WINTER 2015

SENIOR PSYCHIATRIST

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FROM THE EDITOR

SENIOR PSYCHIATRIST

By Philip M. Margolis, MD

Dear Readers,

The best definition of "Senior Psychiatrists" that I have ever heard comes from President Stotland who states in her President's Column, "Senior Psychiatrists are just like other psychiatrists, only older." We are a hardy band and we are in the midst of an "identity crisis." For example we have joined the allied organizations of the APA, have a caucus in the Assembly, and at the same time are moving, perhaps too slowly for me, toward integration within APA.

We want to be a strong, definitive part of APA, and we are not yet there. But, let's face it, we are all in this together. We are all getting older at approximately the same pace.

This magazine is our major communications channel to the APA. As you will note, we are becoming more personal, more personalized, more interested in the world around us and, yes, more interested in ourselves.

The most important current issue (to me) is enabling much more widespread distribution of the magazine. One way is to pay more attention to the District Branches and collaborate with, and enable them to do the distributing themselves.

As noted the APA and the Senior Psychiatrists need to pay more attention to each other. "Helpful" is a critical word for all of us. For example we are "reaching out" again to the American Psychiatric Foundation (APF). Also, Paul Wick has noted the work of the Senior Physician's Section of the AMA. There are good things emanating from the AMA that we can emulate. As Garry Vickar notes in another context, we can even dream.

At any rate we will continue to talk about retirement issues, aging, and a variety of individual accomplishments. We will be talking about how to deal with the world around us and how they will be dealing with us. On a personal note I recently edited a book on "Ethics and Values in Medicine." It may be that we should let people know about various "Chapters" that we all go through as we "get older." (See President's article on ("…Adult Children").

To end on a future note the next issue will focus /contain our mission, the history of the lifers/senior psychiatrists, and a continuation of personalizing trends.

Remember, the future lies ahead!

Cordially yours,

Philip M. Margolis, MD
Editor, Senior Psychiatrist

MESSAGE FROM THE PRESIDENT

By Nada L. Stotland, MD, MPH

I have the honor to serve as the President of the Senior Psychiatrists, May 2014-16. Many of you may know me from my previous stints in leadership roles in the APA and related organizations, but I'll take a moment to introduce myself; collegial exchange is one of the raisons d'etre of our association. I will be 71 in August of this year. I'm a lifelong resident of Chicago and practically the lifelong (51 years) wife of Harold Stotland, who has chosen to work part-time at the law firm where he was a partner. In the course of my career, I have served as a medical student and residency training director; a consultation-liaison service director; the chair of psychiatry at a large community teaching hospital; the Medical Director for Mental Health Services for the State of Illinois, and, throughout, a clinician. I'm particularly interested in psychiatric aspects of women's reproductive health. I also spent eight years at home full-time with our four daughters. Along the way, I accrued a Masters degree in Public Health and a diploma from the Chicago Institute for Psychoanalysis. Now I see a handful of patients at my home office and spend a lot of time with our four grandchildren, inconveniently located on the East and West Coasts.

But enough, or more than enough, about me. There are about 8,000 Life Members/Fellows/Distinguished Fellows in the American Psychiatric Association. We used to be called the 'Lifers,' but we've decided that 'Senior Psychiatrists' is a bit more dignified. We used to have a rather anomalous position as a sort of organization within the organization, but that seemed to pose some problems, and now we are an independent association, with our own staff, the redoubtable Pat Troy and her office, and our own governance. There is no formal office, staff, or structure within the APA to serve senior members specifically. We are a small organization, but we see ourselves as representatives of the 8,000 senior members of the APA, and we are working to make ourselves a niche within it.

Senior psychiatrists are just like other psychiatrists, only older. We have the full range of lifestyles, interests, and professional activities, and maybe more; some of us have more freedom with our time and our money than we may have had earlier in our careers. We are also likely to think about some issues that may not have been in the forefront earlier: second careers or new career directions; developing hobbies and interests; malpractice insurance; dealing with the logistics of closing a practice. We hope to encourage the APA to develop supports for those issues; our organization will undertake to fill in the gap, with the hope of providing a model and inspiring the APA to serve in that role sooner rather than later. We do have an official representative in the APA Assembly: Jack Bonner, MD. He can keep us informed about developments there.

We are also founts of wisdom, both personal and professional; some of us have positions that enable us to share them with younger colleagues, and others would like to. Many of us are able and willing to provide financial support to the APA to support activities that enhance the practice, teaching, utility, and public image of the profession to which we have dedicated our careers.

Some of our sister organizations, including the American Medical Association and the American Academy of Child and Adolescent Psychiatry, offer models for us to study, share, and emulate. In this and coming communications, we will tell you what we have learned and, in fact, provide links to resources available to all of us.

Many of us have adult children embarked on professions of their own. I am struck by the failure of our society to make life easier for my daughters who are mothers than it was for me. I would love to hear from readers, both men and women, about your experiences and reflections in that regard. What advice do we have for our sons and daughters? I will write more about that in future columns.

As I see it, my most important task now is to find out from you what you what and need and what you want to offer. How can we and the APA best serve you? Please let us know. We can publish your observations and suggestions, your stories, in coming newsletters.

COVER ARTIST: *Gail Barton*

Retired psychiatrist, Gail Barton, MD is doing her art full time these days. That means she's creating about 2 paintings a week en plein air (outdoors or in the field — at a cafe or someplace warm enough to paint.) She's also taking classes throughout the year, for instance " the Yin and Yang of Abstract Paintings;" how to transfer slides to the computer; the Business of Being and Artist; Drawing Fog, Mist and Rain in Pastel and Mono-printing.

She has a great new crop of friends that like to go to galleries and museums as well as paint together. Lunch is usually part of that endeavor. Many days you can find Gail framing paintings or driving to the galleries that feature her work, a 50 mile radius is quite far enough, to drop off or pick up returned paintings.

Other art that she creates includes baskets, greeting cards, photography, jewelry, stained glass and wall weavings. Even though she thinks her art is improving, sales are not yet back to before 2008.

She's taken to arts and craft shop sitting lately to see what the particulars are for the publics' tastes. Receptions at the local shows at the galleries give offer another way for her to hear critiques of her work and that of others'.

She's been asked to show at more galleries and to do an occasional commission so her days are full of enjoyable activities. She just hopes she can stay active enough and healthy so she can keep at it for a long time to come.

I HAD A **DREAM**

By Garry M. Vickar, MD, FRCPC

"Let me tell you about a dream I had the other night...." How many times have we heard that in our careers. Well let me tell you my dream and some background and my quasi-professional opinion about it.

In my dream I was making rounds and I was seeing patients in facilities that looked vaguely familiar, although I could not be sure if they were from my early years in training. In my first few years in practice I went to a number of different places that I don't attend now, or whether it was some fabrication because one of the facilities looked very much like my aunt and uncle's house where I used to run away from my parents when I was a little boy. I ran all the way catty-corner across the street because I thought that I would punish my parents by leaving them. So much for that delusion.

So I woke up thinking what in the world does that possibly mean? I recalled some of the facilities. I recalled going up the steps to another one and at the same time I was unable to completely get out of them . I was trapped in one kind of psychiatric unit or another. Not as a patient, not in any great distress, I just either couldn't or wouldn't leave.

By background, I graduated medical school in 1971, finished my training in the United States in 1975, got my American Boards, then my Canadian Boards, and I have stayed in St. Louis ever since. I started full-time practice in September of 1976 and in March of 2015 will retire from practice. Okay, what does this mean? Well, I think the dream means that I am struggling with saying goodbye to what has been part of my identity and my career and my personality and my self image for a very long time. But it was not a scary dream, it was just an acknowledgment dream and it was time to close one chapter and open another.

