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# PSYCHIATRIST ADMINISTRATOR

*NewsJournal of the*
*American Association of Psychiatric Administrators*

Volume 6: 2006 Issue 1

**NEWSJOURNAL OF THE AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS**

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Published 4 times a year
Winter • Spring • Summer • Fall



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# MOVING TOWARDS OPERATIONALIZING RECOVERY

**Sy Atezaz Saeed, M.D.**

Many of the psychiatric disorders have been long viewed as chronic conditions with lasting impairments and pessimistic outlooks. Are these assumptions valid? There has been a growing consumer movement that has challenged both the traditional perspective on the course of these illnesses and the associated assumptions about the possibility of people with these illnesses living productive and satisfying lives. There has also been a change in political and public health perspectives of severe mental illness, stimulated further by the President's New Freedom Commission on Mental Health. In more recent years we have seen emergence of literature on the concept of recovery. The recovery concept has brought forth several questions, such as: how do we define recovery; is recovery possible; how do we measure recovery; and what are the implications of a recovery model for treatment?

In a bold step forward in defining and operationalizing recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently released a consensus statement outlining principles necessary to achieve mental health recovery. The consensus statement was developed through deliberations by over a hundred expert panelists representing mental health consumers, families, providers, advocates, researchers, managed care organizations, state and local public officials, and others.

SAMHSA Administrator Charles Curie said, "This consensus statement on mental health recovery provides essential guidance that helps us move towards operationalizing recovery from a public policy and public financing standpoint."

The consensus statement identifies ten fundamental components of recovery:

***1. Self-Direction***: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

***2. Individualized and Person-Centered***: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

***3. Empowerment***: Consumers have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

***4. Holistic***: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

***5. Non-Linear***: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible.

This awareness enables the consumer to move on to fully engage in the work of recovery.

***6. Strengths-Based***: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

***7. Peer Support***: Mutual support, including the sharing of experiential knowledge and skills and social learning, plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

***8. Respect***: Community, systems, and societal acceptance and appreciation of consumers, including protecting their rights and eliminating discrimination and stigma, are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

***9. Responsibility***: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

***10. Hope***: Recovery provides the essential and motivating message of a better future: that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

The National Consensus Statement on Mental Health Recovery is available at SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov.

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Psychiatrist Administrator is currently seeking psychiatrists interested in serving as a manuscript reviewers for the journal. If you are interested in serving in this capacity, please contact (or send inquiries to):

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**SHIV HATTI, M.D., MBA**

Hello Friends,

Since my last column many exciting things have happened within the AAPA. After a two year hiatus, the APA has accepted our proposal to bring back an administrative course and will be offering the full day course on May 20th and May 21st at the APA Annual Meeting in Toronto. Please encourage your friends and colleagues to attend. This has been a popular program in the past and we expect it to book quickly.

There will be many programs in addition to the administrative course conducted by AAPA members at the Annual Meeting. I encourage you to attend as many of these as possible and support the activities of our colleagues. All aforementioned activities are listed in this edition.

With the assistance of Dr. Barry Herman and Dr. Doug Brandt we obtained funding from Pfizer to support the publication of our journal, *Psychiatrist Administrator*. Many thanks to Dr. Herman and Dr. Brandt for their effort in achieving this goal.

Our annual membership lunch will take place this year on Tuesday, May 23rd. Look forward to an afternoon of camaraderie and learning with an interesting lecture by one of our Psychiatrist Administrators.

In keeping with our goal to increase visibility of our organization, we will be conducting an education campaign at the APA Annual Meeting. In support of this campaign I encourage you to wear your "Ask me about AAPA" buttons with pride and address any curious parties with an explanation of the mission and goals of the AAPA.

We are very excited that Kimberly Bogan, MD from Cleveland, OH will be joining us as an MBS fellow. Dr. Bogan will be attending our annual meeting. Please join me in welcoming her to the AAPA.

Dr. Barry Herman, our AAOL representative to the APA Assembly, remains very active in his work for the AAPA. He introduced an action paper about pharmaceutical companies last spring which was subsequently approved by the Assembly. This spring he will be introducing an action paper about managed care. We will be using the list-serve as a forum for your feedback regarding the action paper and very much look forward to your comments.

I am fortunate to work with an excellent team in the AAPA governing body. Dr. Art Lazarus, our president-elect, has been enormously helpful in all the work we have done this year. Dr. Doug Brandt, our Treasurer, continues to work hard to secure financial support for our activities and to stabilize the AAPA financially. Our next conference call will focus on membership growth.

Your input via email and phone is vital to the operation and growth of the AAPA. These contacts never fail to provide new insight and encourage my work towards the AAPA's goal of promoting medical leadership in behavioral health care.

