THE PSYCHIATRIC SOCIETY OF VIRGINIA

VIRGINIA NEWS

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION SUMMER 2012

A Message from the President

Reviving plain old therapy

By W. Victor R. Vieweg MD, President

My remarks derive from the condensation of an article by Jon G. Allen, PhD published in *Psychiatric News*, May 18, 2012, Volume 47; Number 10, Page 3-3, American Psychiatric Association, from the Experts entitled: Reviving plain old therapy.

Many evidence-based therapies including CBT, DBT, TFP, ERP, SIT, IPT, EMDR, and MBSR are available for specific psychiatric disorders. A half-century ago, Jerome Frank pointed out that therapies were effective more by virtue of what they had in common than what distinguished them. Since then, psychotherapy researchers have been unable to show differences in effectiveness. Extensive subsequent research attests to the fundamental importance of the therapeutic relationship. There is evidence that differences among therapists outweigh differences among therapies.

The generalists must improve their practice of what Dr. Allen calls "Plain Old Therapy". Peter Fonagy, PhD and Dr. Allen asserted that mentalizing (cultivating awareness of mental states such as thoughts and feelings in self and others) constitutes the most fundamental common factor in conducting psychotherapy. To the extent that mentalizing is intrinsic to psychotherapy, focusing on this technique is a core feature of this art.

We must have developmental research linking parents' mentalizing to their children's secure attachment. Children seek comfort and derive a feeling of security from parents who mentalize and securely attached children, having been mentalized. They are better able to articulate their feelings and are more empathic with their peers. Trauma such as abuse and neglect in early attachment relationships may be associated with impaired parental mentalizing and deeply insecure attachment in the child. The crux of trauma is feeling psychologically alone in emotional pain and constitutes a nonspecific risk factor for later psychopathology.

W. Victor R. Vieweg, MD DFAPA President

Anthony Bateman, MA, FRCPsych, and Fonagy developed mentalization-based treatment for borderline personality disorder where developmental adversity makes a substantial contribution. This treatment approach is now more widely applied and constitutes what Dr. Allen calls "Plain Old Therapy" (promoting mentalizing in the context of secure attachment).

However, a good relationship alone is insufficient for change. We generalists must develop a clear formulation of key problems and goals for effective treatment. In addition, when patients need specialized treatments, generalists must refer them. For example, we should not employ "Plain Old Therapy" to treat obsessive-compulsive disorder for patients who can benefit from exposure and response prevention. However, specialists also must be competent practitioners of "Plain Old Therapy" and their methods superimposed upon it. Informed by mentalizing, contemporary attachment research promises to clarify the processes by which venerably therapeutic aspects of the patient-therapist relationship exert their influence in "Plain Old Therapy".

President-elect Rizwan Ali MD is developing our 2013 Spring Program to be held in Richmond in March with the theme "A Place for Psychotherapy in Modern Psychiatry". My above condensation is meant to whet your appetite for our Spring 2013 meeting.

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VIRGINIA NEWS

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John P. D. Shemo, MD, DLFAPA
Ram Shenoy, MD, DLFAPA
Assembly Representatives
Psychiatric Society of Virginia

Ram Shenoy and I again represented the Psychiatric Society of Virginia at the American Psychiatric Association Assembly Meeting prior to the scientific meeting in Philadelphia in early May 2012. I also continued my service with the Assembly DSM-5 Work Group, as a liaison on the Practice Guidelines Steering Committee, and on the Assembly Rules Committee.

An action paper authored by Ram and myself was passed on the consent calender which signifies no votes of opposition in the entire Assembly. This paper requires both action paper authors and APA staff to explain and justify their cost estimates for implementing an action paper if passed. We proposed this requirement as some Assembly-passed action papers in the past have been permanently tabled by the APA Board based on differences in cost estimates. This has occurred even at times when it was clear that the paper was requesting exploration of an option or program and the staff based their estimate not on exploration but on full implementation.