As this chapter is closing, one of my heroes, Phil Margolis, has allowed me to open another chapter. I still think "lifer" is a nicer term, it is one I have aspired to for a long time, but perhaps not politically correct, but as a " senior " psychiatrist, I am joining the ranks of some of my favorite people, some of whom have been great leaders and mentors to me and truly great thought leaders in the field of psychiatry in the United States and to some extent we have Canadians amongst us including me.

So, the new chapter that is opening is to work with Phil on this newsletter.

Now frankly, the clincher after talking to Phil and listening to his persuasive arguments, was the extraordinary pay that I am going to get for this. Once he put it in that context and once I realized that the value of my work is exactly what I am going to get paid, I realized I had found a niche for myself. So I will work diligently to constantly strive for Phil's approval, his extraordinarily huge amounts of pay, but more importantly, the opportunity to socialize, communicate with and keep in touch with my peers, my colleagues, my friends.

This is how I interpreted my dream and this is what I think it meant and obviously the other door has opened and I am grateful for the opportunity to step inside and see what awaits me. I look forward to communications with many other seniors and perhaps other dialogues and discussions as we move from one transition in our lives to another.

Who Are We After Retirement?

An Encounter with the Media

By Norman A. Clemens, MD

Yesterday I put on a tie and a new shirt, tie, and sport jacket and headed off to begin this year's advanced course on psychotherapy with the residents. It felt so good that I kept the duds on all day, though I had most of the afternoon free before a meeting in the evening and could have tossed the coat and tie. For a day I felt like a professional instead of a retiree.

The issue was brought forward in my thinking two weeks ago when I got a cell phone call from Tom Lauricella, a Wall Street Journal writer, about a piece he was writing on retirement. He had been searching for background material and had come across my two articles on "A Psychiatrist Retires" – the decision and the "happening" – in the psychotherapy columns of the Journal of Psychiatric Practice three years before1,[2]. We had a long chat in which his emphasis was the loss of one's professional role and how one adapts to it. I happened to be accompanying my wife as she was doing a weekly monitoring of butterflies in a nature preserve on a beautiful fall day, so here was one piece of the adaptation right in front of us. My wife grumbled as usual about my taking my cell phone with me everywhere, which she thinks is a piece of maladaptation.

I had closed my office in the summer of 2011 after four years of winding down to half time practice. I was 78 then and felt it was time to have freedom to pursue other interests, get more sleep and relaxation, spend much of the summer at our cottage, travel to visit family and friends, and knock off a few items on our "bucket list." Maintaining a full-time office for a half-time practice was expensive, and I had never had an office at home in which to taper off as some psychoanalysts do, preferring to work in a medical facility where I could relate to doctors in other specialties. I had a variety of other interests – choral singing, tennis, sailing, leisure hiking, and biking. None required a coat and tie (except for concerts!)

Nonetheless I have retained my professional identity through continued supervision and teaching with psychoanalytic candidates and psychiatric residents, which allow at least vicarious contacts with patients. Furthermore, I remain in active leadership roles in several psychoanalytic organizations, Choral Arts Cleveland, and now the Senior Psychiatrists. I am on the Psychotherapy Committee of GAP and write or edit bimonthly columns on psychotherapy in the Journal of Psychiatric Practice. (At times all this seems like overkill in the identity department.) My shtick is **"keeping the psyche in psychiatry"** and I am currently trying to see what the American College of Psychoanalysts can do to encourage early career psychiatrists to keep doing psychotherapy as part of their work with patients, so they don't lost that crucial part of not only their skills but their identity.

Which brings me back to the Wall Street Journal article[3], which was published on Sunday, November 2… Tom Lauricella and I had talked about how hard it is to give up the role of physician and psychiatrist – not only "the power of the prescription pad" as I had put it, but also the relationship with patients in which they entrust us with the most intimate parts of their mental lives and bring about changes that they could make in no other way.

There is a bond there, and a sense of responsibility, that is immensely meaningful to us – and that we miss when we have to leave it behind as we move into another phase of our life. I mentioned Kohut's and Erikson's writings on the final phase of our lives when, if we are fortunate, we mature further into "wisdom, humor, and creativity" that helps us to cope with our declining physical and mental powers, our losses among our friends and loved ones, and our anticipation of dying[4].

A few days later Mr. Lauricella paid me the courtesy of going over the part of his draft that mentioned me, in which he had picked up "the power of the prescription pad' rather more than the rest of what I had said. I told him that what really mattered much more were my relationships with patients. The piece was published on Sunday, November 2. Here is what he ultimately wrote:

"When Norman Clemens, now 81, was going through the process of closing down his psychotherapy practice in Cleveland while in his mid-70s, he wondered how his self-esteem and sense of self-fulfillment would fare after he was no longer seeing clients. He wondered if he would grieve the loss of his professional status.

"He says he misses the social aspect of having his office in a medical building with other doctors. And most significantly, he misses the intellectual exercise of working with clients, the trust placed in him by clients and the satisfaction of helping them. 'It was really hard to stop,' he recalls.

"After grieving for that part of his career, he has moved on. 'I have to face the future,' he says.

"He fills his time staying connected to his profession by writing and sitting on boards, and enjoys spending time with his wife as she pursues her interests. And as for social interactions: 'You reach out to form new relationships if old ones are slipping away,' he says."

The WSJ story goes on to cite several authorities on the adaptation to retirement in a very informative article. Noteworthy is that in accommodating my emphasis on psychotherapy, the writer reflected the public's view that psychotherapy is done by non-medical psychotherapists for clients, in contrast to psychiatrists who only write prescriptions for patients. Unfortunately, too many younger psychiatrists have the same view, much to patients' frustration. For us old-timers, that's a hard pill to swallow – another source of grieving as our professional lives slip into the past.

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[1] Clemens, NA. A psychiatrist retires: an oxymoron?. J. Psychiatric Practice 2011; 17:351-4

[2] Clemens, NA. A psychiatrist retires: the happening. J. Psychiatric Practice. 2011; 17:425-8

[3] Lauricella T. For Some, Retirement Brings Grief. One Remedy: Diversifying your interests while you're still working. Wall Street Journal. http://online.wsj.com/articles/for-some-retirement-brings-grief-1414886644 (accessed November 10, 2014). Print publication November 2, 2014.

[4] Clemens, NA. On letting go: with age comes renunciation. J. Psychiatric Practice. 2014; 20(5): 370-2

PRACTICING IN THE NINTH DECADE, OPPORTUNITIES AND ISSUES

By Roger Peele, MD

Given the experience that octogenarian psychiatrists bring to teaching, administrative work, and clinical care, and given the general shortage of psychiatrists, it is important qualitatively and quantitatively that octogenarian psychiatrists be part of American medicine. Some octogenarians even find that they practice with greater effectiveness than they did decades earlier

Watch for Dr. Peele's seminar at the APA Annual Meeting in Toronto.

In addition to helping make the shortage of psychiatrists a little less dire, there is general evidence that working in later in life correlates with better physical and mental health.

This Workshop consists of seven competent and willing octogenarian psychiatrists still active as teachers, administrators or clinicians, who will reflect on their present work, its pluses and minuses, and very much welcome discussion of the pros and cons of active practice in their ninth decade.

Meet the AMA Senior Physicians Section

By Paul Wick, MD,
Chair, AMA-SPS

The American Medical Association Senior Physicians Section (SPS), with nearly 56,000 members, is the largest senior physicians group in the United States. The SPS provides information on current health care topics, state licensure and liability issues, as well as educational activities for the physicians age 65 years and above.

As Chair of the AMA-SPC Governing Council, our council directs the programs and activities of the section. The section brings a clear senior voice of experience into the policy making and programming of the organization. Meetings held twice a year are open to all senior physicians interested in policy discussions and education. Online forums allow members to weigh in on key issues facing medicine. Also, the AMA-SPS has a delegate with voice and vote in the AMA House of Delegates.

Educational programs with topics relevant to senior physicians, such as re-entry into practice, competency of the aging physician, retirement planning and healthy aging are identified and addressed through informative programs,. When necessary, these topics are referred for further study or policy development.

