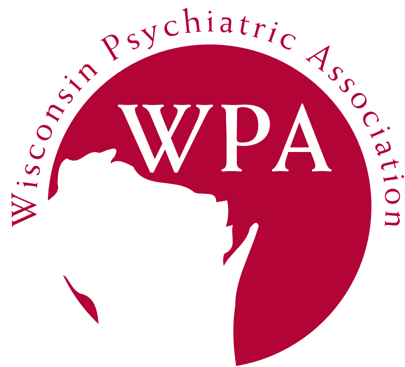

The Wisconsin Psychiatrist

Winter 2007
Vol.47 No.3

Save the Date!
WPA Annual Spring Meeting
April 17-19, 2008
Intercontinental Hotel
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QUARTERLY PUBLICATION OF THE WISCONSIN PSYCHIATRIC ASSOCIATION: NORTHERN, SOUTHERN AND MILWAUKEE CHAPTERS

Recap: Member-in-Training and Early Career Psychiatrist Career Fair

By Claudia Reardon, M.D., PGY-2, University of Wisconsin WPA Resident Representative

For UW and MCW resident psychiatrists and Wisconsin-wide early career psychiatrists, Saturday, 13 October 2007 proved an opportunity for career planning in a relaxed, supportive environment. This beautiful fall day saw several young psychiatrists come together at Country Springs Inn in Pewaukee, WI for a day-long event consisting of speakers offering a wide array of advice on career development.

Carl Chan, WPA President, provided a gracious welcome to attendees, and this was followed by a panel discussion over breakfast with psychiatrists from a variety of sub-specialties and types of practice. This panel included the following, who graciously gave of their time to join us: Jerry Halverson, M.D. (representing academic, hospitalist, and administrative psychiatry), Tom Heinrich, M.D. (academic and C/L), Noah Horowitz, M.D. (psychotherapy), Jeff Marcus, M.D. (administrative), Dave Skripka, M.D. (academic and child and adolescent), Brad Smith, M.D. (forensic), Art Walaszek, M.D. (academic and geriatric), and Ted Weltzin (private practice).

Following the panel, we heard from Mike Arnow, a CPA who addressed basics of financial planning. A buffet lunch was enjoyed while we heard from guest speaker Senator John Erpenbach on the Healthy Wisconsin initiative. Following the working lunch, Larri Broomfield, a healthcare attorney, informed us of the basics of signing a contract.

The above event was generously funded by a grant from the American Psychiatric Association. We hope to hold a similar event every 2-3 years.

The Wisconsin Psychiatrist is published four times a year — Spring, Summer, Fall and Winter — for members of the Wisconsin Psychiatric Association and those interested in its activities. Opinions expressed are the authors' and do not necessarily reflect the policies of the WPA. Articles submitted must be signed and are subject to review by the Editors and/or Editorial Board. Articles may be reprinted. However, attribution to *The Wisconsin Psychiatrist* and two copies of the reprint are appreciated.

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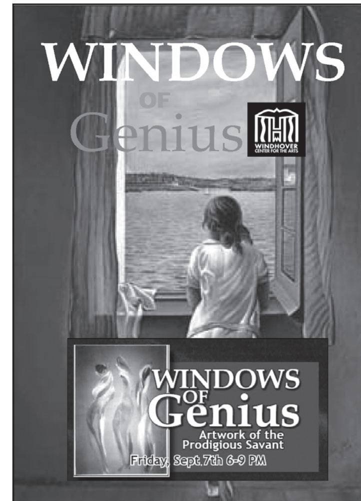
Windows of Genius: A Unique Art Exhibit

By Darold A. Treffert, M.D.

The Windhover Center for the Arts hosted a unique, one of its kind art exhibit from September 7 to October 12, 2007 in Fond du Lac. Titled "Windows of Genius: Artwork of the Prodigious Savant", the exhibit was an overwhelming success with over 400 persons at the opening lecture, and hundreds more subsequent visitors of all ages, and from all walks of life.



The exhibit featured art work—paintings, drawings, sculptures, silhouettes—of 12 prodigious savants from around the world collected by Dr. Treffert during his many years of work with savant artists. Several of the artists from the U.S. and Australia were present for the opening event and demonstrated their abilities first hand.

The exhibit was as much an educational event as an artistic adventure. A continuous loop video provided background on savant syndrome and the prodigious savant—a person whose skill is so spectacular that absent their disability they would be called prodigy or genius—along with a video demonstration not just of the work of the savant, but of the world of the savant as well.

Wisconsin Public Television did a segment on the exhibit for its In Wisconsin program and other foreign television and print journalists also covered the event. Further descriptions and reviews of the exhibit can be seen in the What's New section of the savant syndrome web site at www.savantsyndrome.com.

The hope is this will become a traveling exhibit given its popularity among all age groups, but especially given its enthusiastic reception among students from grade school to graduate school, some of whom have indicated now increased interest in neuroscience in general. Hopefully from this group might come the 'fresh, new explorers' to fully examine the unique window into the brain that savant syndrome provides, a voyage of neuroscientific discovery that has only just begun.

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Competency, Necessary But Not Sufficient

By Carlyle H. Chan, M.D.

Competency has been the goal of residency education for the past several years and now the American Board of Medical Specialties has also embraced the concept, making it a part of Maintenance of Certification. The six core competencies include patient care, medical knowledge, interpersonal and communication skills, professionalism, systems based practice and finally, practice based learning and improvement. Should competency be the goal for specialists like psychiatrists or any specialist, for that matter?

Herbert Dreyfus, a philosopher and Stuart Dreyfus, a computer scientist, thinking and working on artificial intelligence, write about the acquisition of knowledge and expertise in humans. They note that there are at least five developmental stages: novice, advanced beginner, competent, proficient, and expert. (Others have written about a sixth stage, master.)

The initial stages of learning a skill or task are rules based. A novice follows guidelines or instructions on how to proceed. Recall, if you will, the importance of DeGowin & DeGowin's Diagnostic Examination or the Washington Manual or similar texts when you first started your medical training. We regularly looked up the diagnostic criteria and the medicines needed to treat a particular condition at a specified dose. It was through exposure, repetition and practice that we advanced from novice (beginning medical student) to advanced beginner (entering residency) to competent (completion of residency). As we advanced along this path, we no longer simply followed rules, but began diagnosing patients without the textbook symptoms and began using our clinical experience to adapt treatments for those patients who didn't fit the classic diagnostic picture or failed to respond to initial treatments or had side effects. We also began to prioritize our decision making for complex cases.