**The AAPA on line . . .**

Visit our new website: **www.psychiatricadministrators.org**
and let us know what you think.
If you have suggestions, we would like to hear from you!
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# DEALING WITH "DIFFICULT PHYSICIAN BEHAVIOR" IN THE COMMUNITY

**Eric E. Boss, M.D. and Alan D. Schmetzer, M.D.**

## INTRODUCTION:

Most of us have seen examples of "physicians acting badly" within the hospitals and agencies in which we practice or consult. When surveyed in 2004, only 4.3% of respondents reported that physician behavior problems "never" occurred, and the most common response (24.1%) was that some such problem happened "3 to 5 times a year."(1) There are standards that specify what behavior among physicians is out of bounds. The American Medical Association defines disruptive behaviors as "personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively" and includes behaviors that may interfere "with one's ability to work with other members of the health care team."(2) But these statements can be considered vague and difficult to use in day-to-day practice. The authors would offer a set of operational or behavioral definitions, as follows:

Immediately or potentially violent behavior
Intoxication with any substance while on duty
Practicing when too mentally and/or physically ill
Inappropriately seductive behavior
Disrespectful behavior
Negligent practice

These inappropriate behaviors are not mutually exclusive and may occur with colleagues, other staff members, students and residents, or patients. In each case, they can be very problematic. Such activities may not only be issues for morale but may place a hospital, clinic or group practice in serious legal and monetary jeopardy. We begin with a short description of each of these categories.

## THE PROBLEM BEHAVIORS:

Violence in the workplace is generally acknowledged to be a serious safety and health issue.(3) Any of the groups of people noted above may be victims when the perpetrator is a physician. Throwing a scalpel or engaging in intimidation are examples of either immediate or threatened danger. Although not by any means all caused by physician behavior, the rate of nonfatal assaults on hospital personnel is more than 4 times that for all other private-sector workers, so this is already a beleaguered cohort.(4)

Intoxication includes any mind- or mood-altering substance, and it might or might not be due to an illness such as alcohol, cocaine, or other substance dependence. The ones at most risk from the behaviors occurring as a result of intoxication are, of course, patients but anyone present might be harmed through the behaviors or lack of vigilance of an intoxicated physician. Since intoxication also increases impulsivity and impairs judgment, it may also lead to some of the other disruptive behaviors noted.

Practicing when impaired, by mental or physical health issues of the physician's own, is also a behavior that in the main might bring harm to patients, but there could be danger to others in the vicinity as well. Examples of mental health impairment might be psychosis or depression, and while several physical impairments could be cited, dementing and other neurologic or endocrine disorders come readily to mind. If we as psychiatrists were professionally evaluating people with problem behaviors resulting from such disorders, we would probably call them "gravely disabled."(5)

Sexual harassment has been defined by federal statute as any unwanted sexual behaviors which continue after the perpetrator has been told, "No" or "Stop."(6) Harassment is, of course, the extreme of inappropriate sexual behavior, but anyone in a position of relatively less power than the physician may be at risk – students, house staff members, allied health professionals, and even patients – or at least perceive that such a risk exists. In any event, rare would be the times when seductive behavior would not be at the least a distraction in the medical workplace, even when it does not reach the level of a legal violation.

Disrespectful behavior also may be perpetrated against any of the groups listed above, and was found in one survey to be the most common single type of physician problem behavior.(1) Patients are very sensitive to slights in this day and age, as well they should be. Residents and medical students learn what to do from their teachers, so what awful misconceptions might they have should an attending physician display a lack of adequate respect for patients, family members, staff people, colleagues – or even the learners themselves? Such behaviors would include anything from being abrupt or haughty on the one end, to yelling and cursing at the other.

Negligence may occur on its own or in combination with some of the other problem behaviors, such as intoxication or practicing when too physically or mentally ill. In some ways it may be the most difficult within this list to identify, at least prior to some horrendous outcome. Anyone can be accused of malpractice, after all, and lawyers tell us that "everyone makes mistakes – accusations of wrongdoing are just the price of doing business." And yet, although it may not be present every time it is alleged, direct patient harm is the common denominator that all of us fear when disruptive behaviors occur. Certainly others may be harmed more indirectly as well, such as the negligent person's partners whose reputations may suffer, or other healthcare workers who may feel ethically compromised by the negligent physician's behavior. And people in either group could be named as co-defendants in any ensuing malpractice actions. Expert opinion is absolutely essential in identifying and eliminating sloppy, negligent, or potentially criminal practice.

**WHY DO THESE BEHAVIORS PERSIST?**

The answers to this are only partly known, but it is clear that the same relatively few physicians seem to be the perpetrators over and over again.(1) Much of medical practice is still done one-on-one, which causes some of these problems to be insufficiently visible to attract improvement efforts. Also, in an informal survey of practicing physicians, it is clear that that many in our profession *expect* doctors to practice when they are sick – even when other non-physicians might be considered too ill to come in.(7) So it is only a small step from that opinion to the expectation that a physician is "just fine" when impaired with anything from alcohol dependence to schizophrenia or dementia. This is especially true when one considers that this is a self-made decision which may occur under conditions of decreased self-awareness. Our colleagues and families often excuse bad behavior because physicians are "so stressed" by their demanding jobs.(8) And while most physicians are probably accused of acting too "godlike" at times, one survey found that approximately 4 in 10 respondents believed that problematic physician behavior is sometimes excused on the basis of the amount of money certain doctors can generate for their hospital, department, or practice.(9) Medicine as a profession is supposed to be self-policing, but physicians are always busy and may not feel that they have the time to deal with other practitioners whose behaviors are problematic – or perhaps they feel it is not their job anyway.(1)

**ROLE OF THE PSYCHIATRIST ADMINISTRATOR:**

But as both physicians who have more than the average understanding of human behavior, and as administrators, these issues are now, and in the future increasingly will be, given over to the psychiatrist administrator. So we may as well position ourselves to take the lead on this problem. But how should we best deal with such matters?