Most recently, the SPS has sponsored educational programs focused on understanding impairment in older physicians. With a somewhat aging physician workforce, hospital medical staffs and licensing agencies are seeking ways to evaluate cognitive and procedural competency. What role AMA should play in determining competency in an aging workforce is being studied.

Related to this is a study of how to maintain health and wellness as physicians age or "how to grow healthier as you grow older." Certainly volumes are written about such issues but AMA study and policy will have meaning to physicians.

The SPS has a seven member Governing Council elected by online vote of senior physician members. Currently, there are two psychiatrists members, Barbara Schneidman, MD, and myself.

AMA members receive numerous resources including a free JAMA print subscription plus online access to 9 specialty journals. Regular online updates on health topics, CME programs and volunteer opportunities are available. Reduced dues are given to partially retired and fully retired physicians.

The AMA motto is "**Keep in touch with the career you love.**" For additional information, check online at ama-assn.org/go/sps.

WHY A MAGAZINE FOR SENIOR PSYCHIATRISTS?

By Pat Troy, CAE
Senior Psychiatrists, Inc.
Executive Director

You don't have to be around the Senior Psychiatrists very long to know that they are passionate about their profession. They want to give back to psychiatry and they want to help each other through challenges and opportunities. They value each other and are anxious to share perspectives and ideas. They are also passionate about the American Psychiatric Association and their role in it as senior professionals with a wealth of knowledge and practical experience to share. At the same time, they are eager to learn and grow.

Previous publications for the Senior Psychiatrists, Inc., as well as the APA Lifers, have been mostly internally focused newsletters. As we all know, newsletters are well-suited for organizational updates and photos of recent events, but they are not best to dealing with issues, interviews, and the more in-depth commentary.

The magazine format is ideal for longer articles and can provide a great medium for externally focused articles. Look for topics that relate to the opportunities and challenges of practicing psychiatry late in life, as well as ideas for travel and recreation, profiles of interesting members, reflections on the past and more.

We chose the Flipbook format because it is easy to read, especially on an iPad or other tablet. We also offer the magazine as a PDF for simpler reading on a computer. With the Flipbook format you will notice that some sections of the article are highlighted for hot linking.

If you are an APA Life Member, you qualify for membership in the Senor Psychiatrists. If you are new member, we waive the $50 dues for the first year. For more details, go to **http://seniorpsych.org**.

If you would like to contribute an article or cover art, please send to **admin@seniorpsych.org**.

PSYCHIATRIST'S CAMERA

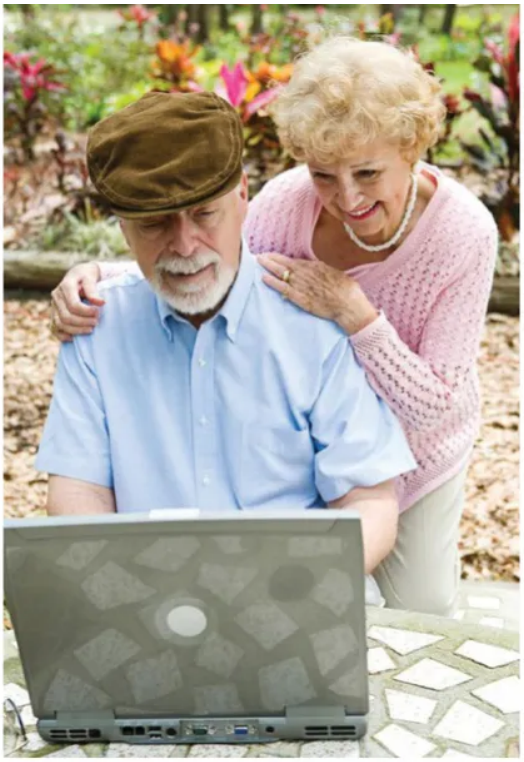
Dr. Nada Stotland Travels to Africa

Victoria Falls, Zimbabwe

In each issue we will feature photos by a member. Please send your submissions to **admin@seniorpsych.org**.

Gabarone, Botswana

Jaipur, India



TOP TEN WAYS
To Cope with Physician Retirement

Sharing a life with a physician is a unique journey. Of necessity, physicians' spouses become independent and self-sufficient from all those years of handling the kids, the house, the job, and everything else on their own. It's a good thing, because "that which does not kill us makes us stronger."

But then, all of a sudden, one day your physician partner shows up in the middle of the day and says, "Hi, honey, I'm home!"

And he or she stays. And STAYS……

So NOW what do you do, having spent a lifetime more or less on your own, when the doctor you love comes home to stay?

Following are ten ways to help you cope with physician retirement. These suggestions were contributed by members of the Wake County, North Carolina, Medical Society Alliance's retired physicians group ASPIRE, along with a few other spouses of retired physicians.

Article by Donna Rovito. Reprinted by permission of the Physician Family Magazine, a publication of the AMA Alliance. bluetoad.com/publication/?i=211676

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1. Ummm … physicians retire?

2. Start planning early. Encourage the doctor to find hobbies or outside activities BEFORE retirement – then he or she can spend more time doing things he or she already enjoys instead of suddenly realizing that his or her entire life revolved around being a doctor (like it probably did).

3. Expect to be asked what you're doing and why you're doing it. Sometimes "advice" on how to do it better will follow. Best way to cope—run some errands outside of the house. Keep doing the things you've always done—volunteering, meeting with friends, working in the yard, etc.

4. Expect to lose control of the home computer. To avoid conflict, it's probably a good idea to get another one for your spouse so you don't have to wait your turn on the computer which has been "yours" since you got it – perhaps as a retirement gift?

5. Help the doctor find opportunities to stay useful, either within or outside of the medical profession. Suggest free health clinics, volunteering with local schools or sports teams, your church, animal shelters, hospice facilities. The possibilities are limitless. No matter what the doctor cares about, he or she will be able to find an opportunity to serve and continue to feel useful.

6. Medical and Surgical Missions are lifesavers for patients in nations with limited access to health care —and can provide several weeks of "me" time for the physician spouse who stays home, while giving the retired physician an opportunity to maintain skills and provide health care to people who will really appreciate it. Or, if you have a desire to serve as well, go on a mission together. You'll both be so busy you'll really appreciate the time together at the end of the long, full days.

7. Let the doctor take over care of the family pet(s). Long walks with the dog are healthy for more than your relationship!

8. Chances are the doctor hasn't had much time to explore his or her inner chef during a busy medical career. Turn on the Food Network or the Cooking Channel, buy a bunch of trendy cooking magazines or cookbooks with delicious looking covers, and arrange a "date" to a fabulous local food store or farmers' market. Perhaps the doctor will even take over the kitchen! (But probably not the cleanup.) And maybe doctor will want to grow his or her own produce? Gardening takes up HOURS and HOURS…..vegetable plants are a great retirement gift, too!

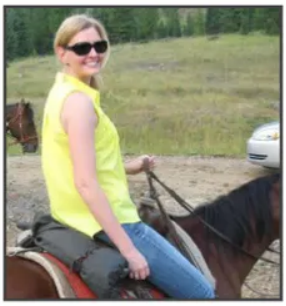
9. Grandchildren! (and Grandpets!) The doctor has time now to attend Little League games, dance recitals, band concerts, school plays and all the things he or she often missed when your own children were small. Make up for lost time.

10. Travel, travel, TRAVEL. And GOLF, of course.

Most importantly of all, though, ENJOY your time together.

a class act:

Program Teaching the School Community to Recognize Warning Signs of Mental Illness Turns Ten



By Lindsey McClenathan, Foundation Development Officer, APA Foundation

Teens will be teens. Their brains are still developing. The adults around them can sometimes be surprised at impulsive or irrational behavior due to their brain function. But not all behaviors can be attributed to these changing and developing teen brains, some might be warning signs of mental illness.

And as Americans continue to bring mental health to the forefront of our national conversation, the American Psychiatric Foundation (APF) hopes to be a part of that discussion.