But how do we as practicing clinicians, move beyond competency? The Dreyfus brothers point out that experts don't necessarily use rules to make decisions. They tend to use "intuition". By "intuition" the Dreyfus duo don't mean a hunch. Rather, they are referring to a non-verbal process of utilizing accumulated knowledge and experience or "know-how", partly akin to pattern recognition. Studies of master chess players reveal that they do not think through their moves or plan three moves ahead, they just "know" the correct move. Master chess players who play multiple opponents simultaneously are good examples. If you have ever tried to teach your children how to drive an automobile, you quickly realized that you needed to deconstruct the techniques you no longer thought about, for example, turning a corner. Trying to verbalize how to keep your balance riding a bike is another.

Studies have also shown that, across a variety of fields and professions including chess and sports, it consistently seems to take about 10 years to become an expert in a field. Now, repeating a task for 10 years does not automatically qualify one as an expert. I believe my prowess as a weekend golfer is testimony to that. Conversely, not practicing a task can cause an expert's skills and abilities to deteriorate. Dreyfus cites the example of an experienced pilot who had not flown a particular plane in years who encountered a problem to which normally he would have responded automatically. However, because he was rusty in his flight skills, he had to think about his response rather than react, and this led to almost disastrous consequences.

It takes a combination of practical experience plus study and application of that study to the task(s) at hand to progress beyond competency. This ability to intuit the correct diagnosis or treatment, while masterful, can also be fraught with the possibility of errors. Two recent books with the same title, How Doctors Think, delve into this process. Jerome Groopman warns us that to guard against these errors we must be ever vigilant and aware of our individual biases.

I would submit to you that this developmental model of how we acquire expertise places the concept of lifelong learning in context. Part IV of the new Maintenance of Certification (MOC), called Performance in Practice, will require us to collect cases from our clinical practice and examine outcomes; design a plan to improve those outcomes; and then review a new set of patient cases to see if those outcomes have, in fact, improved. This should not be just an exercise to fulfill MOC requirements, but ought to be a means of improving patient care as we strive to become and continue to be experts in our field. We may need to overcome our natural narcissistic propensities to make this happen.

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Residency News from the University of Wisconsin

By Claudia Reardon, M.D., PGY-2, University of Wisconsin WPA Resident Representative

As we prepare for another Wisconsin winter, there's lots going on in the University of Wisconsin School of Medicine and Public Health (UWSMP) psychiatry residency program. Check it out:

- The psychiatry residents are taking an active role in invigorating the UWSMPH PsychSIG (Psychiatry Student Interest Group). We recently helped this med student group with their fall kick-off meeting. Over a supper of tacos, students interested in psychiatry mingled with UW psychiatry residents and faculty, and signed up to join the APA (free for students!), as we discussed plans for potential PsychSIG events for the academic year to come. Also as part of PsychSIG, residents have initiated a mentorship program in which med students considering a career in psychiatry are paired up with psychiatry residents for guidance and support. It promises to be an exciting year as residents and students work together to have fun, work hard, and learn lots.
- Angela Janis, first year UW psychiatry resident, was recently a contestant on the well-known game show Jeopardy. She represented us well and made us Badgers proud!
- Last spring the UW residency program instituted a quarterly "Resident Caucus" in which all residents meet together with faculty members including Art Walaszek, residency program director, and Ned Kalin, chair of the UW Department of Psychiatry. The residency program here has always been extremely receptive in hearing residents' opinions about the structure and workings of the residency, and this provides yet another forum for our voices to be heard. The most recent caucus held on 14 September 2007 was a special treat in that we invited faculty members to discuss research opportunities for residents. Residents are now eager and motivated to consider adding research to their repertoire (in their copious free time!).

Medical College of Wisconsin Department of Psychiatry - Resident News

By Andrew Butchart, DO, Medical College of Wisconsin, Department of Psychiatry – PGY-3

The residents at the Medical College of Wisconsin are adjusting to the new academic year quite nicely. The PGY-1 class is working as busy interns and enjoying their first exposure to psychiatric patients as newly minted physicians. The PGY-2 class is settling in to their role as outpatient providers for both psychiatric medication management and psychotherapy. Most of them report that the autonomy they have in scheduling psychotherapy patients is a welcome freedom, and they are enjoying learning about the various modalities of psychotherapy. The PGY-3 and 4 classes are working on the consult-liaison services and inpatient units, as well as serving to lead the residency in chief resident positions. In other recent residency news, the Department of Psychiatry's softball team wrapped up the season in August and posted a better record than in the previous year, despite sustaining a first-round playoff loss. The team had a large number of returning players, as well as some welcome new additions, and consisted of a varied mix of members of the department.

The social committee has been hard at work planning opportunities for residents to socialize outside of the academic setting. One recent event was the Halloween party hosted by last year's psychotherapy chief resident, and new MCW attending psychiatrist, Paul Nicholas. Another social committee event was a "Girls' Night Out" for female residents and female significant others of current residents. A "Guys' Night Out" is being planned currently, as is the annual Department of Psychiatry Talent Show. Finally, looking toward the holiday season, the residents are again planning to purchase gifts to provide to some of the long term residents of the Milwaukee County Mental Health Complex. This has been an annual tradition which has provided these individuals with gifts selected from a wish list, while providing the residents an opportunity to participate in the holiday spirit of giving.

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The Best Specimen of a Tyrant: The Ambitious Dr. Abraham Van Norstrand and the Wisconsin Insane Hospital.

By Thomas Doherty. Madison, Wisconsin: Spenser-Hoyt, 2007. 287 pp (paperback).

Nestled among the effigy mounds on the shores of the lake whose name it shares, Mendota Mental Health Institute has occupied a prominent historical place in more ways than one. Despite a sometimes dark reputation based on the violence of some infamous patients, Mendota has played a remarkably significant role in the histories of Madison, and of Wisconsin, and of modern psychiatry. In Best Specimen of a Tyrant, Thomas Doherty introduces us to the early history of Mendota by telling the story of one man:

Dr. Abraham Van Norstrand, the Institute's third superintendent. Van Norstrand is a complex, larger than life figure: westward pioneer, physician, Civil War officer, entrepreneur, and hospital administrator. Tyrant follows Dr. Van Norstrand through two of his most severe challenges: a grueling campaign in Louisiana with the Fourth Wisconsin regiment of the Union Army, and years later, as superintendent of the Wisconsin Insane Hospital, as he defends himself during an aggressive investigation of his clinical leadership by Samuel Hastings, former state treasurer and social crusader, over the death of a patient. Through his recounting of these two great struggles, Doherty is able to deliver a fascinating character study of a complex and influential physician, as well as to provide an illuminating account of hospital psychiatry during a far more rudimentary age.

