THE PSYCHIATRIC SOCIETY OF VIRGINIA

VIRGINIA NEWS

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SUMMER 2008

James L. Krag, MD, FAPA
PSV President

A MESSAGE FROM THE PRESIDENT

I attended the APA meeting for incoming District Branch Presidents in Washington this May. It was informative and motivating. One piece of advice they gave us was to set realistic goals to accomplish during our one year as President. They recommended setting two main goals.

Since I frequently try to put two cups in a one-cup measure, I decided to listen to what others have learned. So what am I aiming at for my term as PSV President?

I have applied for a grant from the APA that would help us develop a current data base of every psychiatrist licensed in Virginia. The grant also includes funding to help us strengthen, or in some cases revive, the six PSV Chapters currently listed in Virginia. I believe that the PSV would be well served by having strong Chapters that function in close communication and cooperation with the PSV. I am planning to attend a meeting with each of the Chapters in which not only the local members are invited but, with the use of our database, all psychiatrists in the area are invited. The PSV will share this database with the Chapters and develop the ability to send out invitations to all psychiatrists. A bonus outcome will be that some non-members will join the APA/PSV, but the main aim of the effort will be to find ways to better serve our current PSV members in their local areas. With added communication and cooperation, we will become a stronger organization.

Another project that emerged from the APA meeting is finding ways for the PSV to become more involved in affecting our legislators and the continuing changes to our mental health system. I am working with Cal Whitehead, our legislative consultant, and at the Fall PSV meeting, we will explain our plan. At the Fall PSV Meeting, we will also have a presentation from the APA's Legislative State Field Representative. We need to develop an ongoing process that will assist our members in making sure our voices are heard. It is clear that if we wait to be "invited" to share our voice, it is less likely to be heard and others will take the lead. So this will be a system of helping our legislators become better acquainted with psychiatrists both as individuals and as an organization.

> **"It is clear that if we wait to be "invited" to share our voice, it is less likely to be heard and others will take the lead."**

An ongoing project is to support the unification of Virginia's APA-member psychiatrists into one state organization. Currently, a highly populated portion of Northern Virginia is included in the Washington Psychiatric Society. Many important changes are taking place in the mental health system of Virginia. We are receiving unprecedented attention from the governor, the legislators and the Supreme Court. Certainly there are many regions within Virginia, but we share a historical tradition, and we share a common set of laws. A united voice is a more powerful voice, and together we can better help guide these changes.

Please plan on attending our Fall PSV Meeting in Virginia Beach on September 27. If you ever have questions about the PSV or ideas you want to share, please contact me.

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A Message from the Editor

Knowledge and Responsibility

By Kathleen Stack, MD, DFAPA

Kathleen Stack, MD

"Ignorance is bliss"—a common expression that I have come to understand more fully over time. When I do not know something, I have no responsibility to act. Once I learn of a situation, I am left with the internal struggle of what is an appropriate response. There are times I wish I could erase the knowledge and with it, the responsibility for my response.

I was left with this "responsibility" when I read the article by Chris L. Jenkins of the *Washington Post* from June 12, 2008. I now know that nearly $18 million earmarked for substance-abuse services in Virginia was not spent for substance-abuse services. Also, in 2007, the state budgeted $9 million to pay for Medicaid patients to access substance-abuse programs; but the report found that the state had billed only about $120,000, or 1% of the projection, indicating that many addicts might not be accessing treatment they are eligible to receive. There were about 6,000 people on waiting lists during the first quarter of 2007, state records show. The funds were there (somewhere), yet Virginians are not being served.

The article continued, The Joint Legislative Audit and Review Commission, (JLARC) report says that of the $73 million dedicated by the state for rehabilitation programs in 2006, about $55 million went to an array of services, including detoxification and counseling. The audit could not determine where the remaining $18 million went. The report says programs that could have benefited from that money included efforts to help prison inmates who needed substance-abuse services and those designed to hold local officials accountable for the funding they receive.

The 182-page report says there are no systems to determine whether the state's substance abuse programs are effective. It also says that Virginia could better use its resources by implementing more programs that have been tested in other states. In many cases, the audit concluded, people who need services are unable to access the state's programs because of long waiting lists or because they have poor access to transportation or child care.

I did not realize that the funding for substance-abuse programs is taken from annual profits recorded by the Virginia Department of Alcoholic Beverage Control. The article pointed out that money is transferred into the state's general fund, not to the agencies that provide counseling, group therapy and other programs; but state officials said that although the transfer to the general fund is mandated by state law, there is no language that specifies what happens to the money. I have lived in Virginia long enough to have heard of other funds "lost" in the "black hole" of the general fund. It gives me pause.

Now I am left with how this information will effect my personal and professional decisions. Do I write the governor and complain? Should I write him in thanks for the JLARC review? It cannot be easy to have a top-to-bottom review of mental health processes and give the results to the public. Will this information affect my voting for any funding process in the state for which money will be put in the general fund?

In this issue of the PSV newsletter, we are reprinting an article written by Claire Zilber, MD, which was recognized by the APA as the best district branch article about ethics. It encourages thoughtful decision making on a personal and professional level. I believe we, as a community of professionals, are striving for this. The decisions we come to do not need to be the same as other states or among ourselves. The process of becoming informed, comfortable or not, is the first step to responsible decision making.

Commonwealth of Virginia – Mental Health, Mental Retardation, and Substance Abuse Services Board

By Anand K. Pandurangi, MD, DFAPA

The Commonwealth of Virginia has a Board of DMH/MR/SAS, established under 37.2 – 200 of the Code of Virginia. This board is part of the Executive branch of the government, and the members of the Board are appointed by the Governor. There are 9 members representing various constituencies, including one psychiatrist member.