Clearly a written set of policies, procedures, processes, and structures is the foundation for appropriate actions, and 71.7% of physician administrators surveyed in 2004 said that their organization had such a manual. However, only 46.3% believed that this code was uniformly enforced in their organization.(1) At the outset, every person who works within an organization must be made adequately aware of these written codes before they can be used as effective tools. And they must be allowed to ask questions and be periodically reminded, especially after necessary revisions and updates are made, on at least a biennial schedule. There must be simple and anonymous ways of initiating a complaint, and people will need to feel safe, even encouraged to do so – because ordinarily these problems, even though you may not believe it when you're in the middle of one, are under-reported.(1) Earlier reporting and investigation works much like early diagnosis – is it not better to know than to wonder what problems are present? Rudolph Giuliani pointed this out regarding his diagnosis of prostate cancer – on the day of the diagnosis, he said he "was much better off" than he was previously when he didn't know he had the disease.(10)

When actions dealing with disruptive behaviors are instituted, they must be monitored by an uninvolved but knowledgeable reviewer or board to make certain that they are being handled correctly and uniformly. Experts within business law should be utilized, and local authorities on dealing with impaired physicians must be consulted when appropriate. It is important to cultivate an atmosphere of egalitarian fairness all of the time within the organization as a whole, or most people still won't believe everything was on the "up and up". How can this be done? Believe in fairness, talk about it as often as is reasonably possible, and demonstrate it in even your simplest actions. Legally you cannot discuss the discipline of a member of your organization, but you can

always talk about the general concept of equal treatment and make what you can of the process transparent.

When corrective actions are necessary with a wayward colleague, begin with coaching and mediating before resorting to disciplinary proceedings whenever possible. Refer to an outside mediator if need be for fairness sake. Always target the behavior, not the person. Discuss how the right kind of change can do something positive for the physician who needs to mend his or her ways. But don't hesitate to move to a more disciplinary stance if the disruption affects a lot of people in the organization (especially patients), involves high levels of risk, when improvement would produce a high level of benefit, or when lesser interventions are simply ineffective.

Finally, if a physician's disruptive behavior requires removal from active practice, be certain that any potential conditions for return are clearly communicated at the time of dismissal or suspension of privileges, and that they are tied closely to the behaviors of concern. Correspondingly, there must be a plan for adequate assessment of improvement (or lack thereof) prior to any decision regarding a return to the practice, hospital, or organization. Such a review should only be done by a disinterested, appropriate specialist and any report and recommendations must be in writing.(11)

**WHAT IF THERE ARE NO DISRUPTIONS RIGHT NOW?**

When one is not actively engaged in a case of problem behavior, the time should be used constructively to review past allegations and complaints for patterns within a given department, for example, time of day (is everyone too tired and cranky?), or day of the week (are staffing and supervisory numbers at proper levels on weekends?). Even if you never have the luxury of having no such cases on the front burner, it is wise to make the time for these kinds of reviews. It will make your job easier as time goes on if you can identify and proactively attend to hot spots.

Also, this may be the point to interject that some believe nurses (they are the ones most frequently targets of bad physician behavior - cited as 56.5% to be exact, or other allied health professionals are just too "thin skinned" and should "get over it." After all, no one is perfect, and what with more paperwork being required all the time for shrinking reimbursements, aren't physicians entitled to be a little irritable these days? And maybe the problem is not disruptive *physician* behavior, but rather dysfunctional hospitals and clinics with all kinds of bad actors and potentially awful outcomes that should be addressed – what about those? To such arguments, the authors can only point out that physicians say they are, and should be, the leaders in healthcare, and if that is true, then we are responsible for cleaning up all of these messes as well as policing our own profession. And if we do not demonstrate leadership in these matters, we will never develop the level of trust and respect that we must have to fix such problems as they occur.

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*Dr. Boss is a Fourth Year Psychiatry Resident and Dr. Schmetzer is Professor of Psychiatry at Indiana University School of Medicine.*

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## *COMMENTARY ON*
# DEALING WITH "DIFFICULT PHYSICIAN BEHAVIOR" IN THE COMMUNITY

**John J. Wernert, MD, MHA**

There is little debate about the stress levels currently experienced by American Healthcare workers. As price competition increases and reimbursement shrinks, physicians in particular feel the financial pinch of tighter times in a profession previously known for it's handsome monetary rewards. Those physicians that choose to be doctors primarily for the love of the work and reward of patient care have experienced an absolute boom in their clinical arsenal of technology and treatments. We can do more for patients now than any other time in history, yet at considerable cost. Those doctors that joined the profession primarily for the job security and financial reward are struggling to absorb a new paradigm.

As our society struggles with how to pay for the health care we demand, the downward pressure on reimbursement has hit the physicians where it hurts most, in their egos and their wallets. Physicians have lost some of the control they previously enjoyed, and now must answer to many masters. Most physicians have adapted to this new paradigm, and sadly some have not. It is these disgruntled and unhappy colleagues that make up the majority of disruptive and misbehaving physicians.

In our featured article *Dealing with "Difficult Physician Behavior" in the Community,* Drs Boss and Schmetzer offer a unique perspective on a long recognized problem area in medical staff relations. Much like defining "good" versus "bad" artwork, defining disruptive and bad physician behavior is in the eye of the beholder. Boss and Schmetzer offer a set of operational and behavioral definitions that help define inappropriate behaviors, and their potential exacerbants. Responsibility for effectively identifying and dealing with disruptive physician behavior is clearly placed in the medical staff's lap. The cost of inaction is high.

