



# SOUTHLANDS

## **The Newsletter of the Southern Psychiatric Association**

Volume 7, Number 1

JULY 2021

<b>Article Title</b>	<b>Author</b>	<b>Page #</b>
Greetings From the President	Margaret (Kea) Cassada, MD	2
Executive Director Update	Janet Bryan	2
Program Committee Update	Mary Jo Fitz-Gerald, MD, Chair Mark Wright, MD, Co-Chair	2
Report From The APA Assembly	Mark Komrad, MD	2-3
Thank You To Our Supporter: Sheppard Pratt	Janet Bryan	3
Interview with Ronald Burd, MD	Bruce Hershfield, MD	4 – 5
BYLAWS: Proposed Change in Officers' Terms	Vince Liberto, MD	5
Thank You To Our Supporter: Professional Risk Management Services (PRMS)	Janet Bryan	5
Keep Old Shrinks Going?	Steven Lippmann, MD	5 – 6
India's Second Wave of COVID-19: Why?	Satya Harika Manda, MBBS & Steven Lippmann, MD	6 – 7
COVID-19 and Opioid Addiction	Gurpreet Singh Guliani, MD & Steven Lippmann, MD	7 – 8
Maintenance of Bureaucracy (and its Invasive Spread)	William Greenberg, MD	8 – 9
The APA and the ABPN's Maintenance of Certification	Shree Vinekar, MD	9 – 11
Is Psychiatry Ever Going Back to Normal?	Jenny Boyer, MD	11 – 12
To Fight Anti-Asian Hate, We Must Talk About It	Krysti (Lan Chi) Vo, MD	12 – 13
Coping with the COVID-19 Pandemic: A Psychiatrist's Perspective	Shree Vinekar, MD	14 – 15
Member News: Felix Torres, MD, Elected as M/UR Trustee		15
Welcome New Members: Clinton Martin, MD Paul Nestadt, MD Oscar Perez, MD		15 – 16
In Memoriam: Lou and Judy Cancellero	John Hendrick, MD	16 – 17
In Memoriam: Joseph Napoli, MD	William Greenberg, MD	17
Letter from the Editor: Paul O'Leary, MD, 1975 – 2021	Bruce Hershfield, MD	18 – 19
2021 and 2022 Meeting Dates		19
October Annual Meeting Registration Form / Program Agenda		20 – 22



**Greetings From the President**  
By: Margaret Kea Cassada, MD

Here in Mississippi, the cotton is waist-high, and the corn is already above my head – so summer has arrived, even if the calendar still says it is spring. Earlier this year, when my state was still locked down, I planted a vegetable garden, thinking I would have time to tend it. But, as spring progressed, we opened back up (Safely!), and now I am back to business as usual, burning up the roads in the Mississippi Delta. The tomatoes are getting choked out by weeds, but I could not be happier! I am immensely grateful to have the rhythm of my life returning to something like normal after the “annus horribilis” of 2020. I hope spring is unfolding similarly in your neck of the woods.

Our organization proved itself to be strong and resilient last year. We successfully survived unprecedented challenges and held a great meeting, using new technology and immense creativity. We added members, and our office holders continued to meet. All of this was due to the hard work of our dedicated executive director, Janet Bryan. She is the hero of 2020 for the SPA, and I cannot praise her enough.

In October, we will hold an in-person meeting in Huntsville, Alabama, in conjunction with the Alabama Psychiatric Physicians Association. I hope to see you all there, and I hope the meeting will focus on what binds us all together so we can begin rebuilding connections that have frayed over this past year.

Unfortunately, at the meeting, we will miss the familiar face of one of our most dynamic, brilliant young colleagues, Paul O’Leary. I know you all join me in sending heartfelt condolences to his family.

Audrey Hepburn said that to plant a garden is to believe in tomorrow. I remain hopeful and positive for the future of our association and look forward to seeing you all in October.



**Executive Director Update**  
By: Janet Bryan

The year has proven to be one of continuous changes – from the COVID-19 vaccine roll out, the re-opening of businesses, and changes on how we need to adapt as pandemic restrictions are lifted. As we return to some semblance of normal, this year’s annual meeting at the Westin Hotel in Huntsville, Alabama, October 6 through 10, will be an in-person event. We have a variety of topics for the scientific sessions and look forward to connecting with each other

at the social events. Please see the attached agenda for the full program.

If you have not registered for the meeting or hotel, attached is the meeting registration form. Here is the link for hotel reservations at the Westin Huntsville: [Book your group rate for APPA/SPA Joint Fall Meeting Oct2021](#) Reservations for this group rate ends September 17, and there are a limited number of rooms available in the group block.

We are actively recruiting exhibitors for the meeting; please refer anyone to me who you think may be interested. I look forward to seeing you in Alabama this October!



**Program Committee Update**  
By: Mary Jo Fitz-Gerald, MD  
Program Committee Chair &  
Mark Wright, MD  
Program Committee CoChair

The Program Committee is excited about the scientific sessions and speakers lined up for this year’s meeting, scheduled for October 6-10 with the Alabama Psychiatric Physician’s Association at the Westin Hotel in Huntsville.

We will begin with the Welcome Reception on Wednesday evening. The scientific sessions will begin on Thursday afternoon, October 7, and run through Saturday afternoon, October 9. We will conclude with the Farewell Dinner Gala on Saturday evening.

This year’s program includes panel sessions on art and psychiatry, neuromodulation, racism, diversity, and community-based resources and resilience. On Friday and Saturday morning, we will begin with a 30-minute Tai Chi practice. Please see the attached program agenda for the full schedule.

We are looking forward to seeing everyone in Huntsville this October!



**Report From The APA Assembly**  
By: Mark Komrad, MD  
SPA Rep to the APA Assembly

The APA Assembly had its semiannual meeting in April. Like the meeting last Fall, we met entirely on Zoom. I want to report on the latest information and share a few of the actions of the Assembly that might be of interest to the SPA membership.

In January 2021, the APA published an apology for its role in promoting racism in Psychiatry. The apology became one of the APA's most widely read social media posts in years. The Associated Press release is now the most viewed release in the last 5 years on its website.

The APA successfully quashed an effort to allow VA psychologists to prescribe and also quashed an attempt to change the definition of "physician" in the Medicare program to include clinical psychologists.

The APA was also instrumental in designing, and getting Congress to pass, the Behavioral Health Compliance Act to enforce parity laws, especially designed to focus on inequity in mental health care reimbursement.

A new draft of the MOC standards by the American Board of Medical Specialties was issued. It proposed decreasing the MOC interval from 10 years to 5 years! Open commentary was solicited online through early July. The APA reiterated its stance that it does not believe MOC should be used as a requirement for employing psychiatrists. It notified the ABPN that it will be conducting a feasibility study of establishing its own board for initial and ongoing certification. The APA Board of Trustees asked the ABPN to conduct a rigorous study to establish what, if any, value participating in MOC provides diplomates or patients, versus non-certified psychiatrists with respect to patient care outcomes.

An APA model for state telehealth legislation has been provided to 25 different states to help in their attempts to establish laws to continue their current openness to this important modality.

Several interesting APA Position Statements were approved:

- Addressing clinician mental health and mitigating "moral injury" to healthcare professionals during the pandemic.
- Opposing and publicly condemning white supremacy and all forms of institutionalized racism, while educating the public on the harm of erroneously conflating white-supremacist violence with mental illness.
- Requiring psychiatry residents and fellows to be supervised in medical diagnosis and treatment by physicians, board-certified or eligible, and not solely by "advanced practice providers".
- Reducing barriers to interstate telepsychiatry services. Specifically, this position statement supports full license reciprocity across all states, extension of current federal licensing exemption for any patient whose care is supported through federal funding, and national legislation that changes the location of a virtual medical evaluation – from the current standard of being located where the patient is during the encounter, to occurring at

the provider's location. Also, it supports the idea of a national telehealth medical license.

Several "action papers" that were passed may be of interest to SPA members:

- An initiative to annually track the numbers of active mental health practitioners in the US, inclusive of psychiatrists, nurse practitioners, physician assistants, prescribing pharmacists, and psychologists, so that we can understand and predict future needs. These are important data for those thinking of becoming psychiatrists, or who are yet early in their training. It asked that results be widely shared on the APA website and elsewhere.
- The APA was asked to develop disclaimer language about the inability of healthcare providers to acknowledge, address, correct, or refute online reviews, especially false ones. It will engage with other professional healthcare organizations to advocate for federal legislation to require attaching such a disclaimer to any online healthcare review.
- A request that the APA develop a policy to support pre-employment screenings of law enforcement personnel and civilian support staff that includes duty fitness assessments to determine an individual's capacity for adaptability, emotional regulation, stress tolerance, integrity, ethics, resilience, and implicit bias.
- The creation of two task forces: one to develop an official APA position on the use of Transcranial Magnetic Stimulation and one to develop a new APA component in the general area of Neuromodulation.
- A directive to the APA to establish an annual award to the DB whose action has demonstrated a commitment to making amends for both the direct and indirect acts of racism in psychiatry.

Sadly, this year, the Assembly lost two of its beloved leaders who were both Speakers as well as mentors: Joe Napoli and Paul O'Leary. They were both cherished guides to me personally and will be dearly missed by me and all our colleagues.

**Thank you to our Supporter – Sheppard Pratt**

By: Janet Bryan, Executive Director

The Southern Psychiatric Association is extremely fortunate to have the support of Sheppard Pratt. It supports our organization from IT support, accounting and tax support, office and equipment utilization, in addition to exhibiting at our annual meetings. Sheppard Pratt recently opened a new hospital in Elkridge, Maryland. [Sheppard Pratt Holds Grand Opening Celebration for New Baltimore/Washington Campus | Sheppard Pratt.](https://www.sheppardpratt.org/for-clinicians/) For more information, please visit <https://www.sheppardpratt.org/for-clinicians/>

## Interview With Ronald Burd, MD

May 17, 2021

By: Bruce Hershfield, MD



Q: "I really liked your article in the last issue about how psychiatrists should document their notes for Medicare. Would you please summarize the main points?"

Dr. B: "The code has always represented an itemized account of what you did with the patient. The old form, to make accountants happy, started listing all kinds of things that didn't count to clinicians. The new codes represent the medical decision-making, not how many questions you asked. Data go into the mill and then the question is 'How much milling does it take?' So the Relative Update Committee (the RUC) and the CPT – there is a joint committee there – tackled this question and, unfortunately, there is such an array of codes that at this point they have only been able to get through the outpatient setting. I assume we are going to be seeing a similar product for all the E/M codes in the relatively near future. Then, the issue will be how do we translate that to all the other places where they add on E/M services, for instance when you do a surgery when you fill out a 90-day global that includes 3 outpatient E/Ms, "typically" (in RUC talk, that means more than 50%) – how do we count that? It doesn't make much sense to have these 90-day globals, since we all know that if someone has a hip replaced maybe the code is for 3 visits, but somebody is going to take 6 and somebody is going to take 2. How do we accurately account for that and how much expense is in there that is not demonstrable and quantifiable and is it just a fudge factor? I think there is so much complexity in trying to hammer that out that I don't see moving off the global system for procedures – particularly, hospital procedures – anytime soon."