Currently, Dr. Anand K. Pandurangi, Professor of Psychiatry at VCU serves in this capacity. His nomination was made by the PSV and endorsed by the MSV. The term on the board for each member is typically four years and renewable for a second term, but not to exceed a maximum of eight years. The current chairperson of the board is Ms. Victoria H. Cochran of Blacksburg, Virginia, and the secretary is Ms. Jewel Crosby (804-786-7945, e-mail: Jewel.Crosby@co.dmhmrsas.virginia.gov).

The board is described as a policy board (in contrast to a management board) and has, as its main function, the development and review of:

(1) **Policies** (*Example*: policy on mental health management after a disaster, policy on non-discriminatory access to services etc.), and

(2) **Regulations** (*Example:* licensure regulations for facilities, clinics, housing etc, and human rights regulations.)

The board has two standing committees: (1) Planning and Budget, (2) Policy Development and Evaluation. All board policies are available on the DMH/MR/SAS website (www.dmhmrsas.virginia.gov).

The board maintains active liaison with all community service boards, state facilities and agencies and associations involved with mental health, in Virginia. The board and its committees meet quarterly, at a minimum. All meetings are open to the public and meeting dates and locations are posted on the Commonwealth's website. The proceedings of the board may also be obtained through the Freedom of Information Act. The secretary of the board is the best person to contact for all information on the board and its activities, including upcoming meetings, agendas and locations. She may be contacted by phone or e-mail as noted above or by writing to: Jewel Crosby, Secretary, DMH/MR/SAS Board, P.O. Box 1797, Richmond, Virginia 23128-1797.

The board receives a report from the Commissioner of DMH/MR/SAS in person during each board meeting. The report updates the board members on current issues of interest to the department and the community. Typically, the meetings are attended by several staff members of the DMH/MR/SAS. Other regular attendees include the president of the VACSB. Cal Whitehead, PSV lobbyist, has often attended the board meetings to observe and represent PSV concerns. PSV members are encouraged to attend whenever they can, when meetings are held in their region. There is time set aside for public comments, in each meeting. Please contact Ms. Crosby to let her know you plan to attend and any issue you wish to present or comment upon.

Recent policies reviewed by the board pertain to Disaster and Terrorism Preparation and Language and Cultural Preparedness. Upcoming reviews include a policy on Inter-Board Operability. The board is also reviewing performance contracts between the department and CSBs. Current issues in front of the board are how the department is training/implementing the new mental health laws on commitment, increasing outpatient services, and strengthening emergency mental health services.

In The News

Carilion Psychiatry Residency Places Second at APA National Meeting

Congratulations to the Carilion Clinical Psychiatry Residency for impressively placing second at the APA National Meeting's Mind Games competition. Mind Games is a national competition where resident teams compete against each other with board type questions.

In addition to the team's outstanding second place spot in this nationwide competition, members received a sponsored trip to the APA National Meeting to compete, as well as gift certificates to use toward educational books.

The Carilion Clinical Psychiatry Residency team members responsible for this remarkable accomplishment included Dr. Nina Khachyants, Dr. Jatinder Babbar and Dr. Anjali Varma.

Glen Gabbard, MD, moderator (back) and the Carilion Psychiatry Residency team that competed in APA's national Mind Games competition: (left to right) Dr. Nina Khachyants, Dr. Jatinder Babbar and Dr. Anjali Varma.

Dr. Khachyants was born in Tashkent, Uzbekistan, where she attended medical school. She trained as an ophthalmologist and ophthalmic microsurgeon in Uzbekistan, Moscow (Russia) from 1990 to 1993, and in Canada studied reconstructive and plastic eye surgery from 2003 to 2004. From 1991 to 2004, Dr. Khachyants was head of the Eye Microsurgery Department in Tashkent City Hospital. Her family later immigrated to Canada, where she passed all USMLE exams. While studying for these exams, Dr. Khachyants regained a keen interest in psychiatry, an interest she also had as a medical student. Some political issues prevented her when she was a medical student to proceed with a career in psychiatry, but in 2006, she started psychiatry residency and became even more fascinated by it. Dr. Khachyants found the studying and participation in Mind Games to be a great learning experience. Her future plans include pursuing a career in general/geriatric psychiatry with emphasis on psychopharmacology.

Jatinder Babbar, MD, DMH, earned his medical degree from the Armed Forces Medical College, India, and received training in psychiatry in Northern Ireland and England. He is currently the Chief Resident in Carilion Clinic Psychiatry Residency. After completing residency training, he will join Western Psychiatric Institute and Clinic, University of Pittsburgh.

Dr. Anjali Varma is originally from New Delhi, India, where she attended Maulana Azad Medical College, followed by psychiatric residency at Lady Hardinge Medical College. She is currently a fourth year Psychiatric resident at Carilion Clinic and has a special interest in mood disorders and women's mental health issues. Dr. Varma will be going to a child psychiatry fellowship at the Carilion Clinic and has a two-year-old daughter.

The Carilion team is chosen to answer the question, beating out New York Medical and the University of Texas.

Eric Steckler, MD (President Northern Virginia Chapter of Washington Psychiatric Society) and Delegate Dave Albo (R-Springfield) at a recent event for Congresswoman Thelma Drake.