A new survey about physician-nurse relationships uncovers a strikingly high prevalence of disruptive physician behavior that's negatively affecting nurse retention.[1] Lawsuits and civil complaints against hospitals and clinics are on the rise, based on alleged sexual harassment and physical injury perpetrated by angry, disrespectful and potentially violent physicians. A medical staff's ability to tackle the challenges of such behaviors may directly affect accreditation standards of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO).[2] Bad outcomes in all of these areas can translate in to multi-million dollar losses to hospitals in legal, liability and human resource costs. Problem physician behaviors must be causally understood, and addressed systemically.

Boss and Schmetzer nicely define the role of the Psychiatrist Administrator as the "go to" professional to take the lead on this important issue. We as physicians must be willing to police our own house and keep the public safe. This article provides practical advice on how to walk that fine line, and address the issue of disruptive physicians fairly, therapeutically yet firmly so as to insure the continued public trust in our venerable profession.

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*Dr. Wernert is a past chair of the Indiana Medical Licensing Board and has served on the Impaired Physicians Committees at Methodist/Clarian Hospitals and St. Francis Health Centers in Indianapolis, Indiana.*

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# LOGISTICS OF DELIVERING PSYCHIATRIC CARE IN RURAL SOUTHERN LOUISIANA'S REGION III AFTER HURRICANE KATRINA

**Eben L. McClenahan, M.D., M.S.**

## INTRODUCTION:

This article describes provision of psychiatric care in Region III's catchment area of eight parishes (counties) with six community mental health centers, in the area Southwest of New Orleans and West of the locus of Hurricane Katrina's direct impact at landfall. Region III is affiliated with the Office of Mental Health in the Louisiana State Department of Health and Hospitals. Most of the Region III sustained relatively limited damage, and there was a significant exodus from New Orleans to the region's communities which remained viable after the storm. This diaspora led to a 35% increase in the volume of patients seeking mental health services within the region. The author examines four salient administrative issues regarding clinical care of Region III's patients in the wake of Hurricane Katrina:

- availability and deployment of psychiatrists and counselors
- management of, and patients' access to, psychotropic medications
- shortage of hospital beds for psychiatric patients
- future planning for hurricane disasters

## ARMAMENTARIUM OF MENTAL HEALTH CLINICIANS:

Several of our regional physicians evacuated for as much as three weeks and were unavailable. Two Tulane residents, needing sites for clinical rotations, proved helpful. We hosted a total of four SAMHSA volunteer psychiatrists, after Governor Blanco issued an executive order whereby they could provide emergency services. There was often a disconnection between idealistic aspirations of volunteers and needs of Katrina victims (1), and often there was confusion about what direction to pursue (2). Volunteers would, during evenings and weekends, go forth into trailer parks to assess patients, with completion of psychiatric evaluations, for referral to one of our centers for care, whereby we could properly distribute medications and maintain medical records. We also were very fortunate to benefit from the several pastoral counselors furnished by SAMHSA, as they were particularly well prepared to address patients' issues of bereavement (3).

## PSYCHIATRIC PHARMACOPOEIA:

Our two regional pharmacists were displaced out of state, and were unable to return for greater than six weeks because of damage to their homes. Whereas the Red Cross was largely recalcitrant to our needs, the Veterans Administration helped for approximately a fortnight by way of a bus parked in front of the Wal-mart near one of our clinics. United Way provided a $5,000.00 stipend, and pharmaceutical representatives from Pfizer and Lilly were quite generous with samples and vouchers. Due to loss of electricity with resulting high temperatures over a period of a several days within the clinics, all medications, including samples, in stock prior to Katrina, were sent back to the state central pharmacy and then destroyed. The inventory of these medications amounted to $277,000.00, for which we expect FEMA reimbursement. The paucity of medications at times required changing patients to available different psychotropic agents within a specific drug class. Following two months in this dire predicament, and just before the return of our pharmacists, our doctors had even begun to resort to writing some standard prescriptions, yet were aware that our indigent patients could not afford to fill these at a pharmacy. Allotments of the Interim Supply from the state pharmacy provided some relief.

## DEARTH OF HOSPITAL BEDS AND CARE OF PATIENTS:

With the closures of Charity Hospital and DePaul Tulane Behavioral Health Center in New Orleans, a minimum of 150 inpatient psychiatric beds was lost after Katrina. While needing to triage carefully, we also were quite concerned about the potential for sentinel events (4). Many patients with preexisting psychiatric disorders presented to clinics with their empty medication bottles, and often they required increases in their regimens. A

website was available at www.KatrinaHealth.org and provided some assistance toward being able to access patients' medication histories (5). Emergent problems in the context of substance dependence, and de novo illnesses, were also observed. Our clinicians needed to be able to separate wheat from chaff, and to remain alert to identifying normal responses to this devastating event, lest fear and other emotions become hastily labeled as formal Axis I disorders (6). Anger, anxiety, and sadness comprise normal healthy reactions to such abnormal events up until the point when such symptoms become dysfunctional, then requiring appropriate diagnosis and treatment (7).

