant, up to date clinical information for the next clinician.

3. Patient Confidentiality: The EMR has helped greatly in this area, going paperless, has by default, reduced greatly the chances of inadvertently violating patient confidentiality. Always be mindful to shred and not leave around your clinic schedule. The dual identification sometimes requires use of both social security number and date of birth, do not leave this information lying around. When in doubt, always ask patient to sign consent before you release any information.

4. Terminate with Patients Appropriately: Follow up with no show patients, follow up letter maybe sent/sometimes a call is better to make sure you know “the intent” of the patient.

5. Maintain Clear Boundaries: This is another old one. The majority of boundary violations happen accidentally and start as the result of a “boundary crossing”. These are occasional boundary line crossings that occur “from the waiting room to the office” but not harmful to the patient. It is at this time that a clinician may “lower his/her guard” and may ask, (or answer) a seemingly innocent personal question. One of the reasons why psychiatry is such a labor intensive field is because we must always be “on guard” to these slips. Make sure you do not enter business/barter with your patients.

6. Be Nice: I guess this could be linked to the “bad feelings, bad outcomes” nugget, a physician has a fiduciary relationship with his/her patients, a special relationship of trust. Patients are more likely than not to come to see a psychiatrist while in some form of emotional distress. Expressing empathy, understanding and “putting yourself” in the shoes of the patient is one of the best qualities of a well honed psychiatrist.

References:

1. “Six Things You Can Do Now to Avoid Being Successfully Sued Later”. Professional Risks Management Services Inc. The Psychiatrists Program, Used with Permission from PRMS.


Acknowledgement: I would like thank PRMS for their permission to use their flyer for this writing.
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NAMI WALKS VIRGINIA
CHANGING MINDS...ONE STEP AT A TIME!

By Farleigh Fitzgerald
NAMI Virginia
Director of Events and Communications

Every journey begins with that first step! Each year, NAMIWalks Virginia strives to improve lives and communities across Virginia one step at a time. NAMIWalks is a family and community event to raise awareness, educate people about mental illness, and celebrate hope and wellness. NAMIWalks Virginia brings together family members, community leaders, providers, neighbors, and friends to raise crucial funds for NAMI’s Virginia’s programs, promote awareness of mental illness, and celebrate recovery. The Walk relies on funds raised by individuals and the ongoing generous support from sponsors like the Psychiatric Society of Virginia. The funds from the walk help NAMI Virginia continue to provide free trainings and free programs to people searching for information, help, and hope.

NAMI’s programs are changing lives for the better. Connie, from Winchester said, “NAMI taught me that I’m not alone in crises. I was so amazed and thankful that there are groups I could go to. I participated in the Family-to-Family training, and came out of it thinking ‘wow, if this helps me, what could it do for other families?’ I am hopeful for the future. I have learned that change is possible. NAMI has shown me that when you are able to help others, it truly helps you.”

We are very excited to share that NAMIWalks Virginia not only reached, but exceeded our 2013 fundraising goal of $200,000! This is helping NAMI Virginia offer more trainings and reach more people than ever before.

We are very proud to share that for the 2nd year in a row, Virginia ranked SECOND IN THE NATION (after California) for program impact in 2013! Last year, NAMI Virginia and our affiliates held 1,227 program related events and reached 12,291 individuals.

This year’s walk is scheduled for Saturday, October 18th at Innsbrook, and we are grateful to once again have the Psychiatric Society of Virginia as an event sponsor. We have set our fundraising goal at $225,000 so that we can continue to grow our programs across the state and to meet the needs of people living with mental illness and their family members. We are looking for team captains, walkers, and volunteers to help us make this year’s walk the most successful yet. To learn more about NAMIWalks Virginia and to get involved, please visit: www.namiwalks.org/Virginia or www.namivirginia.org.

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The Area 5 Council Meeting was held in Washington, D.C. in conjunction with the Congressional Advocacy Meeting. Unfortunately, this meeting overlapped with the PSV board and scientific meetings in Richmond. Dr. Shenoy attended the latter, while I attended the former.

As many of our members are aware, Area 5 is the largest of the seven assembly area councils, stretching from Virginia and West Virginia in the north to Florida and Puerto Rico in the south to Texas and Oklahoma in the west. We also “house” the military district branch. At the time of the founding of the Assembly there were few psychiatrists in this area; it is now the largest area voting block in the Assembly, which has significance when there is a call for a “vote by strength” on an issue.