Shenandoah Valley, VA

PSYCHIATRIST—Harrisonburg, Virginia. Rockingham Memorial Hospital (RMH) is seeking a board certified/board eligible psychiatrist to join a well-established hospitalowned practice. Outpatient and inpatient care. Current call coverage 1:5. Competitive salary and benefits package including year-end bonus package, malpractice, health, dental and life insurance, 403B retirement plan with employer contribution, CME allowance, relocation assistance and much more. Contact Jenny Hansbrough at 540-433-4439 or at jhansbro@rhcc.com.

Welcome to our New Members

GENERAL MEMBER

Lajuna M. Collins-Morgan, MD .....Hampton, VA
Alican Dalkilic MD, MPH ..... Glen Allen, VA
Lily H. Hodges, MD .....Marion, VA
Kavneet Kohli-Chhabra, MD..... South Riding, VA

MEMBER-IN-TRAINING

Saira Arif, MD .....Roanoke, VA
Christine P. Baker, MD ..... Richmond, VA
Kokil Chopra, MD ..... Norfolk, VA
Geeta V. Nathan, MD.....Roanoke, VA
Ama A. Rowe, MD ..... Richmond, VA

Capt. Steve Brasington, MD, DFAPA (right) was recently restationed to a base in Rhode Island. "Thanks, Steve, for leading the PSV as a valued Board member and as President. You will be missed,"— Jim Krag, MD, FAPA, (left) current PSV President.

Use of Buprenorphine in Opioid Dependence

By Maninder Singh, MD, FAPA

Opiold dependence is a significant problem in the United States and is under-treated. Only 20% of patients get help in spite of effective treatments being available.

The United Nations reports that worldwide, approximately 16 million people abuse opiates but only 7.8% receive treatment. The use of prescription opiates is on the rise as well. In 1999, approximately 4 million people in the United States, or 2% of the population age 12 and older, were using prescription drugs non-medically, which doubles the 2.1 million people who use heroin and cocaine. The 2001 data from SAMHSA (Substance Abuse and Mental Health Services Administration) shows that 36 million people, or 16% of the population, have used prescription medications for a non-medical reason at some point. Data from the National Household Survey on Drug Abuse shows that 2.6 million people misused pain relievers, including hydrocodone and oxycodone.

According to the Virginia drug trends (http://www.usdrugtrends.com/virginia.htm):

Heroin, produced primarily in South America, is an increasing threat to Virginia. Southeast Asian, Southwest Asian, and Mexican black tar and brown powdered heroin also are available. Most new heroin abusers in Virginia are young adults who snort the drug rather than inject it. Heroin is widely available in Virginia's urban areas, but is less existent in rural counties of the Commonwealth. Washington, D.C. is the source city for users living in Northern Virginia. In the Richmond, Virginia metropolitan area, heroin is not only an inner city phenomenon, but has gained popularity among white young people from upper middle class suburbs. Heroin also poses an increasing threat in the Tidewater, Virginia area. OxyContin use is pervasive in Virginia's rural Southwestern counties and is the most commonly abused drug in the Western District of the Commonwealth. In addition, diverted OxyContin is becoming increasingly available in parts of Central, Northern and Eastern Virginia. Law enforcement officials report that OxyContin, once predominantly abused by lower-income individuals, increasingly is being abused by middle-class individuals.

In 2002, the US Food and Drug Administration approved two sublingual formulations of buprenorphine for treatment of opiate addiction to be used for detoxification and maintenance therapy of inpatients and outpatients under the Drug Addiction Treatment Act of 2000. The Drug Addiction Treatment Act enables physicians with eight hours of training to obtain a waiver so that they may treat opiate dependent patients in any setting, be it inpatient or outpatient. The hope is

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APA Assembly And Associated Organizations Report

By Ram Shenoy, MD, DLFAPA

The APA Assembly session preceded the APA convention. The meeting was brought to order by Speaker Jeffrey Akaka in the Washington Convention Center on Friday, May 3, 2008. This was Dr. Akaka's last session as speaker. He was succeeded by Ron Burd, MD from North Dakota. The Assembly had a rather hectic schedule with 30 action papers, one report on Assembly and Board of Trustees relationship and several speeches by VIPs. Of note were Senator Akaka, Junior U.S. senator from Hawaii and the Vice-President of the AMA

In the election for replacing the retiring speaker-elect and the Recorder of the Assembly positions, Gary Weinstein, MD of Kentucky and Bruce Hirschfield of Maryland won respectively. Area Council V was well represented, and the new leaders, John O. Gaston, MD of Georgia, Chair, and Scott Benson, MD, Deputy Chair of Florida, did an admirable job.

Of the 30 action papers submitted and discussed, 19 were passed by the Assembly, one with an amendment, three defeated, two withdrawn and 3 moved to the consent calendar. The Assembly could not reach a consensus on the Board Assembly relationship, and after a long and heated debate, this was tabled.

Of interest was the enthusiasm and involvement of the Members in Training (MITs) who submitted several papers and added to the discussion.

This time, the reception, hosted by the APA Foundation, was held at the Union Station, a historical venue. Several hundred people participated, and awards were given to leaders in innovative care. These included both members of the APA and non-members. The reception for the various medical schools for their alumni followed the pattern set in San Diego in 2007, where most medical schools pooled their resources and held a joint reception in the Washington Convention Center.

I would be deficient in my report if I failed to convey that the APA Convocation had Dr. Oliver Sachs as the chief speaker. He spoke about the role of music in a person's life and also shared his "affliction" with musical hallucinations. It was a very interesting and informational speech. Patty Duke was the chief guest of the APA Foundation's program, "Conversations." She spoke to a record audience about her trials and tribulations with bipolar disorder.

