The Psychiatric Society of Virginia
VIRGINIA NEWS
SPRING *A District Branch of the American Psychiatric Association* 2006

Edward Goldenberg, MD, DFAPA

From the President of PSV: A Seeming Conundrum of Choices

Do you decide which patients to see or how to go about treating them? Well, that depends.

Are you self-employed or work for a clinic, hospital, or other entity which decides for you?

And when you do treat patients, there are many options in therapies, medications, and other treatment modalities.

Let's look at the choices in treating depressed patients these days: various psychotherapies, over thirty FDA-approved antidepressants in the US today (not to mention the non-approved ones), ECT, VNS, phototherapy, etc. Which do you choose?

Shouldn't your choices be predicated on your professional knowledge and experiences as to which treatments are "best" for your patient? If you feel that psychotherapy is indicated, do you do the therapy or refer to a particular therapist? Does that therapist accept the insurance plan your patient has, or conversely, does the insurance plan list that therapist on their panel?

In considering a medication, there may be several antidepressants which are good choices for excellent efficacy with minimal side effects (i.e. better tolerability and compliance). But financial matters (cost, insurance, sample availability) may outweigh other factors.

This is not as simple as deciding whether to keep driving an old Chevy or go into debt and buy a new Lexus. We know both cars could provide reliable transportation, and get you there.

However, when it comes to medications, we often struggle to decide whether or not to prescribe a "cheap" but effective tricyclic antidepressant or a newer more costly SRI. Medication sampling often allows us to begin newer medications which often work more quickly and are almost always more tolerable in terms of side effects. But what if the patient cannot afford the $40 insurance copay or the out of pocket costs to purchase this without insurance?

Less than 20 years ago, managed care companies encouraged us to prescribe TCAs instead of Prozac (some of you may remember this). Over time we "pushed back," and somehow they realized that patients might be more compliant with the newer medications. After a few years, managed care companies came to understand that paying a bit more up front for the newer drugs might help the patient compliance—and also help keep patients out of the hospital (which costs many more dollars).

So where are we today? Managed care formularies tell us (or do they tell the patients?) which medications they can get and how much they must pay. And if your patient cannot afford the medication you prescribe—presumably one you think is best—then the patient may not buy the medication or may take less than prescribed doses or even stop treatment.

Has a patient ever asked you "Why did you prescribe such an expensive medication for me?" Quite likely you attempted to explain that older TCAs might cause unpleasant side effects: too much sedation, constipation, blurred vision, tachycardia, weight gain (with associated diabetes or heart disease) etc. Yet, the third party payer encourages less expensive options.

Make no mistake about this: managed care/insurance company reviewers are not malevolent by nature and do not want to cause your patients harm. But, they want to be "fiscally responsible" and suggest (or insist) on formularies which save them money. After all, everyone knows the costs of health care have gone up tremendously.

I haven't read lately about insurance companies going out of business for lack of profits nor salary decreases for their chief executives. Still, how could they possibly afford to give everyone the "best" medications? Oops, have to be careful here.

We can't say one medication is better than others. But yes, doctor, YOU ARE permitted to use your best clinical judgment. The crux of the problem may be as Rodney Dangerfield said, we "just don't get no respect." But remember, it's YOUR patient. Primum non nocere.

Is it more harmful to prescribe a medication that causes long term side effects or to prescribe one that your patient cannot afford? And if they can't afford it because their insurer prefers to save a few pennies on a less expensive alternative, where does this leave us?

We're left with difficult choices. But, I prefer to recommend to my patients exactly the same treatments as I would recommend to a family member or friend. And if they need to battle with an insurance carrier, I would encourage them and help them as needed to get optimal care. (Definitely no pun intended).

One last comment about choices: this is my last scheduled newsletter as President of PSV. I will turn over the gavel to the very capable Dr. Larry Conell and an excellent board of directors. My sincerest thanks to the members of the board, committee chairs, representatives, and others too numerous to mention, who have given their time to support the efforts of organized psychiatry in VA. You've chosen to be involved and to make a difference in the care of your patients and the directions of our profession. Please stay involved and encourage others to do the same.

Sincerely,

Edward Goldenberg, M.D.