Q: "How did you get involved with this kind of work?"

Dr. B: "I was trying to make my practice as efficient as possible. I wanted to make sure that with my schedule I had created the right size slots to maximize my revenue generation. I took my best shot and then I contacted some folks at the APA and I said, "This is what I am doing – does this make any sense?' They said, "You sound like a smart young man. Do you want to come to a meeting in Chicago and watch what the committee does?" So I did, and I was caught up in coding for what must be 20 years now."

Q: "How did you decide to become a psychiatrist?"

Dr. B: "I grew up in the middle of Montana and I went to college to be either a family practitioner or a surgeon. By the time I went to medical school I had decided to become a cardiovascular surgeon. When I was in my 3<sup>rd</sup> year, a couple of different things happened. I did my surgical rotation, and it was terrible. I don't know if it was my skills that merited being treated that way or it was the surgeons, but either way it was not a pleasant experience. Then I did my psychiatry rotation and they said, 'Gee, you seem

like a nice young man, and you seem interested in this and you're good'. So, I did that. I also liked Neurology. One day, sitting in church services, I watched a man with arm canes go down the aisle for communion and the aphorism came to mind about the neurologist can tell you exactly what is broken, but they can't do a darn thing about it, while the psychiatrist has no idea why it's broken, but can sometimes manage to fix it. We had just had a patient who had come in with significant depression and she looked like she was going to die. We did ECT and within a few weeks she walked out of the place and went back to work. All those things milled together, and I realized that Psychiatry seemed like a good fit for me. Of course, since I was educated in the West, it was not an analytic sort of training, it was just like another branch of Medicine. So, when I was looking for a Residency, I didn't track down my Psychiatry professors, I tracked down the Internal Medicine ones and I asked them where I should go for this. I asked if Mayo is OK. So that's where I did my training."

Q.: "What has influenced you the most since you've been in Psychiatry?"

Dr. B: "The people I have met in the APA have been tremendous – going back to my first weekend ethics workshop. The Assembly and my experience in Area IV have given me the opportunity to meet the national leaders, including the Assembly leaders and people who have been on the Board, like Gary Weinstein and Mary Helen Davis. They challenge me and support me and tell me I'm doing a good job. They think what I am doing is interesting, and I think what they are doing is fascinating. I am interested in how we can make it better. I discovered that I am wired differently from other people. Other people wake up and they wonder how they can have as good a day as they had yesterday. I wake up and I think how I can build and make today better than yesterday was. That's what keeps my feet going farther – trying to make it better."

Q: "What are you working on now?"

Dr. B: "I think it's such an exciting time to be a psychiatrist. The genetics discoveries, the neuromodulators. How does ketamine fit in? I am very excited about the use of MDMA and psilocybin to treat these conditions that we have struggled with for so long – like chronic PTSD and treatment-resistant depression – and what insight the use of those substances teaches us about the neurotransmitters. I am very excited about the whole neuromodulation thing. I am still doing ECT, and I think it's important that we offer that for our patients. We have a long ways to go if you need ECT up in our part of the world, in Minnesota. Just keeping up with what's new and what is happening makes all the difference."

Q.: "What would you have done differently if you had had the chance?"

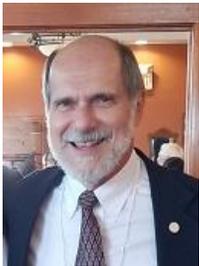
"I might have explored Forensic Psychiatry or Addiction Psychiatry. I'm still hopeful about having some other adventures. It's nice to be able to take care of the local

community, but how do you magnify that? I was doing telepsychiatry before the pandemic, in a very limited way, but now we are all trying to figure out how to deliver the best care through the use of that medium. I think of it like I think about having Residents—it's not better or worse, it's just different. If you have to drive an hour each way for a 15-minute visit with your doctor and hope your doctor is on time, telepsychiatry seems to make a lot of sense."

Q: "Where do you think Psychiatry is likely to be in 10, 15 years?"

Dr. B: "Almost like what has happened with the vaccine. A rapid unfolding since the base technology exists and the understandings exist. I think that's what we are going to be seeing with these new neuromodulators and receptors – how they are put together and the whole idea of Personalized Medicine. We will know that Ron's receptors are put together like this, and Bruce's receptors are put together like that, and Ron's medication won't do anything for Bruce, but *his* medication will work great. So, what happens to our profession, when treating depression and treating psychosis, what if it all comes down to 'Do your genetics and do the math and start him on this?' What if it turns out to be like Dermatology and the only ones who can make a living are the ones who do biopsies and excisions?"

It would be lot of fun if all the psychiatric disorders went away! There is so much suffering out there! Sometimes you can just help somebody. I wish I could tell you all the suffering is just going to go away, but I don't see it. But I can hope."



**BYLAWS: Proposed Change in Officers' Terms**

By: Vince Liberto, MD

At the Annual Meeting in October, there will be a motion to revise the Bylaws. Below is the proposed change:

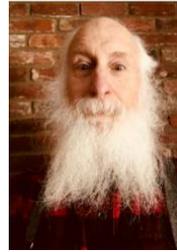
*Addition—Section 5.1a*

*In the event that the annual meeting is canceled, all officers will continue to hold their offices until the next annual meeting takes place.*

**Thank you to our Supporter – Professional Risk Management Services (PRMS)**

By: Janet Bryan, Executive Director

PRMS has been an important supporter of the Southern for many years. They sponsor the Annual Reception at the APA, exhibit at our annual meetings, and sponsor the Thursday evening Reception at the meetings. We value their continued support. Please see their recent COVID resource: [preparing-for-whats-next.pdf](#) ([prms.com](#)). Interested in learning more about PRMS' professional liability insurance program and accessing additional resources? Visit [www.prms.com](#).



**Keep Old Shrinks Going?**

By: Steven Lippmann, MD

So long as older doctors are willing and clinically capable, they usually can productively continue to work. Most should be encouraged to do so. There is much gained by keeping them active professionally, and it also can make them personally happier. Continuing to practice maintains pride and a sense of direction and purpose. For many, being a doctor is WHO they are – a calling, more than a job.

Young people usually have better memory, more energy, and greater ability to concentrate or to multitask. Yet, older clinicians have more clinical experience and broader perspective on present practices. We should facilitate their honed clinical abilities to provide healthcare expertise. They also are frequently experienced at mentoring trainees and teaching medical students. Occasionally, they are in a position to bring up long-forgotten, but still valuable, methods of evaluation or treatment.

There are reasons why some retire before they need to do so. Younger practitioners tend to cope better with the electronic medical record, while older ones may quit practice to avoid having to learn the complexities of computer medicine. They tend to lament how patient to doctor relationships have been diminished. They see how it compromises rapport and harms their own morale; this is especially bad in psychiatry, where interpersonal trust is so much a part of the therapy.

Psychiatry is a prime example of a specialty that does not have enough practitioners. It is one reason why so many people in this country do not equitably receive quality healthcare. The COVID-19 pandemic exacerbates such discrepancies. It has become harder to receive medical care, like for suicidal emergencies and for stroke or coronary care. Preventive, rehabilitative, and elective care medicine are all lagging more than in the recent past. We are already seeing a worsening mental health crisis – rises in rates of depression, anxiety, substance abuse, post-traumatic stress disorder, suicide, and drug overdosing. Even the recent dramatic increase in delivering services by telemedicine has not succeeded in stopping these increases.

The bottom-line: our country can gain much by retaining capable physicians who want to continue on the job. Employers ought to cater to their needs (like at computer skills). Similarly, professional organizations should overtly support them at scientific meetings by offering topics, committees, and breakout sessions targeted to their interests. The same applies to journal articles focused on their kinds of issues and presentation of relevant newer developments in medicine.

All physicians need to take care of themselves through diversion, rest, and avoidance of substance or prescription abuse. They also must maintain their own healthcare, diet, exercise, and social relationships. Similarly, good eye-contact, interpersonal connectedness, and proficient typing skills are helpful. Applying these principles better serves our patients and allows doctors to remain productive longer. Done properly, this can make us happier: personally, professionally, and for the good of our communities.

---

Bruce Hershfield, MD, asked for some comment on physicians who retired and about some who continued medical practice beyond retirement age. Here are a bunch of stories.

My dad was an ophthalmologist, and he practiced well into his mid-70s. He was enamored with ophthalmology throughout his life and really loved his role as a doctor; following retirement he remained professionally active in different organizational and political or social aspects of medicine. A small stroke stopped him from working as an Ophthalmologist, and another ended his life at age 96. I also had an adopted refugee uncle who was a solo general practitioner in a small city where he worked until retiring at age 85. One of those wonderful old-fashioned doctors – he had run a busy office practice, personally did his own hospital-patient care, delivered babies, did emergency room contacts, even a bit of surgery, and made house calls in people's own homes. He died at 86, one year later.

Speaking for myself, I was employed as a full-time academic psychiatrist up through age 71. Subsequently, I continued as a gratis physician in three different clinics. Having helped found a Survivor of Torture clinic a decade or so before, it was a natural for me to keep volunteering at this PTSD service, especially since my parents and family had all been 1936 refugees from the Nazis. Most of my patients were refugees or asylum-seekers. I always enjoyed general medicine and thus continued clinical practice and teaching medical students in one of the University's Family Medicine clinics, caring for people not yet employed or insured after release from prison. I still provide primary care in another free clinic that primarily serves Latin Americans, nearly all of whom are newly arrived in this country, not speaking much English. Regularly writing lots of papers for medical journals and also automotive articles for antique car magazines and newsletters is my other passion.

I have been in a local Kentucky band along with two internists; both practiced internal medicine actively into their upper 80s. One "retired" in his 80s from a downtown inner-city practice by becoming a nursing home doctor. There he did morning sick-call into his 90s. He once told us that, "I am now older than every single one of my nursing home patients." Practice stopped during his early 90s, and death took him at age 96. The other one "retired" from private practice to become a university faculty

internist well into his 90s. This included being an attending with a focus on student teaching, advancing medical ethics, being a jail doctor, and in 2019 volunteering to be an emergency physician in freezing Alaska during a dogsled race at his age 94. Continuing along just shy of his 96th birthday, and still doctoring, he gave a medical ethics lecture to our medical students, right up to his death in 2021. I remember him saying in 2019, when he was 94 that, "still working so far, I do not yet draw from my IRA retirement fund."

