



Synapse



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Robert N. Sobel, M.D., Editor & Syed Abdullah, M.D., Co-Editor

WHPS Spring Meeting

WHPS had an extremely successful spring meeting on May 9, 2008 at Restaurant X. There were 45 guests who attended the meeting including APA members, their spouses, Mental Health Coalition members, Dr. Elaine Eng, President of the Queens Psychiatric society as well as Dr. Nada Stotland President of the national APA. We were honored to have her give her first lecture after becoming president. Dr. Stotland spoke of her plans of setting up task forces to look into more detail about pharmaceutical support. She also spoke in detail about the political landscape and the scientific facts in the abortion debate at the present time in the country.

The meeting began with members of the WHPS executive council presenting what is being done by different board members. Dr. Alan Tuckman was honored with a plaque for his outstanding work on behalf of the WHPS during all his years on the board. He has also continued to write an article for *Synapse* for every issue for several years.

Dr. Nigel Bark had submitted an application to compete in the best practice award for the district branches. Although North Carolina won the best District Branch Award, WHPS was given special recognition by winning in the category of honorable mention. I would like to thank each and every member of the Executive Committee

who collectively worked to achieve this award. We were given a certificate which is being stored with our secretary Dr. Dominic Ferro.

Dr. Diane DiGiacomo

detailed the work of the Mental Health Coalition. The Coalition had a successful elementary school project on Friday May 16, 2008 at Valley Cottage Elementary School. Coalition members continue to do ongoing high school and college programs with NAMI-FAMILYA. Members of the Coalition participated in Mental Health Walk on May 3, 2008 with Mental Health Association. In addition, the Coalition is planning a Public Forum on October 15, 2008 at Rockland Community College. Please save the date to join the Coalition along with their partners, NAMI-



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Dr. Tuckman receives DB award.

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Testamentary Capacity for Psychiatrists

While most legal-psychiatric questions are evaluated by forensic psychiatrists, there are some that are requested of general psychiatrists, specifically because they are treating the person whose capacity is in question or because a family member of a potentially

incapacitated person approaches them by recommendation. There are even situations in which an elderly person making a Will would like to have a record, either a report or a videotape, of their mental capacity at the time they prepared the Will in order to forestall the possibility of a lawsuit in a family where there has been acrimony over the relationship with that elderly person or their assets. We all know, through our work, the terrible turmoil and conflicts that occur in families and how the probating of a Will, after the death of a "loved one," frequently brings out the worst in family members.

Therefore, I thought it would be helpful to provide a short primer on the assessment of Testamentary Capacity, the capacity to make a Will. In contrast, to other forensic evaluations, the assessment of testamentary capacity is often performed following the death of the testator (the individual who made the Will), thus preventing the evaluation of the individual themselves. In these situations, the evaluation of testamentary capacity is only based upon records, such as nursing home, hospital, medical and other records, which describe the individual's thinking, relationships and mental functioning at, and around, the time of the making of the Will. In addition, since most of the parties to the Will contest have a significant bias and vested interest in the outcome, their opinions and information must be considered as potentially tainted. Even the attorney who drew up the Will may have a bias since he/she drew up the Will and would not want to be considered to have been negligent in allowing the drawing of a Will by an incompetent person. Of course, caregivers, such as physicians and aides, can be valuable resources, if it is clear that they are not aligned with one or the other of the parties to the Will contest.

All people are considered competent to have made their Wills unless it can be proven otherwise. In addition, the level of competence required to draw a Will is quite low, not requiring a significant and complex level of knowledge. Generally, the requirements for the testator are that he/she must know that they are making a Will, its significance and meaning, the type and extent of their assets, and their potential

heirs, including "natural" heirs. They must, at least, know that they exist, even if nothing is bequeathed to them. The individual, also, while possibly making foolhardy decisions, must at least have a rational understanding of their decisions.



One of the most common problems undermining testamentary capacity is the presence of a serious psychiatric disorder, with a delusion which directly impacts upon the testator's decision-making. Thus, if an individual believes that a family member has been a "CIA operative" or a political subversive, and there is no basis for that, then they cannot be considered to have made a rational judgment in the distribution of their assets.