For 10 years, an APF program has been empowering teachers, coaches, and other adult members of the school community by giving them the skills to identify mental health problems, talk to the student showing warning signs of a mental illness, and appropriately refer a student to treatment and services. Simply put: Notice. Talk. Act., which is the philosophy behind the program.

The Typical or Troubled?* School Mental Health Education Program is an evidence based program that works as a companion program within a school's existing safety and physical health programs. Originally conceptualized as a response to the 1999 Columbine High School shooting, the American Psychiatric Foundation wanted to get this intervention program right.

Implemented for the first time in 2004 as a pilot program in the suburbs of Denver, Colorado in collaboration with the Colorado Psychiatric Society, Typical or Troubled?* has thrived. Evaluations over the past decade have shown that the training has increased understanding of which key warning signs to look for in a teen or student; established or improved treatment referral protocols in schools; and averted attempted suicides.

One grantee in 2008 told APF that after participating in the Typical or Troubled?® training, while cleaning up after a student became ill, a custodian "saw something unusual and reported it to the [school] counselor. The counselor then spoke with the student and found out that she had intended to kill herself. We were able to provide the student with help and we believe that we probably saved the student's life."

Typical or Troubled?® continues to make strides for teenage mental health by educating those most likely to first recognize a problem. Studies have found that classroom teachers are often the first to notice when a student is exhibiting behavioral health issues.

"If we are to seriously address the problem of mental illness, it will take the whole community linking hands and focusing on the teen years, when so many mental disorders first emerge," said Miami-Dade Superintendent of Schools Alberto Carvalho. "The Typical or Troubled?® program is the best way we know of to do that."

What began as a single in-service training in Colorado conducted by school mental health staff in collaboration with mental health professionals from the local community has become a widely implemented program. After the 2014-2015 school year ends, more than 78,000 school personnel will have been trained to Notice. Talk. Act. at more than 1,000 schools across the country. These schools enroll nearly 2 million students.

This includes wide scale implementations of Typical or Troubled?® in 93 schools in the city of Albuquerque, NM and 450 schools in Florida's Miami-Dade County, our country's fourth-largest public school system.

"We chose Typical or Troubled?® because it had a solid research base and was pilot tested with diverse cultural groups," said Ava Goldman, M.Ed., administrative director of exceptional student education and student support in the Miami-Dade system.

The program's curriculum was designed by combining APF research and analysis with input and feedback, not only from mental health experts, but also those that would be implementing the program. Participants included high school personnel, APA member psychiatrists, and a network of national partners: American School Counselor Association, School Social Work Association of America, American Academy of Child and Adolescent Psychiatry and the Center for School Based Mental Health – a program of University of Maryland School of Medicine's Division of Child and Adolescent Psychiatry.

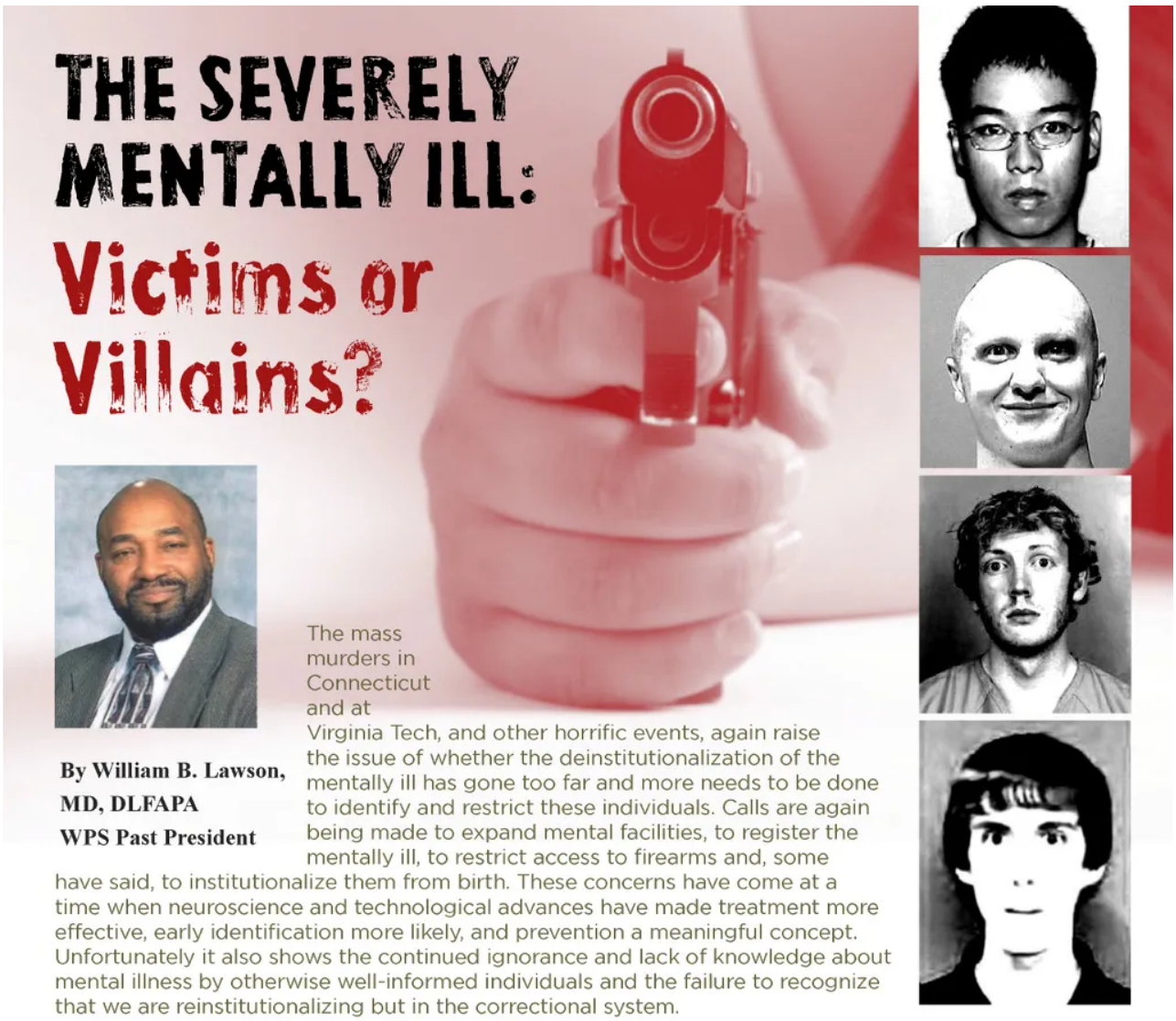
Requests from schools across the country wanting to implement the curriculum continue to increase, and the American Psychiatric Foundation is doing all that it can, but is struggling to keep up with the demand.

Paul Burke, Executive Director at the American Psychiatric Foundation sees this as a great challenge to have. "We have worked over the years to improve upon the already expert content of our Typical or Troubled?® program, and the demand for the materials confirms the value of the program to teachers, parents, and school communities across the nation."

The American Psychiatric Foundation is the philanthropic and educational subsidiary of the American Psychiatric Association. It promotes awareness of mental illnesses and the effectiveness of treatment, the importance of early intervention, access to care and the need for high quality services through a combination of public and professional education, research, research training, grants, fellowships, and awards.

APF is a self-supporting organization that relies on donations from individuals, foundations, and corporations. We encourage you to make a donation and support the Typical or Troubled?® program, or any other APF programs, by visiting them online at americanpsychiatricfoundation.org.

THE SEVERELY MENTALLY ILL: Victims or Villains?