At the outset, it is clear that Doherty could not have chosen a more fascinating central character. Van Norstrand is a strong personality, a leader among men, a warrior through and through. In pursuing his fortune, the "ambitious Dr. Abraham Van Norstrand" was involved in at least three titanic struggles: the U.S. Civil War, the war against mental illness, and every man's struggle within himself, the struggle to wield power in an honest and ethical manner. It may be tempting for the reader to seek a simple resolution to questions about Van Norstrand's character, and to await a verdict of guilty or innocent, but such answers do not come. In the end, Van Norstrand is neither a hero nor a villain; he is both. He is at once a saint and a sinner. By allowing these elements to coexist within him without any rush to judgment, the author presents Van Norstrand as more than a central character; he becomes a protagonist in the classical sense. In so doing, Doherty delivers more than simply a historical treatise; we are presented with a morality play played out on the stage of Wisconsin Insane Hospital (an earlier incarnation of Mendota Mental Health Institute), with the early days of Wisconsin statehood as a historical backdrop.

Beyond its thematic integrity, Tyrant is a meticulously researched piece of historical writing. This is true from the perspective of Wisconsin history, as well as the history of psychiatry. Doherty resurrects the story of a man whose career influenced the state of Wisconsin during its infancy, as well as the fighting of one of our most historically significant wars. In telling Dr. Van Norstrand's story, we are also informed of the role which Wisconsin Insane Hospital played in the evolution of modern hospital psychiatry. Following on the model espoused by Dr. Thomas Kirkbride of Pennsylvania Hospital, the Wisconsin hospital was to be part of a new movement toward enlightened, effective, humane treatment of the mentally ill. By recounting a tragically unsuccessful case and its ensuing investigation, we see that the war against mental illness will be a difficult one. In the book's early chapters, we are introduced to Abraham Van Norstrand, a descendant of Dutch immigrants, born in the Hudson valley, with a powerful constitution. Abraham chooses medicine as his field, and upon receiving his degree, he leaves his home and moved westward in search of his fortune. He gravitates toward Wisconsin, and after arriving in 1847, he proceeds to pursue his fortune through the practice of medicine, and then through investment in real estate and government bonds.

After his financial investments prove unsuccessful, with the advent of the Civil War, he raises a company of volunteers who serve with Union forces in Louisiana, and it is during his military service that we begin to see the complex nature of the man emerge. Although he distinguishes himself as a leader and administrator in the Union army, questions begin to arise regarding his integrity: he appears to have used his office for personal profit, arranging for the sale of liquor to soldiers. Following the war, Dr. Van Norstrand is appointed as the third superintendent of the Wisconsin Insane Hospital, a post which he assumes in 1864. While his wartime military service provided exhilarating and dramatic experiences, his new adventure on the shores of Lake Mendota would prove dramatic, as well. The clinical challenges and administrative battles which he would encounter showed the war against mental illness to be no less daunting.

Having spent a year at Mendota State Hospital as a graduate student, the author proceeds from a frame of reference which appears both knowledgeable and sympathetic. This is fortunate, since the methods of psychiatric treatment during the 1860s were much more limited, and at times more harsh than the clinical methods used at Mendota today. While it is not surprising to note the lack of effective psychotropic medications during the nineteenth century, what is striking is the difference in therapeutic approach during that time. In contrast to today's careful consideration for patients' rights, and concern with the therapeutic alliance

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Southern Chapter Update

By Brad Smith, M.D., Forensic Clinical Director at Mendota Mental Health Institute

I suppose the best place to start in terms of an update is to introduce myself. I am Brad Smith and I recently became the President of the Southern Chapter. Most of my professional practice is in the position of the Forensic Clinical Director at Mendota Mental Health Institute, but I also consult as a clinician to the Department of Corrections and conduct forensic psychiatric consultations privately. During the time that I will serve as the Southern Chapter President, I hope to encourage active participation by the members of the Southern Chapter, not only in the activities of our Southern Chapter, but also in the Wisconsin Psychiatric Association as a whole.

Traditionally, the Southern Chapter has provided professional fellowship and informational meetings three to four times per year. I have found these meetings to be a welcome departure from the more typical professional gatherings at conferences or pharmaceutical sponsored events. Dinner is usually followed by a brief business meeting and then a topic of interest. The topics presented are less likely to be psychopharmacology and more likely to involve a movie review of a film that features mental health, a discussion of pending changes in reimbursement, or a tutorial on the Indian mounds on the grounds of Mendota Mental Health Institute.

In keeping with this tradition, the first gathering that I have scheduled will feature a presentation by David Mays, M.D. on Spirituality in Psychiatry. Dr. Mays was previously the Forensic Clinical Director at Mendota Mental Health Institute. Subsequent to his retirement from Mendota in 2005, he has continued to provide education to mental health professionals in Wisconsin and across the United States on a wide variety of topics. One of the many interesting presentations I have seen Dr. Mays give is on Spirituality in Psychiatry. The presentation will be followed by discussion, and if tradition holds true it promises to be lively. The meeting is scheduled for Tuesday, December 4, 2007 at 6:00 p.m. at my home.

I welcome all Southern Chapter members to block the date for this upcoming meeting. Hopefully, each of you has received an invitation by email or regular mail, but if not, please call me at 608-301-1576 or email me at smithbe@dhfs.state.wi.us to RSVP and to receive directions to the meeting.

I encourage all Southern Chapter members to please share with me ideas you may have about future topics or other activities the we should consider. Thank you for your interest. I look forward to meeting those of you I have not, and getting to know better those of you I have.

Best Specimen of a Tyrant

continued from page 9

between patient and clinician, during the post Civil War era, the basic approach appears to have been one of control, and of breaking the will of the patient in order to make them more docile subjects for "treatment." The staff of the hospital had as their daunting task the treatment of aggressive, often psychotic patients with very few effective therapeutic tools at their disposal. One may thus be reluctant to judge their methods, but nevertheless thankful for advances in the field of psychiatry, both practical and philosophical. Best Specimen of a Tyrant provides a clear illustration of how far we've come in the field of hospital psychiatry in one hundred and fifty years.