Another very common challenge to a Will is that of "undue influence," in which it is alleged that a family member or associate has acted in such a manner as to have taken over the decision making and judgement of the testator, inappropriately influencing their thinking either consciously or unconsciously. This frequently occurs where a caregiver has spent an inordinate amount of time with the testator seeming to isolate them from others and standing in the way of other family members' involvement with them, especially in a weakened, depressed, organically impaired and vulnerable person. It should be remembered, though, that simply because an individual may have dementia, may be frail or may have been taken care of full-time by someone, it does not mean they automatically have had their opinions subverted through undue influence. Demented, frail and dependent people can still be shown to have had the requisite capacity to make a Will without undue influence.

In evaluating an individual who is still alive, for testamentary capacity, it is always essential to see them at least twice, since, especially in elderly people with dementia, their cognitive abilities and memory may vary over time. Even if they are very

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To the Editor:

I wish to applaud Dr. Tuckman for his thoughtful presentation of "Counter-transference in the Courtroom" in the Winter 2008 *Synapse*. It was enlightening, if not surprising, to learn that an attorney, Mr. Tippins, has institutionalized a new crossover psycho-forensic-babble language with its own novel, obsessive vocabulary of subcategories to hyperdefine the obvious and toss a monkey wrench into an already confusing process.

As psychiatrists, unless we are those types who write prescriptions and avoid conversation - a growing trend in the world of insurance driven medicine - we are trained in feelings, transference and counter-transference. I trained a while back. Maybe they don't teach that anymore.

Further, although I have been in court only a handful of times in custody disputes, both my experience and reading affirm that the cross examiner's primary strategy is to demonstrate the expert's bias. As Dr. Tuckman explains, opinion is neither congruent with, nor evidence of, bias.

Since the clever ambulance chaser has invented such pseudo-scientific terms as "aversion bias," and "confirmatory bias," it is well to be forewarned, because, presumably, an "expert" should be conversant with such seemingly critical considerations, and the attorney will do his best to make the expert's lack of such awareness an important, albeit irrelevant, focus to an uninformed judge or jury.

However, you cannot fool an honest person, and any psychiatrist acting in good faith need not be unnecessarily concerned about mistakes predicated by virtue of their humanity.

Fortunately, since I am unlikely to remember the finicky terms cited, they all contain the word "bias," which has popped up before. That one, I remember. As Sigmund Freud first described, and Dr. Tuckman importantly reminds us, counter-transference is ubiquitous, neither forbidden nor shameful, and our willingness to understand it and to impart that understanding in the service of our duty, is paramount. ▲

Richard Brand, MD

Testamentary Capacity, cont'd.

disorganized on one occasion, on another occasion they may actually have the capacity to understand the criteria for drawing their Will. Also, full-time caregivers or family members should not be in the room when the evaluation is performed, and, where possible, they should be brought to the office by different family members for the different evaluations, thus avoiding the possibility of the testator having been influenced or "programmed" just prior to the evaluation.

Of course, for both the living and the deceased, a comprehensive review of all available, especially psychiatric records, is essential. These would include private physician and clinic records, nursing home notes, records of business meetings or other forums in which the individual spoke and participated, and information from any other source which might provide evidence of the testator's thoughts at or around the time of the signing of the Will.

An interesting problem arises when records exist but stop many months prior to the signing of the Will, which showed relatively clear evidence of dementia or other serious cognition-impairing disorder. In this case, unless the records describe a long period of this impairment, which may then be used to extrapolate forward to the time of the Will signing, they may not be adequate to

identify the individual's mental state on the date of the Will signing, since we do know that an individual with significant dementia may have lucid periods in which they could have signed their Will and made their wishes known. There are times when sufficient records are simply not available for a psychiatrist to render that opinion.

When evaluating a living testator, it is extremely valuable to videotape each of the sessions so that a "living record" is available at the time of the individual's death and Will contest. Invariably, if a videotape record is available, the Will contest gets resolved very quickly. The taping need not require a professional videographer, as long as the individual operating the videotape recorder is not a litigant in any future Will contest. The date, time and location of the evaluation should be clearly stated and the tape should not be stopped, for any reason, during the entire evaluation period. This should be stated at the beginning and end of the taping.