Overall there were 35 action papers considered in this Assembly. Among those papers passed by the Assembly were ones:

- Requesting the Veterans Administration to allow its physicians to access state physician monitoring programs regarding a patient's use of controlled substances from sources outside the V.A.;
- Directing the APA to lobby for changes in health plans to waive or minimize deductibles for adults, children, and adolescents with severe mental illness;
- Directing the APA to lobby for the continued availability of medications which, in the opinion of the treating physician, have been effective even when a patient's MCO/insurance carrier changes or the company changes its formulary;
- Stating that medical marijuana is not an appropriate treatment for PTSD;
- Advocating for insurance reimbursement for the collection of urine for drug screening in the treatment of patients with substance abuse disorders;
- Developing a mechanism to provide revenue sharing from the national organization with the district branches;
- Providing continued support to the APA Diversity Leadership Fellowship;
- Supporting the recording and distribution of APA annual meeting course material to members after the meeting;
- Supporting the expansion of opportunities for members-in-training to participate within the APA;
- Recommending that illness severity scales, WHO-DAS II and PROMIS, be located in the part of the DSM-5 listing proposals in need of further study;
- Recommending the development of a "find a psychiatrist" function for patients on the APA website;
- Recommending an APA position statement advocating for non-discriminatory access to care for trans-gendered individuals;
- Supporting a request for the reconsideration of the APA position statement on computerized medical records in light of recent security breaches of computerized medical records;
- Formation of a Council on Global Psychiatry and support for the work of that council through the Office of Minority and National Affairs;
- Requesting that the Focus journal and associated CME which supports members in their maintenance of certification with the American Board of Psychiatry and Neurology, be made a member benefit;
- Asking the APA Board to revise the requirements for votes on national APA initiatives so that only 15 percent of eligible voters would need to vote, but if there was such a low turnout, the initiative would also need to be approved by a two-thirds vote of the Assembly;
- Requesting that the American Psychiatric Association staff meet with district branch leadership to ensure that district branches are in compliance with laws related to non-profit corporations;
- Directing the Speaker of the Assembly to move action papers at the next Board of Trustees' meeting. This action paper was initiated because a recent Speaker of the Assembly elected to not move an action paper at the Board of Trustee's meeting that had been passed by the Assembly because he personally disagreed with the intent of the paper. This issue was discussed in considerable detail during the Assembly meeting with the consensus being that a speaker is obligated to move a paper to the Board of Trustees that has been passed by the Assembly although, as a voting member of the Board of Trustees, the Speaker may then elect to vote against passage of the paper.

There was a "vigorous debate" about the issue of whether the APA should consider re-evaluating its policy regarding pharmaceutical industry support for CME at the annual meeting. The issue was raised that the loss of industry-sponsored symposia was a factor in the declining attendance at the APA annual meeting since these symposia were rated by the membership as being of very high quality and quite "unbiased." Ultimately, the action paper requesting this change in policy failed on a narrow vote.

The Treasurer's report was presented by David Fassler, M.D. The Association did have a deficit this past year of $350,000. Publishing sales were $1 million less than last year, mostly due to decline in DSM-IV sales because of the release within a year of DSM-5. The APA meeting in Hawaii last year earned $2 million less than the previous meeting due to lower attendance. There has been a trend over the past five years of lower attendance at the scientific meeting resulting in lower revenue.

An update on the progress of DSM-5 was presented by David Kupfer, M.D., Darrell Regier, M.D., and Glenn Martin, M.D. Dr. Martin did outline the very active role of the Assembly's DSM-5 Committee as we prepare for the November Assembly vote for approval. The near-final draft of DSM-5 has been posted for final public comment through June 15, 2012. It is noted that the postings of draft Nos. 1 and 2 generated close to

Continued on page 4

APA ASSEMBLY AND COMMITTEE REPORTS CONT.

14,000 comments, all of which were reviewed. The DSM-5 will be divided into three sections. The first section includes an introduction, the "crosswalk" to ICD-10, and a highlight of changes between DSM-IV and 5. The second section will consist of the diagnoses and their criteria, and the third section will include diagnoses for further study. Two items were just recently moved into the third section for further study: attenuated psychosis and mixed anxiety and depression. The major depressive disorder criteria were modified to clarify the distinction between normal bereavement and a diagnosable depressive disorder.