**DISASTER PREPAREDNESS:**

We were not well prepared for this disaster, and therefore while Hurricane Rita was menacing the Gulf, we held several ad hoc teleconferences. Systems of intervention during disasters operationally are difficult to achieve, especially when traversing a large rural area (8). Often erroneous assumptions lead to inadequate delivery of care during crises, such that disaster plans require regular reassessments (9). Toward this end, the Louisiana Psychiatric Medical Association has created the Gulf Coast Institute for the Study of Mental Health in Natural Disasters as a non-profit entity. Anticipating the 2006 hurricane season, we are debating our strategy. We are considering a plan to close all clinics, and to evacuate the regional manager, the regional medical director, and the regional pharmacy director, as well as all the medications to be collected from the our regional pharmacy and the six centers. Our Northern destination would be East Louisiana State Hospital in Jackson, Louisiana. An alternative would be to arrange for medication storage at each of the hospitals situated in close proximity to each of our six centers and endowed with back-up generators.

**CONCLUSION:**

The sequellae of Hurricane Katrina linger. I took occasion to visit the shelter at the Terrebonne Civic Center, in Houma, Louisiana. Two groups of evacuees, those from Eastern New Orleans and those from the Louisiana coastal towns of Dulac and Cocodrie, had been separated deliberately, given differences in their experiences of this tragedy. Whereas the New Orleans population awaited an opportunity to travel in buses to witness the destruction whence to undergo reality testing and to fully embark upon grieving, the other Louisianians were accustomed to at least bi-annual flooding, and they demonstrated considerable resilience, and expressed eagerness to return to their communities to commence rebuilding once again. In the Adrenaline-driven urge to rescue survivors, one should recall the dictum of *primum non nocere*, thus needing to be especially careful to avoid interfering with normal processes of coping amid traumatic experiences (10-11).

Hurricane Katrina was a litmus test for preparedness. Emergency planning at state and local levels may be viewed as akin to a patchwork quilt, wherein some plans might easily unravel while other initiatives are created with elaborate embroidery and taut careful stitching (12). We continue to engage in secondary and tertiary prevention measures to recover from this event and to re-establish as quickly as possible a normal level of mental health services for our now enlarged patient population. We are also undertaking primary prevention in order to avoid future adverse outcomes and to protect against previously identified risks.

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*Dr. McClenahan is Medical Director of Region III, Office of Mental Health, Louisiana State Department of Health and Hospitals, and Assistant Professor of Clinical Psychiatry with Tulane University School of Medicine in New Orleans.*

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**AAPA Annual Membership Luncheon**

Tuesday, May 23, 2006, 12 noon - 2 p.m.
Toronto Hilton - Tom Thomson Room - Convention Level

Andrew J. Kolodny, M.D.
*"The Challenges and Rewards of Psychiatric Administration: The Perspective of an Early-Career Psychiatrist"*

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## CALL FOR PAPERS

The ***Psychiatrist Administrator*** invites articles on all areas of psychiatric administration and management with a focus on the roles and perspectives of psychiatrists in leadership and management roles. Please make submissions and inquires to:

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# ETHICS COLUMN

## Proposed Additions to The AAPA ETHICAL PRINCIPLES FOR PSYCHIATRIC ADMINISTRATORS

*"This country is about, in my judgment, aggressive, open debate. There is an old saying: when everyone is thinking the same thing, no one is thinking very much."*

Sen. Byron Dorgan (D-N.D.)

On October 28, 2000, the Ethical Principles for Psychiatric Administrators was approved by the AAPA. Those principles have been discussed, published, reconsidered, and used since then. No formal requests for changes have been received.

However, without much fanfare or publicity, the American Medical Association revised the Principles of Medical Ethics of the American Medical Association on June 17, 2001. These are the principles upon which the AAPA had based its annotations. These are also the same principles that the American Psychiatric Association (APA) has always based its own annotations upon.

The last publication by the APA, The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, was published in 2001 and does not incorporate the new revisions that the American Medical Association made. Rather, an APA Task Force has been working on a new ethics document since that time. Neither the current document in progress nor the last APA publication addresses issues that psychiatrist administrators face.

Given that the unique needs of the AAPA continue to need to be addressed separately, it seems an appropriate time to review the AMA revisions and update our own ethics annotations accordingly, even though the AMA revisions are modest. To briefly review the AMA revisions, note the following:

**Preamble**

The phrase "patients first and foremost" was added to clarify the responsibility of the physician. The revised wording of this sentence in the Preamble is: "As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self."

**Section I**

Medical service was changed to medical "care" and "and rights" was added to "respect for human dignity".

**Section II**

The phrase "uphold the standards of professionalism" was added.

**Section IV**

The words "and privacy" was added to safeguarding confidences.

**Section V**

The phrase "maintain a commitment to medical education" was added.

**Section VII**

The phrase "and the betterment of public health" was added as a responsibility.

As may be noted, the modest revisions to the prior ethical principles are not extensive and do not effect our prior annotations to these principles. The two new sections should be noted, however, along with proposed annotations.

**Section VIII**

"A physician shall, while caring for a patient, regard responsibility to the patient as paramount."