Throughout the evaluations, it must be remembered that the assessment is for "functional capacity" and its impact on knowledge and reasoning in making the Will, and not exclusively on a diagnosis of the mental or organic disorder. Simply stating that an individual has Alzheimer's disease or

another mental illness will not suffice since there must be a clear connection between the disorder and the impairment in functional capacity to make a Will. Similarly, an individual may be delusional but it must be determined that the delusion has had no impact on the specific factors being assessed in testamentary capacity. The evaluator also must remember that his/her judgment or opinions regarding the wisdom of a testator's thinking, or whether they are simply retaliating against a family member, should not influence the opinion regarding testamentary capacity.

Testamentary capacity invariably involves family members who, as in matrimonial issues, child custody cases, or other family conflicts entail feelings which may go back many years, causing conflict and acrimony and therefore may result in significant turmoil at the time of the probating of the Will. Thus, a psychiatrist evaluating testamentary capacity must be able to separate their view of the dynamics of family interactions (which is not directly relevant) from the specific task of assessing the criteria which are required for drawing a Will competently and voluntarily. ▲

Alan J. Tuckman, M.D.

APA President Nada Stotland Addresses WHPS

The West Hudson Psychiatric Association was privileged, on May 9 2008, to host Dr. Nada Stotland's first professional address since becoming APA President. Dr. Stotland has a remarkable record of accomplishment within the APA and she has been a staunch advocate for psychiatry in the Congress. The first part of her talk focused on psychiatry's role in the wrenching national debate on abortion. Dr. Stotland began with an anecdote concerning C. Everett Koop, M.D., the Surgeon General of the United States under President Ronald Reagan, who was asked to generate a report concerning the impact of abortion on women. Both the President and Dr. Koop were known for their anti-abortion stance, so there was some trepidation, Dr. Stotland recalled, when she was assigned by the APA to present the potential psychiatric effects of abortion to Dr. Koop. Her review of the scientific data strongly indicated that there was no significant psychiatric sequela that routinely or specifically developed as a result of abortion in America. Dr. Koop, despite his political views, responded in a fair and measured way when he concluded in his testimony that "the psychological affects of abortion are miniscule from a public health perspective." Dr. Stotland explained to the WHPS that postpartum psychiatric disorders, both depression and psychosis, are not uncommon after pregnancy, but that abortion poses no additional risk. An unwanted pregnancy can present as a major stress factor, but the strongest predictor for post-abortion psychiatric problems is a pre-pregnancy history of depression. A freely chosen abortion does not routinely result in psychopathology. In fact, Dr. Stotland indicated that there can be beneficial psychological functioning after a woman has taken control of the harsh reality of an unwanted pregnancy and has managed to make a difficult choice and move forward with her life.

Contrary to Dr. Koop's more reasoned approach, Dr. Stotland stated that other anti-abortion advocates, without scientific foundation, have maintained that there is



Nada Stotland, MD, APA President

a "post-abortion depression and psychosis" which results from this procedure and involves psychiatric symptoms similar to posttraumatic stress disorder. The description of such a post-abortion psychiatric disorder represented more of a political goal by some anti-abortion advocates rather than a conclusion based on scientific evidence. Dr. Stotland noted that psychiatrists tended to vary in their individual opinions regarding abortion and that similar to other counter-transference issues, it was essential to focus on the needs of the patient, rather than imposing any personal agenda or point of view. It was important for psychiatrists to be vigilant with regarding to educating the public and legislatures regarding false claims about psychiatric syndromes, so that political objectives do not get embellished with a pseudo-scientific veneer.

The second half of the evening was a recapitulation of Dr. Stotland's address to the APA at the annual meeting as the incoming president. The focus of her speech was on the importance for psychiatrists to continue their advocacy role for the mental health needs of our

patients and to practice without undue restrictions imposed by a powerful insurance and managed care industry. In this respect, Dr. Stotland's point of view was similar to an earlier APA President, Dr. Harold Eist, who addressed the WHPS in 1996. At that point, managed care was a relatively new but already significant force, with regard to its impact on psychiatry and American medicine in general. There was the sense, back then, that with enough pressure from the public and the medical establishment that managed care would implode under the weight of its questionable mission, much like the old Soviet Union. Unfortunately, over a decade later, managed care maintains a persistent if not stronger influence on American medicine. While there is concern about the overall cost of health care, there are no legislative initiatives to fundamentally change the system. Specific managed care practices are only addressed when they become especially egregious and there is a sullen acceptance by the public of the present situation. Perhaps in recognition of

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Buprenorphine for Opiate Dependence

Buprenorphine is a partial opiate agonist used in the treatment of opiate addiction. The concept of partial agonism lacks a certain drama. Americans love the all out effort. Poker games are televised because we want to see someone go "all in." Our athletes take performance enhancing drugs because we like to see them do more with their bodies than a human body can do. We like to buy houses that are bigger and better than the houses we can afford. But it is the partial agonism of buprenorphine that makes it special.