In summary, Thomas Doherty's Best Specimen of a Tyrant will appeal to many types of readers because it succeeds on a number of levels. As a historical work, it illuminates the significant place which the Wisconsin Insane Hospital (today's Mendota Mental Health Institute) has occupied in the history of Madison, and of Wisconsin, and in the history of psychiatry. As a character study, it presents Dr. Abraham Van Norstrand, a fascinating and complex individual, with all of his strengths and weaknesses, in all of his humanity. His story is fresh even 150 years later, because it the struggle of every man and woman, the struggle to do the right thing, to use the power and resources at our disposal in a responsible and ethical manner. With all of the intrigue of a courtroom drama, we are witnesses to "a critical and searching examination" of a larger than life figure. Finally, Tyrant is an important text for anyone with an interest in the treatment of mental illness. It is a sobering snapshot of the standard of care for hospital psychiatry circa 1860, and of how far we've come since then. As in any field, the battles which we wage today are dependent on hard-fought victories of years gone by. Thomas Doherty has ably chronicled a series of such battles in Best Specimen of a Tyrant, a skillfully told story of one warrior who battled the Confederate army, and then returned to the shores of Lake Mendota to battle mental illness. His story remains inspiring, enlightening, and relevant to us still, as we follow in his footsteps, confronting the scourge of mental illness in a new generation of patients on our battlefield by the lake.

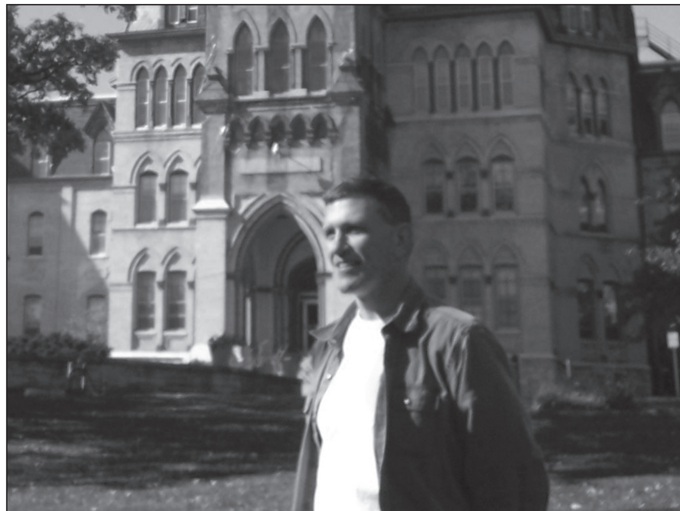
Kenneth C. Casimir, M.D.
Medical Director
Mendota Mental Health Institute

Psychiatrist Orders His Own Psychiatric Consult After Receiving Orders For Third Army Deployment.

By Michael McBride, M.D.

Why would a child and adolescent psychiatrist join the army, only to suffer separation from home and family, sacrifice his private practice, and put himself in harm's way? "You must be crazy," is the response I commonly get. Ever since an e-mail arrived informing of my next deployment to Iraq, my life has been spinning wildly towards the reality of a third call-up and the effects it will likely have on family and career. It is a high time to examine my motivations, judgment, insight, and memory regarding a decision I made shortly after the events of September 11, 2001.

My weltenschauung, "worldview", changed after 9-11. I had never imagined myself serving in the armed forces. I lost my hearing in the left ear at age 6 due to the mumps. I had scratched off the choice of a military career and even found myself joining the Peace Movement in the mid 1980's. I was in a Catholic seminary and with several of my classmates protested outside a Michigan factory that made cruise missiles. After 9-11 the army sent out a request for psychiatrist and surgeons. Like most people struggling with the shock and grief of watching buildings crumble into clouds of dust, I was compelled to do something. The stark realization there exist people not far evolved from the Stone Age; who are eager to destroy the innocent by any means possible; who rely upon archaic myths as the basis for judging others, and thus justifying murder; who have only disdain for democratic principles, crumbled my Franciscan fantasy of world peace and communion based on tolerance, non-violence, and reason. The facts were clear: if we are to preserve the freedoms of a democracy, we must be willing to defend the constitution with military force. My civics lesson had begun. This was my opportunity to participate in the democratic process by volunteering to serve as a psychiatrist in the United States Army Medical Corps.



I was quickly deployed to Landstuhl Regional Medical Center, an army hospital nestled in the Rhine region of Germany. Every soldier injured in Iraq and Afghanistan is evacuated to Landstuhl for stabilization and triage. My job was to evaluate and treat every blast injured patient, as well as attend the psychologically wounded. Common diagnoses included anxiety, depression, acute stress disorder, PTSD, and occasionally psychotic breaks. Equally in need of psychiatric services were the Army Reserve soldiers and airmen who were deployed to care for the combat soldiers. The army called this "Compassion Fatigue". The mission was intense and emotionally demanding. I realized being away from my family, friends, and familiar environment prevented the downloading of stress and secondary trauma a psychiatrist accumulates over the course of their work. After the first tour I experienced the symptoms of depression. The second tour went much better as I had developed skills of resiliency. However, my family suffered as my wife was left alone to parent our two teenagers. They tolerated my absence and survived through foraging ahead in their lives. I am thankful for their support and fortunate they stuck by me. There is a high divorce rate for returning veterans. The sense of being a part of a mission helped to sustain me through the difficult times. My clinic staff and partners at Milwaukee Psychiatric Physicians Chartered carried and nurtured my private practice so I could return and jump back into my routine. I am deeply grateful for their efforts. The war has dragged on longer than anyone expected and many of my physician colleagues in the army have opted to retire. The navy has taken over the army hospital in Germany so all available army physicians can deploy to Iraq. I am scheduled to join the 785th Combat Stress unit from Fort Snelling, Minnesota in December.

My patients tell me they feel sorry for me when they learn of my upcoming deployment. I understand their sentiment and explain how fortunate I am to serve our country. I look around and see the privileges of living in a safe neighborhood, with proper shelter and plentiful food. With the best public school system in the land. Where my children can pursue any dream they imagine. We can speak our mind without fear of persecution, even criticize and openly disagree with our government's policies. Every four years we get to participate in the election of our president and representatives. This reality is not free. I am deeply thankful for those who "paid" for this. I am surrounded by psychiatrist like Tony Meyer, George Ferguson, Mike Deeken, Steven Steury, Ray Headlee, Mark Smuckler, and my mentor Irv Raffe who all served in the armed forces. My father was drafted into

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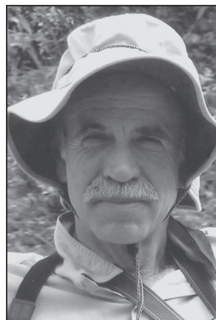
The Biological Roots of Child Psychology

Is Mentoring Biological?

