Texas Society of Psychiatric Physicians
NEWSLETTER
FEBRUARY / MARCH 2002

A Crisis of Capacity

George D. Santos, MD, Chairman, Public Affairs Committee


GEORGE D. SANTOS, MD

Sometimes it is difficult to know where to begin. We as psychiatrists are faced with so many challenges in our efforts to provide basic good medical care, it is particularly frustrating when other factors can have such a negative impact. We spend a great deal of time training and refining our skills and information base. We have all striven to decrease the stigma of psychiatric illness that stems from an inexperienced general public. In many ways these efforts have met with significant success. There are more people seeking care, and the treatment options we have to offer are varied and effective. We are however faced with a growing problem in Texas. We have a crisis of capacity.

Because of a variety of influences over the last several years, the availability of inpatient psychiatric services has been seriously impacted. This is true in both the public and private sectors, and has impact in both inpatient and outpatient levels of services. The TSPP conducted research into this issue, which was published in January of 2000. This study looked at the loss of psychiatric beds since 1996. It highlights a disturbing trend of erosion in the ability to serve the mental health needs of our communities. As this process of diminishing beds continues, it is helpful to review a few of the study's findings to get a clearer picture of the problem we face today.

The TSPP report cites another study, the Hay report, which examined health care delivery nationally from 1988 through 1997. This review highlighted some of the factors which had disproportionately affected the mental health system of service delivery. It showed that behavioral health care benefit costs were cut 54% during the period, significantly more than the 7% cut in general healthcare benefits. The decline in psychiatric services were due to healthcare benefit plans' reduction in expenditures for behavioral health. This reduction in insured dollars providing coverage for mental healthcare services is only one of many factors that contribute to the decline in psychiatric services we now face.

Let me summarize some of the TSPP findings on the availability of psychiatric beds. In January 2000, 82% of Texas, counties encompassing a population in excess of 5 million Texans, had no psychiatric beds. The number of psychiatric physicians actually increased by 2.4% from 1996 to 2000. In January of 2000, psychiatric physicians made up 5.4% of the physician workforce. The bad news, however, was a loss of 4,826 psychiatric beds in 71 hospitals in 36 Texas counties. This represented a 29% reduction of available psychiatric beds during the 1996 to 2000 period of time. There was a 36% drop in the number of hospitals which had psychiatric beds. These reductions were most prevalent in the general medical-surgical hospitals. As we are all aware, there have been more hospital closures in most of our large cities since the time of this study.

Every part of the State has been affected. Harris County had a 52.9% decrease in psychiatric beds. Counties around the State had similar findings: El Paso a 76.3% decline, Dallas a 29.3% decrease, Bexar County a 34.4% loss. If we included the hospital and psychiatric bed closures since the completion of the study, the numbers would be even worse.

It is difficult to put your finger on any one factor as being most responsible for this trend. The TSPP study identified several factors noted by the psychiatrists who responded to a TSPP survey. These factors included: declining admission rates (despite growing populations), declining patient days, and declining reimbursements from public and private payors. Most psy-

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A Call to Action

Quality Care Under Attack!

John R. Bush, Executive Director


JOHN R. BUSH

Quality psychiatric care is under attack from many different directions... continuing managed care limitations on access and reimbursements; State regulatory restrictions; inadequate funding for public mental health; availability and rising costs of malpractice insurance; dangerous encroachment into medical practice by unqualified non-physician providers; discriminatory coverage in private insurance and public programs; closure of psychiatric hospital beds; growing restrictions in workers' compensation coverage; disruptive utilization review hassles; invasions into the patient-physician relationship and patient privacy, to mention a few. Individually and collectively, these attacks are detrimental to patients seeking needed psychiatric care. More and more, these challenges must be resolved at the State level. TSPP works vigorously and effectively on these and many other challenges 24/7 for the benefit of patients and all psychiatrists, regardless of practice setting (private practice, public sector and academic). About 75% of Texas psychiatrists participate in this ongoing effort through their membership in TSPP. TSPP invites and encourages the 25% of Texas psychiatrists who are not yet members to become active participants in organized psychiatry so that TSPP can position itself to be an even more effective advocate for the profession and the patients served by the profession.

At press time, the Governor of New Mexico was considering signing into law a bill passed by the New Mexico legislature which included a provision that will grant prescribing privileges to psychologists effective July 1, 2002. If this bill becomes law in New Mexico, the dangerous consequences for patients in their State will be considerable.

TSPP, along with its allies and friends in medicine, patient advocacy organizations and many Texas psychologists, soundly defeated a similar bill filed in the Texas Legislature in 2001. It is expected that organized psychology will again attempt to gain prescribing privileges by legislative fiat when the Texas Legislature convenes in January 2003. Needless to say, if the New Mexico bill becomes law, it poses a serious threat to our legislative strategies and ultimately to patients in Texas, as well as patients in other States. This is not a "turf issue" between medicine and psychology; rather it is a quality of care issue. Even a majority of psychologists oppose such an unwise expansion in their scope of practice. Texans must not allow further degradation in the quality of psychiatric care for patients to occur. Psychiatric patients deserve and expect the highest quality of care to be delivered. This is the core of TSPPs Mission Statement: "TSPP is dedicated to developing the highest quality of comprehensive psychiatric care for patients, families and communities."

TSPP, along with its allies and friends in medicine, patient advocacy organizations and many Texas psychologists, soundly defeated a [Psychologist Prescribing Bill] filed in the Texas Legislature in 2001.

While TSPP will continue to craft winning legislative strategies, the ultimate key to legislative success rests with members building relationships with legislators: RELATIONSHIPS... RELATIONSHIPS... RELATIONSHIPS!

If you are a member, contact your Chapter leadership or the TSPP Office and volunteer to help in TSPPs Political Action Task Force, a program designed to encourage the formation of relationships between psychiatrists and members of/candidates for the Texas Legislature prior to the convening of the next Legislative Session in January 2003. If you are not a member, please contact the TSPP Office for a membership application and become active in organized psychiatry's many activities advocating for the profession and psychiatric patients.

Psychiatrists in Texas cannot afford to be passive or apathetic. There are too many challenges that need to be continuously and effectively addressed. Active membership involvement allows our organization to be a strong and united voice for psychiatry and for patients. Quality psychiatric care for patients in our State is at stake.

Together, we DO make a difference.

INSIDE...

PRESIDENT'S MESSAGE

Practice of Psychiatry Circa 2002

CHARLES L. BOWDEN, MD

Both in my role of serving as your President, and as a result of the opportunities I have to speak on aspects of mood disorder throughout the U.S and other parts of the world, I am able to meet many psychiatrists in all walks of professional practice. This column draws from those experiences, as well as my experiences as Chair of a large Department of Psychiatry at the University of Texas Health Science Center at San Antonio. Without fanfare, the conditions of most psychiatric practices have improved in the past few years. I believe several developments have contributed to this. Patients and their families have complained mightily to their managed care providers against some of the worst restrictions and bureaucratic impediments to accessing care. This has been responded to positively in some instances. Restrictive gatekeeping is less commonly practiced than was the case 5 years ago. In many instances, patients now have meaningful options for point of service plans that allow them to decide which type of physician they will first see for a medical problem. This has been aided by managed health care assessments that the costs of such gatekeeping restraints were greater than any benefits that occurred.