By William B. Lawson, MD, DLFAPA
WPS Past President

The mass murders in Connecticut and at Virginia Tech, and other horrific events, again raise the issue of whether the deinstitutionalization of the mentally ill has gone too far and more needs to be done to identify and restrict these individuals. Calls are again being made to expand mental facilities, to register the mentally ill, to restrict access to firearms and, some have said, to institutionalize them from birth. These concerns have come at a time when neuroscience and technological advances have made treatment more effective, early identification more likely, and prevention a meaningful concept. Unfortunately it also shows the continued ignorance and lack of knowledge about mental illness by otherwise well-informed individuals and the failure to recognize that we are reinstitutionalizing but in the correctional system.

ARE THE MENTALLY ILL MORE DANGEROUS?

An often cited paper by Richard A. Friedman, M.D, *Violence and Mental Illness—How Strong is the Link?* that appeared in the 2006 *New England Journal of Medicine* (355:2064-2066), examined the original NIMH's Epidemiologic Catchment Area (ECA) study, which examined the rates of various psychiatric disorders in a representative sample of 17,803 subjects in five U.S. communities. Data on violence was collected for about 7000 of the subjects. "Violence" was defined as having used a weapon such as a knife or gun in a fight and having become involved, with a person other than a partner or spouse, in more than one fight that came to blows. The study showed that patients with serious mental illness—those with schizophrenia, major depression, or bipolar disorder—**were two to three times as likely as people without such an illness to be assaultive.** In absolute terms, the lifetime prevalence of violence among people with serious mental illness was 16%, as compared with 7% among people without mental illness.

Subsequent studies have been consistent with these findings. So while violence is more likely, a closer examination reveals the untreated mentally ill are more likely to be

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violent. More importantly not everyone that is mentally ill is likely to be violent. Substance abusers are far more likely to be violent and those with comorbid substance abuse are more likely to be violent. Many of the reports have focused on the concern about individuals in the community with psychosis. However people with such disorders such as major depression and dissociative identity disorder tend to be more violent than the general population.

From a policy perspective it makes no sense to seek some sort of early identification methodology, identify biomarkers or even test individuals based on diagnosis. The vast majority of individuals who have a mental disorder are not violent irrespective of diagnosis. Secondly the mentally ill are minimal contributors to violence as a whole in the community.

One proposal that is constantly made is to identify and somehow put the mentally ill away. However many are already incarcerated.

There has been a 293% growth in the jail/prison population in the last thirty years, making the U.S. the world leader in incarceration rate (Chaddock, G.R., 2003, U.S. notches world's highest incarceration rate. *Christian Science Monitor*, August 18:2). In 2006, James and Glaze reported that between 56 and 66 percent of the 2.2 million people incarcerated in U.S. prisons and jails in 2005 were estimated to have a diagnosable substance use disorder.

Bureau of Justice Statistics Special Report. Washingtice; 2006. Mental health problems of prison and jail inmates. NCJ Publication No. 213600)

It is pretty clear that the effort to deinstitutionalize the mentally ill and return them to the community has been failing because they are then at a greater risk for arrest. The result has been a disproportionate redirection of resources to the correctional system. If there is anything that can come out of the dialogue about mental illness and violence, it is the recognition, probably for all the wrong reasons, that the mentally ill do not have adequate access to treatment. Ironically those that get arrested or are violent are not just those with psychosis. It is clear that individuals suffering from major depression can be violent as well. Terri Williams in her book *Black Rage* makes a compelling case that those involved in gang violence may have under-recognized depression exacerbated by self-treatment with drugs of abuse.

We have made substantial advances in technology. In addition we have improved social perception with the parity movement and the recovery movement. Unfortunately more still has to be done.

PRISON
BY THE NUMBERS

By William B. Lawson, MD, DLFAPA

- The incarcerated are disproportionately poor and minority. African Americans are disproportionately represented in the criminal justice system—10% of African American men between ages 18 to 34 were in prison in 2005 (3 times the rate of Hispanic men and 7 times that of white men).
- African Americans and Latinos make up over half the prison population—far greater than their representation in the larger society.
- Poor, minority substance abusers or mentally ill are more likely to be incarcerated.
- The criminal justice system is not a service provider, yet over 14 million adults in any given year interact with the system.
- Over 8 million adults and over 650,000 youth are under correctional control.
- No longer an anomaly—1:23 adults.
- 4:100 adults are under correctional control.
- 1:100 adults have been incarcerated.
- 3.5:100 youth have been involved in the juvenile justice system.
- 1:5 adults have a criminal record.
- 3.5:100 adults will serve "time" in their lifetime.
- 1:28 children have a parent behind bars.

Preceding Page, Top to Bottom:

Seung-Hui Cho: a senior at Virginia Tech, who shot and killed 32 people and wounded 17 others in two separate attacks.

Jared Lee Loughner: pleaded guilty to 19 charges of murder in connection with the shooting in Tucson, Arizona, in which he shot and severely injured U.S. Representative Gabrielle Giffords among others

James Holmes: set off tear gas grenades and shot into the audience of a Aurora, CO theater with multiple firearms, killing 12 people and injuring 58 others

Adam Lanza: fatally shot twenty children and six adult staff members at Sandy Hook Elementary School.

All descriptions courtesy of Wikipedia.

Reviewing Retirement

By H. Steven Moffic, MD

It has now been almost two years since I decided to retire and wrote the blog about my plans to retire: **"Mental Bootcamp: Today is the First Day of Your Retirement."** And it still may be the first day of your retirement. For me, it is past the honeymoon period. Much has gone as anticipated, but there have been some surprises, both in society and from my perspective.

THE ACA AND RETIREMENT

My retirement came on the cusp of several major changes in psychiatry: DSM-5, reimbursement coding changes, new certification requirements for psychiatrists, and the emergence of "ObamaCare"—to name a few. Personally, I was relieved I wouldn't have to adapt to all of these events, although they could turn out to benefit the field. Certainly, many have vociferously commented on the problems with certification in response to a recent Psychiatric Times blog on the subject. But by far the main reason I retired when I did was to take advantage of Medicare. That reason may diminish for many as ObamaCare emerges.

The February 5th American Psychiatric Association "Headlines" e-newsletter opened and closed with two items related to retirement. The first had to do with the (somewhat controversial) prediction that the "ACA Will Cause 2.5 Million to Leave the Workforce Over Ten Years." If the ACA had been available before I retired, I would have retired earlier. Staying at work just to keep health insurance is not particularly satisfying, but many in the US have had to do so. The final item in the headlines was "Physician Shortage for Those With ACA Coverage Worse Than Expected." It is not clear whether the shortage is partly because more physicians are retiring, but it does seem more likely a result of major insurers cutting their networks. Inevitably, that will put more work pressure on the "providers" who are left to do more work in less time.

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www.psychiatrictimes.com/blogs/couch-crisis/classic-blog-reviewing-retirement?GUID=0551B5AB-F522-4B2C-83CF-8166C96FD415&rememberme=1&ts=22022014

RETIREMENT RECOMMENDATIONS

There are many things to consider before retirement. However, there may be a couple of recommendations I can pass on after two years:

- Plan for retirement, even if you don't plan to retire. This means sound financial planning, developing other interests, and nurturing your relationships with significant others
- Retire, even if you are not retired. Take enough time off periodically, and completely, with no connections to work, so that you can feel emotionally free from concerns about patients and practice

Of course, there is no reason to retire if you really love your work and relationships just as they are.

THE EMOTIONAL HAZARD OF EMPATHY

I expected to enjoy more time with my wife and family, and I have. I won't die regretting that I didn't spend more time with my loved ones, as many do. I feel blessed and oh, so grateful.

Fortunately, with the exception of my teeth, my overall health—especially my mental health—may be even better now than before retirement. Why? I had not recognized the emotional and physical toll being a practicing and empathetic clinician took on me. In retrospect, that emotional toll lessened somewhat as 15-minute med checks became a regular practice. There just wasn't enough time to go into depth with patients, even when I asked them what gave their lives the most meaning. I now wonder: can the lessening of this emotional toll be one reason why psychiatrists have gone along with brief medication checks as much as we have?

What a sense of lightness I feel. Now, I can attend better to almost every area of my daily life. Perhaps living more fully has led me to become a different type of psychiatrist.