Moving Out of Institutional Walls: The Woodville School MCV/VCU Collaborative

By Aradhana Bela Sood, MD, MSHA

The literature indicates and our instincts back this: treatment of individuals outside their normal living environment often leads to half-baked attempts at conceptualizing problems. Poor formulations lead to ineffective treatment planning and less than optimum outcomes. What we do in our offices rarely generalizes to home and neighborhoods.

Early this spring, we got an SOS from a school in the heart of inner city Richmond: their kindergartners and 1st graders were having unprecedented problems with behavior, and the school's ability to handle these issues was stretched beyond description.

The recent shift emphasizing community-based care and the state's funding of additional slots for child psychiatry fellows for community psychiatry has led to a collaboration between VCU Medical Center's Virginia Treatment Center for Children and Woodville Elementary to provide both preventive and tertiary care in a school-based setting. Engaging and involving parents in the venture is the central focus to create a parent/child driven treatment plan that has the potential to work within the neighborhoods and schools in which the children live.

The school has a rich network of community agencies, including Community In Schools (CIS), Milk and Cookies, Child Savers, Richmond Behavioral Health Authority, Family Preservation, National Counseling Group, the police department and Richmond Housing. Enhancing the work of these agencies through direct clinical care, teacher training on normal development, class room management and psychopathology, proactive involvement of families by encouraging their partnership with the schools/agencies, as well as parent training and the involvement of the child in after school structured activities, and stabilizing housing and safety will be a focus of this comprehensive initiative.

By providing a training opportunity for our fellows amidst such a grass roots community effort to promote overall health, we hope to develop their skills and passion for working in the most underserved areas of the Commonwealth. If successful, we hope this will serve as a pilot that can be utilized in other area urban schools.

It is with great sorrow that we announce the recent passing of Michael Jan Rostafinski, MD, one of the founders of the Southside Chapter of PSV. The following article recently appeared in the Richmond Times-Dispatch and highlights Dr. Rostafinski's long-term career in the field of psychiatry.

M.J. Rostafinski, retired physician in Va., dies at 88

By Ellen Robertson
Times-Dispatch Staff Writer

In Nazi-ravaged Poland during World War II, medical student Michael Jan Rostafinski was a wanted man.

The Warsaw native, born to privilege in a Catholic family of scientists and physicians, had joined armed Polish resistance forces, as had his brother.

"One time the Nazis were looking for him, and his mother managed to get word to him that they planned 'to make marmalade of him,'" said his wife, Ann Glass Rostafinski.

He melted into the countryside for two years. Failing to find him, the Nazis retaliated by sending his parents and sister to a concentration camp, which they survived.

Dr. Rostafinski, who completed medical and psychiatric training in Poland, later immigrated to the United States and worked in Lynchburg and Petersburg.

The 88-year-old physician died of cancer Monday at his Petersburg home.

An outspoken critic of Poland's communist regime after the war, he was still a wanted man. In 1955, he left Poland in the middle of the night, in a railroad cattle car bound for France.

His wife once asked him what he had done. He told her, "I blew up a government building."

Dr. Rostafinski, who earned his medical degree at the University of Lublin School of Medicine and did his psychiatric training at the University of Warsaw School of Medicine, arrived in New York in 1957. Being a foreign doctor, he had to recertify to meet U.S. standards and took a course that compacted four years of medical school into one, his wife said.

From 1960 to 1973, he served as director of research and training at Lynchburg Training School and Hospital.

"Initially he was very much interested in mental retardation and had that scientific research mind," his wife said.

Dr. Rostafinski then directed the Petersburg Training School until 1977, during an era of deinstitutionalization of the mentally retarded. He retired in 1985 after working with the criminal population of Central State Hospital in Dinwiddie County.

He then had a private psychiatry and medical hypnosis practice in the Richmond-Petersburg area until 1997 and was a consultant to the Virginia Department of Corrections and Riverside Regional Jail until 2007.

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to allow more patients to get into treatment.

The new office-based opiate agonists improve access to patients that are otherwise reluctant to use the federally supervised Methadone or Opiate treatment programs.

Prior to starting the clinic, I got my DEA waiver for prescribing the medications after finishing the eight-hour training provided by APA, even though I could have just applied for it as a board certified addiction psychiatrist, then staffed the clinic with a nurse practitioner and part-time social worker. I then, with my core group, worked on establishing policies and procedures for the clinic. It was also important to present inservice to the different areas in the hospital so we could have a referral base. Pharmacy was given a thorough inservice on the use of buprenorphine in an outpatient setting. This allowed the pharmacy sufficient time to have buprenorphine available on the formulary prior to the clinic's start date.

Patients are referred to the clinic if they have a problem with opiate addiction, and they are evaluated and are recommended for buprenorphine treatment if they meet the diagnosis of opiate dependence. We provide outpatient treatment with detoxification or induction, stabilization and maintenance. In addition to starting the patients on buprenorphine, they are also required to participate in the psychosocial treatment in the intensive outpatient substance abuse treatment program. They are also required to participate in NA (Narcotics Anonymous) meetings, get a sponsor, and go to aftercare groups. Family involvement is highly recommended, and the social worker contacts family for the treatment plan and for group therapy. Patients are also offered buprenorphine support groups which will be run by the interdisciplinary treatment team.