More importantly, many psychiatrists, especially those in interdisciplinary groups, are taking a close look at reimbursement rates in specific plans, and declining participation in those plans that are antithetical to adequate medical care. Perhaps more surprisingly, insurers are often, then, willing to negotiate a more adequate rate of compensation for care. Hospital and long term care facilities are also able to more firmly set a threshold for the terms under which they are willing to participate in a plan. However, for reasons too complex to address here, most hospital systems have less negotiating room than do psychiatrists and other physicians in ambulatory settings. At the end of the day, more psychiatrists now feel genuinely good about the quality of care that they are able to provide, and patient satisfaction rises commensurately.

Some psychiatrists are now practicing fully or largely outside of insurance plans. Those who elect this path usually develop a business plan that conceives of the cost of care in an illness control sense, rather than a cost per visit sense. To provide a concrete example from my practice, what would it cost annually to provide fully adequate care, independent of the costs of medication, to maintain a bipolar patient in a good state of remission for that period? In many cases, the resultant numbers are feasible for substantial portions of persons with mental illnesses.

Another effectively utilized approach is development of an interdisciplinary group practice, wherein the number of persons with particular training comports with the treatment needs of the particular clientele with whom the group works. To work effectively, these groups need a degree of business integration, not just an agreement to cooperate in a virtual clinic fashion.

A fundamental reason that these generally positive developments have occurred is that the supply-need balance for many types of physicians has shifted in the direction of real shortages in most urban settings. Despite rates of population growth that exceed the national average, every large city in Texas has from 5 to 10% fewer psychiatrists in full-time practice now than they did a decade ago. Because of demographic patterns, and the numbers of physicians in residency training, it seems likely that this real relative shortage will continue. One might think that a perceived shortage would encourage more graduating medical students to select psychiatry. However, the combination of large debt loads of graduating medical students and even more severe shortage situations in several specialties with much higher rates of compensation, e.g. anesthesiology, orthopaedics, and radiology, will likely result in no significant increase in the proportion of physicians selecting psychiatric residencies.

Parenthetically, this developing shortage has not occurred among psychologists. A primary reason is that a substantial portion of doctoral psychology programs are Psychology Doctoral (Psy.D.) programs with little, if any, link to a strong academic institution. Many of these "schools" are virtual, with no real campus and no clinical services. The required supervision of the psychologist trainees from these schools is done for a fee by a large number of practicing psychologists, who consequently have a vested interest in expanding, not contracting, to a level of output that meets actual needs. Concurrently, the profession of psychology has not done an effective job politically or educationally of differentiating the qualifications of a Ph.D. psychologist from a licensed professional counselor, or a Master's degree psychologist.

Problem areas certainly remain. Managed health care restrictions, some unique to Texas, still weigh heavily on hospital-based care. Part of this stems from the determination of payers to restrict hospitalization to that which is absolutely necessary, to authorize an inadequate number of days, and to set payment schedules both to the hospital and the professional staff at levels that are below those needed for any semblance of quality commensurate with medical need. Given the fact that hospitalization IS expensive, we should be supportive of efforts to limit unnecessary hospitalization. However, we should not acquiesce to rates that insure inadequate care, increase risk of bad outcomes as a result of these policies, or otherwise fundamentally violate our obligations to our patients and the profession of medicine. Most psychiatrists in Texas have simply walked away from this component of care. Both in psychiatry and other specialties in medicine there are some efforts to develop "hospitalists' whose largely full-time efforts are devoted to this component of care. I am generally favorable to this development, which is surprisingly similar to some elements of hospital-based care during the middle years of the last century at the Timberlawns, the McLeans and the Sheppard Enoch Pratts of the world. However, if this is organized along lines of simply developing an efficient, but underfunded and understaffed system, we dishonor our patients, our profession, and, for the many of us in academic settings, our trainees.

A peculiarly Texas-based problem is the abysmal funding for all health care and social services. In effect, the worst payors of inpatient care are in many instances state agencies. This is a fundamental problem for MH-MR services as well. Although much is written about restructuring MH-MR programs, the main issue is that the budgeted amounts that agencies such as Texas MH-MR have to utilize are among the lowest in the United States. Add to that a rural leaning group of legislators with a preponderant number opposed to and afraid of increasing taxes, and the difficulties posed medically indigent patients, or those caught up, both appropriately and inappropriately, in the criminal justice system, and the problems do seem insurmountable in the short term. This dimension of our difficulty will not be won by your individual efforts as a psychiatrist. Only through your active participation in TSPP, in TMA, and in other organized professional or political action groups will we ultimately improve these efforts. This task is particularly difficult in Texas, since many of the entities that should be shouldering a substantial portion of payment of tax revenues pay nothing. As examples, Dell, Southwestern Bell, and many of the largest banks in Texas legally paid no taxes to the state in 2001. Similarly, often Texas lets federal funds go untouched. CHIP (Texas Children's Health Insurance Program) provides an important health benefit to low income families. The legislature appropriated funds for the current biennium that are projected to be at least $20 million short of the amount needed given current utilization projections. Without identifying additional funds, the state will fail to receive $3 in federal funds for every $1 appropriated by the state under this Title XXI federal health insurance program. In other words, identifying an additional $20 million would bring a $60 million match from federal funds.

In summary, enjoy the opportunity for a more adequate quality of practice that is developing for many of us, but realize that all of your colleagues are not able to declare victory in this very complex political and regulatory environment. Remain active, and encourage your colleagues to do likewise in TSPP. In particular, understand that only to the degree that we elect politicians, leaders of professional organizations, and secure appointees to key boards who have an understanding of the needs for change in the way medical care is funded and regulated will the health benefits that we have the skills to provide be realized.

IN MEMORIAM

E. Winston Cochran, MD
Village Mills

Robert L. Stubblefield, MD
Houston

Your Committees at Work...

TSPPs committees met in Austin on February 16, 2002 and conducted their business, as follows:

Budget Committee: The committee reviewed financial investments and approved some investment changes. Financial reports were reviewed which indicated positive results thus far in FY 2001-2002. Contributing to the good financial performance is the decision to assume dues accounting from APA. It was also acknowledged that APA has made an effort to reimburse TSPP for past dues collected. The committee approved a dues reduction for a member and an APA dues waiver request of one member.