Here are three more vignettes from Louisville. All of them involve psychiatry faculty at our University. One switched from pediatrics to psychiatry at age 44. She formally retired at age 67; however, she stayed very medically active through her 80s at grand rounds, a doctors' breakfast club, departmental activities, regular and frequent counsel and religious care to hospitalized patients, and prominent publications of numerous articles for a physicians' journal. She has been so busy that most people (including me) thought that she was actually still employed. The other two still work clinically, at advocacy or research, and/or at scientific journal publications. At 77 and 82, they remain so productive in our department and medical school that they have retained the high standard needed to keep a tenured University faculty status.

Lastly, I remember talking to an obstetrician friend in the doctors' parking lot of the hospital, shortly before COVID-19; he was about 87 years old. When I asked why he continued in medicine, his response was, "well, can you think of anything that would be more fun than delivering a couple of babies today while teaching a bunch of medical students who have never ever seen anything like that before?" Of course, I could not.

So be it ... staying on the job, it keeps you young and helps the world.



### India's Second Wave of COVID-19: Why?

By: Satya Harika Manda, MBBS & Steven Lippmann, MD

India is in a second outbreak wave of COVID-19. Case numbers have risen exponentially from mid-March, after months of declining. On May 6, the Indian government reported the highest single-day spike recorded worldwide, taking the pandemic total to 21 million cases and more than 200,000 deaths. The morbidity and mortality (currently >400,000) numbers are still rising. Hospitals are overwhelmed. Desperate people are seeking oxygen, and bereaved families await outside crematoriums in long queues.

What went wrong? How did India get into this dire situation? Experts warned about a second wave, and they urged precautions. However, the Union Health Minister declared, "We are in the end game of the COVID-19 pandemic in India." Also, claims based on models about herd immunity, and emergency use authorization of indigenous vaccines, created a sense of complacency among administrators.

Initially, India handled COVID-19 well, by imposing a nationwide lockdown, international/domestic travel bans, and other strict measures. However, after local governments lifted restrictions on public gatherings, people started coming back to theaters, stores, weddings, and festivals. Many persons in educational institutions, workplaces, or public transport stopped wearing masks, and/or socially distancing. Subsequently, asymptomatic carriers emerged and contributed to a sudden upsurge in infections. Super-spreader events followed. They included political rallies in five states before the recent election and religious events, like Kumbh Mela, where millions of people took holy baths in the Ganges.

Additionally, virus variants from other countries like B.1.1.7 (Alpha), P.1 (Gamma), and the new mutant B.1.617 version induced a sudden increase. Of these, the B.1.617.2 sub-lineage (Delta), which harbors mutations such as L452R, E484Q, and P681R in the spike protein, became the leading variant in several areas. It exhibits enhanced transmissibility and virulence. The Pfizer-BioNTech and Oxford/AstraZeneca COVID-19 vaccines (two-dose regimens) were over 87% and 59% effective against symptomatic illness by the B.1.617.2 variant, two weeks following a second dose. Yet only 10% of the Indian population had received two vaccination doses by the end of April. Inadequate vaccine supplies left vulnerable groups more susceptible to acquiring the new variants. The Delta variant virus has now begun spreading to several other continents. With more people infected, there is a greater risk of developing still more new coronavirus variants – with enhanced transmissibility, greater virulence and/or more treatment resistance.

India's experience suggests that other countries ought to adopt strategic plans. Vaccination is the most important. Healthcare, paramedical, governmental, and/or public health or social service workers should organize awareness campaigns to reduce vaccine hesitancy and to try to vaccinate most of the population. Wearing facial masks and following social distancing in public should be made mandatory – irrespective of vaccination status – during an overt pandemic. Limiting social gatherings, enhancing testing capacities, genomic virus sequencing from positive cases, imposing international travel restrictions, surveillance of travelers, and two weeks of compulsory quarantining are recommended. Administrators must fund facilities for making oxygen and disease-mitigating pharmaceuticals. The manufacture of

ventilators, the establishment of escalating COVID-19 care hospital facilities, and more training for medical personnel, all need to be encouraged. A plentiful supply of masks and protective gear is necessary.

Without these measures, we may see further – and more intense – pandemics.



**COVID-19 AND OPIOID ADDICTION**  
by Gurpreet Singh Guliani, MD & Steven Lippmann, MD

The COVID-19 pandemic has particularly impacted people who abuse opioids. The USA had over 81,000 drug OD fatalities in the 12 months ending May 2020 – the highest number recorded in a one-year period. This compares to 70,630 in 2019. The pandemic widely prompted people to relapse, increasing the incidence of chemical dependence. About 13% of Americans reported starting or increasing chemical substance usage as a way of coping with stress and/or emotions related to COVID-19.

Synthetic opioids, like fentanyl, are the primary drugs precipitating these overdoses. Such fatal toxicities escalated by 38% over the previous 12-months, as of June 2020.

Uncertainty about the future, financial crises, homelessness, unemployment, school interruption, and social isolation have all compromised emotional health. Interpersonal relationships, optimism, and a sense of personal direction and purpose or value, all declined. Feeling captive to an illicit drug trade, users tend to turn to unknown suppliers, receiving substances of unknown potency and quantity; this is especially dangerous with fentanyl. People have lost loved ones, jobs, their homes, their academic attendance, their family connections, and social interactions. The pandemic lockdown's physical distancing caused further isolation by limiting peer-driven support groups like NA and AA and in-person contact with sponsors.

Troublesome events from so many sources increases stimulation in the amygdala, which over-activates fear circuits in the brain. It's unfortunate, but understandable, that returning to familiar drug abuse patterns diminishes such anxiety. Former drug users who have been sober for a while have diminished drug tolerance. That is especially dangerous, often resulting in fatalities. The COVID-19 pandemic has been called a "national relapse trigger." Unfortunately, some people with a proclivity for drug abuse had federal stimulus checks mailed to them while

they were isolated from work, schooling, and social contacts, so some of the money went for drug purchases.

Patients mostly transitioned to telemedicine sessions. Was this a further contributor to this epidemic? While information can be well-exchanged during a telepsychiatry session, there are limitations. Interpreting body language and subtle facial expressions, taking vital signs, doing a physical examination, testing drug levels, and recognizing signs of intoxication are all suboptimal. When the technology required is not universally available, it becomes a challenge for patients and clinicians. This hinderance already existed for financially disadvantaged people but became worse during the pandemic.

A vigorous innovative approach is required to overcome these difficulties. We all benefit when we are flexible. We need to use motivational interviewing, meditational techniques, health education materials, and advocate for providing better access to technology. It would help if more practitioners could make themselves available at a wider array of times. So would increasing the access to buprenorphine and methadone. As soon as we can, we should encourage groups like Narcotics Anonymous to start meeting in-person again.

We need to use this crisis as an opportunity to *do something*.



**Maintenance of Bureaucracy (and its Invasive Spread)**  
**Re: American Board of Medical Specialties (ABMS) Standards for Continuing Certification: Draft for Stakeholder Comment**  
By: William Greenberg, MD

Reading the 29-page April 2021 *ABMS Standards for Continuing Certification: Draft for Stakeholder Comment*, I found it difficult to meaningfully comply with its request for line-by-numbered line specific annotations and comments, with limited word count. I am therefore sharing my principal observations with colleagues who might understand more down-to-earth language.

I find the proposed changes in this document very disappointing and disturbing – wordy, repetitive, supercilious in tone, and paternalistic. It is reflective of an organization seeking significant “mission creep” and attempting to justify its expensive and time-consuming activities, and even to expand them, by offering to provide services already provided by others.

In 1999 the ACGME (Accreditation Council for Graduate Medical Education) established 6 Core Competencies that it felt practicing physicians should possess: practice-based learning and improvement, patient care and procedural skills, systems-based practice, medical knowledge, interpersonal and communication skills and

professionalism. Those of us who have been residency training directors are certainly familiar with these, as are those whom we trained in residency programs for the last two decades. Now, however, the ABMS has adopted these, calling them “ABMS/ACGME Professional Standards” (taking top billing), proposing to continue monitoring and evaluating physicians after their training has been completed, using specialty-specific “milestones.” Although these competencies are routinely evaluated for trainees, the ABMS has not been well-positioned to provide more than a standardized cognitive examination with multiple choice answers, testing on some selected medical facts, guidelines and standards. One has hardly any reason to believe that re-certification exams effectively and robustly test clinical skills or attitudes or ethical behavior in actual practice.

So, how to significantly expand the scope of activities of the ABMS and its Member Boards? Their attempt to try to continuously address physicians’ professionalism is detailed in this ABMS draft proposal. The ABMS (line 298 and following) “...plans to gather information principally from individual state medical licensing boards, the Federation of State Medical Boards, or ABMS...and other sources...including but not limited to peer review, case logs, restrictions of prescribing privileges for controlled substances; termination, suspension, restriction or denial of medical staff appointments or privileges, sanctions or other actions by the Center for Medicare and Medicaid Services or other governmental authority; and indictment, conviction or guilty pleas for felonies...” However, this wide range of data collection of course entirely just duplicates those other organizations’ purview and decisions. Trying to justify this expanded scope of the ABMS purview just adds more paperwork and redundant bureaucracy to the lives of practicing physicians, while creating still more fees to pay. And besides the listed state licensing boards, etc., our professional medical organizations (eg, American Medical Association and APA) also are called upon to review members’ ethical behavior and take appropriate action.

I know of no one who thinks that the ABMS is an appropriate organization to be taking on this much-expanded and duplicative mission. I and my colleagues instead perceive the ABMS with its Member Boards as an expensive, self-protective organization seeking to justify itself when it is being challenged on its (until recently) *de facto* monopoly status, and challenged by widespread dissatisfaction with the increasing demands of its maintenance of certification (MOC) process, increasingly leading physicians to walk away from the whole business.

Of course, most state licensing boards also require a significant number of CME hours to be completed, though they do not call for cognitive examinations. Re-certification examinations were originally intended to identify practitioners who might still be practicing but suffering from cognitive decline. Subsequently, the mission expanded to generally test physicians on evolving knowledge and standards.

Although I – and, I believe, most of my colleagues – do not object to the administration of an initial examination to achieve board certification, my experience with continuing periodic exams does not suggest that they effectively identify which practitioners keep up to date on the most pertinent information for their practices. They also do not necessarily reflect the quality of their work. Instead, the language of the ABMS and its Member Boards simply asserts or implies that passing the cognitive exams meaningfully warrants that the examinees are proficient in their medical knowledge and that patients can thus rest assured. But there are no valid studies demonstrating that those preparing for and passing MOC examinations then significantly and meaningfully practice better. The language in ABMS and Member Board literature simply asserts or implies that this is the case. But this is advertising and marketing – organizational activities whose purposes are to persuade people to buy the products they are selling, as opposed to ascertaining and reporting scientific fact. Physicians should be able to tell the difference.