In conclusion, the initiation of a buprenorphine clinic into any facility requires four essential steps. First, you must identify the need for the clinic to exist in your facility. Second, all staff that will be directly involved with the clinic must be thoroughly trained and available prior to the start date. Third, you must educate all staff on the use of buprenorphine, the primary purpose for the clinic in your facility, and the appropriate referral process in your facility. Last, it is imperative that once the patient is screened and accepted into the buprenorphine clinic that the patient is involved in some other form of substance abuse therapy to allow for the best potential treatment and outcome.

What Is Happening in PSV and Charlottesville — A Resident's Perspective

By Laura Dauenhauer, MD, Resident, University of Virginia

It has been an honor and a pleasure to serve as the University of Virginia's resident representative to the Psychiatric Society of Virginia (PSV) Board of Directors this past year. Like many residents, I knew very little about the PSV prior to holding this position. I was interested in learning more about the mental health care system in Virginia. This experience was even more valuable than I expected. I met psychiatrists from all corners of the state and various scopes of practices. I had the unique opportunity to listen to passionate discussion about the state of the mental health care system and how to improve the system for both patients and psychiatrists.

This was a particularly exciting year with the General Assembly passing many new laws regarding mental health care. It has also been a confusing time for residents, as the system is changing around us with the continued closing of state and private hospital psychiatric beds and the shift of focus to outpatient treatment. An insight that I have gleaned from this experience is just how important it is for psychiatrists and residents to be active in this process. We need to be sure our voice is heard as these changes come about. Involvement in the PSV, at the state level and the APA, offers us a way to channel our efforts together and bring about the changes we desire.

Many residents at UVA have been actively involved in efforts to improve the mental health system in the Charlottesville area over the past year. Due to a need for increased access to psychiatric care, Region Ten Community Services Board recently opened a crisis stabilization unit, the Wellness Recovery Center. This unit is staffed by resident physicians from UVA under the direction of an attending physician. The residents have been actively involved in the project as it has evolved from a day treatment center to a partial hospitalization program.

Many of the residents, despite the demands of residency, also volunteer at the Charlottesville Free Clinic, providing outpatient psychiatric care to patients who are working but do not have health insurance. Our care for these patients fills a gap in the mental health system that would otherwise go unfilled.

Another exciting new development in Charlottesville and the surrounding counties, is the recent addition of Crisis Intervention Team (CIT) training in the police forces. This is an important collaboration between law enforcement and the mental health system. Residents at UVA have also been involved in the implementation of CIT. Some of the residents have taken a more active role and have undergone the training themselves and are now involved in the training of police officers. This service will enhance access to mental health services by providing alternatives to hospitalization or incarceration.

On a final note, I have been impressed this year by the Board's continued efforts to involve residents more actively in the PSV and APA. This was a specific focus of each board meeting that I attended. One activity that has come about as part of this effort is the resident poster session, now an annual event at the PSV Fall Meeting. This was intended to help residents engage in and have a venue to present their research as well as encourage more residents to attend the meeting—it was a huge success last fall.

I would encourage all residents to attend the fall meeting this September and to take an active role in the APA and PSV; there is no better time to start getting involved than early in training, and particularly during a time of such change within the system.

A Lesson I Learned As An Intern

By Greg Carr, MD

Starting any new residency elicits many obstacles to overcome—from obstacles such as instantly being seen as a physician who is expected to confidently practice medicine, to navigating through each new rotation. Just like medical school, once you become comfortable, and you start all over in a new rotation, hopefully with more knowledge and know-how. However, the largest obstacle I found myself and my fellow colleagues facing during our internship year was our medicine rotation; oddly, this rotation seemed to be a prelude to a challenge psychiatrists will face throughout their careers.

Firstly, it is never easy to rotate with enthusiasm and a deep thirst for knowledge in a specialty one is not pursuing—not that all the medical interns seem much more enthusiastic. For example, although I was interested, I could not muster my attendings' overwhelming thrill in recounting how low a patient's albumin was to the fifth doctor that passed us in the halls during rounds. Don't get me wrong; I decided to go into medicine because I found, and still find, the physiology and pathology of the human body interesting, and it was interesting to put my knowledge into practice during my internship year. But unless you are pursuing particular medical specialties, you do not have the urgency to learn material you will not be putting into practice on a daily basis. Of course passing Step III holds its own urgency in getting the basic knowledge down, but unless you are going to be running codes, and having new interns looking to you for guidance with complete medical competence and know-how, the desire to somehow just muddle through the rotation is what a dwindled and diminished urgency tends to evoke.

That said, medical interns have an advantage to psychiatry interns by being under-the-gun so to speak, not coming off of two or more months of psychiatry and expected to jump back into medicine at full speed, and in the comfortable confines of rotating within their own department. Sadly, no matter the connection of everyone being a medical doctor, there is still exclusiveness within various specialties. One of my attendings asked me three times if I was going to switch to medicine because she just didn't get psychiatry—then again, I have heard psychiatrists say they couldn't see themselves treating hypertension ten times a day either. I realized after my fourth month in medicine, that medicine residents complained much more consistently from day to day than I ever heard psychiatry residents within my program

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APA Governance: Where the Rubber meets the Road

By Asha S. Mishra, MD, DFAPA

I have been a member of the APA since the 1980s, but until a few years ago, I mostly limited my participation to paying my dues, leafing through the journals, and on occasion, stealing attendance at the APA and/or our district branch meeting. I am sure there are many others like me who serve the APA in this limited manner, asking for nothing more from the APA. A few years back, I became involved in the governance of the APA, first as a corresponding member and then a member of the Committee on Women and the Committee of Asian American Psychiatrists. It was the beginning of a learning experience in the workings of the APA, but it still was a view into a room through a key hole. More recently as a member of the Asian American Psychiatrists and as chair of the Committee on Women, I have had the good fortune of having the door to APA governance opened to me. I can tell you that it is at once an intimidating and humbling experience. I feel the weight of the responsibility in this assignment and have a new respect for all those before me who have been serving the APA, charting new courses and breaking new grounds. Until recently, I had not paid attention to things like the APA's position on sociopolitical issues, government affairs and the mammoth work that goes on behind the scenes to manage the interests of all current and future APA members and, most importantly, the issues of importance to the patients we serve.