The manuscript is currently undergoing a very careful final review process by the "Scientific Review Committee" which is assessing evidence and rationale for proposed changes. The members of this Committee are described as "smart outsiders" who have not to this point been involved in the work of development. A Clinical and Public Health Committee is also actively reviewing proposed changes to address when available scientific studies and clinical experience are inconsistent. They are also looking at the public health and clinical implications of the proposed changes. For example, families of children with autism spectrum disorders are expressing concerns that some children may be disenfranchised from services based on the revised criteria. The Work Group on Personality Disorders has been struggling with the issue of changes to criteria for over five years and at this point, it seems most likely that Axis II will be abolished.

At the end of the last comment period in mid-June, frequently asked questions and answers will be published on the DSM-5 webpage on the APA website.

In the Assembly Leadership Elections, Mindy Young, M.D. from California was elected as Speaker-Elect, and Jenny Boyer, M.D. Ph.D. JD, from Area V (Arkansas) was elected Recorder for 2012-2013. Scott Benson, M.D., also from Area V (Florida) was elevated to Speaker of the Assembly.

The membership report revealed that the APA is something of an "aging organization" with 21.5 percent of members 71 years of age or older. It does seem quite positive to me that the largest percentage of contributors to the APA Political Action Committee are from the member-in-training and early career psychiatrists.

There will be major upcoming revisions and revaluations of the CPT codes. Final code changes are expected sometime in September from CMS and the code changes will become effective on January 1, 2013 for Medicare. The members of the assembly committee working with CMS are under strict confidentiality requirements and therefore could not share much of the proposed changes even with the Assembly. It is known that 90862 as a usable code will end on January 1st. Additionally, all of the psychotherapy codes (90804 to 90809) will be deleted and replaced with new codes that reflect "interactive complexity." The Committee is strongly urging psychiatrists to prepare to use the evaluation and management (E&M) codes. The APA will attempt to educate and help members learn to use these codes. It is noted that these code changes initially apply only to Medicare. Insurance companies usually follow suit but there will likely be delays in implementation. There is a power point presentation from the Committee Chair, Ronald Burd, M.D., available at the APA Lifelong Learning Website.

It was pointed out that there is currently a major shortage of psychiatrists working in the Veterans Administration system. There is a VA program for members-in-training. This program will require a six-year commitment to the VA at standard pay in exchange for the elimination of medical school debts.

The Psychiatric Society of Virginia was for the second year in a row awarded the honorable mention in the Assembly District Branch Best Practices Award competition for our successful "day on the hill" which was held in conjunction with the Medical Society of Virginia's "white coat day."

Finally, I do wish to post a note of reassurance for colleagues I interacted with in Philadelphia. As some of you may have heard, I became ill with a severe headache on the train back from the May APA meeting in Philadelphia to Charlottesville. Ultimately, after a brain MRI and an LP, I was found to have viral meningoencephalitis. I was hospitalized, started on antiviral treatment through a PICC line and discharged from the hospital to continue with outpatient IV treatment. This was, incidentally, the first day of work I have missed due to illness in the 37 years since I obtained my M.D. degree. After about 12 days of outpatient treatment, I developed rather sudden onset renal shutdown which required dialysis, and a dense delirium which lasted for six days and for most of which I have no memory. I, interestingly, can recall the exact moment when my working memory re-emerged.

I am now doing much better and was just able to complete the Assembly report for the Psychiatric Society of Virginia Newsletter, which I had started on the train from Philadelphia.

My point of reassurance is that I have been myself reassured by both infectious disease and neurology consultants that this condition was not communicable. It involved the reactivation of a childhood virus. Thus, no isolation procedures were utilized or required in either the intensive care unit or the dialysis unit. I did lose 13 pounds during this experience as I was not able to eat or be fed for six days, but I do not recommend this as a diet plan.