Changing the frequency of re-certification exams from every 10 years to every 5 simply adds another burden to diplomates. I see no real evidence of the value of even the 10-year exams, despite decades of requiring it. Doubling the frequency of these exams would certainly benefit the coffers of the ABMS and its Member Boards, while representing a significant expense to those taking them.

And egregious profits, overly generous salaries and huge accumulated assets are listed for small “non-profit” ABMS Member Boards: eg, why does the very small American Board of Psychiatry and Neurology still have gross receipts of \$37 million and assets of \$150 million?

More frequent exams add to our burgeoning bureaucracy and add unnecessary costs to the health care system. We are already suffering from excessive bureaucracy in an inefficient and cost-shifting climate that results in worse health care outcomes than other developed nations, while costing far more than any other country. Physicians are being replaced by mid-level “providers” who increasingly can practice independently, who are being turned out by their expanding schools in ever-increasing numbers, and who can afford to work for lesser compensation because they train for fewer years. Physicians are getting tired, burned out and often depressed; the percentages of those who identify themselves as suffering “burnout” hovers near 50%, depending on the specialty.

The ABMS, instead of addressing these problems, is planning to create more unnecessary and duplicative work.

I, and many of my colleagues, see the ABMS not as offering a solution, but quite frankly, as being part of the problem.



## **The APA and the ABPN's Maintenance of Certification**

By: Shree Vinekar, MD

Member to Member, an e-mail platform for APA members to communicate with each other, has about 210 psychiatrists. Many of them express their opinions freely.

Many are worried that a large number of members are leaving the APA.

We do not know if this is related to the APA supporting the American Board of Psychiatry & Neurology (ABPN)'s Maintenance of Certification (MOC) program. Perhaps they are so focused on their struggle to maintain their MOC that they don't have time to support an organization that doesn't support them in this process. Many feel that they are unwilling captive candidates who are manipulated into participating in this process. Obtaining board certification and maintaining certification of competence is no longer a purely voluntary process. More often than not, it is experienced as an imposition that is not truly justifiable.

I suspect a very large number of non-academic members who are not required by their employers to stay up-to-date with MOC are disillusioned with the burden. I believe that some feel the APA does not listen to their concerns about this. Some of the leading members formed a MOC caucus to voice their concerns and demands. Also, the Assembly members formed a MOC committee to discuss these very issues. Additional “listservs” were like silos; APA members could not view what was discussed on any one of them if they did not belong to it. This arrangement was obviously disrespectful to many thoughtful members.

We must understand why this whole system is coercive and infringes on the freedom to practice Medicine. No board has obtained Informed Consent from any doctors that they would be willing to lose their jobs or their privileges to practice their specialty if they failed to be continuously certified by ABPN and take such a great risk to their careers by participating in BC/MOC process. Not all private or public sector employers consider Board certification as a prerequisite, especially when psychiatrists are in short supply all over the country. There are so many other non-board certified and non-recertified clinicians who are practicing their specialties without being burdened by such requirements.

The “carrots (karats) and sticks,” the CEO of ABPN so openly and so proudly talks about, have serious adverse effects on the candidate members, certified members' families, employers, and, most importantly, their patients. The karats are not for the candidates but for ABPN, yet sticks for sure on a slippery future for the participants. Psychiatric treatment facilities in the near future will be manned by the “neo-psychiatrists” or NPs in large numbers. Under such circumstances, both BC and

MOC need to be entirely voluntary without any direct or indirect coercion. APA should be on the side of the members and help eliminate any direct or indirect coercion in the work field of their members.

We understand that 50% of the APA membership is over 60 years old. Very few of the younger ones want to start their own private practices. The mental health field is becoming more competitive. More Nurse Practitioners are grabbing jobs that used to go to psychiatrists. It makes no sense to some employers to require them to hire “high salaried” psychiatrists who have to keep up to date with Board requirements when they can use less-trained NPs more cheaply to do what they see as the same job. Such requirement also does not make sense if one is looking up to such qualifications as a guarantee for the quality of service and overall good outcomes for patients

We all have learned that the APA had been receiving \$1 million grant money annually, from 2017 to 2019, from the ABPN and that it received \$2 million dollars in 2020 for a total of \$6 million over the past few years (including 2021). This raises serious concerns about conflict of interest. In fact, the Immediate Past Chair of the MOC committee of the Assembly moved to get all area councils of the APA Assembly to accept that APA had a serious conflict of interest.

The ABPN is loaded with \$122 million-plus (see IRS form 990 filed by ABPN for 2018 available for view on google.com) in reserves (see below). No one I know is opposed to life-long learning, and maintaining professional competence, but no one I know likes the way this is being done. Validating the competency of psychiatrists every 10 years is based on faulty logic and insufficient scientific evidence. Many young psychiatrists carry a burden of as much \$250,000 in educational loans when they are starting their post-residency careers. If they have already passed their Board examinations and are practicing actively and are accumulating the minimum number of hours of continuing medical education that their state licensing boards require, that should be sufficient to show they are maintaining their skills.

In spite of the knowledge that many members are opposed to MOC, the APA continues to apply to receive the \$2 million grant per year. The APA’s MOC caucus – members who have gotten together to discuss this – has urged the APA to break this relationship and not support the ABPN’s monopoly. On April 24, the APA Board of Trustees voted to accept National Boards of Physicians & Surgeons (NBPAS) – in addition to ABPN – recertification as valid. NBPAS certification costs only \$169 every 2 years, which is a much cheaper alternative to the nearly \$500 every year for MOC (costing the candidates nearly \$5,000 per ten years and in addition \$1,000 and \$4,000 per year, including direct and indirect costs).

NBPAS is truly a non-profit organization, operated by volunteer physicians. This is in contrast to ABPN, which

pays its CEO nearly \$1 million dollars, including a hefty bonus. (See the attached form 990 filed by ABPN in 2018.) It also shows that ABPN calls itself a nonprofit organization. Its financial statement will show that it accumulates nearly \$10 million as reserves after expenses every year, and a total balance of reserve on form 990 reflected as \$122 plus million at the end of 2018. Interest income on the investment of this reserve annually is more than \$2 million.

Doctors preying on their younger colleagues is deplorable; we must avoid ever doing it. The APA may need to sever its relationship with the ABPN and/or promote the NBPAS and other alternatives to be developed by a lifelong component of APA itself – setting up its own system of ensuring that psychiatrists are up-to-date. We cannot afford to let a conflict of interest affect our ability to assure our members and the public that we are serious about protecting the quality of our profession. Although the APA could set up a process for certifying its members as maintaining professional skills, it has not done so. It is also hard to advocate for, and ostensibly certify as competent, a physician at the same time. Therefore, the MOC caucus recommended NBPAS as a cleaner solution. There is no conflict of interest here!

In response to member outrage at the ABPN Vision statement, in early 2019 the CEO of the APA sent a letter to the ABPN, to the effect asking it not to exploit its members. That was a good letter, endorsed and signed by the incoming and outgoing presidents. In spite of this, in 2020, it appeared the CEO openly supported ABPN and the new President chose to go silent on this issue in spite of his campaign agenda to eliminate MOC. It came to light that APA had received another \$2 million dollars in grant money from ABPN early in the year 2020.

Also, the Department of Justice (DOJ) wrote a letter on September 10, 2018, to the State of Maryland to the effect that it considered ABPN a “monopoly.” Psychiatrists on Member-to-Member urged APA to stop participating in supporting it. The following is the conclusion of the “Division”:

“The Division is encouraged that the Maryland legislature and the Maryland Health Care Commission are studying specialty (sic) board certification and its effect on competition in markets for physician services. The Division recommends that Maryland explore ways to promote competition in specialty (sic) board certification without unnecessarily interfering with individual business decision-making.

We appreciate this opportunity to present our views.”

Sincerely yours,  
Robert Potter, Chief Competition Policy & Advocacy  
Section Antitrust Division U.S. Department of Justice

As far as I can tell, the APA did nothing to promote competition in the specialty board certification and recertification process for some 32 months after the DOJ opinion became public news.

No one from the BOT nor the CEO or any of the Presidents of APA provided a clear explanation or rationale for this questionably suspect relationship with ABPN. Many members commented on it for months and years, raising eyebrows. In the third week of May 2021 the CEO of the ABPN stated on the proprietary Website of APA that ABPN had a “collaborative” relationship with APA to provide free CME programs for members to help them maintain their skills and go through the MOC process. This was also sent as an e-mail to all members. It does not require a degree in marketing to see through this. The timing of such announcement (circa May 18, 2021) is also curiously intriguing – soon after the APA agreed to recognize NBPAS as an alternative to ABPN MOC on April 24. Now it is the moment to publicize this widely to all members so they know they have other choices.

I am told that a majority of APA members support the *status quo* and those who are taking exception to the current status are in a minority – the “doubters.” The numbers, however, speak for themselves. The American Board of Medical Specialties (ABMS)’s own Vision Commission surveyed physicians, and only 12% found MOC valuable. A recent survey of The APA revealed that 41% of its members are NOT Board Certified and 24% are Certified by being “grandfathered” into the current program; and, so only 31% were participating – and, of those, 4% are not currently meeting the continuous certification requirements. So only 27% are meeting MOC participation criteria.

Not all “38,000” members of the APA are awakened to all the relevant issues. But all should have a sense of fairness. They should insist: “Stop the MOCKery”. Actively, sincerely and enthusiastically working to promote competition would please a lot of us.

The following is the detailed picture of the “Money Train” (2018 IRS Returns form 990 filed by ABPN)

<b>Total Revenue</b>	<b>\$24,675,818</b>	
<b>Total Functional Expenses</b>	<b>\$14,043,178</b>	
<b>Net income</b>	<b>\$10,632,640</b>	
<b>Notable sources of revenue</b>		<b>Percent of total revenue</b>
Contributions	\$0	
Program services	\$20,335,737	82.4%
Investment income	\$2,652,719	10.8%
Bond proceeds	\$0	
Royalties	\$0	
Rental property income	\$0	
Net fundraising	\$0	
Sales of assets	\$1,677,796	6.8%
Net inventory sales	\$0	
Other revenue	\$9,5660	0.0%
<b>Notable expenses</b>		<b>Percent of total expenses</b>
Executive compensation	\$3,462,178	24.7%
Professional fundraising fees	\$0	
Other salaries and wages	\$2,143,483	15.3%
<b>Other</b>		
Total Assets	\$125,510,031	
Total Liabilities	\$3,039,437	
<b>Net Assets</b>	<b>\$122,470,594</b>	



## Is Psychiatry Ever Going Back to “Normal”?

### “I Got the New World in My View”

By: Jenny Boyer, MD  
APA Area V Trustee

Some of us are seeing our patients again in our offices. But, after the COVID-19 experience, we might not return to “normal” as we might have anticipated. Psychiatrists and patients may both resist it. The epidemic may have changed some fundamentals of psychiatric practice.