Children and Adolescents Committee: The committee reviewed recommendations of a Senate workgroup studying children's mental health issues and expressed a desire that a child psychiatrist be invited to future meetings of the work group. The committee discussed the status of managed care in several Texas cities.

Continuing Medical Education Committee: The committee reviewed and approved the Mission Statement for the CME program. The committee reviewed evaluations of the 2001 Scientific Program and continued its program planning for the 2002 Annual Scientific Program. The program for the 2002 TMA Section on Psychiatry program was reviewed and preliminary plans for the 2003 Section on Psychiatry program were discussed. The committee reviewed the 2000 and 2001 Needs Assessment recommendations of members and made plans to submit a Needs Assessment to the membership in 2002.

Early Career Psychiatry Committee: The committee reviewed a number of topics including encouraging participation by early career psychiatrists, activities for the Annual Conference, a mentoring program and submission of a candidate for Area 5 representative.

Fellowship Committee: The committee reviewed applications for APA Distinguished Fellow. Four applications were conditionally approved and two applications were deferred.

Forensic Psychiatry Committee: The committee reviewed the recent Attorney General Opinion on blanket prohibition on physician advertising and the 2002 TMA Section on Psychiatry program which will feature a mock trial. The committee also discussed the SB 553 Task Force on Trial Competency and the Insanity Defense and reviewed sections of TSPPs Strategic Plan pertaining to the committee.

Government Affairs Committee: The committee reviewed the psychologists' prescribing bill passed by the New Mexico legislature and discussed its potential impact in Texas and other states. Several other legislative issues were discussed including interests of physician's assistants and the business lobby. Updates were provided on the work of various legislative interim committees. Plans for launching TSPPs Political Action Task Force were reviewed and specific candidates were identified as Champions.

Long Range Planning Committee: The committee discussed financial and governance issues currently facing the APA. The committee recommended that a task force be formed to provide guidance to the TSPP Assembly Representatives regarding the APA issues discussed as well as guidance on how best the TSPP Assembly Representatives can best represent the interests of TSPP in APA governance and policymaking.

Managed Care Committee: The committee reviewed APAs position statement on Pharmacy Benefit Managers and discussed the CHIP program. The committee recommended the following policy statement to address the recent cost-saving measures by Medicaid regarding formularies: 1) Choice of medication shall be made by the treating physician; 2) Medications shall not be switched or substituted without consulting the treating physician; and 3) No "fail first" medication policies should be supported.

Members-in-Training Section: The committee discussed its efforts to effectively communicate with each other and topics for future *Newsletter* articles. The committee reviewed the policies of various residency programs regarding their support of organized psychiatry activities. Members were apprised of an opening for an ECP Area 5 Representative and reviewed their assignments in TSPPs Strategic Plan. The committee will continue to work on member involvement and ways to disseminate information about career opportunities.

Membership Committee: The committee reviewed membership statistics and a study of membership by Chapter and of non-members. The committee expressed the desire that TSPP send letters to non-members inviting their membership in the Society. The committee also discussed APAs policy requiring Chapter members to be members of the District Branch and APA and ways to assist Chapters with the policy.

Public Affairs Committee: The committee reviewed Chapter efforts to develop disaster response programs and ideas for developing a media plan. The committee also discussed the psychiatric bed closing crisis and requested that TSPPs hospital bed study be updated.

Professional Practices Committee: The committee reviewed a draft of Guidelines for Office-based Outpatient Withdrawal Techniques being developed by the Task Force on Addictive Disorders.

Public Mental Health Services Committee: The committee reviewed potential budget reductions for TXMHMR, NorthStar and the problems with Metracare in Dallas. The committee was also briefed on two important TXMHMR Task Forces: Mental Health Services and Benefit Design.

Task Force on Addictive Disorders: The committee approved Guidelines for Office-based Outpatient Techniques for Alcohol, for Anxiolytic/Sedative/Hypnotic Drugs, and for Opiates. The Guidelines will be submitted to the Professional Practices Committee for review and consideration. The committee decided to begin development of Guidelines for Outpatient Withdrawal Techniques for Stimulants and Hallucinogens.

UR Complaint Service Committee: The committee received an overview and update on TMAs hassle factor Program and discussed ways to maintain an ongoing collaboration with TMA. The committee also reviewed improved ways to file complaints with the Texas Department of Insurance through their website.

Executive Council Actions...

The Executive Council met in Austin on February 17, 2002 and approved the following actions:

★ At the request of the Budget Committee, the Council approved adjustments in TSPPs investments, approved a dues reduction for one member, and approved a waiver of APA dues for one member.

★ The Council endorsed the TSPP CME Mission Statement recommended by the CME Committee:

> "The mission of the TSPP accredited CME program is to provide information available in the field of Psychiatry to psychiatric physicians so that they may be kept up to date with medical developments in research, clinical practice, economics, legislation, ethics and other issues pertinent to their practice and be better able to serve their patients and practice their profession. Selected information is presented in one major conference annually using a lecture/discussion format, small group discussions and poster sessions. Other educational presentations are used from time to time. In addition to the annual conference, other CME presentations may be developed by the CME Committee. The CME Committee facilitates the development of other accredited CME conferences of benefit to the membership."

★ Upon recommendation of the Fellowship Committee, the Council conditionally approved applications of four members for APA Distinguished Fellow.

★ The Council approved a request of the Long Range Planning Committee to form a task force to provide guidance to the APA Assembly Representatives regarding current APA governance and organizational issues and to recommend how TSPP Assembly Representatives can best represent the interests of TSPP in APA governance and policymaking.

★ Upon the recommendation of the Managed Care Committee, the Executive Council approved the following policy on Medicaid formularies: 1) Choice of medication shall be made by the treating physician; 2) Medications shall not be switched or substituted without consulting the treating physician; and 3) No "fail first" medication policies should be supported.

★ Upon recommendation of the Membership Committee, the Executive Council approved four membership applications for Members-in-Training.

Congratulations...

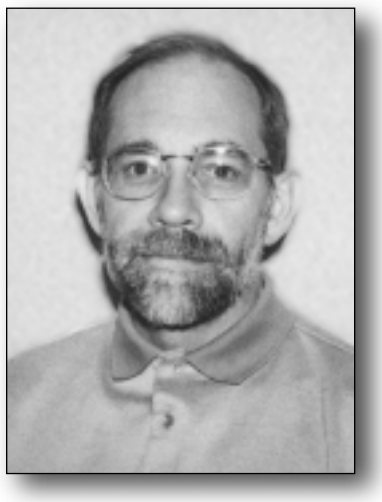
The APA will recognize the following TSPP Fifty Year Life Fellows and Members during the Annual Meeting Convocation Program in Philadelphia on May 20, 2002: **James M. Bailey, MD** (San Antonio); **Percy William Bailey, Jr., MD** (Kingwood); **Mischa Caplan, MD** (Houston); **Irvin A. Kraft, MD** (Houston); **Robert L. Leon, MD** (San Antonio); **James D. Malone, MD** (Fort Worth); **Laurence C. McGonagle, MD** (San Antonio); **Bonner L. Shinn, MD** (Dallas); and **Walter F. Speakman, MD** (Blanco).