The administrative relevance of this new Section seems to be similar to the added phrase in the Preamble. Both put added emphasis on the principle that patients' needs should clearly come first among any competing ethical principles. Since psychiatrist administrators, by the nature of their work, pay extra attention to the other responsibilities to one's organization, the colleagues who work there, and society, this added emphasis on the patient makes ethical conflict more likely. To address this altered emphasis on the AMA principles, the following annotation is proposed.

**Proposed Annotation**

*The psychiatrist administrator will do everything possible to keep the needs of patients served by the*

*organization primary, while still attending to organizational responsibilities. Whenever possible, the psychiatrist administrator will endeavor for the functioning of the organization to correlate with the well-being of the patients in that organization, such as through the provision of competent, cost-effective care.*

**Section IX**
"A physician shall support access to medical care for all people."

In many ways, this new Section is a specific qualification of Section VII, but deemed worthy of special emphasis. The reason for this emphasis is the continued growth of the huge numbers of uninsured or underinsured in the United States, compromising timely access to medical care. No solution is proposed here, such as a national healthcare system like Canada or England; rather, it leaves how to support this principle up to each physician. In fact, national health insurance by itself does not seem to be adequate for access. Nation health insurance may provide the potential for better access, but education of the public, cultural competence and stigma reduction are among other factors that influence access. This seems to be a critical new principle, because if people do not have access to medical care, it makes moot all the preceding principles for that particular individual. For psychiatrist (or any medical) administrator, this new principle has additional relevance, as it can be applied to one's own organization.

**Proposed Annotation**
*Given that psychiatrist administrators are particularly familiar with providing access to medical care for patients, and often have public visibility, one should advocate for timely access to competent care not only for patients at one's institution, but for all potential patients. Such advocacy can be done through various channels and various mechanisms.*

We would appreciate any comments or other suggested revisions to our Ethical Principles for Psychiatric Administrators, whether for the new or prior annotations. Please send them to the Journal Editor, Sy Saeed, M.D. at saeeds@ecu.edu or the Column Editor Steven Moffic, M.D. at smoffic@mcw.edu.

**Issues Workshop - Topic: 53. Health Services Research**
Wednesday, May 24, 2006, 9:00 AM - Wednesday, May 24, 2006, 10:30 AM
Toronto Convention Centre South Level 700 Room 714 B

Buwalda, V.J.A., Debipersad, P., Berg, H. van den, Tilburg, W. van, Hermann R.C. and Riba, M.B
*"The Quality Information System: A New System for Measuring Process in the Doctor-Patient Relationship"*

**Issue Workshop**
Thursday, May 25th, 2006, 9:00-10:30 am
Toronto Convention Centre South Level 700 Room 705

Arthur Lazarus, M.D.
*"So You Want to be a Clinical Investigator?"*

**COLUMN EDITOR:** Josephine L. Dorsch, MALS, AHIP

# LITERATURE SCAN

The *Literature Scan* is our regular column that reviews recent literature of interest to administrators in behavioral health care systems. The column covers a period of approximately 6 months. Papers are selected on such topics as administration, consumer satisfaction, delivery of health care, education, efficacy, ethics, evidence-based practice, leadership, and management. The daily demands of administration and practice often leave little time for browsing journals. It's our hope that this column may fill the gap.

**Brown J.** The spectrum of informed consent in emergency psychiatric research. *Annals of Emergency Medicine*. 2006 Jan;47(1):68-74.

There is poor agreement about the application of current regulations about informed consent in emergency psychiatric research. The author evaluated the variation in requirements for informed consent in studies evaluating chemical tranquilization of agitated patients by examining the methods used in twelve studies. Seven studies used informed consent, 3 studies used a waiver of informed consent, one implied that neither consent nor a waiver of consent was needed, and in one case, the primary method for consent was not specified. The author concluded that there needs to be much greater clarity about the use of waivers of informed consent, in particular in emergency psychiatry research.

**Cohen A, Houck PR, Szanto K, Dew MA.** Social inequalities in response to antidepressant treatment in older adults. *Archives of General Psychiatry*. 2006 Jan;63(1):50-6.

The authors used Cox proportional hazards regression analyses to examine the association between socioeconomic status, indexed by census tract median household income and educational attainment, and treatment response and remission according to the Hamilton Depression Rating Scale. The analysis found that subjects residing in middle-income census tracts were significantly more likely to respond to antidepressant treatment than subjects residing in low-income census tracts. No association was found between socioeconomic status and remission, however.

**Essock SM, Mueser KT, Drake RE, Covell NH, McHugo GJ, Frisman LK, Kontos NJ, Jackson CT, Townsend T, Swain K.** Comparison of ACT and standard case management for delivering integrated treatment for co-occurring disorders. *Psychiatric Services.* 2006 Feb;57(2):185-96.

Essock and her co-authors sought to determine whether any additional benefits are evident when assertive case management is used instead of standard case management for patients with co-occurring disorders. They randomly assigned 198 clients who had co-occuring disorders and were homeless or unstably housed to either one of the models and assessed multiple outcome domains every 6 months. Participants in both treatment groups improved over time, and few differences were found between the 2 models.

**Hoge CW, Auchterlonie JL, Milliken CS**. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association*. 2006 Mar 1; 295(9):1023-32.

The objective of this study was to determine the relationship between combat deployment and mental health care use during the first year after return home, assess actual use of mental health services, and attrition from military service. Combat duty in Iraq was associated with high utilization of mental health services and attrition from military service after deployment. Thirty-five percent of Iraq war veterans accessed mental health services in the year after returning home; 12% per year were diagnosed with a mental health problem. The high rate of using mental health services of Iraqi war veterans highlights challenges in ensuring that there are adequate resources to meet their mental health needs.