Patients who previously had been taking leave from work to travel to an office now have their sessions on a cell phone, a computer or an i-pad. They may prefer telephone visits – such as some who are on vacation or who don’t have access to computers – or just because they don’t feel comfortable using them. I have established patients who literally beg me to have phone appointments in order for them to maintain their hourly employment as they do not have annual or sick leave. And some of them do not have sufficient broadband available to them for other video technology to work; and, so the best they can do is to use the cell phone. Even cell phones will not work for some patients who live far out in the country, but they will drive to a place where they can connect and sit in the car until I call. These patients are poor; they cannot access services without the phone.

Technology may give them access to a wider array of therapists or subspecialists. They can also keep their psychiatrists – for whom may have developed significant attachments – when they move from one part of the country to another (if state by state licensing restrictions are permanently relaxed). It can be safer and cheaper than seeing their psychiatrists in person, and it is almost always better for the environment.

Meetings may now be “hybrid” – either face-to-face or “virtual” – and one of the first of these is likely to be the SPA’s in Huntsville in October. It will be easier to communicate at the face-to-face meetings, but it will be cheaper to attend them virtually because of the savings in travel, hotel rooms, and food. I have trouble myself deciding if I want to attend in person or virtually. I do love to see the people, but I also prefer less travel and stress and expense.

Administrators are encouraging their employed physicians to return to face-to-face visits and are also trying to hire new employees. However, those who have experienced virtual care have noticed some benefits that they are not willing to relinquish. They note that they do not feel as much “burnout”. Some psychiatrists who live in the same town in which they provide teleservices are not willing to drive to the clinic anymore. Areas that have a scarcity of psychiatric physicians are pleased to be able

to use the new technologies. Providing virtual care is more relaxed – we do not have to dress to the same level of professionalism.

One drawback to virtual care is the decrease in social interaction and the loss of opportunities for consulting with colleagues “in the hallway”. But we can talk to each other on video several times a day. Not everyone does – but it does give a chance to relax for a few moments and to show that we got our hair cut or to talk about personal things.

I am expecting patients to seek psychiatric care in record numbers. We have, after all, gone through a traumatic year and a half, with hundreds of thousands lost and millions ill. How many families have lost loved ones – many without even being allowed to say “goodbye” in person or to attend the kind of funeral that would have helped them get through the worst times of their lives?

There will always be a need for face-to-face sessions, in particular for those most in crisis, or for the hearing or cognitively impaired, where communication is so compromised. Patients with triple diagnoses – e.g. psychiatric, substance use, and general medical disorders – may also need them. Older patients tend to have more complicated medical problems, besides being more uncomfortable with the new technologies, and may insist on being seen in person.

In all cases, patients need to get quality care from those who can hear them, can use all their senses to evaluate them (particularly when they are not reliable reporters), and are not in a hurry. I would like to see Congress pass legislation that mandates insurance companies pay for access to care via phone, video and face-to-face appointments – to give patients the choice. The APA is already advocating that Congress do this.

I remember the lyric that protesters sang in the 1960s, from Sister Gertrude Morgan’s 1957 record: “I got the new world in my view.” I think it was part of my reaching out to a broader world view – a possibility of opportunity, never imagined by those who were living immediately around me. The words inspired me that I *could*. We can all do that with regard to telemedicine now – have a “new world” in view. As she sang: “On my journey I pursue”.



### **To Fight Anti-Asian Hate, We Must Talk About It**

By: Krysti (Lan Chi) Vo, MD

Editor’s Note: This is a version of an article first published in Clinical Psychiatry News

[https://docs.google.com/file/d/1sEne6vwhoCTecYI8AwEoDkQWZW27-gbu/edit?usp=docslist\\_api&filetype=msword](https://docs.google.com/file/d/1sEne6vwhoCTecYI8AwEoDkQWZW27-gbu/edit?usp=docslist_api&filetype=msword)

Words matter. So, hear me when I say: I am Asian. I am American. I am a woman. I am not “COVID-19”. I did not create this virus. I did not place it in my pocket and bring it to the world, sprinkling it like pixie dust.

It’s the story of how the powerful use of words throughout my life inflicted racism upon me, even when I didn’t acknowledge them. Currently, I serve as a physician, psychiatrist, and advocate. I lead telehealth and have developed software that screens for suicide risk (with support of a digital health grant). My mission, at its core, is to destigmatize mental illness through cultivating thoughtful conversations.

I am a daughter, a sister, an aunt, a friend, and an American. I am working hard to create a life I love – the embodiment of the American Dream. If you meet me face to face – no C.V., no email – I look Vietnamese. However, I am not the color of my skin or the shape of my eyes. I am no more defined by my lingering Vietnamese accent than I am by its Texan counterpart. Yet, throughout my life, my Vietnamese ethnicity has been a marker that others have used to define me and objectify me.

When I was a Resident, one of my most traumatic experiences was when Donald Trump was running for President in 2016. He was using words and rhetoric that objectified women by classifying and quantifying their attractiveness. In a recording, he said he would grab women by the \$%&#@ . . . and had been allowed to so because he was a celebrity. That episode affected me profoundly. As a child and adolescent psychiatrist in training, I knew the impact those words could have on future generations.

But then, the effect turned to assault. Words matter. As I made my nightly walk home on NYC’s Upper East Side, a man followed me. When I walked up the stairs to my building, he actually grabbed me . . . by the \$%&#@. He did this with the same casual manner that one might greet a coworker with a high-five. He then turned and walked away, laughing. I was overcome that I could be so violated, and yet thankful that he hadn’t done anything more. He didn’t run away. He walked out as calmly as he had walked in despite violating a most private piece of my femininity. And he laughed. It angered me and made me feel demeaned. I was overcome with shock; shock that I could be so violated and yet thankful that he hadn’t taken any more aggressive liberties. So often, attacks against women end so much worse.

Why would this man do this to me? To anyone? I do know this: the things we normalize through the words we hear – in the world, the news, the media, and at our dinner tables – become action. He felt entitled. That’s because words matter.

I was born in Vietnam; my family legally immigrated to the United States when I was 5. Throughout grade school, I began to realize the power of spoken words, especially

when I was frequently told to go back to where I came from. I was an unwelcome foreigner. “Where are you from?” . . . “No, where are you really, really from?” I felt eyes peering through me when my mother packed our culture’s traditional foods for lunch. “Ew, what’s that?” . . . “That’s gross it...smells.”

As I pursued my education, the “Where are you from?” didn’t stop, but took on a new connotation, as if I were some exotic pet that men had seen walking down the street. “Ooh, what is that?”

While history is riddled with the objectification of women, rarely would any woman expect to have a stranger approach her and objectify her with a statement such as: “I only date girls with breast implants.” For Asian women, however, experiencing verbal objectification has become the norm. Each approach I faced was followed by a story about Asian girlfriends. I became used to unsolicited words and attention from men who objectified me as an exotic fetish. I tried to pretend it was OK, but why? America has a long history of hypersexualizing Asian women. These words dehumanize Asian women and – as we have seen – can lead to violence.

Over the past few weeks, people have been talking about the mass shooting in Atlanta. The victims, like us, were human. These women killed in Atlanta had husbands, children, siblings, and parents. Whether or not this act was perpetrated by someone with a sexual addiction doesn’t matter. What happened is rooted in the systemic racism that has stereotyped Asian women as sexual objects. The perpetrator targeted a group of people because of the systemic racism ingrained in him.

Everybody is influenced by words. Even among my own friends and family, some of the most compassionate people I know, I’ve heard disparaging remarks against Chinese people, from other Asians, repeating the same rhetoric they’ve seen in American newspapers and Asian media outlets, echoing the former president’s coronavirus references to the “Chinese virus.” What feeds this virus of hate?

Pointing out problems doesn’t make them go away; we have to talk about solutions. What can we do to make a positive impact? I encourage others to engage in activities where they, too, can feel empowered. Since the beginning of the pandemic, I’ve been empowered by my leadership position with the APA’s Caucus of Asian American Psychiatrists. I’ve used my voice to raise national attention to the anti-Asian hate activities. I’ve also launched various free support groups for Asian American Pacific Islander (AAPI) professionals and health care providers. I want to feel a sense of connection with others who share my experiences.

Clinicians need their own space for processing, too. My colleagues are shocked by the number of Asian-American patients who are reaching out to them for care. Most of

them have not worked much with them before this. Asian-American clinicians may start to experience bystander trauma, because, for the first time, they are thinking, “It could have been me.” They have the extra burden of providing a safe space for processing their clients’ trauma while also processing their own. We may have experiences of discrimination or racially motivated assaults and can re-experience this trauma through our work.

If you are able to take care of yourself and feel empowered to make a difference, there are many ways to help fight against anti-Asian sentiment. We have to check our biases and those of our families, friends and colleagues. Everyone, even mental health professionals, has biases and is affected by disinformation. Do we, or our families, have unconscious biases against a particular minority group? If so, discuss it.

This is systemic, and no one person or group is responsible for the whole problem. White men are not to be vilified. Conservatives Republicans are not our enemy. Each of us is human, with our own flaws. Let’s discuss racial issues with our families and friends. Whenever people say something hateful or discriminatory toward another ethnic group, we have to help them realize their biases and change them. Write to your elected representatives. For example, you can write to support legislation that is similar to the COVID-19 Hate Crimes Act, which passed the Senate on April 22, with 94-1 bipartisan support. This is a step in the right direction, but there is still more we must do.

The next step is speaking about your experiences publicly and promoting the voices of others. I dedicated a section of my social media platforms to amplifying Asian voices, sharing news, and updating my hashtags to support the #StopAsianHate movement. I’ve also hosted all AAPI guests on my podcast, “Wine and Psych”, for the month of May, honoring #AAPIHeritage month. I made it a point to form relationships with other advocates, AAPI mental health professionals and those personally affected by anti-Asian hate.

Speaking up and speaking out didn’t take away my worries, but it did remind me that I am not alone. I can take action and demand action. I do not have to hide in the shadows, but can stand in the light, using my voice to call out injustice and intolerance.

I hope that, for AAPI clinicians who may be affected by these current events, this validates your experiences. You are not alone. For others, I hope this helps you to learn the plight of many AAPI people in this country. Together, we can use words to create better neighborhoods, a better country, and safer spaces for all communities, especially the marginalized.

Words matter.