EVOLVING INTO A PUBLIC PSYCHIATRIST

Have I missed my work? That is the most common question I get. The answer has come to surprise me. My wife says that I'm no longer a psychiatrist, which is certainly true in some ways because I no longer see patients. True, I'm no longer a clinical psychiatrist. I do miss so many of my patients and feel thankful when I run into them and find out how well they are doing. Actually, they seem to feel less need to keep confidentiality now, including introducing themselves to my wife and letting them know how they knew me.

I continue to be a writing psychiatrist, even more so now—and I am free to say what I want without the fear that my job will be affected. I am still a speaking psychiatrist, presenting at meetings and conferences. I'm still a board psychiatrist, sitting on some professional and community boards if I think I can be of value. I can also quit doing any of these whenever I want.

However, most of all, I'm a public psychiatrist. By public psychiatrist, I don't mean a public health psychiatrist. I mean it in the way I recall Ralph Nader once talked about being a public citizen, working for the greater good.

I had thought that people would share even less of their problems and questions with me once they knew that I had retired. It has been the opposite, as if no longer having patients meant that I wouldn't view them in a clinical way. Did my new status de-stigmatize me?

I have been asked to do more publically, such as join in on panels to discuss movies that have psychological meaning; speak at synagogues on the overlap of religion and psychiatry; and become part of a project to build resilience in teenagers. And, most unlikely, I was asked to lead the memorial eulogy at our 50th high school reunion.

I wrote in my original retirement blog that Dr Nuland felt that the hardest task in retiring, even to his beloved and popular writing, was that he would "no longer be seen as anybody's healer." That may be true for surgeons like him, who can no longer cut up bodies and put them back together again, but not for this psychiatrist. I'm a different kind of healer—but still a healer of sorts. I retain my professional identity, as do a couple of other colleagues and friends of mine who have retired. One got more involved with his church; the other is addressing major problems in our mental healthcare system in Milwaukee.

This leads me to wonder if there is a way to get psychiatrists more involved in everyday life. As part of politics, and political gridlock and conflict? As part of the education of children, to teach more about how to achieve mental well-being? As part of the entertainment industry, given the shattered lives of so many celebrities? Must we retire to do this? We have so much to share and contribute to society.

2014 BERSON AWARD RECIPIENT: PAUL WICK

By Stephen C. Scheiber, MD

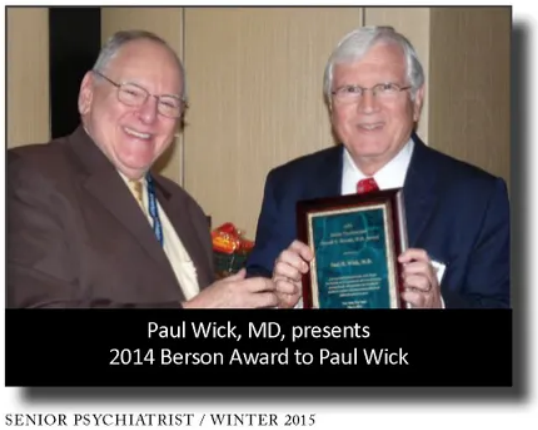
The Harold E. Berson Award is presented to the psychiatrist who has made a significant contribution to psychiatry after becoming a Life Fellow of the APA.

Paul H. Wick, MD, Berson Award Winner

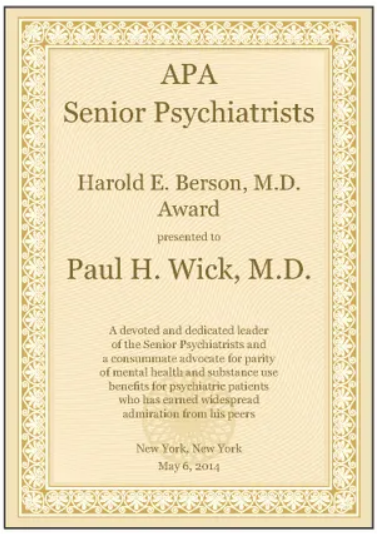
Paul Wick, MD, DLFAPA, is the current and first President of Senior Psychiatrists, formerly called Lifers of APA. Contributions to APA have included being an APA Delegate to the American Medical Association (AMA) 2010-current, previously Alternate Delegate 2000-2009, member of the APA Council Healthcare Systems Financing 1999-2005 and 2009-2015, Chair of the APA Committee on Managed Care 2005-2009 and Assembly Representative from the Texas Society of Psychiatric Physicians (TSPP) 1995-2003. He was President of TSPP 1990-1991. He has been a Distinguished Life Fellow of APA since 2003.

Being an advocate for parity of mental health and substance use benefits, he has been involved in APA Council and work groups to improve patient access and better clinical practice conditions for psychiatrists. Working with physicians of other specialties to further the practice of medicine, he is a current member of the Governing Council and Chair-Elect of the AMA Senior Physicians Section. A current area of study with this group has been cognitive competency in the aging physician.

Previously practicing with a large multi-specialty group clinic, he now is medical director of an outpatient day treatment program for geriatric and chronic mentally ill adults and consults to a regional public mental health clinic.



Paul Wick, MD, presents 2014 Berson Award to Paul Wick



APA
Senior Psychiatrists

Harold E. Berson, M.D. Award

presented to

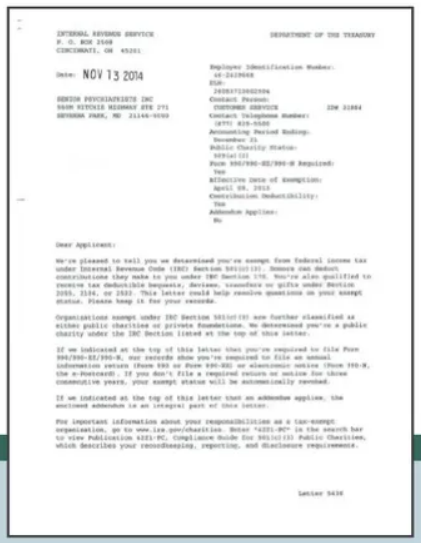
Paul H. Wick, M.D.

A devoted and dedicated leader of the Senior Psychiatrists and a consummate advocate for parity of mental health and substance use benefits for psychiatric patients who has earned widespread admiration from his peers

New York, New York
May 6, 2014

501(c)3 Status Granted for Senior Psychiatrists, Inc.

Donations are now tax deductible!



The mission of Senior Psychiatrists, Inc., is to **provide support and education** to address the needs of psychiatrists who qualify for Life Membership or Fellowship in the American Psychiatric Association; to **increase awareness** within the profession of the needs and contributions of senior psychiatric physicians; to **provide mentoring** to psychiatrists at earlier stages of their careers; and to **encourage charitable giving** to support psychiatric education.

By Pat Troy, CAE
Senior Psychiatrists, Inc.
Executive Director

The mission statement of the Senior Psychiatrists, Inc. says it all. They are about giving back to their beloved profession. It is only fitting that they would meet the stringent IRS requirements for 501(c)3 status. We are pleased to report that in November 2014 the Senior Psychiatrists, Inc. received a unqualified 501(c)3 determination letter. For any non-profit, receipt of this coveted status is a significant milestone.

What this tax status means is the when you make a donation to the Senior Psychiatrists, Inc. you can take it off of your income tax as a charitable tax deduction.

Our new status arrived at a great time for donors - -right before year-end.

I know we all get bombarded for requests for donations, but when we have the opportunity to help a new organization get itself established, that is a very special and not to be missed. Your donation, even if very modest, can help make a huge difference in the ability of this fledgling organization to become self-sustaining.

Consider a donation today. To donate online, go to http://seniorpsych.org/donate or you may mail your donations to Senior Psychiatrists, Inc., 550M Ritchie Highway, #271, Severna Park, MD 21146.