This past May, I was appointed as chair of the Committee on Women (COW) and have been blessed with a great group of women psychiatrists from North America helping me in this task. The most visible task of each component of the APA is the component workshops at the APA meeting and the awards that they may be sponsoring or handling the nominations for.

I also know now, from what was hidden all along in plain site on the APA website, that all the components and committees work behind the scenes in the issuance of APA's policy and position statements. There are currently 97 councils or committees listed in the APA's directory of components. The COW reports to the Council on Minority Mental Health and Health Disparities. The Joint Reference Committee (JRC) oversees the work of the components, serving as a judicial body of and for the solution of administrative problems arising between councils. JRC is responsible for monitoring and evaluating the functioning of the components and handling the overlapping concerns of several councils. JRC refers actions or issues to the appropriate councils for assignment and study by a component. For example, one of the charges for COW at this time is to review, revise, retire or rewrite the APA's existing position on women's reproductive rights and abortion. Policy documents are approved by the APA Assembly and Board of Trustees. These are then posted as the Position Statements that define the APA's official policy on a specific subject.

The issue that has additionally grabbed my attention, and should grab yours as well, is the report on some pharmacists refusing to fill prescriptions of birth control pills and the so-called abortion pill. There are some more recent troubling trends with the opening of "Christian Pharmacies" that will not stock anything that has something to do with birth control, be it contraceptive pills or the condoms. These pharmacists claim to not be able to leave their conscience at the door in the practice of their chosen fields. As if this was not enough of a challenge in the health care field, there are some OBGYN physicians who feel that provision of indicated care in the area of reproductive health poses a moral challenge for them. Some have said that they cannot discuss the option of termination of a pregnancy, no matter what the context is for that indication or request. They are claiming a moral conflict in even giving their patients the names of others who may be willing to provide the requested care. The California Supreme Court is deliberating a case brought on by Lupita Benitez, a lesbian who was refused artificial insemination. The doctors in that practice claimed that their Christian beliefs did not allow them to perform insemination on unmarried women, regardless of their sexual orientation.

These interpretations of "conscience" coming in the way of performance of one's job is a pill that I refuse to swallow. I am all for the respect of one's conscience, but refusals based

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An Open Letter to Psychiatrists to Become Advocates through PSYCHMD-PAC

Dear Virginia Psychiatrist:

If you listen to ***NPR*** or watch ***PBS*** you know they ***are dependent on the support "from people like you."*** A portion of the annual dues paid by PSV members are the primary source of funds to support our legislative advocacy effort, but increasingly important is ***the PSYCHMD-PAC***.

The Governor, General Assembly members, and the public have been increasingly focused on changes to commitment laws, mental health system funding, access to treatment, and society's perception about the mentally ill. ***More than ever before, psychiatrists are engaged in the public policy debate.*** PSV advocacy is essential so your voice may be heard.

This year, we are also partnering with the Medical Society of Virginia (MSV) and other specialty societies to ***protect Virginia's medical malpractice cap***, which will mature at $2 million this July. The trial lawyers are working hard to convince Delegates and Senators to raise, or even eliminate, the cap. ***We need your help to protect this cap.***

We consistently ***advance high standards for health care professionals***. This includes appropriate limits on scope of practice for non-physicians. As concerns about patient safety grow, Virginia should not expand healthcare services through special-interest legislation without demanding proper education.

To make the voice of psychiatry heard, we need your help. ***PSYCHMD-PAC, our political action committee, is your vehicle. We must increase our participation in politics to advance our profession and support our patients.*** Please join us in making a contribution to PSYCHMD-PAC by visiting www.psva.org. Thank you in advance for your support.

James L. Krag, MD, FAPA, PSV President

Visit **www.psva.org** to make a contribution to **PSYCHMD-PAC**

American Psychiatric Association

APPLICATION FOR FELLOWSHIP *has been extended*

Submission Deadline: October 1

Eligibility Criteria:

General Member for at least five consecutive years

•••••

Certification by the American Board of Psychiatry and Neurology, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Association

•••••

Two letters of recommendation from current Fellows, Life Fellows, Distinguished Fellows or Distinguished Life Fellows

•••••

30-day review period for the district branch to offer comments about the Fellowship candidate

•••••

Approval by the APA Membership Committee

•••••

Approval by the APA Board of Trustees

Applications and Letters of Recommendation should be sent to:

American Psychiatric Association
Membership Department
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209-3901

Submissions may also be faxed to (703) 907-1085.

Great Ideas, Passion and Perseverance: A Recipe for Success
The Virginia Collaborative CAPPEDS Initiative

By Aradhana Bela Sood, MD, MSHA

The scarcity of child psychiatry expertise was a problem even in 1994 when I took over as training director of the CAP program at VCU/MCV. It has reached gargantuan proportions in the new millennium, with less than optimum care being provided to children that heightens morbidity and mortality. Eighty percent of the MH needs of the children and adolescents are provided by pediatricians, family practice (FP) care doctors and often adult psychiatrists (AP) who are not comfortable in this role because of a lack of training during medical school.