## **Coping with the COVID-19 Pandemic**

A Psychiatrist's Perspective  
By: Shree S. Vinekar, MD

I am happy to announce, one year after I wrote about it in the June 2020 issue of Southlands, that I have successfully avoided any COVID-19 infection. I have been working just about every day on a psychiatric inpatient unit – almost 7 days a week 365 days a year – hardly taking any holidays or weekends off. That means the precautions – like the social distancing, the mask, PPE, COVID testing of patients and using common sense to prevent airborne infection – did work quite well for a nearly 80-year-old. We had only 2 or 3 patients and 3 or 4 staff members who came up with a positive test for COVID-19 infection, though even some clinical leaders contracted it. All returned to work.

I do not know if anyone has made efforts to collect statistics of mortality and morbidity from COVID-19 in all the inpatient psychiatric units, especially in the state hospitals and correctional systems. Smita Gautam, MD, and her colleague, Mona Masood, MD, at Northwestern University have done a fantastic job in providing crisis-oriented emotional support to nearly a thousand psychiatric and other medical staff. Other sectors of the healthcare system did not fare as well. The impact of the COVID-19 pandemic on correctional systems, nursing homes, and hospitals was significant. It warrants deep analysis into the root causes of failures, as well as a need for the institution of protocols to ensure resilience in the face of future pandemics – or subsequent waves of the current one. The protocols need to include the impact of pandemics and response measures on the emotional health of all the affected, including staff as well as inmates of correctional facilities, patients, residents of nursing homes, and their families. Additionally, there may be a significant neurological impact of COVID-19 infections that can lead to psychiatric disorder. Short term effects, which may turn into long-term ones, need to be addressed.

Some of us members on the APA e-mail list succeeded in putting together a letter to the Governors and to the Commissioners of Correctional Systems in many states, giving basic information about preventing and mitigating risks of the spread of COVID-19 in the correctional system facilities.

Nursing homes all over the US were “sitting ducks” for COVID-19. The families of the elderly in the nursing homes did need emotional support to prepare them for losing touch with their loved ones and, in many cases, for their deaths. without the opportunity to say “good-bye” or even experience a proper funeral. A concerted effort to organize emotional support and provide education would have been worthwhile.

One of my patients told me she got a call from the nursing home administrator informing her that her 90 year-old grandmother had come down with COVID-19, and she was advised to approach a funeral home that could provide the cremation and funeral service for \$1,200. She understood she would not be able to see her grandmother and was prepared to see her ashes in an urn. Her grandmother is a tough one and survived and is still living in the same nursing home. Others were not so lucky. Some of my patients had 3 or 4 casualties in their immediate families over a span of 2-3 months. In another instance, an elderly family member insisted on attending a funeral service for a relative, which caused COVID-19 to spread among the attendees. She succumbed to it herself. Elderly family members who lose their children or grandchildren understandably prioritize attending the funeral – over protecting their own health by avoiding social contact. It has become a norm to limit the funerals in this COVID era to having only 2 or 3 close family members physically present. Large attendance at funerals presents the risk of spreading COVID-19 infection. The prospect of not only losing a “loved one”, but also not being allowed to pay last respects, can further exacerbate the emotional impact of normal grief.

The stories of overloaded hospitals with understaffed and underequipped conditions are too horrible to tell here. One of our hospitals dedicated 95 beds to COVID-19 and eventually had to open up 120, with some patients in tents pitched in the parking lot with space heaters to keep patients and staff warm. The infectious disease specialists whom I talked to told me they had nothing new to offer and, if the pulmonary support did not work, they could only provide life support and palliative care. So, this was the reality last year, and, in some ways, it still is. Psychiatrists should get more actively involved in relieving the emotional suffering that comes along with such a disaster.

Dr. Sue Varma of New York City recently gave a presentation on the local TV channel, “CBS This Morning” quoting the study that 1 in every 3 COVID-19 victims suffered from a neurological and/or psychiatric syndrome/sequelae. This is going to present a staggering problem. Most young individuals seem to bounce back with no appreciable after-effects of the COVID-19 infection. Others may not be as fortunate. Reference: [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(21\)00084-5/fulltext...](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00084-5/fulltext...)

[Watch CBS This Morning: COVID-19's impact on mental health - Full show on CBS](#)

In our VA in Oklahoma City, Dr. Shanna Thomas and her colleague ran into a case of encephalitis with delirium in a COVID-19 patient. Not only the viral infection by itself directly affects the Central Nervous System but also its potential adverse sequelae associated with the vaccines – even if statistically uncommon – very rarely can also cause a neuropsychiatric syndrome. All these are

neurological and psychiatric consequences of this pandemic. There is no question that the benefits of vaccination far outweigh any risks. The anxiety consequences were recently summarized by Dr. Phebe Tucker of OU Medical Center and her associate, Dr. Christopher Czapla, in a “Psychiatric Times” lead article.

The above is just a snapshot of a massive tragedy our nation has faced in the last 14 months. The full picture will continue to emerge over the next few months. We psychiatrists will need to pay particular attention to the emotional suffering and trauma inflicted by the pandemic, which is undoubtedly a global disaster. Certain sections of the population suffered inordinately more damage and had relatively meager resources to cope with the medical and psychiatric sequelae. It is interesting to note that none of us is as obsessed with cleaning surfaces with antiseptics as we were when this pandemic broke out. We learned and accepted that it was airborne infection just like flu – but more deadly and more contagious.

Psychiatrists, who were initially considered at low risk for contracting this infection in work settings and were the last to get access to PPE, still need to be encouraged to take the proper precautions. We can try to help increase the country’s vaccination rate to 75%, even though some health care professionals have been hesitant to get it themselves. It is easy to understand how laymen can get influenced by their politicians and other sources of misinformation.

We are not infectious disease specialists, but we are experts in understanding psychological resistance and we can certainly play a special role in educating everyone on how to best cope with the pandemic.

## MEMBER NEWS



**Felix Torres, MD elected as M/UR Trustee**

Felix Torres, MD, was elected as the APA Minority/Underrepresented (M/UR) Representative Trustee. Dr. Torres is very involved in many psychiatric organizations, and we are honored to have him as a member.

CONGRATULATIONS Dr. Torres on your appointment.

## WELCOME NEW MEMBERS!!



**Clinton Martin, MD**

Dr. Clinton Martin is the Regional Chair for the Department of Psychiatry at UAB Huntsville Regional Medical Center. He has a strong interest in treating adolescents who have psychosis, adults who have ADHD, and patients who have major depression.

He began his residency at St Elizabeth’s Hospital in Washington D.C. and moved to Birmingham in 2011 to pursue his Child and Adolescent Psychiatry Fellowship. During his combined training years in General and Child Psychiatry, he received several awards – the Mid-Atlantic Group Psychotherapy Society Scholarship Award, APF-Janssen Resident Psychiatric Research Scholar Award, the Outstanding Resident Award, Resident Poster Awards, and the Leadership Award. He also served as the Chief Resident for the fellowship program at UAB.

He has been recognized by UAB as an outstanding clinician educator. He currently serves on several committees at the national level, including the American Board of Psychiatry and Neurology (ABPN), the American Academy of Child and Adolescent Psychiatry (AACAP), and the APA.



**Paul Nestadt, MD**

Dr. Paul Nestadt is an assistant professor in the Department of Psychiatry and Behavioral Sciences, and also in the School of Public Health, at Johns Hopkins. He serves as the co-director and supervising psychiatrist for the Anxiety

Disorders Clinic there, where he utilizes behavioral therapies such as CBT, as well as psychopharmacology for anxiety disorders. He also founded and attends in the esketamine clinic, and is an inpatient attending on the dual diagnosis Motivated Behaviors Unit.

He currently does research on practical risk factors for suicide, such as firearm and opioid access. His interest in the field began during his postdoctoral fellowship in the Psychiatric Epidemiology Training Program at the School of Public Health, where he is currently course director for the doctoral level program “Suicide as a Public Health Problem.”

He is a leader in education regarding suicidality, anxiety disorders, and psychiatric evaluation at Johns Hopkins, where he teaches and provides supervision for medical students, residents, and doctoral students studying the epidemiology of mental illness. He is a Fellow of the APA and is on the Council of the Maryland Psychiatric Society. He has written several chapters for leading psychiatric and medical textbooks, has authored over 40 peer-reviewed papers, and is the managing editor of the Johns Hopkins POCIT Psychiatry guide app. He has spoken nationally and internationally on the topics of suicide risk and the roles of firearms, opiates, and screening.



**Oscar Perez, MD**

Dr. Oscar Perez is a native of Chihuahua, Mexico. He finished medical school at the National Univ. of Mexico in Mexico City prior to doing his postgraduate education in Psychiatry at Oklahoma HSC, in OK

City and the Baylor College of Medicine in Houston.

He is Board-certified in Psychiatry and in Addiction Psychiatry by the ABPN. He is licensed in Texas and New Mexico and has been practicing in El Paso since 1985. He focuses on treating adolescents and adults and provides treatment for substance abuse. He is the Medical Director of the newest psychiatric hospital in El Paso, Rio Vista Behavioral Health, where he is also in charge of seeing inpatients plus running his own outpatient private practice.

He is a Distinguished Life Fellow of the APA and serves as Hispanic Representative to the Assembly. During his time in the Assembly, he has authored many action papers urging the APA to advocate to stop social media's negative interference with private practice. In addition to the APA, he is a member of the American Society of Hispanic Psychiatry, the Texas Society of Psychiatric Physicians, the Senior Psychiatrists Society, and the American Association for Social Psychiatry. He has also been involved with civic organizations, such as the League of United Latin American Citizens, where he was part of the healthcare board, in addition to presiding over the physicians' chapter.

He has also been involved in the academic sphere, where he started the outpatient psychiatric clinic for the Department of Psychiatry at Texas Tech HSC in El Paso. There, he was a clinical associate professor of Psychiatry, teaching medical students as well as psychiatric and family medicine residents. At the current time, he is a preceptor for physician assistant students from different schools.

He has dedicated his career to serving and empowering the immigrant community of El Paso, TX, and is a proud West Texas resident.

## In Memoriam



IN MEMORIAM: On Having a Mentor  
Lou and Judy Cancellero  
By: John Hendrick, MD



Dr. Louis Cancellero – many of us knew him as Lou – was an astounding doctor and teacher. One of the great good fortunes of my life was that fate threw the two of us together. The recent passing of his dear wife Judy, also a wonderful friend, caused several of us to remember the two of them and their unforgettable contributions to the Southern.