INSIDE THIS ISSUE

James Krag, MD, FAPA

"Our Children Deserve Better"

Children and adolescents with psychiatric disorders are not receiving adequate services. In the guest column, Brian Meyer, PhD states that, "Sixty-two thousand children and youths in the Commonwealth suffer from significant functional impairment in their homes, schools, and communities, but only one in five receives treatment." He notes, "Pediatricians and family practitioners prescribe 80 percent of psychoactive medications to children, but few have been trained in pediatric psychopharmacology."

Because there are not enough specialists in child and adolescent psychiatry and because too few general psychiatrists are seeing the younger population their pediatricians and family physician's are trying to do the best they can. I believe that this contributes to the call for psychologists to prescribe medication because many psychologists are coaching the pediatricians and family physicians on what to prescribe.

Current Psychiatry Residencies provide very little child and adolescent training leaving graduates feeling unprepared to treat this large segment of the population. Yet based on U.S. Census data approximately:

* 25% of the U.S. population is 17 or under.
* 18% of the population is between 5 and 17
* 11% of the population is 65 or over

So even after four years of psychiatry residency training most psychiatrists consider themselves to be "Adult" psychiatrists rather than "General" psychiatrists and therefore not capable of providing psychiatric care to about one fourth of the population.

Since Virginia only produces about five or six Child and Adolescent Psychiatrists a year we can not rely only on these important subspecialists to provide care to this population. Let us accept that fact and make plans on how to best provide services to our children and adolescents. If we continue with the current systems of training we are perpetuating inadequate psychiatric care.

One approach to solving this problem in the long term is that psychiatric training in Virginia and the U.S. could be altered to include more training in child and adolescent care. To exclude about one fourth of the population from training goals seems unreasonable. I propose that we eliminate the term "Adult Psychiatry Resident" and replace it with "General Psychiatry Resident". An increase in training related to children and adolescents would help in treatment of adults as well since all adults were children and often the issues adults are dealing with relate to child and adolescent periods of their lives. Training programs could produce General Psychiatrists with broader capabilities while still relying on subspecialists, as important consultation resources, in specific age populations such as Geriatric Psychiatry and Child and Adolescent Psychiatry as well as diagnostic sub specialists such as in Addictions, Affective Disorders and so forth.

Another, more immediate solution is for psychiatrists who have specialized in treatment of children and adolescents to share their expertise with non-specialist psychiatrists and pediatricians.

Dr. Bela Sood, Chair, Division of Child and Adolescent Psychiatry at Virginia Commonwealth University Health Systems and Medical Director, Virginia Treatment Center for Children recently stated, "Because we train too few people in child psychiatry for the state, I propose we proactively look at ways of leveraging the existing child mental health expertise to educate, train and provide tools to those that are presently providing the bulk of the care. This will equip them to provide the type of treatment

that these kids so clearly deserve."

She has been an active member for the past two years of the Child and Family Behavioral Health Policy Planning Committee and says, "The general consensus is to begin a planned program of education and training of not only primary care but also adult psychiatrists around child behavioral care using several existing models that have been successful in other parts of the country. For example I travel PRN to Rappahannock CSB to do teaching rounds, around child cases for a group of adult psychiatrists. This has been very well received; I regularly respond to pediatrician requests for doing seminars around psychopharmacology and psychopathology; I am also developing a collaborative model of teaching with the AAP, Medical Home Plus and INOVA Fairfax Hospital for pediatricians. The focus is to consult but ultimately train and educate, so that a person like me is not needed as much. I suggest we begin to look at a similar model for adult psychiatrists too."

Psychiatrists can say they are not prepared to treat children and adolescents but we are already ahead of our pediatric or family medicine colleagues because of our familiarity with the medicines used to treat psychiatric disorders. A disincentive to caring for children is that they often take longer to deal with and the reimbursement for seeing them is inadequate for the time spent. As Dr. Meyers points out, "I also believe that we must become advocates for our field and for our patients, and that means we have to become political advocates as well. Much as I find entering the political arena uncomfortable, I'm tired of letting managed care companies and politicians who want to "save" money determine what is best for our patients. We have to do a better job of educating politicians about what we do and the fact that it works. If

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VIRGINIA NEWS

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We welcome letters to the editor and editorial contributions.

David Markowitz, MD, DFAPA

N'awlins

"It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself." – Ralph Waldo Emerson, American Poet

Once the decision was made to spend two weeks in New Orleans on a SAMSHA (Substance Abuse and Mental Health Service Administration) team in December the imagination runs wild. Told that I would drive from clinic to clinic, work fourteen-hour days, miss meals, and generally be run ragged, the second thoughts began. Chosen for the team because I am a child psychiatrist, and the community had requested one, I imagined the need to be great. It was, but...