Recognizing this problem, the seeds of the CAPPEDS (Child and Adolescent Psychiatry PEDiatricS behavioral health collaborative program) were laid in Virginia in 2003. An informal networking began between child and adolescent psychiatrists (CAPs) and their pediatrician colleagues in the Richmond area. The idea was to improve the expertise of pediatricians in behavioral health, thereby improving the care for affected children and their families.

The program started as a "curb side" consult service in which: A) some pediatricians obtained immediate access to a CAP who listened to the history/problem and provided immediate feedback about a viable plan until the child could be seen by a CAP; or B) provided face to face consultation for high risk children; C) took on care until the child became stabilized and was referred back; or D) was provided ongoing care. In addition, collaborative office rounds occurred once a month through an HRSA grant, in which pediatricians learned about common problems affecting children and their families. The overall satisfaction was high in both the providers and receivers of this consultative model.

Meanwhile, solving work force shortage became a national priority for the American Academy of Child and Adolescent Psychiatry (AACAP). Fortunately, great minds think alike! Similar models were being proposed and created in other states, such as Massachusetts and Minnesota. A summit held in Richmond, Virginia in the spring of 2007 was attended by 60 pediatricians, CAPs, AP's and invited stakeholders (DMHMRSAS, CMS, Anthem, Sentara) to assess interest in rolling out this model statewide. It received overwhelming support. Our colleagues from Massachusetts and Minnesota served as consultants.

Well, one year after the summit—there is great news! There is active discussion with the office of the Commissioner of MHMRSAS on how to implement this model based on a prototype of regional teams comprised of a CAP, therapist and a case manager that span the state (especially our rural areas). Pediatricians/FP/ AP would have to enroll in the program, seek consultation with the team, and eventually learn to manage patients with mental health problems effectively. What a terrific way to leverage expertise and improve the quality of care to the children, youth and families of Virginia!

Stay tuned…more good news is coming! Please forward any innovative ideas you may to successfully implement this (especially in rural areas) to:

Bela Sood, MD
bsood@mcvh-vcu.edu

Colleen Kraft MD
docmom3@aol.com

Carol Davis Ethics Award: On Philosophy, Ethics and Personal Development

By Claire Zilber, MD *Printed with permission from Colorado Psychiatric Society*

APA annually gives the Carol Davis Ethics Award for the best district branch newsletter article about ethics. This year, Dr. Zilber was granted the award for this article.

Do you consider professional ethics as nothing but a set of rules involving our conduct with patients? Follow the rules and you'll stay out of trouble? In truth, the philosophers who evolved concepts of personal and professional ethics were less concerned with rules than they were with social justice, personal well-being, and refining the life of the mind. If we contemplate what it means to be ethical psychiatrists, we may consider not only our behavior with patients and colleagues, but also our demeanor in all aspects of our lives. We may advance our experience of professional ethics in a myriad of ways, including teaching, changing public policy, or even extending polite courtesy to strangers.

In the fourth century BCE, Hippocrates instructed physicians to practice professional ethics, "to preserve the purity of my life and my art." In addition to prescribing regimens "for the good of my patients according to my ability and my judgment," he also vowed to teach students the art of medicine "without fee or written promise."

In Hippocrates' time, physicians taught only the sons of physicians for free. In contemporary society, there are many more ways to discharge our duty to educate. Teaching medical students, residents, fellows, psychoanalytic candidates and colleagues through lectures or supervision remains a valuable and honorable activity. Educating our patients, their families and the public is a newer way to pass on the gift of medical knowledge. If you don't love lecturing, you could volunteer for CPS' Public Education and Information Committee, help arrange other peoples' lectures, and still be advancing the ethical duty to teach.

Freely transmitting our knowledge is not the only avenue to enhance our experience as ethical individuals. The seventeenth century German philosopher, Gottfried Liebniz, envisioned a "society united to serve goals of justice and charity that transcend self-interest."[1] He would have approved of California's Proposition 63, which in 2004 established a 1% tax on all personal incomes over $1 million to fund new mental health programs. Anticipated to generate $275 million in '04 - '05, $750 million in '05 - '06, and $800 million in '06 - '07, it has exceeded expectations. In reality, it raised $1.18 billion in '05 - '06, and is projected to raise $1.25 billion in '06 - '07. Proposition 63 also prohibits the state from reducing support for mental health programs below a certain level. Despite this, and even as new programs are receiving their boon, existing programs are facing budget cuts. Over the long term, it is hoped that the new programs will reduce the number of mentally ill residents who are incarcerated or hospitalized, which should lower treatment costs statewide.[2]

While California may not yet have achieved the ideal mental health system, the individuals who conceived of Proposition 63 were working from an ethical foundation and have advanced Liebniz's goals of justice and charity.

A Dutch contemporary of Liebniz, Baruch de Spinoza established three "rules of living" to assist individuals in their pursuit of mindful happiness. The first rule is to get along with the rest of humanity, that is, to follow accepted social customs and behave amicably with all other people. By following simple courtesies, such as returning phone calls from prospective patients even when our practices are full, perhaps offering a few referral suggestions, we promote the well-being of the public and our profession. Spinoza would agree, and would add that by spending a few minutes in this courtesy, especially because there is no financial profit, we advance our personal development.[3]

The truly ethical psychiatrist, the ethical human being, looks beyond mere rules and examines his or her own values to further individual development and refine the life of the mind. We need not all teach. Nor need we all become involved in politics. I do believe we should be polite to anyone we encounter, although we may differ in our ideas about courtesy's extent. As each of us strives to reach our intellectual, humanistic and spiritual ideals, our contemplation of ethics helps inform our growth. Out of such contemplation, a personal plan to advance ethics will emerge.