POLITICAL ACTION

Psychiatrists and colleagues in Houston recently hosted a reception for Representative Kyle Kanek. Dr. Janek is in a race for Texas Senate. Pictured (l-r): Matthew Brams, MD, Alice Mao, MD, Kyle Janek, MD, and George Santos, MD

Unequal Protection

Joseph Castiglioni MD, PhD



JOSEPH CASTIGLIONI, MD, PHD

Among the questions that most psychiatrists ask themselves before they begin specialty training are two basic ones: first, what is a psychiatrist, and second, what makes a psychiatrist different from other medical specialists? There must be a fundamental difference, because insurance companies say there is via the different coverages for treating illnesses of the "mind" compared to illnesses of the "physical body." These coverage limitations trivialize the medical aspects of psychiatric practice and pose dangerous challenges to the discipline and practice of Psychiatry.

Social introductions often remind me of the uncertain ideas many people have about psychiatrists. A new acquaintance's reactions to me may change when the nature of my occupation is revealed. Often, there is a stunned silent pause. I imagine that the other person wonders what to make of me. Do I have some special power to read minds? Will I use it to analyze him or her during the social hour? Since I am someone who chose to work with the mentally ill, am I perhaps a little kooky myself? Should he step back from me- politely- but quickly? On the other hand, some introductions meet interest and a mildly deferential curiosity about the secrets of the human soul I might share over a cup of coffee. Occasionally the response becomes a request for illumination of his specific life situation and its management- a reaction perhaps not so different from that experienced by a dermatologist or family physician. But often the feelings transmitted to me are awkwardness and uncertainty, even a feeling of danger, reactions which I believe would not arise if I had answered, "I'm an obstetrician."

The amazing contrast to this feeling of uncertainty and possible danger is the attitude that psychiatric ministrations are trivial. After all, anyone can do psychotherapy! All you have to do is sit in the same room with the patient for long time...

The logic behind this attitude eludes me. For the sake of discussion, let's consider the positions of some of our siblings in the family of medicine. A huge percentage of patient visits to family practice offices result from emotional needs rather than physical needs. Mothers delivered their infants successfully for millennia before obstetricians were invented. Simultaneously, the mentally ill were abused, incarcerated or killed to relieve their demonic possession or redeem their moral deficits, until psychiatrists began to treat their conditions as another human malady. Yet obstetrics is perceived as a basic and essential component of the health care system, while mental health services often are "carved out" for discriminatory administration.

Most people empathize with those who suffer from medical illnesses that are clearly visible as undesired burdens on the afflicted, such as heart disease or lung disease. Many have suffered from or witnessed at close-hand such conditions of the body. All humans share the experience of birth, from one or more vantage points, and can relate to both the mother and the baby. Until recently, few of those who suffered from mental illness got empathetic recognition. Despite the relatively high incidence of treatable mental conditions, most Americans have no personal understanding of severe depression, psychosis or extreme irrational anxiety as illnesses of the biological body. Even seeing a family member paralyzed by depression may not enlighten someone disposed to blame the behavior on sloth or other moral imperfection. Lack of a basis in personal experience for understanding another's pain may cause the complaints to be pigeonholed in the category of "miscellany and other strange things." The intangible, and therefore deniable, nature of mental illnesses promotes their easy dismissal.

Art both reflects and drives a society's attitudes, and from that fact we may find hope. Some recent books and movies have depicted victims of mental illness as persons deserving respect and concern. Yet, while they may depict the illness itself with greater accuracy and sympathy than in the past, they still often minimize the role of psychiatric care in helping to manage the conditions. For example, the otherwise beautifully executed movie "A Beautiful Mind" suggested that love and uncommon will power pulled Dr. Nash from the worst of his psychosis. True, these aspects of the biopsychosocial model contribute greatly to recovery from psychosis, but enough appropriate medication on board makes a difference, too. For the most part in our culture, formal treatment for a mental condition remains suspect and merits only a dismissive acceptance. Despite efforts to destroy stigmas against the mentally ill and their treatment, our success in changing this attitude remains incomplete.

The domain of Psychiatry straddles the borderland of body and mind, that artificial divide created by Western philosophy. Biomedical research of the last few years proves that the mind and the body are not separate entities; instead they comprise an integrated system in which the body's mechanisms beget the mind and the mind modifies the body's functions. Psychiatrists have the most comprehensive training and theoretical background to treat this symbiotic entity. This perspective, and skill in using it, are what make our specialty valuable to the world.

The editors invite comments on this and other topics of interest to readers by sending Letters to the Editor.

MEMBERSHIP CHANGES

New Members

Since our last Newsletter publication, the following membership applications and status changes have been approved by the TSPP and transmitted to APA for approval and enrollment:

Member in Training

Beard, Laura, MD, Dallas
Carlson, Paul, MD, Dallas
Chenik, Richard N., DO, Lubbock
Cobb, John M., MD, Lubbock
Cruz, Francisco, MD, Houston
Elawady, Mohamed, MD, Galveston
Listengarten, Dmitry, MD, Galveston
Queenan, Kip, MD, Dallas
Salazar, Ricardo, MD, San Antonio
Temerova, Andra, MD, Lubbock
Vela, Vanessa, MD, Galveston
Yeganov, Vladislav, MD, Dallas

General Member

Benzick, Jeffrey, MD, San Antonio
Bogan, Robert E., MD, Spring
Graves, Gregory, MD, Dallas
Merkl, Christopher, MD, Houston
Taylor, Linda, DO, Austin

Member in Training to General Member

Chomchai, Jim, MD, Houston

Transfers from Other District Branches

Frazier, Demitrous, MD, San Antonio
Gabbard, Glen, MD, Houston
Istanbooly, Faye, MD, Rancho Viejo
Palchuru, Sree, MD, Houston
Patel, Neena, MD, Dallas
Poa, Edward, MD, Houston
Renazco, Marco, MD, Fort Worth
Shuey, Richard, MD, Austin
Streem, David, MD, Houston
Vail, Theresa M., MD, Tyler
Vaswani, Sanjay, MD, Dallas
Vital, Terri, MD, San Antonio
Walker, Daniel G., MD, Beaumont

TSPP Chapter Activities

APA President Visits Houston. APA President, Richard K. Harding, MD was an invited speaker at a recent meeting of the Houston Chapter. Pictured (l-r): Irvin M. Cohen, MD (Past TSPP President and Past APA Assembly Speaker, Richard K. Harding, MD, Pedro Ruiz, MD (APA Secretary), and George Santos, MD (Houston Chapter President).