The Uses of *Wisdom*

By Nada L Stotland, MD, MPH

"Our wisdom comes from a lifetime of experiences. We are physicians; we had to postpone gratification, study, plan, and persist to learn and practice medicine. As we started out in our personal and professional lives, we may have thought, therefore, that, with proper preparation, we could control our futures. By now, we have also learned that, as hard as one may try, one can't anticipate, much less control, all the things that happen in professional or personal life."

– Nada Stotland, MD

The other night, one of my daughters called, in tears, worried about her own daughter-my cherished granddaughter. I was 750 miles away. I couldn't be there to assist in person. So why did she call? Of course, she wanted reassurance. I could remind her of all her daughter's strengths, but I could not promise that her daughter's problem could be resolved, or resolved easily. What could I offer?

Wisdom. I could tell her that sometimes bad things happen to good people, that all children, even children of good parents, have problems at one time or another. I could tell her that that's just life, could radiate calm, the knowledge that life goes on, one gets through hard times. I have perspective, have attained these valuable attributes and abilities just by living, mostly with my eyes open, for seventy-one years. There is absolutely no other way to get them. That is wisdom.

Some wisdom is nothing more than common sense: the ability to see a situation clearly, identify the possible responses, note the risks and benefits of each in the particular situation, and make the logical choice. In my experience, common sense, or the lack of it, seems to be largely innate. I suppose that people with very little common sense, if they can acknowledge the deficit, can learn to take special care and consult with others before making decisions.

Various stresses can put a strain on common sense. For an example of interest to us as we grow older, doctors can, and too often do, forget to consider the downsides or quality of life aspects of proposed treatments in the driven attempt to do something, almost anything, to address a symptom or to prolong life. When I was in medical school, a revered surgery professor taught us 'a bump in the boob belongs in a bottle.' Of course I was aware of the horrors and dangers of undiagnosed, untreated, breast cancer. I could and can understand how desperate physicians were and are to spare their patients those horrors and dangers. At the same time, I wondered whether anybody had bothered to investigate the possibility that some such 'bumps' ever resolved without treatment, and to weigh the physical and emotional costs of the radical surgeries universally employed to treat 'bumps in the boob' at that time. It was a common sense question better kept to myself in the context of medical school in the 1960s. It has taken nearly fifty years for medical science to seriously address this question.

I have tried, with considerable success, to find doctors for myself and my family who suffer as little as possible from interventionist tendencies. Still, when one of my daughters was perhaps two years old, every few months she would wake up crying in pain, unable to tell us what place in her body was hurting. We learned that giving her one baby aspirin on those occasions would solve the problem. At the next routine pediatrician appointment, I wondered aloud whether she could have migraines, since I had them. The pediatrician suggested an EEG, because migraines were sometimes associated with seizure-like EEG changes. If there were such EEG findings, he suggested, our two-year-old could be started on an anti-epileptic medication regimen. I reminded him that her symptoms, whatever the cause, were being successfully treated with one baby aspirin every few months.

Personal experience is another stress on common sense. My internist's wife had died of breast cancer. I've had a few mammographies, but far fewer than he would have liked. I am low risk. I started bearing children in my early twenties, and breastfed some of them. There was no family history of cancer. And, like it or not, the size of my breasts did not pose a challenge for manual examination. Now the recommendations for mammography are beginning to catch up.

Anyway, enough of common sense and our family's medical experiences. Politicians are all too aware that emotional appeals can cancel out common sense. Some people are born with it; others never acquire it; and some can learn from experience; that's a kind of wisdom, too.

But the wisdom we develop with age is different. It's not just a matter of learning common sense: to control the impulse to make a rash injudicious remark, or look for portion sizes when comparing the calorie count of items in the grocery store.

Our wisdom comes from a lifetime of experiences. We are physicians; we had to postpone gratification, study, plan, and persist to learn and practice medicine. As we started out in our personal and professional lives, we may have thought, therefore, that, with proper preparation, we could control our futures. By now, we have also learned that, as hard as one may try, one can't anticipate, much less control, all the things that happen in professional or personal life. We have learned patience: that most medical symptoms and other life problems, as urgent as they may feel at the moment, will pass without any intervention if we can just wait. We are psychiatrists. We have seen all or most of human beings' pathologies and miseries. At this point, there's very little we encounter for the first time. Very little shocks us. We also know that human beings are characterized by deep internal contradictions; the same person can be generous and stingy; cold and warm; bright and dull; ethical and unethical. We know that a human being is very likely to behave in future circumstances much as he or she has behaved in similar circumstances in the past-and that they can also be unpredictable. We know how it feels to be in love; afraid; aroused; turned off; disappointed; elated; ashamed; guilty, proud; and most other emotions. We have been successful and unsuccessful. People have gone beyond the call of duty to help us; other (or the same) people have betrayed us. We know that these things happen, and often unexpectedly.

My daughter knows that I love her, but that's not the only reason she called. She needed wisdom. read somewhere of a study showing that children with grandmothers are more likely to thrive than those without grandmothers. I have never accepted the argument that women are not biologically programmed to live beyond menopause. First of all, statistics about average life expectancies are misleading. It was infancy, childhood diseases, infectious diseases, and childbirth occurring well before menopause that lowered the average life expectancy. Women who survived those did not keel over at menopause. If women were meant to die at menopause, what would happen to the children they gave birth to just before menopause? That defies common sense. The survival of women-and men-into our 'senior' stages of life is the major source of wisdom for society, and society desperately needs wisdom.

Our psychiatric associations need, and should treasure, honor, reward and exploit, our wisdom. The purpose of our new organization is to encourage our American Psychiatric Association to do so and to support the APA in this ongoing effort. We are all APA members with wisdom.

HIGHLIGHTS FROM THE MAY 2014 NYC RECEPTION

Dr. Stephen Scheiber

Dr. Captane Thompson, Dr. Sheila Hafter-Gray

Left to Right: Dr. Phil Margolis,
Dr. Michael Burnstein, Nancy Margolis

Left to Right: Dr. Saul Levin (APA CEO),
Cindy Tunney (American Professional Agency),
Dr. Paul Wick (Senior Psychiatrists' Past President)

Dr. Stephen Scheiber presents
2014 Berson Award to Dr. Paul Wick

Deanna Wick, spouse of Dr. Paul Wick,
Berson Award recipient

Our appreciation to the
American Professional Agency
for sponsoring the reception.

A Major Force Only Partially Realized

By Jack McIntyre

There are more than 8,000 Senior Psychiatrists in the APA, defined as Life Members, Life Fellows and Distinguished Life Fellows. This is approximately 20% of APA membership but the current contribution of the APA Senior Psychiatrists as an "organization" to the working of the APA does not reflect that percentage.

Why? One reason is that only 200 senior psychiatrists are active dues-paying members of the Senior Psychiatrist "organization." Another reason is that APA has been ambivalent and, at times confused, about the role, or the potential role of the Senior Psychiatrists "organization" or "component."

Currently, the organization is "Senior Psychiatrists, Inc." and is considered an "APA Allied Organization" with a representative (Jack Bonner, MD) in the APA Assembly. Does it make sense that 20% of the members of APA should be considered an "allied organization?" These organizational issues are under discussion at present and hopefully will be resolved in a manner that allows for a more robust contribution of the Senior Psychiatrists component/ organization to the activities of APA.

Think for a moment about the involvement of other age-specific groups in the APA – namely Members-in-Training (MIT) and Early Career Psychiatrists (ECP).

Over 25 years ago, APA recognized the importance of involving residents and fellows in the organization and developed special components for the residents and fellows. Positions on the BOT and fourteen seats in the Assembly (two from each Area) and a position on the Assembly Executive Committee were established. Similarly, representation from the Early Career Psychiatrists was established. These organizational initiatives were forwarded-looking and have significantly contributed to the successes APA has enjoyed. Essentially everyone in APA has supported these initiatives recognizing that residents and younger members are not only the future of APA but also of the profession.