In addition to our usual contingent of district branch representatives, area representatives and MiTECP representatives, we were also joined by our Assembly staff liaison, Area 5 Trustee, the Assembly speaker and speaker-elect, and candidates for Assembly offices.

An area of active discussion was the success the APA had just that week achieved in backing off congressional support for the CMS’s proposal for dropping antidepressant and antipsychotic medications from the protected Medicare and Medicaid formularies. These formularies, which include all the proprietary Medicare Part D formularies as well as the Medicaid formularies, are quite restrictive. They have been required, however, to include “all or substantially all” of certain classes of medications including, for example, antineoplastic medications, anti-HIV medications, and anticonvulsants when used to treat seizure disorders. The antidepressants and antipsychotics are the only psychiatric medication classes included on this list and CMS was attempting to revoke this protected list status. One of their justifications was based on their taking a discussion in the APA Practice Guidelines on the Treatment of Major Depression out of context. Specifically, the guideline points out that most FDA approved antidepressants will benefit about 60 percent of participants in clinical trials. CMS attempted to contend that this made them essentially bioequivalent and “interchangeable.” In doing so, they totally ignored the reality that the 60 percent of depressed subjects that benefit are not the same 60 percent with each antidepressant. Some patients respond to a wide variety of antidepressants while others can demonstrate highly selective response to a very limited number of antidepressants.

Congressman Tim Murphy from Pennsylvania used the APA rebuttal document to the CMS proposal in his questioning of CMS officials before the congressional committee. This in turn prompted the Obama administration to rescind the proposed rule change (at least for now).

A Division of Government Affairs update to the Area 5 Council pointed out that congress is doing very little real work at present to avoid actual votes in which they would have to take a stand during an election year. For example, the Helping Families in Mental Health Crisis Act (HR 3717) is in the Senate and has received bipartisan support, but again will be unlikely to move to a final vote in the house during an election year. SGR repeal and medicare physician payment reform remains before congress. Despite the fact that short-term patches have cost more than the cost of repeal, again because it is an election year, yet another patch is most likely.

APA remains vigilant in monitoring how the Parity Law plays out within existing commercial as well as ACA’s “Insurance Marketplaces.” I do continue to serve on the Board of Trustee appointed Health Reform and Parity Work Group.

The APA has been successful in negotiating with OPTUM to stop punitive audits of APA members. Members with issues or concerns with OPTUM should contact hsf@psych.org.

Finally, the action paper, of which I am first author, titled “APA Referendum Voting Procedure,” which has been unanimously passed twice now by the Assembly but not yet acted on by the Board of Trustees, has been endorsed for a third time by both the PSV and Area 5 and will be yet again presented for endorsement by the full Assembly. This paper is formulated to change the procedure for presenting grassroots initiated referenda to the APA membership for consideration. Under the present procedure, the referendum is attached to the officer election ballot. While the office candidates are elected by a majority of whomever chooses to vote, the passing of a referendum requires a majority of at least 40 percent of all eligible voters. Forty percent of all eligible voters have not voted in an APA national election in more than 15 years, and only 19 percent voted in the 2013 election. Thereby, no referendum has passed since 1980, even when the affirmative percentage of voting members was as high as 80 percent, as occurred in 2011 when a referendum directing the APA to more aggressively address the increasingly onerous and expensive maintenance of certification requirements of the proprietary American Board of Psychiatry and Neurology received that margin. The action paper aims to have referenda distributed not with the annual officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership. It also specifies that it is the will and intent of the Assembly that this action paper, now twice reaffirmed, be presented to the Board of Trustees. I believe this action is critical in maintaining the APA as a member-driven organization.

As always, Ram Shenoy and I remain ever available to address your concerns for our patients and profession within both Area 5 and the full APA Assembly.
IN THE NEWS

UVa Resident Update

By Mandrill Taylor, MD, MPH, PGY-3
Joseph Otonichar, DO, MS, PGY-2

The University of Virginia continues to celebrate the amazing accomplishments of our resident physicians who have shown themselves beyond capable in being future thought leaders in the field of psychiatry. Aside from the individual accolades highlighted below, many of our training physicians participate in a variety of extracurricular activities for their professional development. Several of our residents regularly attend multidisciplinary monthly discussions regarding cultural issues and literature review with the Department of Anthology. Our program also maintains a tradition of reviewing films after clinic hours with faculty members and deliberating on their psychiatric themes, which both advances our knowledge base as well as strengthens our kinship with one another.

In short, our department would like to acknowledge all of our residents in their continued dedication and strong work ethic. Below are some individual distinctions that we would also like to acknowledge.