The only problem was finding the patients! One team was deployed on the cruise ships docked on the Mississippi River, and they had a designated population and offices. On the land-based team, we were to find the need and fill it. However, the mental health clinics were just opening and many patients did not know we were available. In fact, most prior clinic patients were still in Baton Rouge, Houston, or scattered across the country. Those clinics were overloaded, but we were not.

So who was the population in need that we were to serve? It became clear that the children's clinics, while always answering the phones with how pleased they were that I was available to help them, and that they would get back to me shortly, were too disorganized to make use of my services. While struggling with the frustration, it also became clear (as we were previously instructed) that anyone we spoke with might benefit from our training. Although I did have brief opportunity to work in some structured settings, such as a make shift clinic in the public library, most of my time was spent in a more unstructured way. The public library was a great experience, working with a family practitioner to provide the mental health needs for some patients from the community, but mostly treating the depression, anxiety, and sleep disturbances of the nineteen remaining staff from the two hundred-thirteen prior employees of the library. Briefly working at a mental health center, I found talking with the staff more a priority than seeking out patients. They, too, were victims, some displaced from their homes, others missing family members, etc.

The word "patient" began to be defined differently. Going to a grocery store involved checking with the deli clerks and customers to make sure they were coping, helping them identify family and friends they were concerned about, and providing education about available resources. The fun part, we also did the same in some great clubs in the evenings.

Driving through subdivisions in Chalmette, a devastated town in St. Bernard Parrish, we would bring water and support. The locals would thank us for our help and concern, tell us their stories, inform us whether or not they had adequate support systems in place, and were generally appreciative of our presence. I will never forget the 50-year-old father of three adolescent children turning more and more red-faced as his anger exploded talking about his struggles to get electricity for his home. When he finally did, the contractor set up the power lines through the home next door. The catch... the home next door was scheduled for demolition. When I asked him about his blood pressure, he informed me he had five previous MI's! Helping him to settle down, agree to get back on his anti-hypertensive medications, and to see a primary care physician was no small undertaking.

Most of our time was spent in a tent village in Chalmette. The tent village consisted of approximately five hundred residents from the community who lived there, five hundred contractors and security personnel living there and about five hundred residents from the community who came to the tent for meals. Follow-up care for that population was very uncertain, so prescriptions were mostly limited to symptomatic care and refills. Again, providing information about available resources and arranging transportation (an often almost impossible task) were priorities.

Stories abounded, mostly survival stories and stories of resiliency. I met my "patients" in the cafeteria while we ate. Most were eager to share their tales, show their pictures, admit their fears, and reveal their symptoms. I heard about the man whose job was to protect the yacht he was building by staying on it during the storm. Eventually he had to jump in the river and swim for safety before it was destroyed. However, his concern was for his bipolar girlfriend who could not get her medication. This was easy to remedy.

I met with a local contractor, an alcoholic, who had saved multiple lives when he used his ax to escape through his attic during the flooding, and then pulled in "passersby" with a garden hose to his roof. He was now working putting up drywall in damaged homes, but unfortunately his alcohol abuse and agitation led to his "removal" from the tent village.

I spent a great deal of time with a couple in their early sixties and their extended families. The patriarch had a gun to his head one month before but now he and his family were beginning to rebuild their home and plan for the future. Although still struggling with suicidal thoughts, he and his wife would tell their stories and show their pictures to anyone who would listen. Therapeutic boundaries had a different meaning in this

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Brian Meyer, Ph.D., Chair of the Child and Family Behavioral Health Policy and Planning Committee and Executive Director of the Virginia Treatment Center for Children in the Department of Psychiatry at the Virginia Commonwealth University Medical Center.

The Crisis in the Children's Behavioral Health System in Virginia

This column first appeared in the Richmond Times-Dispatch in 12/05.

The children's behavioral health system in Virginia—the system of services and supports for children and youth with mental health disorders, substance abuse disorders, and/or mental retardation—is in crisis. 62,000 children and youth in the Commonwealth suffer from significant functional impairment in their homes, schools, and communities, but only one in five receives treatment. Several studies on the subject of children's behavioral health in Virginia conducted over the last five years have identified the same problems and proposed similar solutions. Nevertheless, little has changed. The system remains underfunded, services are fragmented and uncoordinated, and information about available services is hard to find.