Similarly, shouldn't we maximize the potential impact of our Senior Psychiatrists who represent a wealth of experience, knowledge and wisdom?

In order for this to happen we have to accomplish two objectives:

(1) We have to increase the number of active dues-paying Senior Psychiatrists. The annual dues of $50 should not be a deterrent for most. If everyone who reads this newsletter makes sure that they have paid their dues for 2014 and then recruits two senior colleagues who are not active members that would be a major step forward.

(2) We must convince the current APA leadership of the wisdom of positioning the Senior Psychiatrists so that they can assist in a major way in moving the agenda of APA forward.

Assuming we are successful in achieving these objectives what are some of the specific agenda items that should be pursued? Under the very capable leadership of Paul Wick, MD considerable gains have already been achieved despite a small number of active members and a confusing APA structure.

(1) A major focus of the organization should be to identify and articulate the needs of senior psychiatrists and help meet those needs through education and collaboration. Clearly, issues of retirement, closing a practice, professional involvement after retirement would fall into this category.

(2) Facilitate the ongoing professional contributions of our Senior Psychiatrists. At the last several APA meetings, the Senior Psychiatrists led by Sheila Gray have presented a symposium related to the practice of psychiatry as a senior. Also at the APA Annual meeting, the Senior Psychiatrist organization has hosted a reception for members and for APA leaders. This fall a new Senior Psychiatrist digital magazine will be launched.

(3) Capitalize on the wisdom and experience of senior psychiatrists. Dr. Nada Stotland has led a new program to provide mentoring for younger colleagues. Also there has been considerable interest in pursuing volunteer opportunities for senior psychiatrists both in this country and internationally.

The continuing contributions of Senior Psychiatrists can be extensive. Be an active member of our organization and recruit others!

An additional request. I have been asked to chair the Membership Committee for our organization. Do you have any recommendations for members of the Committee? Please send them to me at **jmcintyre@unityhealth.org**.

History Project

By J. Pierre Loebel, MD

I have for some years conducted interviews with older psychiatrists who are members of the AAGP and the Lifers (now Senior Psychiatrists, Inc). I have adapted the format from similar interviews that have regularly appeared in The Psychiatrist, published in conjunction with the British Journal of Psychiatry. The interviews are not intended or designed to provide a detailed record or analysis, but to capture some of these persons' professional experiences, especially as they have changed during their careers.

The process is explained to the interviewee and signed consent obtained. Following the interview which originally was recorded and lasted about 1 hour, it was transcribed, edited, reviewed by the interviewee and submitted for publication in the LifersLine, then posted on the website.

It has been decided to replace this process by a brief phone introduction, followed by the completion of a questionnaire and consent form. The follow-up phone call will provide the opportunity for additional comments.

I will edit the completed questionnaire and submit it in the form of an article to the editors of Senior Psychiatrist for approval. This is a great opportunity to assimilate the experiences of senior psychiatrists and there will be value for teaching and research.

If you would like to be considered for an interview, please contact **admin@seniorpsych.org**.

OBITUARY

John C. Urbaitis, MD

By Jack W. Bonner, III, MD
(with Bruce Hershfield, MD)

As the Assembly Representative for the Senior Psychiatrists it is fitting that I comment on John Urbaitis, a member of our organization, who died August 15, 2014 at the age of 73 while visiting Edinburg, Scotland. John, a resident of Baltimore Maryland for 45 years beginning with his residency at Johns Hopkins was a product of the "golden age of psychiatry." He lived as a child on the grounds of the state hospital where his father served as superintendent. Cared for by patients with chronic disorders – the influence of his babysitters, his father and the hospital ambiance combined to produce a well-respected psychiatrist who put the well being of his patients uppermost in his priorities (as he also did in his work with organized psychiatry).

John directed the Community Psychiatry program at Sinai hospital and later was Director of the Department of Psychiatry. He was a Founding Director of the Maryland Council of Community Mental Health Centers and served the community including its most vulnerable with great skill and wisdom.

From Area 3, John was active in Maryland Psychiatric Society activities – as President and as a member of the Editorial Advisory Board of The Maryland Psychiatrist. He was one of two representatives to the Assembly (1983–99) and later became the Area 3 Deputy Representative followed by ascension to the Area 3 Representative position. More recently (2007) he was elected to and served on the APA Board of Trustees.

John's APA credentials and contributions speak for themselves. He clearly served his and our patients well, his opinions were thoughtful, carefully articulated and respected. He was the recipient of several awards recognizing his many contributions including the Ron Shellow Award in this Assembly.

John was kind, soft-spoken, not prone to rash statements, a good listener, a husband and father, a good friend, and, he was a good cook.

The world is a better place because of John Urbaitis and those of us who knew him are most fortunate.

Report of the APA Assembly Representative

November 7-9, 2014

By Jack W. Bonner, III, MD
Assembly Representative

The Assembly met in Washington, DC at the JW Marriott Hotel. As usual, there was a great deal of work to be done in a moderate amount of time. Some items of interest are as follows:

1. PRACTICE GUIDELINES:

Several guidelines pertaining to evaluation of the patient were reviewed and approved. They include:

Review of Psychiatric Symptoms, Trauma History and Psychiatric Treatment History as part of the initial Evaluation
Substance Use
Suicide Risk
Aggressive Behavior
Cultural Factors
Medical Health
Quantitative
Involvement of Patient in Treatment Decision-Making
Documentation

There was much discussion in the Reference Committee about the desirability of various elements but the vote was an "all or none" one which led to passage of each. They had been available for review and comment by APA members for several months. The Assembly recommendation will go to the Board of Trustees for final approval. If approved, these Guidelines are extensive and are worthy of review by psychiatrists in practice.

2. ETHICS COMMITTEE:

The AMA Principle of "A physician shall support access to care for all people" was amplified by the Ethics Committee to add annotations applicable to psychiatry. After much discussion the annotations were not approved and the AMA Principle stands without further elaboration.

3. ACROSS:

The Assembly Allied Organizations and Section Liaisons (AAOSL) was renamed the Assembly Committee of Representatives of Sub-specialties and Sections (ACROSS). Its members are called Sub-specialty Representatives or Section Representatives as appropriate. Our organization, Senior Psychiatrists, is a member of ACROSS insofar as we currently are considered a Section.

Membership in ACROSS requires at least 100 APA member psychiatrists. Since our membership is comprised solely of APA members we clearly meet that requirement as long as we maintain a membership of 100 or more. There is a desire to make the requirements sufficiently broad so as to be inclusive rather than exclusive. This may lead to more fine-tuning of the membership requirements at a future Assembly meeting.

4. OTHER:

Numerous other Action Papers were considered. The Component Directory will be published electronically with a phasing-in over the next few years. And finally, the Assembly will next gather for its Fall meeting at the Omni Shoreham Hotel. This ends a very long association with the JW Marriott hotel in Washington.

As always, please let me know of any issues relevant to the Assembly. Your opinions and guidance on matters coming before it are always welcome.

HELP THE FUTURE WORK OF OUR ORGANIZATION

Senior Psychiatrists is now a 501(c)3 organization which allows your contributions to be deductible as a charitable contribution. Previously known as the Lifers of APA, Senior Psychiatrists was separately incorporated in Maryland and was notified by the Internal Revenue Service on November 13, 2014, of its status as a 501(c)3 organization.

Senior Psychiatrists is the organization specifically formed to meet the particular needs of psychiatrists at this stage of their professional career whether they are retired, partly retired or fully in practice. It will meet those needs by:

- Educational activities at APA meetings
- Educational articles in its magazines and website
- Other informational resources relevant to members
- Representation and education regarding the needs of senior psychiatrists at the APA Assembly

The organization needs your support to carry out its mission. It is dependent on the support of contributions from members, corporations and other individuals.

Help the work of Senior Psychiatrists by making a contribution today! All contributions are tax deductible to the fullest extent allowed by law. You may use the form below for your donation.

SENIOR PSYCHIATRISTS

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