First, partial agonism makes buprenorphine effective at controlling the withdrawal symptoms related to opiate dependence. Delicate timing is involved, but if used properly, a person can be switched over to buprenorphine with minimal discomfort, and with minimal disruption to their lives. Because buprenorphine blocks opiate receptors but only partially stimulates them, it can induce withdrawal in a person who is regularly using opiates. However, if a person waits until they are in mild withdrawal, then buprenorphine can mitigate and resolve the withdrawal syndrome within a few hours to a day.

Persons with opiate dependence are expert at recognizing the early signs of withdrawal, and, if properly educated, they can identify the right time to start the buprenorphine. If the dose is escalated slowly, say 2 mgs every hour, then one can reliably avoid worsening withdrawal symptoms. Once the person is feeling more comfortable, he/she can continue to take 2 mgs as needed throughout the day. Usually 16 to 24 mgs during the first 24 hours is sufficient to control withdrawal. Then, detoxification by

gradually tapering over days to weeks can be accomplished. Alternatively, a person may elect maintenance therapy to prevent relapse.

The second benefit of partial agonism is that buprenorphine is effective as a maintenance drug. Many patients report greatly decreased cravings for their opiate of choice once they are on buprenorphine. As is the case with methadone maintenance, relapse is futile as the opiate receptors are blocked. In fact, buprenorphine binds the opiate receptor more tightly than other opiates, so the blockade is even more effective. And because buprenorphine is a partial agonist, escalating the dose does not result in an escalating high. In effect, buprenorphine has a ceiling beyond which no further opiate stimulation is possible.

Third, partial agonism means that buprenorphine has a lower street value. Studies have shown that opiate addicts report that buprenorphine does not provide much of a high and they rate it as a drug that they would not be very interested in using again. I have heard from patients that they have illicitly bought or shared buprenorphine, but it has uniformly been to control withdrawal symptoms. I heard from one patient that he took it when he was already high and that it made him sick, presumably because it displaced the opiate pain medication that he had been taking earlier that day and precipitously decreased his level of opiate receptor stimulation.

Fourth, partial agonism is the reason that regulatory authorities have allowed buprenorphine to be prescribed in office based practices. The greatly reduced street value and the limited abuse potential have

been somewhat reassuring. Still, FDA has put additional safe guards in place. For one, they have required that physician receive special training in the use of buprenorphine, typically a one day course. A second safe guard is the creation of a combination medication: Suboxone consists of both buprenorphine and naloxone. The naloxone is an opiate antagonist and is added to prevent IV use of Suboxone, as the naloxone would put the opiate dependent person into an immediate state of full withdrawal. Suboxone is taken sublingually because the buprenorphine is well absorbed by that route, but the naloxone is not.

During the last two years, I have prescribed Suboxone for dozens of patients. As one would expect, some cases have been quickly lost to follow up and others have followed a relapsing and remitting pattern. However, many have used the medication to put an end to the soul draining effects of opiate dependence, and made significant positive changes in their lives. The rate of psychiatric comorbidity is high, and many of the patients seeking treatment with buprenorphine have stayed on in my practice for treatment of Obsessive Compulsive Disorder, Attention Deficit Hyperactivity Disorder, Depression and other conditions. Certification in the use of Suboxone can be a satisfying and effective addition to a psychiatric practitioner's training. ▲

Dominic Ferro, MD



APA President, cont'd.

this, Dr. Stotland in her address to the APA welcomed for the first time, psychiatrists who worked for the managed care organizations. They were to be considered just another part of the full spectrum of psychiatric practice, which traditionally has included very different modes of biological, psychological, and social modes of

treatment. Dr. Stotland did not detail what her agenda might be to meet the challenge of the insurance industry's impact on the practice of psychiatry, but she did maintain that she would be a staunch advocate, both at the local and federal level for psychiatrists and our patients. I am sure I speak for all of us at WHPS in that we

would support any specific plan of action that she would find advisable in this regard. We are optimistic for her presidency, considering the determination and thoughtfulness she demonstrated during her evening with us at WHPS. ▲

Marc Tarle, MD

WHPS Spring Meeting, cont'd.