**Lukens TW, Wolf SJ, Edlow JA, Shahabuddin S, Allen MH, Currier GW, Jagoda AS; American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department.** Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient

in the emergency department. *Annals of Emergency Medicine.* 2006 Jan;47(1):79-99.

The clinical policy focuses on 4 critical issues concerning the medical assessment and management of emergency department patients who present with psychiatric symptoms. 1) What testing is necessary in order to determine medical stability in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and psychiatric symptoms? 2) do the results of a urine drug screen for drugs of abuse affect management? 3) does an elevated alcohol level preclude the initiation of a psychiatric evaluation? and 4) what is the most effective pharmacological treatment for an acutely agitated patient? (Practice Guideline)

**Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, Hegerl U, Lonnqvist J, Malone K, Marusic A, Mehlum L, Patton G, Phillips M, Rutz W, Rihmer Z, Schmidtke A, Shaffer D, Silverman M, Takahashi, Y, Varni A, Wasserman D, Yip P, Hendin H..** Suicide prevention strategies: a systematic review. *Journal of the American Medical Association.* 2005Oct 26;294(16):2064-74.

In 2002, an estimated 877,000 lives were lost worldwide through suicide, representing 1.5% of the global burden of disease. The authors undertook this study to examine evidence for the effectiveness of specific suicide-preventive interventions and to make recommendations for future prevention programs and research. Data showed that education of physicians and restricting access to lethal means were found to prevent suicide. Other methods including public education, screening programs, and media education need more testing for evidence of efficacy. (Systematic Review)

**Paetzold RL.** Mental illness and reasonable accommodations at work: definition of a mental disability under the ADA. *Psychiatric Services*. 2005 Oct; 56(10):1188-90.

The author reviews the law and presents some ADA cases that have involved mental illness to demonstrate the difficulties that can arise for persons who seek to work despite their mental illnesses.

**Tryer P.** Do psychiatric journals have a future in the age of the Internet? *Canadian Journal of Psychiatry.* 2005 Oct;50(11)677-9.

This article addresses the issue of open access and how subscription journals will be able to deal with it. The author offers 3 solutions. First, each journal can have both a paper-based and a Web-based version. The space freed up in a journal by putting more information on the Web-based version could be used to publish more interesting editorials, debates, discussions about controversial issues, and stimulating correspondence. Third, more space could be devoted to systematic and other reviews concentrating on the evidence base for clinical decision making.

**Walter HJ, Gouze K, Lim KG**. Teachers' beliefs about mental health needs in inner city elementary schools. *Journal of the American Academy of Child and Adolescent Psychiatry.* 2006 Jan;45(1):61-8.

Teachers from 6 elementary schools in a major midwestern city were surveyed to assess their beliefs about the major mental health problems facing schools. Disruptive behavior was endorsed by approximately 50% of teachers as the largest mental health problem facing their schools, and lack of information/training was endorsed as the greater barrier to surmounting mental health problems. Teachers, if they serve as effective gatekeepers to mental health issues, would benefit from education, training, and consultation from mental health professionals.

**Wu EQ, Birnbaum HG, Shi L, Ball DE, Kessler RC, Moulis M, Aggarwal J.** The economic burden of schizophrenia in the United States in 2002. *Journal of Clinical Psychiatry*. 2005 Sept;66(9):1122-29(8):911-21.

The authors report that the overall U.S. 2002 estimated cost of schizophrenia is $62.7 billion, with $22.7 billion excess direct health care cost. The total direct non-health care excess costs, including living cost offsets, were estimated to be $7.6 billion. The total indirect excess costs were estimated to be $32.4 billion, with unemployment as the largest component of overall schizophrenia excess annual costs.

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*Jo Dorsch is the Health Sciences Librarian at the Library of the Health Sciences-Peoria, University of Illinois at Chicago, where she is also a professor with an adjunct appointment in the College of Medicine.*

# INSTRUCTION FOR AUTHORS

The *Psychiatrist Administrator* is the official publication of the American Association of Psychiatric Administrators (AAPA). Established in 1961, AAPA is the premiere educational, networking, and support resource for psychiatrists interested in administration and management. The AAPA promotes medical leadership and medical excellence in behavioral healthcare systems, including services for mental illness, substance use disorders, and developmental disabilities.

The choice of *"Psychiatrist Administrator"* is intended to distinguish the NewsJournal from other publications in mental and behavioral health administration in terms of its focus on the roles and perspectives of psychiatrists in leadership and management within evolving systems of care.

The purpose of the NewsJournal is to provide up-to-date, accurate, and easily understandable information to our readership and to contribute to the body of scholarly work in the area of psychiatric administration and management. Your article should be written in a clear, straightforward style that is pleasant to read.

## PREPARATION OF MANUSCRIPT

Manuscripts should be typewritten on standard (8 1/2" x 11") white paper with 1" margins on all sides. The entire manuscript, including references and figure legends, should be double-spaced. Each element of the manuscript should begin on a new page: title page, abstract, text, references, tables (typed 1 per page), figure legends. Number pages consecutively through the manuscript. Manuscripts should be no more than 3000 words of text (not including references or tables).