Heart of Texas Chapter. This past year, the TSPP Heart of Texas Chapter has been revitalized through the initiative of Gail Eisenhauer, MD. Pictured below are Heart of Texas members who attended their meeting in January. Front row (l-r): Max Schubert, MD; Gail Eisenhauer, MD; Helen Zaphiris, MD; and, Victoria Morgan, MD. Back row (l-r): Lainie Shook, DO, Aurora Mignosa, MD, and, Suresh Durgam, MD.

The Ethics Corner

Milton Altschuler, MD

In the past several months there has been an increase in the number of people questioning me regarding the various remunerations for activities sponsored by the pharmaceutical industry. These remunerations have ranged from subsidization of programs, payment to attend dinner meetings and payments to act as a consultant for marketing products.

Perhaps the increase and the inquiries have been due to the increase in the compensation by the pharmaceutical industry to psychiatrists attending their programs. An article in the New York Times on January 18, 2002 was devoted to the issue that Merck Pharmaceuticals was going to abandon much of these various remunerations. Interestingly enough, that specific article mentioned expensive weekend trips and other more expensive remunerations than I am aware of among psychiatrists in Texas.

The AMA guidelines published in 1990 on ethical considerations between physicians and the pharmaceutical industry gives a fairly descriptive general view of the situation.

The pharmaceutical industry does provide excellent benefits to physicians and patients in the form of free samples, free medication to individuals unable to afford the medication, and, just recently, Pfizer Pharmaceuticals announced a subsidization of their medication for seniors who have low income and are unable to afford the full price of their medications. They also provide educational programs for the physician and various research articles at the physician's request.

Apparently the major issue deals with the marketing of their products. The subsidization of dinner programs, lunches, sampling by pharmaceutical representative, payment for "consulting fees" and other means of rewarding physicians are primarily marketing expenses for the physicians to use their products. By themselves there is no ethical violation in the accepting of these fees as long as the physician maintains their primary responsibility toward their patients. This always continues to be the overriding factor in the practice of medicine. There are no hard and fast rules, nor any "line in the sand" that tells individual physicians "this is right and this is wrong." It is for this reason that ethical papers are written as guidelines rather than regulations. No one knows what amount of money corrupts the prescribing of medications for patients. Perhaps it is $50 for one individual and $10,000 for another. Each person must search within themselves when they are prescribing medications for patients and ask themselves "is this medication the most efficacious for this specific individual?"If it is not and the physician is writing a script because they had just attended an expensive program put on by a specific pharmaceutical company then they have to question their own ethical boundaries. Again, referring to the AMA ethical guidelines between physicians and the pharmaceutical industry, there are no hard and fast rules, but there is an attempt to place the issues I have described into perspective. In spite of being redundant, primary consideration of the physician is not toward the good will of the pharmaceutical industry but toward the efficacious treatment of each and every individual patient that the physician sees.

I would welcome any questions or further discussion, which I will be happy to include in the next column.

AMA ETHICAL OPINION ON GIFTS TO PHYSICIANS FROM INDUSTRY

Many gifts that are given to physicians by companies in the pharmaceutical, device, and medical equipment industries serve an important and socially beneficial function.

For example, companies have long provided for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with the principles of medical ethics.

To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted.

Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (e.g. pens and note pads).

Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible.

Since the giving of a subsidy directly to a physician by a company's sales representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor, who, in turn, can use the money to reduce the conference's registration fee.

Payments to defray the costs of a conference should not be accepted directly from the company by the physicians who are attending the conference.

Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of the physicians who are attending the conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time.

Subsidies for hospitality should not be accepted outside of modest meals or social events that are held as part of a conference or meeting.

It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging and meal expenses.

It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging and meal expenses.

Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out of pocket expenses.

Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution.

No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices.

In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

American Medical Association Code of Ethics for the Medical Profession, Dec. 3, 1990

A Crisis of Capacity

continued from page 1

chiatrists noted lack of adequate insurance coverage and managed care gate-keeping as major barriers to accessing care. A large majority of psychiatrists believed that State regulations added costs and delays to patient treatment.

I would add that some of these same factors have grown and multiplied over the years. Managed care companies have greater influence in part because actual number of behavioral healthcare organizations (BHO) is shrinking into fewer, but larger companies. These larger BHO's, with consequent greater market influence, are notorious for dictating what levels of care will be used and what constitutes medical necessity. It is routine today for one of the largest BHO's to deny any use of partial hospitalization, or Day Hospital, as being "the same as inpatient." They now only want to use Intensive Outpatient (IOP) services, as these are cheaper. We are all familiar with the long-standing managed care BHO practice of delaying, and/or decreasing the actual payment of services to the physician or hospital. In Houston, I am the Medical Director of a large psychiatric hospital. There are many times when we are called in the night by a general hospital that has an insured patient in their emergency room whom no one will accept for transfer. The problem arises when no physician will accept that insured patient because that particular insurance company, one of the largest BHO's, has a well-earned reputation and history of hassle and nonpayment. This is what I have come to refer to as the functionally uninsured.

The net effect of all of these factors, increased costs and decreased revenues, has led to the decline in available services, both inpatient and outpatient. It has also created a system in which we may no longer have sufficient capacity to meet all of the needs of those who seek mental health treatment.

There is additionally an important impact in the relation between the public and private sector. They have been brought into closer direct competition. This has been at the cost of indigent services, as well as private/insured services. The public sector of mental health treatment in Texas has always suffered under the burden of inadequate funding. Texas has long been ranked near the bottom, around 47th, for per capita funding for mental health. The trend of the last several years has changed the nature of the public sector as well. It has worsened an already difficult setting. The MHMR's of our State have a relative financial mandate to increase their earned income in the provision of their services to the pubic. That is to say the general revenue funds will not increase significantly. So, in order to function, more income must be generated locally. The required efforts to manage costs have understandably led to decreased overall services. This has meant, at least in Houston, decreased services for the indigent. The "safety net" for the indigent is vanishing. There is considerable effort underway to increase those patients who have insurance of some sort, third party, managed care, or federal. As such, in some important ways the public sector has come into greater competition with the private sector.

Add this in to the burden of doing business in the private world. The costs have continued to rise and the reimbursements decline. The hassle factor has worsened. Many psychiatrists are leaving inpatient practice. More hospitals are looking for "Hospitalists." Where this is not necessarily a bad idea, it is also not necessarily good care. It is certainly not good continuity of care. In the end, as we have seen in the TSPP study, many hospitals have simply gone out of business, or at least gone out of the psychiatric business.

Many of these conditions have reached a level that the "market" may demand change. We cannot have a growing population and a shrinking base of mental health service capacity. The recent challenges to our communities have sensitized many of us to the dire nature of the situation. In Houston, we had floods that closed or affected several of our hospitals. It became clear that there was no reserve capacity in our community to accommodate the further closure, or even the temporary interruption of services of any of our major psychiatric facilities. The September 2001, terrorist attack fortunately did not lead to a large increase in need of inpatient services down here, but did result in greater outpatient treatment needs. The diminishing services to the indigent risks increased use of more expensive and less effective emergency treatment, or worse use of the jail system. The question is, do we any longer have the capacity to meet our basic needs, much less extraordinary needs. It appears we are at the limit.