Again, my critical point of reassurance is that the lifetime incidence of this condition is 1 in 2 million and, most importantly, this was/is noncommunicable if we did have any contact at the Assembly APA scientific meeting or committee meetings.

As always, Dr. Shenoy and I remain available to prepare and submit action papers and advocate for concerns of the membership of the PSV.

Do you know what your online profile says about you?

J.E. Nieves, MD & Gregory Briscoe, MD

J. Edwin Nieves, MD, DFAPA

Gregory Briscoe, MD

We read with great interest a recent article on the green journal that should probably be mandatory reading for all psychiatric residents[1]. An excellent example of "electronic medicine gone wrong," the article basically covers the case of a patient whose family member posts disparaging comments about the discipline, the treatment plan and a particular psychiatric resident in a blog, in contrast to the supportive and cooperative attitude when seen in person by the provider. The comments specifically mentioned the resident by name.

Now, there are many angles to this story and we agree with the authors that one of the most important ones is the potential impact these undermining comments may have in derailing the treatment plan of the patient, but the point we would like to address today is the potential impact these comments may have in the professional futures of the medical students, residents and attendings.

The use of the internet has become widespread, nearly 80% of people aged 15-50 have internet connection to their home and about 75% report going on line to look up health information[2]. Just about every serious mental illness category has its own advocacy and education websites. Patients and their loved ones can look up medication information, institutional quality control results and even their doctors' credentials prior to their visit. We would all agree that an informed patient and family are better equipped to ask relevant questions and participate in their treatment plan, thus improving outcomes, but what about the impact of information that may be available on the internet about us?

A recent article found that 94% of an internal medicine physician cohort in a state had information about them available on line, 93% of the websites contained professional information, while approximately 33% had personal information available[3]. Some of this information may have been published by the physicians themselves and may include practice location, specialties, appointment, etc. However, much of it may be gleaned from other nonphysician authored online sources such as public quality rating scales, publications and professional information[3]. These sources have the potential to give a false, misleading or incomplete portrayal of the practitioner and could impact potential future employment opportunities for residents and young faculty. Although I am neither, I have to accept that this article made me curious about my online profile.

I googled myself and thankfully only found some minor discrepancies. Several websites that have me listed as having my own business out of the VHA hospital in Hampton (manta.com). In another one (vitals .com), I am listed as addiction specialist, it lists my training history and academic appointment and the fact that I am bilingual. Health.pth.com has my primary specialty as geriatric psychiatry (incorrect), and while all training, career & contact information is for the most part accurate, it lists Kathy's cell phone number as my contact. Carionltd.com has just about the same information except lists my fax number with an area code of 517. Healthgrades.com has the same information plus they offer a list of all actions taken against me which is, thankfully, none. It is perhaps important that we check periodically our "online profile" from time to time and correct any discrepancies if possible.

All of these websites contain multiple tabs inviting the reader to "complete a survey on this doctor," others invite the reader to compare me with other "top ranking psychiatrists in the area." I was pleased to see that some of my friends and PSV members are recognized as top psychiatrists in the area, but concerned that these websites also include tabs for Facebook, Twitter and blogs that have the potential to make general comments widespread and may affect a professional reputation. Moreover, in a recent study only 37.5% of medical students and residents used their Facebook privacy settings[4]—the potential for inadvertent exposure is obvious.

Physicians need to be alert to the kind of information we disclose online, both purposefully and unwittingly, and should think about any website as if it was an "a virtual extension of your office wall"[3]. Younger physicians that have grown up with social networking (Facebook & Twitter) may not be alert to the impact that personal self disclosure may have in their practice, given that it may be available to their patients and that personal postings are vulnerable to be incorporated into their clinical persona. This has the potential to complicate and burden the therapeutic relationship with their patients. Given the popularity of these social networks and the recent encouragement to "blog," it is important that we keep in mind that self disclosed information is more less within the "public domain" and accessible to patients, residency training directors as well as prospective employers. Given the popularity of electronic communication among younger physicians, perhaps "digital professionalism classes" should incorporated into medical school and/or residency training curriculums[4].