• Drs. Damon DeLeon, PGY-3, and Toral Desai, PGY-2, will present case report on Neuroleptic-induced hypothermia in February issue of Current Psychiatry entitled “Confused, Cold, and Lethargic” at the upcoming annual meeting.
• Dr. Andreanne Gingras, PGY-3, will present poster entitled “A Pilot Study on Combining Naltrexone and Topiramate” at the annual meeting of the American Psychiatric Association.
• Dr. Josepha Ilounakhahme, PGY-3, will present poster entitled “Child and Adolescent Fellowship Program at Harvard University” at the annual meeting of the American Psychiatric Association.
• Dr. Megan McPhee, PGY-3, will present poster entitled “A Pilot Study on Combining Naltrexone and Topiramate” at the annual meeting of the American Psychiatric Association.
• Dr Crystal Hagood, PGY-4, will present poster entitled “A Pilot Study on Combining Naltrexone and Topiramate” at the annual meeting of the American Psychiatric Association.
• Dr. Elia Margarita Valladares-Juarez, PGY-4, and Caridad Ponce-Martinez, PGY-3, will present poster entitled “A Pilot Study on Combining Naltrexone and Topiramate” at the annual meeting of the American Psychiatric Association.

In addition to these achievements, many of our residents have been selected and will be attending a variety of fellowships after their general training is complete this year.

• Dr. Damon DeLeon, PGY-3 - Child and Adolescent Fellowship program at Brown University
• Dr. Andreanne Gingras, PGY-3 - Child and Adolescent Fellowship program at the University of Virginia
• Dr. Josepha Ilounakhahme, PGY-3 - Child and Adolescent Fellowship program at Harvard University
• Dr. Megan McPhee, PGY-3 - Child and Adolescent Fellowship program at the University of Virginia
• Dr Crystal Hagood, PGY-4 - Geriatric Fellowship program at Emory University

Our department would also like to acknowledge the achievements of recent graduate, Dr. Manan Shah. Dr. Shah was recently published in the Journal of Neuropsychiatric Disease and Treatment with article entitled “Update on Optimal use of Lisdexamfetamine in the Treatment of ADHD”. Dr. Shah also recently received the Mentee-Mentor Award with Dr. Vishal Madaan through the Indo-American Psychiatric Association with their project entitled “Wishing from the Observing Genie: Creating Opportunities for Indian Physicians in the US Psychiatry-Trainee Workforce”.

PSV Participated in White Coats on Call

David Freeman, MD
PGY-IV, Chief Resident
VCU Department of Psychiatry

It’s about asking for what you need – be your own best advocate. As a chief resident for the VCU psychiatry department, I am frequently in the role of mentor for junior residents. A dilemma that consistently arises is a resident’s awareness of a need, coupled with anxiety about escalation of the issue to the higher level. “There’s a big issue with on-call coverage, but I’m worried about talking to the program director about it.” My counsel is constant: if you perceive a necessary change, go ask for it. Be your own best advocate. Logically, if I did not attend MSV’s annual White Coats on Call, I would be in violation of my own advice!

When I first went to the Virginia statehouse in 2013, my overwhelming affect was anxiety. Anxiety abates with repeated exposure, and I have even come to enjoy being an advocate for psychiatric and medical interests to the Virginia legislature. This year, a small cadre of resident and community psychiatrists visited the offices of many legislators to offer our perspective on important issues. Mental health and mental health law are at the forefront of the public consciousness in Virginia at present. With organization by MSV, Andrew Mann, Cal Whitehead, and Ralston King, we navigated the halls of the statehouse, spoke with senators and representatives, and advocated strongly for our positions on upcoming legislation regarding ECO/TDO laws, licensing, and mental health funding.

Just as I encourage my residents, I encourage all residents to join White Coats on Call next year, and to be Virginia’s – and your own – best advocate.
PSYCHMD-PAC: What Is It And Why Should I Give?

A Political Action Committee (PAC) is an independent organization that solicits contributions from individuals or entities who share common interests. PACs contribute funds to candidate campaigns as a demonstration of support for that candidate’s philosophy or viewpoints or position of influence. These political contributions help offset the expenses of campaigns which include things like staff and communications (website, mailings, yard signs).

The Psychiatric Society of Virginia (PSV) started the non-partisan PSYCHMD-PAC to raise money to fund General Assembly candidates who support good mental health care policy. It is a political marketing vehicle used to allow psychiatrists to direct our message to important decision-makers. PSYCH-MD PAC contributions are made annually to candidates who demonstrate a commitment to policies that will improve access to and quality of psychiatric care.