They were the very embodiment of the accepting and endearing fellowship of the Southern that so many of us love and appreciate. Judy became a friend to my wife Dee and was so kind as to introduce her to so many of you. Judy's kind demeanor and warm embrace helped make it so much easier for us to make friends. Dee remembers a meeting in San Antonio when they were watching Lou and me laugh and talk with a large group of other doctors and Dee said, "I love hearing Lou's & John's stories".... Judy replied with a gentle smile, "Isn't it a Blessing to KNOW all those stories already." Oh, how she loved Lou! Dee said that Judy and she spent more than a few hours together, traveling to and from meetings. "We talked about everything – she was funny, kind, loving and incredibly insightful – with an unerring BS meter!"

Lou introduced me to most of you and was always pressing me to be more and more involved. He pointed out that it was worth the time and effort because of the quality and character of our members. He was right. But his mentorship didn't end there. We were both on faculty at East Tennessee State University. Lou hired me to be the Inpatient Chief of Psychiatry at the affiliated Mountain Home VAMC where I eventually became Chief of Psychiatry. He continued to push me throughout our association there. When he pushed, I sometimes stumbled and may have even scraped a knee or two, but they healed, and I became the better doctor and person for it.

Lou earned a PhD in Neurosciences at Duke before getting his MD. So, as a psychiatrist, he knew more about brain function than many of his peers. This was a focus of developmental interest in the curriculum at ETSU. For

years, he taught a traditional neuroscience curriculum every other year (to two combined classes at a time). His depth of knowledge of neuroanatomy was legendary.

I had been teaching clinically on the unit, of course, and I had a few general psychiatry courses when, with no small bit of trepidation, I started auditing Lou's residency didactics. His course was 12 very packed hours. He and I both knew our residents needed more than just the basics necessary to get them through boards. Especially critical were brain functions, behavioral neurology and discoveries from imaging.

I had two years between his lectures, so I started studying. Over the years I audited his courses three times and eventually filled in when he was out of town. I remember a dinner with Judy and him that my wife and I attended. I confessed I was unsure if I was ready to fill in for him. He looked at me, smiled and said, "You know so much more than you think you do, get over it, you've got this!" Judy immediately volunteered, "John, he always says this about you". My wife ribbed me and said, "I always tell you this, too." So, the three of them got me. I pushed through that first one and it eventually became all 12 of those initial lectures plus about 36 hours on the more complex issues of behavioral neurology. I taught over 100 residents in my time at ETSU, and he probably taught 3 or 4 times that many. It was good that I took this academic chore on when I did, as Lou passed fairly unexpectedly a few years ago. My first independent lecture on Advanced Topics in Behavioral Neurology was repeated for over a decade. He was a tough critic, but I was so much the better for his guidance and mentorship. That lecture remains my baseline "traveling show", and I hope will be the nidus of a new residency we have planned, delayed by our recent damnable pandemic.

Lou made me a better teacher and a better doctor and the two of them made Dee and me better people. We shared so many good times – most especially at the meetings of the Southern. I am sure I speak for the entire organization when I say we miss you both, and we loved you so!



**In Memoriam:**  
**Joseph Napoli, MD**  
By: William Greenberg, MD

More than anything else, I remember the hours we spent driving together to an APA Area Council meeting or Assembly meeting, often 4 or 5 hours each way. He usually drove, and I would navigate, as, until recently, he did not have GPS turn-by-turn navigation in his car. Sometimes I was not a very good navigator, because we both would get lost in talking nonstop for those 4 or 5 hours. We were both Assembly Representatives for many years, and for 4 recent years, he was the Area 3 Rep, and I was the

Deputy Rep. We would talk about the agendas, about action papers, about strategizing, about whom to appoint to which positions, about obscure psychiatric conditions, about APA politics, about national politics, about religions, about history. Amid all our enthusiastic conversation, not infrequently we might talk about a missed turn. *Mea culpa*: I was supposed to be the navigator.

He was a dedicated and inspiring mentor to our younger colleagues, not only encouraging and offering advice, but actively stepping in when more political advocacy clout was needed. His exceptional efforts, for example, helped us get an APA Committee on Women.

We both shared involvement in disaster work, but Joe Napoli's involvement was truly noteworthy and lifelong. Early in his life he was a volunteer firefighter. In our organization he spent over two decades in responding to disasters, addressing first responders, participating in disaster preparedness planning groups and exercises, teaching courses on disaster response (including many APA courses), and treating patients with PTSD and other trauma-related disorders. He was willing to undergo administrative and legal struggles to get their valid diagnoses and disabilities properly recognized. A recipient of the APA Bruno Lima award in 2003, he was instrumental in resurrecting the relevant Component addressing Disaster Psychiatry as an APA Committee. He personally responded in the wake of airplane crashes, floods, hurricanes, the destruction of the World Trade Center towers, and numerous other crises and disasters.

As active as he was in the New Jersey Psychiatric Association and the Area 3 Council, he was not limited by local geography. He was involved with everyone, connecting with members from all areas. Everyone knew Joe; everyone could appreciate his dedication, his energy, his friendliness, his sense of humor and his intelligence.

Joe reached the pinnacle of his APA career a year ago, succeeding to the post of Speaker of the Assembly. Tragically, just then he was diagnosed with a glioblastoma, with a prognosis of perhaps a year of survival with aggressive treatment. The subsequent surgery and chemotherapy had a very appreciable impact on his ability to function as he had, but he still bravely contributed whenever and to whatever extent he could. As Speaker, he chose the theme, "Promoting Resiliency." By being consistently uncomplaining and encouraging, upbeat and inspiring to those of us with whom he was able to communicate, he truly embodied resiliency himself. We could learn and take inspiration from his example.

Sadly, Joe passed away in April, leaving behind his wife Loretta and his two daughters of whom he was so proud. As with so many others whom he knew and whom he laughed and shared stories with, I will miss him greatly.



**LETTER from the EDITOR: PAUL O'LEARY, MD  
1975-2021**

By: Bruce Hershfield, MD

When I got a message to call Janet Bryan first thing in the morning, I figured it was not good news. When she asked if I was sitting down, that clinched it. She then told me Paul O'Leary, our President-elect, had suddenly died in his sleep on May 12th. This was shocking – he was so young and so bright.

He was the first person I attempted to recruit for the Southern when I was appointed to the New Member Task Force. Of course, he said “yes.” (He was that sort of person.) I had known him through the APA Assembly and knew of his work with the AMA. I can picture him at the APA meeting in New York in 2014, striding through Times Square with his daughter in his backpack. And smiling, with that happy look in his eyes, as he did. The last time I saw him was shortly before he died, when he was on the “zoom” program committee meeting, helping to plan our get-together in Huntsville. He had a beautiful Japanese background in the room where he was sitting, and he was joking about it. He had the skill of making people who were working with him feel like they were having fun at the same time.

Paul was born in Birmingham, attended the University of Alabama there (graduating *summa cum laude*) then went on to get his MD and MSc in Health Informatics at UAB. He completed his psychiatric residency there, then did fellowships in Child & Adolescent Psychiatry there and Forensic Psychiatry (at Emory). He was very good with using technology to help psychiatric organizations and our patients, and he went on to launch SHKOP Medicine LLC and SQO Medicine, LLC (each one named from the initials of one of his two daughters). He was the President of the Birmingham Psychiatric Society, worked on the Legislative and Public Affairs Committee of the Alabama Psychiatric Physicians Association, and became Speaker of the APA Assembly.

I have written many obituaries of psychiatrists, but never for one who was about 30 years younger than I am. As Dr. Mary Helen Davis commented, “We have lost him way before his time, as his footprint on our profession and our

organization was yet to be fully realized. It will be hard to meet in Alabama without him.”

*(As e e cummings' poem “Buffalo Bill's Defunct” goes, “and what i want to know is how do you like your blueeyed boy Mister Death”)*

Mary Helen also writes, “In a year characterized by grief and loss, the death of Paul O'Leary has been a devastating gut punch. I first met Paul when he was a resident, when he accompanied Dan Dahl to the Assembly. I knew instantly that he was the future of the APA. His enthusiasm, passion and eagerness were contagious. We watched him grow into various leadership roles – as early career psychiatrist, Alabama Rep to the Assembly, and on to become its Speaker. His service to the Southern was substantial. He could handle dual roles, managing to be simultaneously active in the AMA and the APA, the Alabama Psychiatric Association and the Southern. We learned of his marriage, followed by the birth of his two daughters. He was so proud of those two girls, and they would frequently “photo bomb” his professional work if he was making a conference call. He was patient and fun-loving with them, including them in dinners and activities at professional meetings. He was an amazing restaurant resource; his passion for fine dining and exquisite wine was legendary. He methodically kept dates and lists of those culinary experiences. He asked me to speak at our upcoming meeting in Huntsville on the topic of grief, with special consideration for describing my subspecialty interest in oncology to residents and members-in-training. He was one of those special people who gave back in abundance whatever he learned from his mentors.

He embodied Southern hospitality, welcoming and reaching out to all. He was enthusiastic about our profession and our patients. He was an innovator and was eager to accept change. He was a catalyst on every project that I had the opportunity to share with him.”

Our Rep to the APA Assembly, Dr. Mark Komrad, wrote, “Paul was a remarkable leader with just enough charisma to inspire you to open not just your mind, but your heart to his ideas. He was one of the younger colleagues who gave me confidence that the leadership of our next professional generation was in good hands.”

Now, he is gone. His mother said at the memorial service, “Why did this happen? How could this happen?”

I understand that he has left us, and I do not pretend to know when it is the right time for each of us to leave. But, if I was presented with a motion calling for him to leave us now – at 45 and without warning and with his time as our President about to start at a meeting we had scheduled in his home state – I would have to vote that I do not approve.