FAMILYA, and Nathan Kline Institute at this great event.

Dr. Lois Kroplick, along with Rena Finkelstein, president of NAMI-FAMILYA, will be giving a presentation in Chicago on Oct. 3, 2008 at the Institute of Psychiatric Services. The presentation will discuss the development of the Coalition, and its many successful projects. The emphasis on different advocacy groups working together has made the Coalition a tremendous success and has served as a role model for other district branches in the country. As part of the APA giving the Coalition and WHPS a grant, we had committed to do this presentation at this conference to help educate and inspire other district branches to start coalitions.

Dr. Flax continues to work on grant writing projects. We are still waiting for the grant from Senator Morahan. The women's group

has been meeting every 4 to 6 weeks with a steady number of women ready to use it for patient discussion as well for personal help. Our Ethics chair has nothing to report (Thankfully!!). Our membership numbers are steady with no new members to report. Dr. Mavromatis is continuing with the depression screenings at colleges.

This last spring meeting did drain our treasury since we did not charge our members and subsidized the dinner for others. Our treasury currently has \$7000 at present.

We are now busy planning our Fall meeting. At the upcoming Board meeting there will be a discussion if we should continue charging people for these dinners or subsidize them as we did this time. In the meantime we will continue to build bridges with other mental health agencies in the county. By working together we can



Dr. Adhuhahlia presenting Dr. Nigel Bark with award.

achieve so much more and our patients certainly will benefit.

Our next board meeting is at the Dellwood Club on Friday, June 20, 2008 at 12 noon. If any WHPS members or nonmembers would like to attend this meeting, please contact me at 845-362-2115. ▲

Madhu Ahluwalia, MD, President

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District Branch Representative's Report

The APA Assembly established the District Branch Best Practice Award in 2002 "to recognize the efforts and innovative programs of a District Branch in the past year. The Assembly Awards Committee calls for District Branch Representatives to complete a survey about what efforts make routine functions work well and what innovative programs the District Branch has implemented in the past year. The survey is meant to identify strengths of District Branches that can be effectively adapted by others." Since West Hudson has so many innovative and successful programs I thought it might win. The application required completion of a questionnaire and detailed descriptions of the District Branch's activities. The descriptions came mainly from the grant applications and the reports that went along with those – thanks especially to Jim Flax and Lois Kroplick, Rena Finkelstein and many others.

There were nine subject headings on the questionnaire. Three were left blank: Governmental Affairs, Special Member Group Efforts and Psychiatric Preparedness. The other six headings (followed by what was described in the application) were: Membership: now computerized with e-mail addresses and the Booklet "Choosing a Psychiatrist"; Finance: the two APA grants and the Senator Morahan grant; Newsletter: its 12 awards and the key to its success being the same excellent editors since 1989 and a solid core of regular contributors; Meetings: the Executive Meetings are efficient, well-run, pleasant, interesting, lunch time meetings; Public Affairs: see below (four pages in the application).

Public Affairs included the Coalition and its four major annual activities: Breaking the Silence Public Forum, College/High School Education Program, Elementary School Project, Picnic for Parity/Walk for

Mental Health; Mental Illness Awareness Week and Depression Screening – now expanded to include Bipolar, Generalized Anxiety and Post Traumatic Stress Disorders; and Public Education which included the Web Site and the Information Booklet "Choosing a Psychiatrist". The final area asked about was Private Practice: the free telephone information advertised through the Yellow Pages yielding five calls weekly for ten years; the "Choosing a Psychiatrist" booklet and the Private Practice Support Group and Women's Committee were mentioned here.