By Douglas A. Kramer, MD, MS



In the AACAP presidency of Thomas Anders, M.D., mentoring is one of the main themes of his two-year term (Shrier, 2005). When I do presentations at a Grand Rounds, or an Annual Meeting of the Academy, I list ten mentors who have been important in my intellectual and personal development. The list begins with my college ethology professor, includes my graduate school major professors, several psychiatrists, and Walter J. Freeman, M.D., who is not a psychiatrist.

Dr. Freeman completed medical school at Yale, and an internship in internal medicine at Johns Hopkins, following which he began his career in research. He is an electroneurophysiologist with over 50 years of research experience in the operation of the brain, especially in the field of perception, and a deep interest and congenital knowledge of psychiatry.

His father, Walter Freeman, II, M.D., was a prominent psychiatrist in the middle decades of the last century, one of the founders and the first Secretary of the American Board of Psychiatry and Neurology, a department chair, and now a controversial figure in the history of biological psychiatry. There have been five biographies written about this Dr. Freeman, the latest being The Lobotomist. Initially formulated as a condemnation of that era of psychiatry, and of the chief proponent in the United States of the procedure, it was ultimately written in a manner sympathetic to Walter's father and others of that era who attempted to relieve the suffering of the most severely ill patients (El-Hai, 2005).

The change in appellation, from Dr. Freeman to Walter, represents a change in my experience of the relationship, and I believe in his as well. He and I shared articles by email during a courtship process around my inviting him to participate in a symposium for an Annual Meeting of the Academy. That eventually occurred in Miami in 2003, an event at which Lyman Wynne, M.D. (1923-2007), also participated. The symposium was called, "The biology of interaction: genes, environment, and the brain." Walter's role was to focus on the interaction of the brain with the environment.

The courtship actually lasted two years. A similar proposal for our 2002 meeting in San Francisco had not been selected. That initial proposal had been the basis for my asking Dr. Freeman to speak as he is on the faculty at UC-Berkeley. He came all the way to Miami the next year anyway, as did Dr. Wynne from Rochester, NY. Just as we often comment about matching a face with a voice, even more mysterious is matching a face and a person with electronic mail. What a pleasant experience! I had wondered what kind of man would spend 50+ years looking at 64-channel rabbit electroencephalographs. I did have a hint about that man, however, from an earlier book in which Freeman (1995) had said, "The most important function of brains is to interact with each other to form families and societies."

He is a kind, gentle, humble, energetic, intellectually curious, personally open, and very interesting man. I wonder if mentorship includes an element of transference? Dr. Anders didn't say. I used to think of Gregory Bateson (1972, 1979), another in the list of ten mentors, as the most intelligent human I had ever encountered, but Gregory and Walter are certainly equals. I don't think they ever met, although both were in northern California for much of their lives. To give the reader an idea as to why I find Walter so fascinating, I will provide one paragraph from a recent article (Freeman, 2003):

"In Platonic, Aristotelian, and Thomist doctrines a separation is made between the material and spiritual domains with identification of a spiritual agency, the soul, that moves the body. In the Cartesian metaphor, the soul is to the body as a pilot is to a ship. Most scientists today have adopted monist views that give no place to soul. Those adhering to a passive view of cognition find the source of agency instead in the genetic and environmental determinants of behavior, and debate the relative primacy of 'nature' vs 'nurture'. Those practicing an active view propound the primacy of self-determination but find themselves uncomfortably skewered on the horns of the unresolved antinomy between 'free will' and 'determinism'. New developments in the sciences of nonlinear dynamics, complexity, and chaos indicate that this conflict is a pseudoproblem (Freeman, 2000). No human action is entirely determined by either genes, world or self but instead by an ever-shifting balance of interactions among the three formants."

Early in our email relationship, he had commented that my writing about psychiatric issues sounded somewhat deterministic, e.g., Kramer (2001). I noted in his writing opposition to both genetic and environmental determinism, but certainly didn't see myself as deterministic. After all, I am open and caring and intellectually honest - like most psychiatrists - especially child psychiatrists. A quote from Walter's latest book says it well (Freeman, 2000), "I think we can do better, at the very least to remove the dead hand of sociogenetic determinism."

Walter spoke again at the 2006 AACAP Annual Meeting, in San Diego (Freeman, 2006). I showed him the two now recent columns (Kramer, 2006a, 2006b) on creationism and 'neo-creationism.' He sent me a nice email about the ideas in those

columns, and again mentioned that I write well about the determinism of genes and the environment as the two entities interact. I continue having the nagging thought that I am missing something, but what was it?

How often does it happen at the Opening Plenary of a convention that a substantial portion of an audience, as well as an organization's President, are in tears? Well, through the efforts of the Academy, Dr. Anders (who read the details of a nomination), and History and Archives Chair David Cline, M.D., this is exactly what happened in San Diego. The AACAP bestowed upon Sir Nicholas Winton the 2006 Catcher in the Rye Humanitarian of the Year Award (Baker, 2006). Although still active at 97 years of age, he was not present to receive his award, but three of his 'children' were.

Nicholas Winton was knighted for having arranged the rescue of 669 endangered children from Czechoslovakia between March 14, 1939 and August 2, 1939, children who almost certainly would have perished at the hands of the Nazis. Two hundred and fifty additional children were aboard a train in Prague, scheduled to depart on September 1, 1939, when the borders were closed with Germany's invasion of Poland on that date. Winton was a 29-year-old London stockbroker when he organized these rescues, but the world wouldn't learn of his actions until almost 50 years later when his wife asked him about some old papers she had discovered in their attic. He actually told her they were 'just some old papers and to throw them away.' As a result of his actions, and of the many others who assisted in the project, known as "The British Committee for Refugees from Czechoslovakia, Children's Section," not only did the 669 children live, but they now have over 5,000 descendants (Minac and Pass, 2001).

About six weeks after the Plenary in San Diego, I was asked at a Grand Rounds that I had the honor of giving, part of the Warren Wright Lecture Series at Northwestern University, a question that brought me back to the issue that Walter Freeman keeps mentioning. The question, which I answered poorly at the time, had to do with the enormous conflict present in today's world and whether or not humans were capable biologically of doing better. Of course, that question was relevant in 1938-39 as well.

I doubted that Homo sapiens could do better. We are bestowed through natural selection with two motivating influences to engage in apparently altruistic behavior, kin selection and reciprocal altruism. The former, in the service of inclusive fitness, is useful in our work as child and adolescent psychiatrists, but doesn't apply to those who are not related genetically. In all likelihood, kin selection is a motivating force when humans use aggression to protect kin, mates, and territory from possible harm. The related principle of reciprocal altruism explains fitness expenditures toward non-kin from whom one might reasonably, and selfishly in a fitness sense, expect some future (reciprocal) action. A sports example is an easy way to demonstrate this. Team participation is an aspect of human sociality: "I'll work hard to throw a pass to you if you'll work hard to catch it." Success is beneficial to the fitness of both participants in terms of resource allocation and possible future mating opportunities.