A separate page should be included giving the title of the paper, the names, titles, and affiliations of each author, and the mailing address, e-mail address, and phone and fax numbers of the corresponding author. Any grant support requiring acknowledgment should be mentioned on this page. Acknowledgments other than those of grant support should be put at the end of the text.

An abstract should be provided, preferably no longer than 200 words.

Tables should be typed double-spaced one per page. Provide a clear, descriptive title for each table. Tables should be numbered consecutively as they appear in the text.

Figures should be numbered consecutively as they appear in the text. Illustrations - line drawings, graphs, or charts - should be of camera-ready quality.

References should be numbered consecutively as they are cited in the text, with reference numbers typed as superscripts. References should be typed double-spaced beginning on a separate page after the text and acknowledgments. The NewsJournal uses the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (Vancouver group) as its guide for reference style. Abbreviations of journal names must conform to Index Medicus style; journals not listed in Index Medicus should not be abbreviated. List all authors when there are no more than six; for more than six authors, list the first three, followed by et al.

## MANUSCRIPT REVIEW AND EDITING

Manuscripts are reviewed by the editor, editorial board members, or other reviewers. Manuscripts may be edited for clarity, style, conciseness, and format. The edited manuscript will be sent to the corresponding author for approval. Authors may be asked to respond to editorial queries or make revisions.

Authors will receive page proofs before publication. The author should return corrected proofs to Frances Roton, Executive Director AAPA, within three days of receipt; delays in returning proofs may result in postponement of publication.

## MANUSCRIPT SUBMISSION

Manuscript submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere.

Three copies of the manuscript should be sent to Sy Saeed, M.D., Editor, *Professor and Chairman*, Department of Psychiatric Medicine , Brody School of Medicine at East Carolina University, Brody 4E-100, 600 Moye Boulevard, Greenville, NC 27834. The manuscript should be accompanied by a transmittal letter giving the name, address, email address, and phone numbers of the corresponding author. The letter should indicate that all authors have seen and approved the manuscript and that the manuscript has not been published or is not under consideration for publication elsewhere. A disk copy of the complete manuscript, including tables and references, should also be submitted. Please label the disk with the name of the first author and title of the article and indicate what hardware and software were used.

**You can also submit the manuscript electronically by sending it as an e-mail attachment to the editor at** saeeds@ecu.edu**.** If you have any questions about specific details not covered here, please e-mail saeeds@ecu.edu.

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## Component Workshop

Wednesday, May 24, 2006, 9:00 - 10:30 a.m.
Toronto Convention Centre North Level 200 Room 201D
Chair: Sy Atezaz Saeed, M.D.
Brian M. Hepburn, M.D., Nalini V. Juthani, M.D. Arthur L. Lazarus, M.D.,
Shirish V. Patel, M.D., and Lydia Weisser, D.O.

***"Doing More with Less: Challenges and rewards of Becoming a Psychiatrist Executive"***

*Increasingly, psychiatrists are assuming executive roles as health systems consolidate operations and the complexity of care delivery increases. The psychiatrist executive's position may be viewed as the hub around which the many spokes of the wheel of the mental health system turn. The psychiatrist executive is responsible for integrating the needs of the patients and the physicians in the community into the vision, mission and goals of the health system. Psychiatrist executives face a variety of challenges. The critical skills of a successful psychiatrist executive include strong leadership, technical expertise, and management know-how. Managing change has become one of the most critical competencies of psychiatrist executives. Asking to do more with less is a common problem that psychiatrist executives face today. With this predicament come a set of challenges and rewards.*

*This workshop will take an interactive case consultation approach. Workshop will start with a case presentation followed by brief case-relevant discussions by the faculty. Faculty, representing a broad range of administrative and leadership roles and experiences will facilitate collaborative discussions involving case conceptualization and formulation; problem identification and analysis; and strategies for selecting effective interventions. Participants will be invited to actively participate by sharing their difficult and challenging cases in administrative psychiatry.*

## Workshop

Tuesday, 23, 2006
11 a.m. - 12:30 p.m.
Toronto Convention Centre South Lelvel 700 Room 717B
Dimitri Markov, MD (chair), Elisabeth J. S. Kunkel, MD (co-chair), Michelle B. Riba, M.D.,
David J. Lynn, M.D., Marina Goldman, M.D., Michael J Vergare, M.D., and John-Paul Gomez, MD

***"Career Advancement in Academic Psychiatry for Early Career Psychiatrists"***

Academic psychiatry has undergone significant changes over the past few decades. Departmental structures became more complex while clinical, research, and teaching responsibilities have expanded. These numerous responsibilities are often poorly integrated. Junior faculty often struggle to understand what is expected of them in order to advance within their departments. Junior faculty need a clear road map to develop a successful academic career. Recent literature emphasizes the need for mentors who can help early career psychiatrists set priorities, align conflicting clinical, research and teaching responsibilities, and be effective at meeting departmental expectations.

Faculty will discuss with participants practical issues of academic career development. The workshop will be highly interactive with emphasis on eliciting the needs of early career psychiatrists and providing guidance from senior academic faculty. At the conclusion of this presentation, the participants will be able to understand how to negotiate the complexities of academic psychiatry departments; to improve their ability to prioritize conflicting responsibilities; and to focus their own career path with a goal of effective career advancement.

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