The single greatest cause of the deficiencies in the children's behavioral health system is lack of service capacity. According to one estimate, the children's behavioral health system in the Commonwealth is underfunded by tens of millions of dollars. Only two communities in the state have a comprehensive continuum of low-end, mid-level, and high-end services. Even minimal services such as individual and family therapies and medication management are unavailable in many local areas, with rural areas disproportionately underserved. Waiting lists of 2-3 months for an appointment with a therapist and 4-6 months with a child psychiatrist commonly confront families with children in crisis, even in urban areas.

Even if children's behavioral health services were sufficiently funded, Virginia would not have the trained personnel to provide them. Only five new child psychiatrists graduate from training programs in Virginia each year, many of whom move elsewhere for employment. Other behavioral health clinicians do not have the specialized training needed to work with children, youth and their families. Those that do often work from old models and do not provide their clients with the more recent evidence-based treatments that work. Pediatricians and family practitioners prescribe 80% of psychoactive medications to children, but few have been trained in pediatric psychopharmacology.

Even if sufficient behavioral health services were available, most families do not know where to find them nor how to access them. Most communities do not have local behavioral health resource directories, nor has a statewide directory been compiled. Health care and school professionals are often unaware of what services are available in their community. Parents needing services for their children do not know where to turn, and are left feeling frustrated, angry, and helpless. Even when they can access services, parents are often seen as the problem rather than as co-participants in their child's treatment.

The results of these problems are very disturbing. Waiting for needed services means that many children become worse before they receive treatment; some have to be psychiatrically hospitalized before they can access treatment locally. Public school systems are forced to manage untreated children who may be disruptive, destructive, or suicidal. When there are no other alternatives, many youth become involved with the juvenile justice system; 60-80% of incarcerated youth have mental health and/or substance abuse disorders.

Worst of all, many parents are forced to choose between having their children's behavioral health needs go unmet and giving up custody of their children to the State for the sole reason that their children have significant behavioral health needs. A recent study found that 23% of children in state custody, or about 2,000 children, have been placed there solely to obtain needed behavioral health services. The destruction of families because of a lack of available behavioral health services for children is a tragedy. As a society, we should not and must not tolerate this.

Because of these problems, in 2002 the Legislature mandated the creation of the Child and Family Behavioral Health Policy and Planning Committee, which is composed of state agency staff, local service providers, parents, and other stakeholders. The Committee provides an annual report to the Governor and Legislature on the state of children's behavioral health in the Commonwealth. In its 2005 report, the Committee proposes a series of common-sense solutions to these problems. The Committee recognizes that the Commonwealth does not have sufficient monies to fund all of the unmet needs at the present time, so it recommends three funding priorities during the next two fiscal years.

First, expanded services should be funded, including evidence-based therapies, school-based mental health services, and behavioral health services for youth in detention centers. Second, funds should be provided for regional trainings for children's health care providers and current behavioral health professionals, as well as for scholarships for child psychiatrists and psychologists who would be required to pay back the Commonwealth by working in an underserved area. Finally, a parent information and education network should be established so that parents across the state can find and access needed services. The total cost of these recommendations is $8,240,000.

Children's behavioral health needs have not been a priority in Virginia. In a time of competing priorities, $8.24 million may seem like a large amount, but vulnerable children cannot wait. We can support their treatment now, or we can pay later for expensive services like acute psychiatric hospitalization, residential treatment, incarceration, and state custody. The human cost is incalculable. How many families must be destroyed before action is taken?

One measure of a society is how well it takes care of its most vulnerable citizens. It is time to take care of ours.

Are You Eligible…
For DISTINGUISHED FELLOWSHIP?

APA Distinguished Fellowship is a national honor awarded by the APA to psychiatrists who have made and continue to make significant contributions to the profession and the community.

The APA Membership Department annually sends to each District Branch a list of its members who have been APA General Members or Fellows for a combination of at least eight years. Those eligible will apply through their local District Branch and PSV will supply the application and instructions.

THE FOLLOWING CRITERIA MUST BE MET:

Not less than eight years as a General Member or Fellow of APA

Primary identification must be psychiatry for those in combined fields (e.g., psychiatry and pediatrics).