Nicholas Winton's altruistic acts were beneficial neither to his inclusive fitness, as none of the children he rescued were related to him beyond common ancestry with Adam or Eve, nor did he have any reasonable expectation that they might reciprocally enhance his own fitness through future acts of their own.

The confluence of thoughts about our Opening Plenary, the poorly answered question in Chicago, and the emailed comments from my mentor turned friend about genetic and environmental determinism, lead to my realization that (1) biological research tells us how organisms behave 'on average,' but does not predict the behavior of any one individual, and (2) that Dr. Freeman's research provides a model for such non-determined behavior originating within individual brains.

With the earlier quote as an introduction, Freeman's half-century of experience with mammalian brains has lead to the conclusion that brains are active investigators of their environments, analogous to Piaget's description of cognitive development, not passive recipients of information. In fact, everything that a brain knows, in the sense of synaptic patterns developed from prior experience, it has learned from a lifetime of testing hypotheses, cataloging the results, and testing new hypotheses. Freeman (1991) rejects the idea that brains can know anything beyond their own constructed experience.

According to Freeman, each brain is "isolated within a solipsistic barrier." Brains create meaning from experience, experience that results from "constructing actions through its body into the world." The meaning so created, in terms of patterns of neural activity coordinated within an entire cerebral hemisphere, belong only to that brain, and cannot be transferred to another brain. Freeman (2000) again, "Our isolation provides the gift of privacy but also the curse of loneliness."

So what was Nicholas Winton doing when he made the decision resulting in 669 children living, and an additional 5,000 lives being created to date? He wasn't engaging in kin selection, or reciprocal altruism. He wasn't doing anything 'on average.' He was certainly engaging in an intentional act. Every intentional act, according to Walter Freeman (2000), "is an expression of the internal state of meaning in the brain and body."

That "internal state" lead to his decision and his subsequent actions. My further reflections on Sir Winton's children and their descendants lead me to our work as child and adolescent psychiatrists. We receive announcements for high school, college, and even medical school graduations from current and former patients. We receive wedding invitations and birth announcements. Occasionally, we save lives almost as certainly as did Nicholas Winton. It would be impossible to make

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Wisconsin Medical Society files suit to stop $200 million raid on fund for injured patients

By Edward Krall, M.D.

On October 29, 2007, the Wisconsin Medical Society officially filed suit (case no.: 07-CV-4035) to remedy what it contends is an illegal taking of $200 million from Wisconsin's Injured Patients and Families Compensation Fund (IPFCF). The action comes just days after Governor Doyle signed the State Budget on Friday, October 26th.

"This is just the first step in what may very well be a lengthy process in the courts," said Tom Pyper, of Whyte Hirschboeck Dudeck, S.C., who is representing the Society. "Judicial timelines are very difficult to predict. The Society is prepared to exhaust every legal option in defending injured patients and families and Society health care providers from what it believes to be an illegal taking."

Society President and WPA Council member, Clarence Chou, MD stated, "It is with great reluctance that we've filed this lawsuit, but the Society is dedicated to protecting patients' access to health care," "There is no doubt that during litigation it will be more difficult to recruit and retain high quality physicians when the practice climate in Wisconsin is unstable. But it would have been worse to let the government steal money from a fund that provides support for injured patients and their families."

Named in the suit are Sean Dilweg, Commissioner of Insurance, Michael Morgan, Secretary of Department of Administration and Dawn Marie Sass, State Treasurer.

The suit asserts eight causes of action, including the seeking of a permanent injunction against transferring money from the Fund "because the Act is unconstitutional or otherwise invalid or unenforceable…". The complaint further states that this transfer of money "constitutes an unlawful tax and is, accordingly, invalid and void…".

Physicians and certain other health professionals are required to pay fees to the IPFCF. The Fund, established in 1975, ensures monies are available to support patients injured due to a negligent medical act. Fund payments cover medical bills, replace lost income and make injured patients economically whole, to the extent possible. No taxpayer dollars are in the Fund. 2003 Act 111 established the Fund as an "irrevocable trust" to make sure the money was there for injured patients and their families.

Mark Grapentine, Senior VP of Government Relations of the Wisconsin Medical Society, summarized by saying, "I think that right now we need to get the word out to all physicians whether WMS members or not, that the Society is working hard to protect the Fund. We will want to continue to keep all physicians and the public aware of what is going on and why the Society has deemed it necessary to take the extraordinary step of suing the state.

When asked if physicians should contact their legislators, he further stated, "Communications with legislators or the Governor won't help much right now, as they have already voted/signed the budget into law. However, physicians should certainly keep the recent roll call votes in mind for future reference."

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Army Deployment

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the Navy after completing his residency in OB/Gyn. He served his two years of active duty during the height of the Vietnam War and I never heard him complain though he had to shut down his private practice. I am a fortunate one. I now understand and fully appreciate the rights and responsibilities of living in a democracy.

As a child and adolescent psychiatrist I feel I am uniquely qualified to understand and treat this young generation of soldiers, most of whom hail from rural towns and the south. I have learned how many come from abusive homes with divorced parents. Many have had a prior history of ADHD and other psychological disorders. Many have joined the military as their only means out of poverty or cycles of self-destruction. I know this first hand as I have witnessed a half dozen patients from my private practice who surprisingly found their way into the military. One returned from Iraq and tragically committed suicide this summer. It is with growing optimism that I read the military is finally grasping the enormity of psychological distress caused by war. Psychiatrist in nearly every clinical setting will have opportunities to serve those American citizens who have suffered the effects of combat and military stress. As a country it is our duty to provide the best care possible to these individuals and their families. The shameful exposure of squalid conditions and substandard care at Walter Reed Army Medical Center must be corrected. As citizens of this country we have a debt to pay to those who volunteered and were injured. It is a price we all can pay for living in a democracy.