Sometimes, psychiatric issues are so hush-hush that they go unseen until there is a crisis. Well, we are there. So it is now our task to bring this message to the public. It comes to our organization and our colleagues to develop and carry this message to the Legislature. This issue is tied to almost every one of our legislative agenda items. We must have more successful efforts in the arena of managed care reform to help bolster the public and private sectors. Both in fact are increasingly reliant on this form of patient revenue to stay afloat. Managed care is not going to just disappear, but it can be molded into a less horrifying form. Hopefully, we can make headway in decreasing the cost of providing psychiatric care. This may require efforts to modify the explosion of regulations aimed at psychiatric care to a more manageable level. There are many ways to address these issues, but we have to begin with educating people that there is a crisis in our State, and it can affect all of us. It clearly affects those with and those without insurance who may need psychiatric treatment. All of our TSPP branches will hopefully make efforts to get this message out and give it the local flavor that is meaningful to each community's legislators. With coordinated efforts, we can be successful in moving that pendulum at least a little way back into the right direction.

APA Launches Political Action Committee

Jack McIntyre, MD, Chair, APAPAC Board of Directors

In response to APA members' interest in expanding APA advocacy and with the recent change in APA's tax status, psychiatrists are now able to support federal candidates who will best represent psychiatry's interests in Congress through the American Psychiatric Association Political Action Committee (APA*PAC*). APA*PAC* now provides the association with a direct opportunity to support the election of federal candidates who will best advocate for psychiatry's interest in Congress.

Here is what one of psychiatry's strongest allies in Congress has to say about why APA members must actively support their PAC: "If you want to influence public policy, you need to take advantage of every venue in which there is an opportunity to make your voice heard. That means going to local meetings with your elected representative, it means writing letters on issues, it means joining coalitions for group meetings with your representative on issues, and it means participating in PAC events. PACs provide you with another opportunity to make your voice heard and to have direct interaction with elected representatives," says Congressman Pete Stark (D-CA), the Ranking Member on the House Ways and Means Health Subcommittee.

A strong, vigorous PAC is an integral part of APA's campaign to educate and influence Congress about the needs of our profession and our patients. Thanks to APA lobbying — and including the efforts of the now defunct Corporation for the Advancement of Psychiatry's PAC (a group of politically concerned psychiatrists that, until the establishment of APAPAC, served as the only organized entity that allowed psychiatry to take a more active role in the political campaign process) — 66 Senators sponsored a parity amendment in the Senate, and 244 Representatives have publicly stated support for parity in the House. It is not coincidental that many have received CAPPAC support. We are making progress on Medicare reform, protecting the privacy of medical records, and ensuring quality care to our patients by making certain that only appropriately trained physicians be allowed to prescribe psychotropic medications. Your PAC support enables APA to maintain our proactive education and lobbying campaign. In addition, as APA members, we must be certain that no laws are made and no regulations are established that would negatively impact our practice of psychiatry or psychiatric patients without the opportunity for comment and education from the psychiatric community. This marks the first time that the APA has a political fundraising voice and individual APA members will be able to directly participate in advancing our goals for our patients and the profession of psychiatry.

"If you want to influence public policy, you need to take advantage of every venue in which there is an opportunity to make your voice heard.

Congressman Pete Stark (D-CA)

As APA President Richard Harding states, "Psychiatrists have traditionally been lousy politicians. Many APA members find the national political process distasteful, but our choice is a simple one — have a seat at the table or cede our place to others who most certainly do not have our patients' and psychiatry's best interest in mind."

We must reinforce our advocacy with tangible support for our political friends and tangible opposition to those who oppose us, or we will pay a heavy price. With Election Day 2002 only eight months away, we face a crucial time that will determine what protections are in place from abusive managed care practices for patients and the profession, protection of the privacy of medical records, any expansion of prescribing privileges to non-physicians, the future of mental health parity, and reimbursement funding for psychiatrists. Supporting the PAC will enable the APA to maintain and increase our proactive education and lobbying campaign on these, and other, issues.

With the well financed, determined efforts of those who want to elect candidates positioned to oppose mental health policy in the interests of our profession and patients, we must take every step possible to elect candidates who will have the courage and determination to work with us. Congressman Jim McDermott (D-WA), a psychiatrist, notes that "…Participation in this country's democracy matters. As a psychiatric physician, voicing your opinion on policies before the Congress and engaging in debate can make a significant difference in the direction of health care policy, and in particular, mental health policy."

I urge you to take an active roll in advocating for both your practice and your patients through your voluntary APA*PAC* contribution; because how far Congress is able to go in the session to protect our patients and our practice will depend on our ability to reach, educate, and elect Members of Congress. The success of APAPAC depends 100% on your voluntary support. Please send your voluntary contribution to APA*PAC* – 1400 K Street, NW, Washington, DC 20005. Corporate contributions will not be accepted.

For more information on how to become involved with APAPAC, please contact Jason Pray at (202) 682-6393, or by e-mail at apapac@psych.org.

Texas Society of Psychiatric Physicians

COMMITTEE/EXECUTIVE COUNCIL MEETING SCHEDULE

Adolphus Hotel, 1321 Commerce St., Dallas, Texas

Reservations: 1.800.221.9083

Saturday, April 20

8:30 AM - 6:00 PM	Committee Hospitality Room	James Allred (Mezzanine Level)
	Refreshments & Light Hors D'oeuvres For Committee Members	
8:00 AM - 9:00 AM	UR Complaint Service Cmte	David G. Burnet (Mezzanine Level)
	Task Force on Addictive Disorders	John Neely Bryan (Registration Level)
9:00 AM - 10:30 AM	Public Mental Health Services	David G. Burnet (Mezzanine Level)
	Children and Adolescents	John Neely Bryan (Registration Level)
	Continuing Medical Education	Dan Moody (Mezzanine Level)
10:35 AM - 12:00 PM	Ethics	Dan Moody (Mezzanine Level)
	Budget	David G. Burnet (Mezzanine Level)
	Professional Practices	John Neely Bryan (Registration Level)
12:05 PM - 1:30 PM	Foundation Board of Directors Luncheon	Pat Morris Neff (Mezzanine Level)
1:30 PM - 3:00 PM	Managed Care	John Neely Bryan (Registration Level)
	Members in Training	Dan Moody (Mezzanine Level)
	Long Range Planning	David G. Burnet (Mezzanine Level)
3:00 PM - 4:30 PM	Forensic Psychiatry	John Neely Bryan (Registration Level)
	Early Career Psychiatry	David G. Burnet (Mezzanine Level)
	Membership	Dan Moody (Mezzanine Level)
4:30 PM - 6:00 PM	Government Affairs	David G. Burnet (Mezzanine Level)
6:00 PM - 7:30 PM	Reception	Sam Houston A (Mezzanine Level)