The District Branch should not resubmit the names of members who were nominated but not approved the preceding year. The purpose of this requirement is to allow time for members being re-nominated to improve their qualifications in areas where previously they did not show adequate strength. While a waiver of the two-year requirement is possible, there must be compelling reasons adequately documented by the branch.

The General Member or Fellow should be an outstanding psychiatrist who has made and continues to make significant contributions in at least five of the areas listed below. **Excellence,** ***not mere competence, is the hallmark of a Distinguished Fellow.***

Certification by the American Board of Psychiatry and Neurology, the Royal College of Physicians and Surgeons of Canada, or equivalent certifying board.

Involvement in the work of the District Branch or other components of the APA.

Involvement in other medical and professional organizations.

Participation in non-compensated mental health and medical activities of social significance.

Participation in community activities unrelated to income-producing activities.

Clinical contributions.

Administrative contributions.

Teaching contributions.

Scientific and scholarly publications.

At least three of the letters must be from Distinguished Fellows of the APA The District Branch Distinguished Fellowship Chairperson shall forward nominations to the APA Membership Committee by the 1st of July.

…….Or for FELLOWSHIP?

If you have been an APA General Member for five consecutive years, the APA will notify you that you may apply for nomination to Fellow. You will apply directly to the APA; they will provide the form and instructions.

YOU MUST MEET THE FOLLOWING ADDITIONAL CRITERIA:

ABPN, RCPS©, or AOA certification.

Three letters of recommendation from APA Fellows or Distinguished Fellows.

Approval by the PSV.

Contact Sandra Peterson at the PSV office if you are interested and eligible for either Fellow at 804-754-1200 or e-mail at spetersonpsv@comcast.net.

PsychMD PAC 2005 Contributions

Thanks to the generous support of the psychiatrists listed below, PsychMD PAC raised $7635 in 2005. Please join with them in 2006 to strengthen organized psychiatry's advocacy efforts and increase our political visibility.

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PsychMD-PAC raises money from Virginia psychiatrists to fund the General Assembly and statewide candidates with positions that promote a better environment for psychiatric care delivery. Political contributions help offset the expenses of campaigns and allow psychiatrists to target our message to important decision-makers. With your support of PsychMD-PAC we can achieve our mission of educating candidates about our professional concerns.

Yes! I will support my profession in 2006 at the following level:

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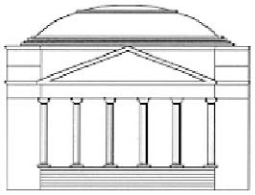

Winter-Spring 2006
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March 24: Jail Diversion: Innovative Practices that Work

Fred Osher, M.D., University of Maryland – Responding to Co-occurring Disorders in the Justice System
Joan Gillece, Ph.D., NASMHPD – Developing Multi-agency Partnerships
Randolph DuPont, Ph.D., University of Memphis, and Major Sam Cochran, Memphis Police Department – Jail Diversion Strategies in Practice: The Memphis Model CIT Program

May 8-12: Juvenile Forensic Evaluation

May 19: Rational Understanding in Evaluating Juvenile Competence

Thomas Grisso, Ph.D., University of Massachusetts Medical School

June 1-2: Sex Offender and Sexually Violent Predator Assessment

Marnie Rice, Ph.D., McMaster University and Toronto University
Anna Salter, Ph.D., Author and Consultant

The listed programs are planned for Charlottesville, VA
For program and continuing education information, please contact els2c@virginia or (434) 924-5126
For registration information, please contact smw9w@virginia.edu or (434) 924-5435

Our Children *continued from page 2*

we don't stand up to the managed care companies and their political allies, who will?"

The PSV can choose to take a leadership role by promoting the work begun by child/adolescent psychiatrists. We can:

* Establish a committee to explore possible ways to expand the child and adolescent training in our General Psychiatry Residency programs to produce psychiatrists that are better prepared to serve a wider age spectrum.
* Collaborate to find ways to fund added Fellowship positions for training of specialists in treating children and adolescents.
* Foster a system that will help current psychiatrists feel more competent to work with children and/or adolescents.
* Help our current specialists in child and adolescent care collaborate in a more consultative role with pediatricians and family physicians.

As Dr. Sood has pointed our, "Our children deserve better. I am very committed to being collaborative and providing the best possible care to the children and adolescents of the commonwealth. To be successful and to have any longevity the process must be thoughtful, strategic and visionary."