1 Gabbard, GO : "Clinical Challenges in the Internet Era" Am J Psychiatry 169:5 May 2012 460-463.

2 http://www.internetworldstats.com/stats.htm accessed 5/20/2012

3 Mostaghimi A, Crotty BH, Landon BE: "The availability and nature of physician information on the internet" J Gen Intern Med, 2010 Nov;25(11):1152-6 epub 2010 Jun 11 accessed 5/18/2012.

4 Gabbard, GO, Kassaw, KA, Perez-Garcia, G: "Professional Boundaries in the Era of the Internet" Academic Psychiatry, 35: 168-174.

The Navy's Approach to Psychiatric Trauma

By Keisha McFarlane, MD, LT MC USN

In military psychiatry, we are faced with finding innovative ways to treat trauma patients. At the Naval Medical Center Portsmouth (NMCP), the Traumatic and Operational Stress Services (TAOSS) Clinic, headed by Dr. Suzanne Dundon and LCDR David Weis, does just that. This program is based on the following three-step protocols, whose treatments have been researched, proven to be effective, and is approved by the Department of Defense. The first is entitled "Prolonged Exposure Therapy". In this treatment; the patient, under the direction of a therapist, revisits their trauma from past to present in order to discharge his or her tension associated with the trauma. They are given home assignments to write down places they are no longer able to go as a result of the trauma. They are asked to expose themselves to these places and stay for up to one hour. The protocol consists of ten sessions and they meet with their therapist one to two times per week.

The second protocol is entitled "Cognitive Processing Therapy", which focuses on Cognitive Behavioral Therapy for trauma patients. It consists of twelve sessions and the patient meets with their therapist one to two times per week. The patients are initially asked to write impact statements regarding how their lives have changed since the trauma. The therapy allows the patients a safe environment in order to experience the emotions associated with the traumas, and they are asked to read the impact statement to themselves daily.

The third protocol is entitled "Eye Movement Desensitization and Reprocessing Therapy." It consists of two to twenty sessions (depending on the degree and amount of trauma) in which the patient initially starts by processing their first trauma, with a goal to process the most recent trauma.

The TAOSS Clinic has been at NMCP for the past three years, and during this time, there has been statistically significant improvement in patients' depression, alcohol use, and Post Traumatic Stress Disorder.

Share, Collaborate and Celebrate

By Hugh M. Bryan III, MD
MSV President

Dr. Bryan is an orthopaedic surgeon in practice in Gloucester, Virginia. He is a member of the Virginia Orthopaedic Society and current president of MSV. He has served on the MSV Board of Directors and has been the vice speaker and the speaker of the MSV House of Delegates.

There are many reasons why I think you should join us for our Annual Meeting in Williamsburg. More than any of our other events, the Annual Meeting will help you make connections, influence policy and strengthen your efforts to advocate for your practice and your patients.

The Annual Meeting provides you the opportunity to engage with your peers. There is great potential to learn from each other's experience and ideas. From several exciting social opportunities to valuable policy meetings and a return of last year's popular town hall format and CME, MSV will maximize networking and exchange of knowledge for attendees. The speakers will introduce some exciting ways for members to influence policy discussions online this year, but sometimes there is no substitute for a face-to-face meeting.

The staff at MSV is working hard to make this year's educational sessions more rewarding, timely and relevant than ever. With our engaging learning opportunities, MSV will equip you with the knowledge and tools you need to design a payment model that will prepare your practice for the future and help you succeed during uncertain times. The practical, hands-on and unique sessions will improve quality of care and value for your patients. No matter what your interest, specialty or geography, there is much to be gained by participating in our sessions.

Finally, it's hard to believe that nearly a year has gone by since I was inaugurated as MSV president and it's already almost time for me to pass on the presidency to Russell Libby, MD, FAAP. Being president has been an incredible privilege full of many challenges and successes. The Annual Meeting provides us the opportunity to celebrate our accomplishments together, making them that much more rewarding.

I look forward to seeing all of you in Williamsburg this November!

WHY BECOME AN APA FELLOW?