Treatment of Individuals Found Not Guilty by Reason of Mental Disease or Defect

An update from Mendota Mental Health Institute's Forensic Program

By Brad Smith, M.D., Forensic Clinical Director at Mendota Mental Health Institute

Mendota Mental Health Institute (MMHI), one of Wisconsin's state psychiatric hospitals operated by the Department of Health and Family Services (DHFS), specializes in serving patients with complex psychiatric conditions, often combined with certain problem behaviors. Located on the historic and picturesque north shore of Lake Mendota in Madison, MMHI provides a secure setting to meet the legal and behavioral needs of our patients. The hospital services include the Forensic Program, the Civil Program, and Outpatient and Consultation Services. One hundred eighty one of the hospital's two hundred sixty six beds comprise the Forensic Program. The Forensic Program admits individuals ordered here by the criminal courts for assessment of, or treatment to become competent to proceed, or for treatment and rehabilitation upon a finding of not guilty by reason of mental disease or defect. How does someone get found not guilty by reason of mental disease or defect? What happens when someone is determined to be not guilty by reason of mental disease or defect? Does the person ever get back to the community? Hopefully, the following review will help answer some of these very common questions while providing a glimpse of some of the evolving treatment and rehabilitation efforts being made at MMHI.

In Wisconsin, the insanity defense is called not guilty by reason of mental disease or defect. There are many common misconceptions regarding this legal defense option. Despite popular beliefs that an individual is "getting off easy" during hotly contested cases in which the attorneys (and expert witnesses) disagree, typically these cases consist of both sides recognizing the mental disease or defect and entering into a plea bargain. In addition, individuals may end up staying longer in a forensic hospital than he/she might have spent in prison if found guilty. Wisconsin law indicates that an individual is not criminally responsible if, at the time of the alleged crime, he/she had a mental disease or defect and either lacked substantial mental capacity to appreciate the wrongfulness or to conform conduct to the requirements of the law. If a defendant enters this plea, the court will appoint a psychiatrist or psychologist to conduct an evaluation and additional experts may be hired by either side. If a judge or jury is convinced that a person meets criteria for this special plea, the individual is committed for treatment to the DHFS for a period of time that is dependent upon the crime committed. The judge may order the commitment to commence as an inpatient (such as at MMHI or Winnebago Mental Health Institute), or as an outpatient with various conditions. Those who begin their commitment in the hospital have the right to petition the court every six months to be discharged to a conditional release program. The release is to be granted unless the court determines there is a significant risk of bodily harm or serious property damage if the person is released. To assist in this decision, the court will appoint independent evaluators to assess the risk of the individual petitioning. The treating clinicians provide factual summaries of an individual's treatment history, but the opinion regarding release is provided by independent evaluators with the judge making the final decision.

When an individual is admitted to the Forensic Program at MMHI following a court finding of not guilty by reason of mental disease or defect, he will be assessed by multidisciplinary team in order to establish an initial treatment plan. The diagnoses and presenting problems vary, but the most common presentation or underlying reason for the criminal act is either some form of psychosis or some form of mental retardation or developmental delay. Occasionally we also encounter individuals who do not have an identifiable mental disease or defect, either reflecting a difference of opinion of MMHI clinicians compared to the court evaluators or cases of successful malingering. The majority, however, are clearly in need of treatment and rehabilitation. In the early stages the main goal may be as focused as reaching a state of minimal aggression and/or reducing the severity of overt psychotic symptoms. This type of stabilization is most often achieved in the maximum security section of the hospital. Once an individual stabilizes from the most acute symptoms, the potential transition to medium and then minimum security can be pursued. These transitions also typically involve changes in the overall treatment approach–from stabilization of acute symptoms to a recovery model of preparation for successful reintegration into the community.

While continuing with the type of psychiatric treatment with which most of us are familiar (medication treatment and/or psychotherapy), the multidisciplinary approach starts to take more shape in a variety of ways as an individual moves to less restrictive units. AODA assessments and treatment services are an enormously important component of recovery for many of the patients. Educational resources allow individuals to work on completing their secondary education, with opportunities to pursue further education through correspondence courses. Vocational rehabilitation services entail supervised employment on the grounds of MMHI in a variety of different functional levels of employment opportunities. Some even make the transition to employment opportunities in the community at large if their security clearance allows. Recreational and leisure interests are cultivated to promote pro-social behaviors and

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Treatment

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interactions. Music therapy programs and other artistic opportunities offer means of increasing expression and enhancing therapeutic efforts. Cultural awareness opportunities through treatment groups and educational offerings are also available. Various other treatment groups are offered to focus on particular treatment needs, such as sex offender treatment and dialectical behavioral therapy. The treatment teams utilize these and other opportunities to work to develop treatment plans that can help a person decrease his risk of relapse of mental illness symptoms and/or decrease the risk of danger he presents to himself or the community.

Perhaps the most profound evolution in the delivery of treatment at MMHI over the last several years has been the development of treatment malls. Previously, the vast majority of treatment programs were provided on each individual hospital unit (four in maximum security and five in medium/minimum security). The treatment mall is a separate area of the institution that was designed to provide the space and equipment to enable the majority of the treatment and rehabilitation groups to occur off the hospital unit. Not only has this improved the delivery of service from a staffing efficiency issue, but this has created a pro-social means of the patients simulating experiences closer to life in the community. It is in many ways an attempt to work on deinstitutionalizing individuals who are court ordered to be institutionalized. Instead of staying on one hospital unit with the same twenty or so other patients, and the same staff, each individual has a schedule of therapeutic groups and activities that occur with other patients and other staff members in a different physical space. Many have given the analogy of having a class schedule for school. In addition, work activities could occur in various other parts of the institute, which again aims to promote experiences likely to be a part of a successful transition to the community. Hopefully, the individual is able to utilize the treatment and rehabilitative services to optimize his recovery and be in the best mental condition possible to continue progression to less restrictive units in a safe manner.

The issue of release involves numerous factors. Oftentimes stabilization of symptoms of mental illness is not enough for the court to release an individual. Sometimes even successful integration of various rehabilitation and recovery efforts are not enough. Other factors include the nature of the crime, the likelihood of AODA relapse, the proposed aftercare plan, the support (or lack thereof) from family, community sentiment, effectiveness of the attorneys, and potentially many others. Most of our patients do get released back to the community. Wisconsin has a very comprehensive conditional release program with monitoring carried out by the Department of Corrections and the DHFS conditional release service providers. The low recidivism rates in this program are impressive—typically around 2-3%. However, some of our patients have faced and will face significant challenges to their efforts to be released. Some may spend as much time in the hospital as they might have spent in prison if found guilty. Our aim is to provide the treatment and rehabilitative services that can help the individual lower his risk of danger and hopefully also lead to an overall path of recovery.