Edna St. Vincent Millay wrote about the loss of people like this, in "Dirge without Music":

*"I am not resigned to the shutting away of loving hearts  
in the hard ground.  
So it is, and so it will be, for so it has been, time out of  
mind:*

*Into the darkness they go, the wise and the lovely.  
Crowned  
With lilies and with laurel they go; but I am not resigned.  
...*

*The answers quick and keen, the honest look, the  
laughter, the love,—  
They are gone. They are gone to feed the roses. Elegant  
and curled  
Is the blossom. Fragrant is the blossom. I know. But I do  
not approve.  
More precious was the light in your eyes than all the  
roses in the world."*

---

## **2021 Annual Meeting—Huntsville, AL**

**With Alabama Psychiatric Physicians Association**

**October 6 – 10, 2021**

**The Westin Huntsville, Huntsville, AL**



## **2022 Annual Meeting—Baltimore, MD**

**With Maryland Psychiatric Society**

**September 7 – 11, 2022**

**Royal Sonesta Hotel**

**Baltimore, Maryland**



## **SPA OFFICERS 2019-2020**

President: Margaret Cassada, MD

President Elect: Vacant

Vice President: David Casey, MD

Secretary-Treasurer: Rodney Poling, MD

Board of Regents, Chair: Thomas Franklin, MD

Board of Regents, 2<sup>nd</sup> Year: Abhinav Saxena, MD

Board of Regents, 1<sup>st</sup> Year: Lauren Pengrin, DO

Immediate Past President: Mary Helen Davis, MD

Executive Director: Janet Bryan

"Southlands" articles represent the views of the authors and are not official positions of the Southern Psychiatric Association. Comments and Letters to the Editor are welcome and should be addressed to the Editor at BHershfiel@aol.com

(Bruce Hershfield, MD, 1415 Cold Bottom Rd, Sparks, MD 21152)

## **"SOUTHLANDS" EDITORIAL ADVISORY BOARD**

Harold Eist, MD

William Greenberg, MD

Steven Lippmann, MD

Jessica Merkel-Keller, MD

Denis J. Milke, MD

Stephen Spalding, MD

Editor: Bruce Hershfield, MD

Assistant Editor: Janet Bryan



The Southern Psychiatric Association  
and the Alabama Psychiatric Physicians  
Association present:

# Resilience: COVID-19 and Beyond

October 6-9, 2021

## SPA/APPA 2021 CONFERENCE REGISTRATION

**PLEASE PRINT CLEARLY (One form per registrant)**

Name \_\_\_\_\_ Designation \_\_\_\_\_

Practice Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State ZIP \_\_\_\_\_

E-mail \_\_\_\_\_ Dietary Needs \_\_\_\_\_

### FOUR-DAY REGISTRATION

- SPA/APPA Member \$395
- Nonmember \$510
- ECP \$250
- RFM No Fee
- Guest \$195 (includes farewell dinner)
- Guest Name (s) \_\_\_\_\_

### ONE DAY ONLY

- Thursday \$185
- Friday \$185
- Saturday \$185
- RFM No Fee
- Thur  Fri  Sat

### SOCIAL EVENTS (Please check if attending)

- Wednesday reception - No Fee
- Thursday reception - No Fee
- Saturday Farewell Dinner (Member) - No Fee
- Saturday Farewell Dinner (Nonmember) - \$95

### ACCOMMODATIONS

**The Westin Huntsville, 6800 Governors West, NW, Huntsville, AL 35806.** The discounted room rate is \$155 per night. Reserve a room online at [www.tinyurl.com/WestinHuntsville](http://www.tinyurl.com/WestinHuntsville). The room block expires Sept. 17, 2021

### DETAILS

More conference information is online at [www.alabamapsych.com/physicians](http://www.alabamapsych.com/physicians). If you have special needs and/or need assistance, please contact Janet Bryan at (410) 938-3452 or [JBryan@sheppardpratt.org](mailto:JBryan@sheppardpratt.org).

### REGISTRATION

Register online at [www.tinyurl.com/2021ResilienceHuntsville](http://www.tinyurl.com/2021ResilienceHuntsville) or mail form and payment to Southern Psychiatric Association, Attn. Janet Bryan, 6501 N. Charles St, Baltimore, MD 21204. Phone (410) 938-3452 • Fax (410) 938-3159

### PAYMENT

- Check payable to Southern Psychiatric Association
- Credit Card:  VISA  MasterCard  American Express

Cardholder Name \_\_\_\_\_ Email address for receipt: \_\_\_\_\_

Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_ Security Code \_\_\_\_\_

Billing Address \_\_\_\_\_ City, State ZIP \_\_\_\_\_

Signature \_\_\_\_\_ Amount: \$ \_\_\_\_\_



The Southern Psychiatric Association  
and the Alabama Psychiatric Physicians  
Association present:

# Resilience: COVID-19 and Beyond

October 6-9, 2021  
Westin Huntsville



ALABAMA PSYCHIATRIC  
PHYSICIANS ASSOCIATION  
A District Branch of the American Psychiatric Association

## SPA/APPA 2021 CONFERENCE TENTATIVE AGENDA

### Wednesday, Oct. 6

6:00 p.m. – 7:00 p.m.

Welcome Reception at the Hotel

Dinner on Your own

### Thursday, Oct. 7

8:00 a.m. – 10:30 a.m.

SPA Council Meeting

11:00 a.m. – 4:00 p.m.

Registration

1:00 p.m. – 5:00 p.m.

Exhibit Set-up

12:15 p.m. – 12:30 p.m.

Welcome

Margaret (Kea) Cassada, MD,  
SPA President

Godehard Oepen, MD, PhD,  
DLFAPA, APPA President

12:30 p.m. – 1:30 p.m.

**New Antidepressants and the  
Pharmaceutical Pipeline:**

**Where are we Going?**

Richard C. Shelton, MD,  
Professor, University of Alabama -  
Birmingham

1:30 p.m. – 2:30 p.m.

**Mass Incarceration and America's  
History of Racial Injustice**

Charlotte Morrison, Senior  
Attorney, Equal Justice Initiative

2:30 p.m. – 3:00 p.m.

Break

3:00 p.m. – 4:00 p.m.

**Grief & Resilience: Managing  
Losses Great and Small**

Mary Helen Davis, MD, DLFAPA,  
Independent Practitioner,  
Integrative Psychiatry

4:00 p.m. – 4:30 p.m.

**Resident Research Award  
TBA**

6:00 p.m. – 8:00 p.m.

Off-Site Reception

### Friday, Oct. 8

7:00 a.m. – 8:00 a.m.

**Registration & Check-in, Exhibit  
Visitation, Continental Breakfast**

7:00 a.m. - 7:30 a.m.

**Tai Chi Practice**

Gary Weinstein, MD, Clinical  
Professor, Department of  
Psychiatry, University of Louisville  
School of Medicine

7:45 a.m. - 8:00 a.m.

**Welcome**

Godehard Oepen, MD, PhD,  
DLFAPA, APPA President

Margaret (Kea) Cassada, MD,  
SPA President

8:00 a.m. – 9:00 a.m.

**Art and Psychiatry Panel**

**Van Gogh: Madness and Creativity**

David Casey, MD, DLFAPA,  
Professor and Chair, Community  
and Family Psychiatry, University  
of Louisville School of Medicine

**Art and Mental Illness: Artistic  
Creations of People with Severe  
Mental Illness**

Godehard Oepen, MD, PhD,  
DLFAPA, Psychiatrist, Ascension

9:00 a.m. – 10:00 a.m.

**COVID-19 Vaccine Update**

Sandra Fryhofer, MD, Adjunct  
Associate Professor of Medicine,  
Emory University School of  
Medicine

10:00 a.m. – 10:30 a.m.

Break and Exhibit Visitation

10:00 a.m. – 10:30 a.m.

**Southern Psychiatric Association  
Business Meeting**

10:30 a.m. – 11:30 a.m.

**Neuromodulation Panel**

Michelle Cochran, MD, DFAPA,  
Partner and Medical Director,  
NeuroScience & TMS Centers

Charles Hayden, MD, Medical  
Director, TMS Huntsville

11:30 a.m. – 12:30 p.m.

Lunch and Exhibit Visitation

12:30 p.m. – 1:30 p.m.

**ADHD Medication Update**

Mark Wright, MD, Adult, Child/  
Adolescent Psychiatrist, Lexington  
Behavioral Medicine



## AGENDA, cont.

1:30 p.m. – 2:30 p.m.

### **Ethics Panel**

#### ***Psychiatric Ethics: Update and Challenges***

Rebecca Brendel, MD, JD,  
Associate Director, Center for  
Bioethics, Harvard Medical  
School

Steven Lloyd, PhD, Vice Provost,  
University of North Georgia

Afternoon/Evening Open

## **Saturday, Oct. 9**

7:00 a.m. – 8:00 a.m.

### **Registration & Check-in, Exhibit Visitation, Continental Breakfast**

7:00 a.m. – 7:30 a.m.

### **Tai Chi Practice**

Gary Weinstein, MD, Clinical  
Professor, Department of  
Psychiatry, University of Louisville  
School of Medicine

8:00 a.m. – 9:00 a.m.

### **Racism Panel**

#### ***Six Es of Racism***

Rahn Kennedy Bailey, MD,  
DFAPA, Chairman, Department  
of Psychiatry, Louisiana State  
University

### ***Mental Health Justice: Strategies to Abolish & Decolonize Carceral, Colonial Psychiatry and Build Collectivist, Global Liberation Psychiatry***

Ayesha Khan, PhD, Postdoctoral  
Fellow in Infectious Diseases,  
Mayo Clinic

9:00 a.m. – 10:30 a.m.

### **Diversity Panel**

#### ***A Brief History of the Civil Rights Movement in Huntsville, Alabama***

Sonnie W. Hereford IV, BSEE, MS,  
Senior Systems Engineer, 5 Stones  
Research

Stephen M. Taylor, MD, MPH,  
DFAPA, FASAM, Chief Medical  
Officer, Behavioral Health  
Division, Pathway Healthcare

### ***Promoting Diversity at UAB School of Medicine - Successes and Challenges***

Roger Smalligan, MD, MPH, FACP,  
Regional Dean, University of  
Alabama at Birmingham School  
of Medicine - Huntsville Regional  
Campus

10:30 a.m. – 11:00 a.m.

### **Break and Exhibit Visitation**

11:00 a.m. – 12:00 p.m.

### ***Preventing Violence, Seclusion and Restraints: The State of Affairs***

Sylvia Atdjian, MD, DFAPA,  
Associate Professor, Psychiatry  
and Behavioral Sciences, Johns  
Hopkins University School of  
Medicine

12:00 p.m. – 1:00 p.m.

### **Community Based Resources and Resilience Panel**

Jacqueline Maus Feldman, MD,  
Professor Emerita, University of  
Alabama

### ***Mental Health Equity: Resilience and Recovery***

Timothy E. Stone, MD, Psychiatric  
Director, Wexford Health-  
Alabama

1:00 p.m. – 6:30 p.m.

### **Afternoon Open**

6:30 p.m. – 7:00 p.m.

### **Cocktail Reception**

7:00 p.m. – 9:00 p.m.

### **Farewell Dinner Gala Celebration**

## EDUCATION

### ***Accreditation Statement***

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Association of the State of Alabama through the joint providership of the Medical Foundation of Alabama and the Alabama Psychiatric Physicians Association. The Medical Foundation of Alabama is accredited by the Medical Association of the State of Alabama to provide continuing medical education for physicians.

## REGISTRATION

Go to [tinyurl.com/2021ResilienceHuntsville](https://tinyurl.com/2021ResilienceHuntsville) to register online or print a registration form at [www.alabamapsych.com/physicians](http://www.alabamapsych.com/physicians).

## ACCOMMODATIONS

**The Westin Huntsville, 6800 Governors West NW, Huntsville, AL 35806.** The discounted room rate is \$155 per night. Reserve a room online at [www.tinyurl.com/WestinHuntsville](https://www.tinyurl.com/WestinHuntsville). The room block expires Sept. 17, 2021