- Being a Fellow is an honorary designation that was created by the APA Membership Committee and Board of Trustees to recognize early career members who have demonstrated allegiance to their profession and commitment to the on-going work of the Association.
- Fellows are permitted to use the FAPA designation on all of their professional documentation.
- All newly appointed Fellows are publicly recognized at the Convocation of Fellows and Distinguished Fellows, which is held every year during APA's Annual Meeting.
- Fellows receive a lapel pin as a symbol of their status and an embossed Fellow certificate to display with pride in their office.

The deadline for Fellowship applications is September 1.

How Do I Apply? Visit **http://www.psych.org/Resources/Membership/FellowsDistinguishedFellows.aspx**

MSV LEGISLATIVE SUMMIT REVIEW

By Ralston King

On Friday, June 1st, the Medical Society of Virginia (MSV) hosted their annual MSV Legislative Summit to hear proposals on current issues that are affecting the practice of medicine in Virginia. Those in attendance included; MSV members, local and specialty medical societies, MSV staff, and lobbyists. Below is a brief summary of proposals and the request made to MSV.

Much discussion that surrounded the MSV Legislative Summit dealt with Medicaid reimbursement for physicians. It has been over 10 years since Virginia's physicians approached the General Assembly asking for an increase and in recent years, it has been a struggle to make sure rates do not get cut. With an increase in Medicaid recipients, but a decrease in Medicaid payments due to inflation, another possibility will be inflation rate adjustment. Hospitals and nursing homes annually receive this adjustment rate. This proposal could quite possibly be better in terms of long term payment than a one-time Medicaid reimbursement.

Top issues and concerns in the day to day practice of medicine have come from the emergency physicians that have continued to battle reduced Medicaid payments under a federal system that mandates all emergency departments provide care to all those who walk through the door. A complicated state system for mental health patients also has concerned emergency physicians the inability to deliver quality care and efficiently provide the proper setting for MH patients.

In policy talks that will involve business, insurance, and provider stakeholders is the worker's compensation system. It is believed that the insurance companies will put legislation in that would create a fee schedule for worker's compensation cases. With business premiums increasing annually, insurance companies are pushing businesses to help advocate for a fee schedule. While insurance companies claim that premiums will go down it is not mentioned that access will be affected along with quality care.

Each issue will be discussed and voted on at the Medical Society of Virginia's House of Delegates at MSV's Annual Meeting in November. As we continue to keep a strong relationship with the Medical Society of Virginia, we will keep you updated on changes and greatly appreciate any feedback you can give regarding proposals.

SUMMARY OF ISSUES

Medicaid Reimbursement Increase
Hugh Bryan, MD

• MSV, along with coalition of health care entities, has been successful in avoiding cuts to physicians Medicaid reimbursement during the past four years. There has only been one general increase in physicians reimbursement during the past 10 years. Physicians should be treated on an equal basis and an inflation adjustment should be instituted.

• Request that MSV coalition should develop process for budget amendments to provide annual increase in physicians' reimbursement that is equivalent to that by the hospitals Medicaid.

Payment Increase
AAP-VA Chapter

• With an increase in Medicaid recipients, but a decrease in Medicaid payments due to inflation, we request an inflation rate adjustment. Hospitals and nursing homes request and receive each year an adjustment rate of inflation from the general fund.

• Request MSV work with AAP- VA, VACEP, VAFP, PSV, VSEPS, VOS who have all signed on to help develop a strategy to increase physicians Medicaid rates in 2013.

DMAS PEND Program Elimination
VACEP

• DMAS created administrative process in nineties to address the concern of "misuse" of emergency rooms by Medicaid recipients. The assumption was that reducing payments to emergency physicians would help reduce the number of Medicaid recipients who use the emergency department. Post implementation, the federal government implemented EMTALA which requires all EDs to treat everyone who shows up regardless of pay. Level III claims still linger and make up 60% of ED Medicaid claims. DMAS reviews about 95% of Level III claims and approximately 60% of them are cut in half.

• Request MSV lobbying team formally assist VACEP to ensure PEND program is eliminated.