We urge you to contribute to PSYCHMD-PAC today! Advocacy groups representing diverse views on policy have PACs. It allows us to compete for attention in a crowded environment.

To make a donation, recommend a candidate, attend an event, or get additional information on PSYCHMD-PAC, follow the link below or contact PSV Advocacy Coordinator, Ralston King at rking@whiteheadconsulting.net for questions/assistance. https://secure.societyhq.com/psv/PsychMD-PAC.iphtml

Where do Psychiatrists Rank Compared to Peers and Adversaries?

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Welcome to Our New Members

DISTINGUISHED FELLOW
Vikram Khot, MD ................................................. Manassas, VA
Kara K. Beatty, MD ............................................. Henrico, VA
Bandhan Chakraborty, MD ...................................... Richmond, VA
Trecia Henriques, MD, JD .................................... Richmond, VA
Danielle K. Ivanova, DO ...................................... Charlottesville, VA
Kathryn Q. Johnson, MD ....................................... Roanoke, VA
N. Chesterfield, VA

FELLOW
Christian D. Neal, MPA, MD ..................................... Forest, VA

GENERAL MEMBER
Maria L. Almond, MD ............................................. Farmville, VA
Kumar Bahl, MD ..................................................... Leesburg, VA
Stella Bassey, MD .................................................. Roanoke, VA
Jason Beaman, DO ................................................... Roanoke, VA
Namita Dhiman, MD ................................................... Lynchburg, VA
Sarah E. Hazelwood, MD ......................................... Marion, VA
Stacey R. Helps, DO ............................................... Virginia Beach, VA
Steven Hutchens, MD ............................................... Crozet, VA
Jeffery N. Musselman, DO ....................................... Roanoke, VA
Philip G. Schlobohm, MD ......................................... Hampton, VA
Nicholas Taintor, MD ............................................... Waterford, VA

MEMBERS IN TRAINING
Ruhina N. Ali, MD ................................................. Roanoke, VA
Kara K. Beatty, MD ............................................. Henrico, VA
Bandhan Chakraborty, MD ...................................... Richmond, VA
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PSYCHIATRY IN THE CURRENT PERIOD

By Ramakrishnan S. Shenoy, MD, DLFAPA

I got involved in Psychiatry after a period of time working in Internal medicine in India and the Indian army. I was working in a hospital in southern India when the Chief psychiatrist died. I was made the acting Chief. The whole staff was corrupt. I had to force some of them to leave because of their aggression to the patients, who were intellectually disabled or had major medical problems. Some of the staff was planning to hurt or kill me. I decided to move to the United States. I have been in this country for 44 years.

In coming to the US, it was not easy, but I entered with eight rupees in my pocket. My sister helped me to move to a house. I applied for many medical jobs, but was denied because I did not have American training in a US college. Within two weeks the Vietnam War started and all the medical psychiatrics were sent to Vietnam. I had been asked to work at Central State Hospital before the Vietnam War and I took the job refusing all the great requests for me to work in the famous hospitals.

My stay in CSH was very short and I was transferred to MCV (now called VCU Health Systems). I finished my residency for the third time (India, The Indian Army and MCV). I preferred to join the Veterans’ Hospital in Richmond, VA and worked as the Chief for 21 years. I retired and went to work in Central State Hospital in Petersburg. I retired from that hospital after more than 10 years and I am still working there part-time.

During my work at Southside Virginia Training Center (SVTC), a hospital for the intellectually disabled, my interest was more because I had family members who had problems and were not treated. I wrote a lot of papers, books, treatments and did teaching to newcomers on how to handle difficult cases.

In the years that I worked in Richmond, I was taught by well known psychiatrists who mostly used psychotherapy, a very interesting way of treating patients. In addition, we were encouraged to go to other hospitals to learn the techniques of psychiatry treatment.

I feel very sad when I see new ‘to be psychiatrists’ and even some of the older physicians who are not using psychotherapy and cognitive behaviors. The psychologists seem to understand this and have done a good job. Current medical treatment of patients with mental illness seems to be usage of medications, some of which the physician does not seem to know anything about the side effects and dangers when two different medicines are used. Some of the physicians have been disbarred for not seeing a patient and understanding his issues. There have been recent deaths and illness when medications are used without the physician knowing how to handle it.

My thought is that physicians should have good information, especially when starting new medications. There is no shame in asking a senior physician’s help. A good and thorough review of the patient and the family should be needed to know the issues that may be needed for treatment. You need to get full information as to whether the parents or other family members have genetic issues.