West Hudson did not win (perhaps because the wonderful things done here were not all innovative in the past year. Any new ideas for the next year? Perhaps from someone not already doing something?). North Carolina Psychiatric Association (a large District Branch) won but we did get Honorable Mention. I was presented with a certificate at the Assembly which I presented to our President at the Dinner Meeting on May 8th; a recognition of the many great things members in the West Hudson Psychiatric Society do for their fellow Psychiatrists and for the Mentally Ill. The Assembly met for the two and a half days before the APA meeting in Washington DC to discuss the APA's business and to try and improve things for psychiatrists and the mentally ill. Some would say we spent too much time discussing things of lesser importance like a "Mission Statement" and Assembly/Board of Trustees relationships (see below). We heard reports from the Medical Director Jay Scully and the Officers of the APA: there are 38,615 members; revenue was about \$55 million in 2007, expenses \$53 million. \$1.6 million went to DSM V, \$2.7 million budgeted for this year. (www.DSM5.org has the names of all the members of the Task Force and Work Groups). The new web site (www.psych.org) is much improved, getting

about 112,000 visits a month. APA's consumer web site, www.healthyminds.org, has about 95,000 visits a month.

Senator Akaka (one of the first US Senator to cosponsor a parity bill in the early 1990s, and one of the 13 who voted against the Iraq war) addressed the Assembly about the mental health needs of veterans. (Thought to be the first time a Senator has addressed the Assembly – he is the uncle of the Speaker of the Assembly). We heard how the APA supported both the Senate and House Parity Bills that were passed (half a loaf being better than none) and because of that has greater influence on the compromise bill now being discussed. The APA is actively working against the 10% cut in Medicare and against the 50% co-payment for psychiatric care. We heard how active the APA is in the AMA and how important that is for psychiatry both at the National and State levels (and it depends on psychiatrists being members of the AMA); and of the continuous battle against psychologist prescribing.

The Assembly passed action papers that asked the APA to create a task force to investigate the psychiatric needs of men and boys analogous to the Committee on Women; and a task force to review the health care systems in other countries and their impact on psychiatry, survey the members and propose a position paper for APA's consideration. It voted to give grants to District Branches to facilitate consultation with primary care physicians; to make the NOS diagnoses in DSMIV more meaningful (to include significant distress



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District Branch Report, cont'd.

or impairment) before its next printing; to support pregnancy and parental leave during residency without having to repeat the whole year. On 'consent' (without debate) the Assembly voted that the APA should advocate that all Veterans Administration Hospitals with psychiatric units admit involuntary patients; and it approved the Practice Guidelines for Panic Disorders.

There was considerable discussion on a 'Mission Statement' that the Board of Trustees could not agree on and sent to the Assembly for its opinion: "The American Psychiatric Association...helping psychiatrists provide the highest quality care". The APA at present has a more elaborate mission statement of six lines but there is a belief that a very brief statement would be useful. It was agreed that this should perhaps be called a slogan rather than a mission statement. I personally supported it and voted for it but it was defeated on a "vote by strength" (where the number of members in the district branch are counted, because the counting of voters seemed too close).

Many people wanted to include the word 'physicians' instead of or as well as 'psychiatrists'. (I say we should be proud to call ourselves psychiatrists.) Others objected to 'provide' (too close to 'providers') or just thought it was silly and unnecessary.

There has been a feeling in the Assembly that it is ignored by the Board of Trustees which is the body responsible in law for the running of the APA. And that the Board makes decisions without discussion or even informing the Assembly. Thus the Assembly asserted itself by passing a motion to increase the Assembly's review of the budget before it is approved by the board and one to allow Areas to nominate their representative to the Nominating Committee rather than the current practice of giving three names and letting the President choose. However a motion that provided a mechanism to override the Board's decisions was withdrawn. Instead the Assembly approved a document from a task force appointed by APA President Robinowitz on "Improving the relationship between the Board and the Assembly"

which listed ways of increasing communication and making the President and other members of the Board available to the Assembly to answer questions. This seems the right way to go to ensure the members concerns about their profession and their patients as expressed in the Assembly of District Branches are translated into APA policy and action.

This is only a sampling of what went on at the Assembly meeting. I believe it includes the most important items. The Assembly is the means that members' voices can be heard in the APA. If you feel strongly about any issue affecting you as a psychiatrist or concerning the practice of psychiatry or patient care let me know. We can write an action paper or position paper to go before the Assembly! ▲

Nigel Bark, MD

SYNAPSE is available on the World Wide Web at <http://www.rfmh.org/whps>

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