Sunday, April 21

9:00 am - 12:00 pm	Executive Council	Sam Rayburn AB (Registration Level)

TMA Section on Psychiatry

Forensic Psychiatry and Medical Practice

The TMA Section on Psychiatry Program "Forensic Psychiatry and Medical Practice" arranged by R. Sanford Kiser, MD, Program Chair and TSPP President-Elect, will be conducted on April 19, 2002 in Dallas at the Adams Mark Hotel. Upon completion of this program, participants should be able to: 1) utilize information from recent laws and regulations that affect patient care to achieve optimal treatment outcomes; 2) apply the skills necessary to testify in various settings for the best benefit possible; and 3) identify the various legal and regulatory entities that create and maintain rules and/or statutes affecting patient care and use these entities as a resource.

The program, which begins at 8:30 am in the Dallas Ballroom A-3, will feature a mock medical malpractice settlement conference with speakers from the Texas State Board of Medical Examiners and a mock psychiatric malpractice trial led by Michael Arambula, MD. The program will also include the following presentations: "Working with Attorneys" by William H. Reid, MD; "Assessment of Threats" by Victor Scarano, MD; "A Mock Worker's Compensation Hearing for Psychiatric Problems" led by Peter N. Rogers, JD; and "Psychiatric Profiling of Terrorists" by J. Douglas Crowder, MD. The meeting will conclude at 5:00 pm.

From the Outside

Daniel Creson, MD,PhD

The importance of understanding the past in order to make sense out of the present is often overlooked. One lifetime is sufficient to loose much of the richness of the lives that have gone before. Our predecessors in this profession of psychiatry were real men and women not cardboard cutouts. They should be remembered as such. Please attend to Beth White's appeal in the article that follows. When we fail to respond we deny future practitioners any perspective on the foundation on which their professional lives are built.

Who Will Tell the Story?

Elizabeth Borst White

The questions began when I saw the 1917 advertisement, "For Nervous and Mental Diseases — Alcohol and Drug Additions." The picture is a palatial estate, Dr. Greenwood's Sanitarium, located in the coolest part of Houston with artesian water and electric lights. This ad answered the basic historical questions of who, what, where and when, but it piqued my interest. I wanted "the Rest of the Story."

How many others at this time were treating private patients for drug and alcohol addictions in Houston? In Texas? What treatments were available? Research revealed neuro-psychiatry as the new medical specialty practiced by Dr. Greenwood and other contemporary physicians. This same research uncovered ads for other sanitariums that specifically excluded patients with addictions. Was this to avoid a social stigma or an attempt by the practitioners to differentiate diseases and to provide specific treatments for a variety of conditions?

My questions and research have focused on one small institution in Houston, Texas. The story of this small hospital is just one of thousands to be told about mental health care in Texas. There are hundreds of other sanitariums, clinics, and hospitals in Texas whose stories are just as important. In addition, there are the stories of individuals, their careers, and accomplishments in mental health care that should be preserved.

The story of psychology and psychiatry in Texas is largely untold. This history is not without moments of melodrama. These include the forensic circus of the Governor of Louisiana held against his will in a Texas psychiatric hospital, the complaints of citizens that mental patients housed in jails kept them awake at night, and the pointless murder of a medical superintendent on the front steps of Austin State Hospital. This is the history of real people, often eccentric, frequently brilliant. It is not just the history of practitioners but also of influential families like the Hoggs, the Moodys, and the Hobbys. It is a history of those who were not just care providers but legislators, judges, ranchers, and entrepreneurs.

Because the history and development of mental health programs and services in Texas have been largely ignored, the Houston Academy of Medicine-Texas Medical Center Library has established a Center for the History of Mental Health Care in Texas. This Center is already collecting and will provide access to primary materials documenting mental health care in Texas. Some materials will focus on the changing opinions and actions in the State's role in caring for the mentally iil. Other materials will focus on the career of one individual and his or her contributions in a community or institution.

Copies of speeches, minutes of meetings, letters, hospital records, audiotapes, videotapes, legislation, newsletters and other printed materials provide valuable primary information for historians and researchers. Descriptions of treatment, memorabilia from special events, photographs of people and buildings can help fill the gaps in our understanding of mental health care in our State.

The Center for the History of Mental Health Care in Texas is asking for your help in locating additional materials to enhance this historical resource. Donations of documents are always appreciated, but just as valuable would be information on where collections are located. One function of the Center will be to serve as a reference center to help individuals locate materials in collections throughout the State. We already have a large database, the *Gazetteer of Texas Physicians*, which allows us to locate biographical information in national and regional medical journals. A related database for oral history interviews and manuscript collections in other repositories is being built with a focus on mental health practitioners.

Selected materials will be made available through the Internet as full text documents. An example is the story of *Little Rock Joe* (http://mcgovern.library.tmc.edu/Psych/Contents). This is an exceedingly rare book written by a patient at the Terrell, Texas asylum. This web presentation, a collaborative effort with the Center for American History at the University of Texas – Austin, is a unique resource for the study of care from the patient's point of view.

Who Will Tell the Story? You! You can help to build the collections and databases in the Center for the History of Mental Health Care in Texas by providing documents to be preserved and information on other collections available for researchers.

Much of this history has been lost. Because much more will disappear in the near future, it is critical to take action now to preserve our heritage.

Elizabeth Borst White is Director, John P. McGovern Historical Collections and Research Center, Houston Academy of Medicine-Texas Medical Center Library, 1133 John Freeman Blvd., Houston, Texas 77030, Telephone — 713-799-7139; Email — mcgovern@library.tmc.edu

Medicaid Fee Increases Approved

Acting on recommendations submitted by the Physician Payment Advisory Committee (PPAC), the Texas Health and Human Services Commission on January 18 began implementing additional increases for physicians and other practitioners participating in the Medicaid program.

Medicaid fee increases were a top priority for the Texas Medical Association and TSPP during the 2001 session of the Texas Legislature.

The first increase is for CPT code 99213, which will rise from $27.28 to $29.52, an 8.2 percent increase. The second increase is targeted to "high-volume" Medicaid practitioners. A "high-volume" practitioner is defined as a primary care physician who averages at least 300 Medicaid patient encounters per month, or a specialty care physician who provides the top 50 percent of services within his or her individual specialty. Fee increases will be implemented statewide in both the traditional Medicaid and Medicaid managed care service areas.