Disclosure of Physician Identity in Malpractice Case
Scott Reed, MD

• Proposing in a medical malpractice case that identity, credentials and written opinion of any physician be made known to the defense. Before a medical malpractice case can be filed, it must be certified as having merit by a physician who could reasonablly serve as an expert witness in the field. The identity of this physician and their opinions concerning the case are not discoverable by the defense because it could lead to abuse by the plaintiff's attorney.

• Request MSV draft legislation to require the identity, qualifications and opinion of the certifying physician be part of the discovery process for the defense.

Mental Health Issues in the Emergency Department
VACEP

• Inappropriate medical clearance requested by receiving facility, often resulting in unnecessary testing, expiring ECO's and a lack of bed space. Lack of inpatient bed availability resulting in TDO denial because there is no receiving facility to

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MSV SUMMARY OF ISSUES CONT.

name, which results in Emergency Physicians being required to release patients who have been deemed a danger to themselves or others.

• Request MSV assist to develop administrative and legislative strategy to work with DHBHDS, HHR, AG's Office, and legislature to address issues.

Emergency Custody Orders (ECO) & Temporary Detention Orders (TDO)
RAM

• For the purpose of medical and psychological evaluation, stabilization and treatment of a patient, RAM is requesting MSV seek an alternate pathway to attain Emergency Custody Orders (ECO) and Temporary Detention Orders (TDO). The current protocol for an ED physician to obtain an ECO or TDO within the Commonwealth requires oversight and validation by a Magistrate, which may take hours to accomplish. Other states have enacted legislation to provide physicians the authority to detain and provide necessary evaluation and emergent management of a patient.

• Request MSV work with RAM, PSV, and VACEP to amend current legislation.

Dispensing of Expired Medications by Free Clinics
RAM

• Physicians would like to be able to give expired medication samples to free clinics for use within the uninsured population. Most medication samples are destroyed and wasted due to the VA Board of Medicine not allowing drugs that exceed expiration date to be dispensed. However the expiration date does not mean the drug will stop working or become potentially harmful after it expires. What are the repercussions?

• Request MSV work with the Board of Pharmacy and the Board of Medicine to study possibilities.

Methadone Maintenance Programs
Mary McMasters, MD

• Propose to require that Methadone Maintenance Programs check the VA Prescription Monitoring Program about each patient & inform other prescribers of Controlled Substances of Patients receiving Methadone. Patient must provide consent to contact all prescribers of controlled substances revealed on his/her PMP query.

• Request MSV exhaust regulatory/legislative remedies.

Gun Safety
RAM

• Propose physicians go on record supporting programs that reduce violence and increase gun safety. Also, oppose repeal of existing state or federal laws and regulations that promote safety and responsibility in the purchase, possession or use of firearms.

• Request MSV go on record supporting firearm safety, educational programs, and sale and distribution of firearm laws.

In The News

APA Annual Meeting Presentations

At the recent APA Annual Meeting two PSV members from the Eastern Virginia Medical School gave presentations.

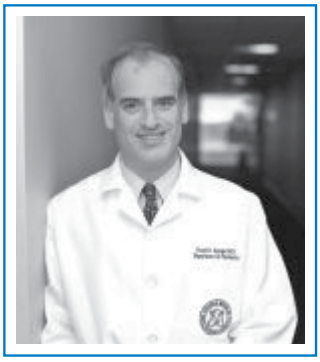
Stephen I. Deutsch, MD, PhD, the Ann Robinson Chair and Professor of Psychiatry and Behavioral Sciences, EVMS

Description, Rationale, Organization and Presentation of the Clinical Examination of the Mental Status

Dr. Deutsch presented definitions of terms commonly used in performing and presenting the mental status examination. He described the examination and provided the learners with an approach to organizing and presenting the data collected during the examination.

Bedside Evaluation of Frontal Lobe Functioning

Dr. Spiegel reviewed key functions attributable to the frontal cortex, common disturbances of frontal lobe function found in primary psychiatric and general medical conditions, and approach to the assessment and presentation of frontal lobe functioning.