N'awlins *continued from page 3*

environment, and when they learned it was my birthday, they led a chorus of "happy birthday" for the population of the tent, began telling jokes and playing party games. At first, questioning my role in this scenario from a therapeutic realm, I felt embarrassed. Then I recognized how badly they needed to normalize their lives, to celebrate milestones and to bring joy back to their lives. They were mobilizing their defenses at the highest level...humor.

This was also Christmas. We set up games and crafts for the children, and gifts did abound on Christmas day. However, none of us will forget the 5-year-old girl living in the tent with her family, working diligently for almost an hour on a Christmas card. Once it was complete she gave it to the staff and said, "Give this to a girl who does not have a home" and cheerfully skipped away. Having her family together in a tent was all she needed to feel completely intact.

Sure, there were frustrations. New Orleans is the site of a disaster made only smaller by television reports. I went to provide one service, but provided another. A few physicians I met could never make that adjustment. But if these survivors cannot teach you flexibility, no one can.

Any one interested in serving in the devastated gulf region can apply by contacting Westover Consultants at www.psych.org/disasterpsych/katrina/volunteersurvey.cfm. Questions go to tgraham@psych.org. Of course you can also contact me at dmarkowitzmd@yahoo.com.

PSV IN THE NEWS

PSV ANNUAL FALL MEETING
OCTOBER 6 & 7, 2006

Mark your calendar for the next PSV annual fall meeting.

Please join us at the Omni Charlottesville Hotel.
Please call the Omni at 434-971-5500 and book your room (single and double) at $159 plus tax before Friday, September 15, 2006.

Congratulations to PSV member Edward Kantor

Congratulations to PSV member Edward Kantor for receiving the American Psychiatric Association's 2006 Bruno Lima Award for Excellence in Disaster Psychiatry. This award is determined by the Committee on Psychiatric Dimensions of Disasters and recognizes outstanding contributions of District Branch members to the care and understanding of the victims of disasters. Contributions include designing disaster response plans, providing direct service delivery in time of disaster, or in disaster consultation, education, and/or research.

Special thanks to PSV members Drs. Adam Kaul & Edwin J. Nieves

A special thank you goes out to PSV members Drs. Adam Kaul and Edwin J. Nieves for volunteering at the 2005 Virginia Association of Free Clinics Annual Conference held in Portsmouth, Virginia in on November 13-15, 2005. Dr. Kaul (see photo) spoke at a pre-conference session, the Fall 2005 CME Program for Free Clinic Medical Professionals, on "Screening for Mental Health Disorders." and Dr. Nieves provided a general workshop session titled "Working With Non-Compliant Patients." Both presenters were well-received and appreciated for their donation of time and expertise.

The Virginia Free Clinic Association of Free Clinics has 48 member Free Clinics with a total of 61 clinic sites serving 110 cities and counties. Virginia has the second most Free Clinics of any state in the country and together they served 64,000 Virginians last year. A Free Clinic is a private, nonprofit, community-based or faith-based organization that provides compassionate, quality health care at little or no charge to low-income, uninsured people through heavy use of volunteer health professionals and partnerships with other health-related organizations. Free Clinics provide general medical, mental health, and dental services; diagnostic and lab services; and prescription medications. Just under 6,000 licensed medical professionals volunteered in a Free Clinic last year, of which 2,500 were physicians and 117 mental health counselors. Demand for mental health services in Free Clinics continues to grow each year - mental health counseling visits alone grew 417% in the past three years. *Psychiatrists interested in volunteering in a Free Clinic in Virginia or learning more about Free Clinics can visit the Virginia Association of Free Clinics website at www.vafreeclinics.org or contact Mara J. Servaites, MSW, Program Manager at 804-340-3434 or mara@vafreeclinics.org.*

DISTINGUISHED FELLOWS LIFE ELIGIBLE MEMBERS AS OF JANUARY 1, 2006
Not mentioned in the Fall/Winter News

Douglas H. Chessen
David William Reid
Thomas K.S. Tsao
William G. Wood

RECENTLY NOMINATED DISTINGUISHED FELLOWS 2005
Not mentioned in the Fall/Winter News

Steve J. Brasington
Bruce J. Cohen
Antony Fernandez
Cheryl W. Jones
Richard a. Kaye
Dorothy A. O'Keefe
Janakibai Theogaraj

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Reminder There is Still Time to Attend the Spring Meeting
March 24-25, Richmond Marriot West
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FALL MEETING
October 6-7
Omni Charlottesville Hotel