Physicians classified as "high volume" practitioners were notified by the state recently. On average, "high volume" specialists will receive a 6.1-percent payment increase, while "high volume" primary care physicians will receive a 1.9-percent increase. The PPAC recommended giving "high volume" specialty physicians a larger percentage increase since primary care physicians principally will benefit from the increase in CPT code 99213 as well as increases previously enacted last year.

The newest recommendations build on a fee increase enacted September 1, 2001, that raised the fees for Texas Health Steps (EPSDT) medical screening exams from $49 to $70. All of the fee updates were ordered by the last session of the legislature, which directed the state Medicaid program to increase payments for Medicaid professional services by $50 million over the 2002-2003 biennium. The legislature directed the Medicaid program to use the new monies to improve primary care services and also to reward the vital "high-volume" practitioners along the Texas-Mexico border, in inner-city communities, and in rural counties.

In other Medicaid news, state rules making it easier to enroll children in the Medicaid program took effect January 1. The new rules were established by the legislature last year when it passed – at the urging of TMA and TSPP – Senate Bill 43 by Judith Zaffirini (D-Laredo).

Some 600,000 eligible children are expected to benefit from the simplified Medicaid system.

Parents may now fill out and mail a simple and shorter application for both Medicaid and the Children's Health Insurance Program to the Texas Department of Human Services (DHS). In-person interviews with DHS staff are not required for a child to be qualified for Medicaid. In addition, ongoing health coverage is provided for at least six months without reporting changes in income or resources to DHS.

Parents can receive an application by calling (800) 647-6558,or their local DHS office, or logging on to www.texcarepartnership.com.

MIT Section

Looking Forward

Scott Woods, MD

I hope you'll allow me some latitude in the next few paragraphs, but I thought I'd share some of the musings of this resident nearing the end of training. I'm a second-year child psychiatry fellow at UT Southwestern and in five short months, I'll finish what has amounted to twenty-five consecutive years of formal education and training. I still vividly recall my first day of gradeschool and the anxiety and excitement I felt then. Those same mixed feelings are re-emerging as I approach my last day of school ever. My extended adolescence is almost over, and I daily wonder "what will I do next?" Like all good parents, residency training has prepared me to succeed on my own, and I eagerly anticipate beginning my career. The anxiety kicks in as I realize that I still haven't finalized what I'm going to do starting July 1, but I'm pretty sure my student loan repayments begin on that day. For me, three factors have helped mitigate some of the anxiety and make this transition one to look forward to.

First, I feel that whatever I choose to do, I have the confidence that I am a well-trained child and adolescent psychiatrist who can handle about any clinical problem that walks through the door (some of you more seasoned docs are no doubt chuckling right now). There is the wonderful feeling of competency that emerges as we're nearing the end of training that really propels us forward into becoming good clinicians. I know that feeling sometimes wanes and is tempered by the cases that leave us feeling helpless and scratching our heads. I'm already compiling a list of colleagues to call for help when this happens (please be advised: you may be on the list).

The statistics showing the prevalence of mental illness in kids and teenagers is impressive, and the fact that only a fraction ever receive treatment is worrisome and saddening.

Second, it's exciting knowing that my services as a child psychiatrist are greatly needed and will only become increasingly so in the coming years. Whether or not these services will be greatly valued (i.e. reimbursed) remains to be seen. The statistics showing the prevalence of mental illness in kids and teenagers is impressive, and the fact that only a fraction ever receive treatment is worrisome and saddening. As you've probably heard, the Surgeon General and other national experts are foreseeing a potential crisis in the next two decades. While part of the problem lies in a severe shortage of child psychiatrists all over the country, it also involves the ever-present funding issues, plus early recognition and referral for those kids who suffer and need help. While our residents in child psychiatry interact a great deal with the pediatric residents (which helps with awareness of the problem), there is no formal training or exposure to child psychiatry during pediatric residency. My hope is that this will change. A resident at our institution's busy peds clinic told me recently that around one in five kids she sees these days is there for some type of behavioral or emotional problem. And even when the problem is recognized by the primary docs, they can't seem to get these kids referred for help. My experience in Dallas has been that parents must wait up to two or three months for an evaluation by a child psychiatrist. Often the treatment is relegated to ten-minute med-checks for what are usually complicated biopsychosocial issues that never get uncovered. We can do better.

SCOTT WOODS, MD

Finally, I'm excited about starting my career because I know without a doubt that there's nothing else I'd rather be doing. Sometimes I still can't believe that I'm going to make a respectable income for doing something so challenging, rewarding and fun for me. We should all feel this way about our jobs. Today, for instance, I got to spend an hour talking with a thirteen-year-old girl with conversion disorder and spent an hour playing with Play-Doh and drawing pictures with, a five-year-old who has selective mutism. What an awesome day!

My hope is that other aspiring doctors will see what a great profession this is and want to be a part of it. Whatever I end up doing after graduation, I hope I'll maintain this enthusiasm and enjoyment for many years, and for all the graduating psychiatrists this year, I wish you the same.

CALENDAR OF MEETINGS

MARCH

1-2 **TMA Specialty Retreat**
"Building Synergy to Prepare for the Perfect Storm"
Thompson Auditorium, TMA Building
Austin, Texas
Contact: Lisa Jackson, 512/370-1300

APRIL

12-14 **Current Controversies in Forensic Psychiatry**
Tulane University School of Medicine
Chateau Sonesta Hotel, New Orleans, LA
Contact: 800/588-5300

19 **TMA Section on Psychiatry**
Forensic Psychiatry and Medical Practice
Adams Mark Hotel, Dallas, Texas
Contact: 512/370-1300

20-21 **TSPP Committee and Executive Council Meetings**
Adolphus Hotel, Dallas, Texas
Contact: Debbie Sundberg, TSPP Assistant Director, 512/478-0605

26 **HIPPA Compliance Seminar**
Batterymarch Conference Center, Boston, MA
Contact: Cynthia Smith, 800/245-3333 ext. 347

27 **Houston-Galveston Psychoanalytic Institute and Society**
"Passions in the History of Psychoanalysis"
Joyce McDougall
Kleberg Auditorium, DeBakey Building, Baylor College of Medicine
Houston, Texas
Contact: 713/523-9942

MAY

18-23 **APA Annual Convention**
Philadelphia, PA

NOVEMBER

15-17 **TSPP Annual Convention and Scientific Program**
"New Frontiers in Psychiatry"
Worthington Hotel, Fort Worth, Texas
Program Contact: Debbie Sundberg, TSPP Assistant Director, 512/478-0605
Hotel reservations: 817/870-1000

15 **TSPP Committee Meetings**
Membership Luncheon
Reception with Exhibitors

16 **Scientific Program**
Annual Business Meeting
Executive Council Meeting
TSPP Awards Banquet

17 **Scientific Program**

TSPP MEMBER INFORMATION UPDATE

NAME

ADDRESS

CITY STATE ZIP

( ) ( )
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512/478-5223 (fax)/TSPPofc@aol.com (E-mail)

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