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[1]Stewart, Matthew. The Courtier and the Heretic: Liebniz, Spinoza and the Fate of God in the Modern World. WW Norton & Co, New York, 2006. p. 16.

[2]San Francisco Chronicle, July 31, 2006

[3]Stewart, ibid., p.58

PSV is Active in Implementation of New MH Laws

By Cal Whitehead

PSV leaders are having a busy summer working with Virginia agencies and other interest groups to implement the new mental health laws governing civil commitment procedures. Several psychiatrists and our PSV staff are involved in rolling out changes that became effective on July 1. Educating psychiatrists, other mental health professionals, and the public is our immediate goal. We urge our colleagues to contact PSV for direction to resources and feedback on how the evolving mental health system is reacting to new policy.

The PSV website (www.psva.org) has links to information about new laws including:

- **Department of Mental Health Mental Retardation & Substance Abuse Services (DMHMRSAS) Website on Mental Health Law Reform**

  www.dmhmrsas.virginia.gov/OMH-MHReform.htm

  Includes FAQ's, Independent Examiner certification, summary of legislation, and understanding new commitment criteria.

  Please pay special attention to the document, *Understanding and Applying Virginia's New Statutory Civil Commitment Criteria*, authored by Bruce J. Cohen, Richard J. Bonnie and John Monahan, which is available at: http://www.dmhmrsas.virginia.gov/OMH-MHReform/080603Criteria.pdf

- **Supreme Court Commission on Mental Health Law Reform**

  www.courts.state.va.us/cmh/home.html

  Contains a meeting schedule, interim reports, and task force topic areas.

For concerns about new laws, future areas to address, volunteers for appointments to Virginia policy workgroups, and Physicians for Mental Health Reform (PMHR), PSV members may contact PSV Advocacy Coordinator, Cal Whitehead (cwhitehead@whiteheadconsulting.net, 804-644-4424).

Thank You!

Thanks to the following psychiatrists who have participated in recent meetings on mental health laws, public funding, psychiatric workforce and ongoing reform.

Ed Kantor, MD
Supreme Court Commission on Mental Health, Legislative Task Force

Anand Pandurangi, MD
DMHMRSAS Board Member; Supreme Court Commission on Mental Health, Workforce Subcommittee

Joel Silverman, MD
DMHMRSAS Funding Allocation Consultation Group

Bela Sood, MD
Psychiatry-primary care pilot projects for child/adolescent services

Vic Vieweg, MD
Supreme Court Commission on Mental Health, Parity Subcommittee

Helen Foster, MD
Virginia Coalition for the Mentally Disabled

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complain. I began to understand their position through empathy and rising above the situation, which was the beginning of my deeper understanding of becoming a psychiatrist.

During my medicine rotation, I was reminded of the expectations of being a psychiatrist. For example, when a medicine intern complained about a patient, it was viewed with empathy; however, when I voiced frustration about a patient it was occasionally received with, "Aren't you a psychiatry resident?" However, when I left my first medicine rotation and returned two months later with more psychiatry under my belt, I was more aware of the dynamics created by certain patients and was not sucked into the chaos as many medicine interns and residents were. That was a big lesson for me in learning my place in society as a psychiatrist.

Psychiatrists are expected to handle situations with the insight that true reality testing provides, along with good affect tolerance skills. Can people actually feel confident that their therapist will lend an empathetic ear if we are not seen doing so in every situation?

This would seem like an impossible burden of perfection to achieve. We know we are just human and possibly know our suppressed faults more intimately than others. However, if we are expected to be able to help others, then others will always hold us to higher expectations. I believe that is a big lesson I learned in my medicine rotation; we may be put down and put in similar situations as everyone else, but we are expected to react to everything with higher standards. The fact that we are physicians holds us to higher expectations and standards than the general population, but the fact we are psychiatrists holds even higher expectations and standards.

I guess it's time to get my ducks in a row, or just don't tell anyone we are psychiatrists; probably not the latter.

THE PSYCHIATRIC SOCIETY OF VIRGINIA
VIRGINIA NEWS
2209 Dickens Road
Richmond, VA 23230-2005

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on conscience should be limited when they involve someone else's life and someone else's family's health and welfare. As health care providers, we do not and should not have the luxury of imposing our values on others. Our professional duties must take precedence over our personal beliefs, and if we can not live with that, then we would be best advised to go into a field where this would not be a conflict. While one could argue that "buyer beware," and state that the patient has the option of taking his or her business elsewhere, in reality if the patient lived in a remote area, where the nearest alternate doctor, pharmacy or pharmacist was miles away and the patient had no means to get there, there would be no way for this patient to boycott such a pharmacy or provider. We need to be extra careful, lest our decisions create even more disparities in health care.

Issues like these and several others will continue to crop up, and I am counting on each one of us getting involved in tackling them, hand in hand, with the wonderful organization that we have in our APA. We need to ensure that somebody is always minding the store on our and our patient's behalf. We need to commit to not let scientific misinformation create more barriers to care and instead let our interests, as responsible health care providers and members of this society, always guide us in our "position statements" and in our day-to-day work. Thanks for all you do to make our world and our organization a better place!

Thank You

PSV would like to thank the following preliminary exhibitors for the PSV Fall 2008 Meeting—

Making Our Voices Heard

AstraZeneca

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Bristol-Myers Squibb

•••

Centra Health

•••

Janssen Pharmaceutica Inc.