David R. Spiegel, MD; Associate Professor, Department of Psychiatry and Behavioral Sciences, EVMS

UVA Matching in Psychiatry Student Lunch

By: Chadrick Lane, MD Candidate, 2014
UVA School of Medicine

Upcoming 4th year medical students at UVA had the opportunity to discuss a future in psychiatry with our recently matched rising residents. In what we hope to be the first of many, students graduating this year organized a presentation outlining the steps to successfully matching in psychiatry. Focusing on tips for interviewing, scheduling, electives, and more, a foundation was paved for experiencing an informed and smooth application process. The hour long gathering not only attracted those most certain, but also a fair share of students on the fence regarding their specialty. Our pioneer event was a wonderful success, with much thanks to PSV for providing a delicious lunch!

Dr. Granoff Wins Peoples Choice Award

Abbot Granoff, MD won the Peoples Choice Award at the Virginia Bonsai Society's annual show at the Norfolk Botanical Gardens this past May. His tree was a field collected 157 year old California Juniper - Juniperus californius styled in an informal upright fashion, over the past 47 years. His restyling was done over the past 7 years.

Peoples Choice Award at the Virginia Bonsai Society's Annual Show

Eastern Virginia Medical School

Eastern Virginia Medical School is happy to honor the graduation of Vladimir Prem, MD, Gregory Carr, MD and Kevin Lamm, MD. In July we look forward to welcoming Hasan Memon, MD, Sukdeep Rahi, MD, Syeda Younus, MD, and Noah Matilsky, MD. Additionally, Robert P. Archer, PhD, Professor of Psychiatry and Behavioral Sciences, is being honored by the Association of Psychologists in Academic Health Centers. Dr. Archer will receive the Joseph D. Matarazzo Award for Distinguished Contributions to Psychology in Academic Health Centers. We were also proud to see our own Dr. David Spiegel featured on 'Good Morning America'. We are looking forward to the upcoming year and excited to be part of PSV.

Chesterfield CSB Employment Opportunity

Chesterfield CSB is looking to hire a full time Board Eligible or Board Certified Psychiatrist to join the Medical Services Team. This is a full time job as a County Employee with all the attendant benefits. If interested, or know of someone who would be interested please contact Asha Mishra, MD at Mishraa@chesterfield.gov.

THE PSYCHIATRIC SOCIETY OF VIRGINIA
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HONORING DR. JOHN URBACH FOR HIS SERVICE AND DEDICATION

Dr. John Urbach has been the residency training director at the Medical College of Virginia department of psychiatry since 1984. He was born in New York City, raised in between Staten Island and Teaneck, New Jersey. He completed a degree in anthropology & biology at Cornell, Medical Degree at University of Michigan and his residency at Duke University.

Over the years, John has overseen the training of hundreds of psychiatrists. Those of us who trained under his tutelage always remember his welcoming smile, calm approach and interest in culture and diversity. His door was always open to all his residents, no matter what level or how trivial the concern.

> *"Simply put, John Urbach has been the mind, heart and soul of the VCU Psychiatry Residency Program since 1984. Every resident who has passed through this program under his tutelage has benefited from John's scholarly and generative mentorship, hard work, attention to detail, kindness and wit. He was ever concerned for and dedicated to our well-being, education and professional maturation."*
> *- Yaacov R. Pushkin, MD*
> *(Chief Resident 1991-92)*

"As a native Richmonder who spent 9 years MCV/VCU for medical school and psychiatric training, I took much of my medical education for granted. I don't think I appreciated the quality of my Psychiatric training until getting out in the "real world", seeing the high percentage of our graduates who became Board Certified and realizing how many learning experiences we had that many elsewhere were not afforded. My clearest and fondest memories of Dr. Urbach are of his mentoring as an Attending on the old Adolescent Psychiatry unit we had at MCV before VTCC was fully folded into the University. To an aspiring Child Psychiatrist, he demonstrated calmness, thoughtfulness and compassion with the youngsters and their families."
- Greg Fisher, '92