Photo Correction: WPA ran the wrong photo in the last issue of graduating residents. To the left are the 2007 graduating residents: Art Walaszek, Residency Training Director, University of Wisconsin; with Jeremy Peacock, Azhar Yunus, Bob Vickrey, Chris Nevers, Cindy Singley & Charlotte Ladd

Act 2

By Alice O'Connor, Public Affairs Councilor

The Governor's budget bill was finally signed into law in October with no health care reform plan, no mental health parity, but a sizable reimbursement rate for psychiatrists who are non-institutional providers as one of our modest successes. The Governor did about 33 other partial vetoes including authorizing a planned raid on the Patient's Compensation Fund. The Wisconsin Medical Society has filed a court injunction in an attempt to prevent a $200 million transfer from the Injured Patients and Families Compensation Fund (IPFCF). New developments suggest the Governor may resurrect a hospital tax as a "trade" for the IPFCF funds thereby negating the need for a raid on the PCF Fund.

The budget bill, now law, increases rates for psychiatric services by 20%, beginning July 1, 2008 and is intended to address a significant problem with the Medicaid (MA) and BadgerCare recipients accessing psychiatric services. Currently, 16% of licensed psychiatrists in Wisconsin are certified to participate in the MA program, but not all MA certified providers submit claims for services. The state's MA program currently reimburses psychiatrists approximately 32% of the amounts psychiatrists' bill for outpatient and mental health services. Psychiatric and dental services are the only MA non-institutional service that many MA and BadgerCare recipients cannot access due to the lack of willing providers. Additionally, The Centers for Medicare and Medicaid Services have designated most areas of Wisconsin as "shortage areas for psychiatric care." A survey sponsored by the University of Wisconsin found that nearly 80% of all licensed psychiatrists practiced primarily in Milwaukee and Dane Counties. This rate increase is long overdue and mental health advocates now hope we can more concentrate on full mental health parity legislation.

The Senate Democrats adopted the budget bill and chose a new leader, Senator Russ Decker (D-Wausau). In an expeditious coup that removed Senator Judy Robson (D-Beloit) as the existing Senate majority leader and put Senator Decker in charge, this also signaled that Governor Doyle will have to work more closely with the Senate. This means, other changes were made on the powerful Joint Finance Committee where Senator Decker tried to smooth over ruffled feathers by at least giving Senator Robson one of those coveted spots. Another female who joins her is Senator Julie Lassa (D-Milladore). Senator Mark Miller (D-Madison) will now be the Senate Co-Chair. For our purposes, even though the players have changed, policy efforts won't. New attempts to revive Healthy Wisconsin, the business financed health care reform plan will be resurrected shortly. Meanwhile, Assembly Republicans who ended up negotiating their budget issues directly with the Governor through their Speaker Mike Huebsch (R-La Crosse) view themselves as the real winners in the budget act because of reductions in spending they successfully obtained. The GOP will continue to oppose the Healthy Wisconsin Plan as well as any efforts for mental health parity legislation which they still see as an added cost to businesses.

The Mental Health Fairness Coalition of which I am a part, continues to meet with Assembly Republicans one-on-one in hopes that we can find a lone Republican willing to look at new information that is now available and shows that insurance coverage for mental health services does not necessarily translate into exorbitant cost increases. We point to the federal parity numbers as one small example. We now have other data as well. Any of you who have something that you think might benefit our efforts should send that information my way.

With the ink barely dry on this budget, thoughts are already turning toward the November 2008 elections, and differences will be huge. One subject that is sure to set the stage for spirited debate (besides the Presidential election) is the estimated $700 million "structural deficit" that state lawmakers will face as they craft a 2009-2011 budget bill again. A series of very tough votes were avoided this time to balance the budget by short-term through fee increases, extra bonding and deferred payments that don't begin until 2009.

A few other partial vetoes in the Department of Health and Family Services

- Removes requirement that DHFS request a federal waiver in order to offer health opportunity accounts to BadgerCare recipients and provide the Joint Finance Committee with an implementation plan.
- Deletes requirement DHFS develop and implement disease management programs for conditions identified by health risk assessments that are to programs developed by the Marshfield Clinic.
- Affects requirement DHFS provide supplemental reimbursement to pharmacies participating in the Medicaid, BadgerCare and SeniorCare programs to compensate for any reduction in drug product costs reimbursements under the federal deficit reduction act.
- A $1 cigarette tax increase that is expected to generate about $25 million in new revenues.

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Is Mentoring Biological?

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similar calculations as were done for Sir Winton, but our work does result ultimately in our patients leading better lives, and being better parents themselves than they might otherwise have been, thus creating a cohort of 'children' and their families going forward who would not otherwise have done so. And the same is true for mentors and those mentored.

Walter Freeman's former students held a scientific conference in January 2007 in honor of his 80th birthday (Menon et al., 2007). Google "Stanford + Brain + Dynamics" to view video and PowerPoint archives of the event. Included is Dr. Freeman's presentation of his latest findings. Comments and topic suggestions are welcome at: dakrame1@wisc.edu

Dr. Kramer is in the Division of Child & Adolescent Psychiatry at the University of Wisconsin School of Medicine and Public Health. He is Co-Chair of the AACAP Family Committee.

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National Depression Screening Day, October 10th a huge success.

Lt. Governor Barbara Lawton's initiative to create a Wisconsin based National Depression Screening Day (NDSD) was a huge success. Even though the goal was to reach 100,000 participants, it broke 725,000! Over 13,000 people have already taken the screening, and over 1,200 people have stated that they will seek additional help from a professional. The Wisconsin Association of Manufacturers and Commerce, the leading business lobbying organization, was one of the first participants to endorse this with their employer groups.

2007 APA Ethics Workshop

By Mahmoud Ahmed, M.D.

Recently I had the chance to attend an impressive workshop sponsored by the APA. The topic of this non-industry sponsored meeting was "Ethics in Action: the Basics and Beyond". This meeting lasted only a day and half, but the materials presented were of great and of essential values to our profession. The presenters gave valuable and pertinent practical guidelines to some of the major ethical issues facing the practice of Psychiatry in the 21st century. There were open, honest discussions about the proposed "The Principles of Medical Ethics with annotations especially applicable to Psychiatry"

These included many questions like, why do we need our own statement on ethics and why not to use the AMA principles. Why do we need an update we have already one published on 2001?

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Medicaid Tamper-Resistant Prescription Information for State Health Policymakers.

Background

Starting on October 1, 2007, in order for Medicaid outpatient drugs to be reimbursable by the federal government, all written, non-electronic prescriptions must be executed on tamper-resistant pads. This requirement was included in section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007. On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS), issued a letter to State Medicaid Directors with guidance on implementing the new requirement.

CMS has outlined three baseline characteristics of tamper-resistant prescription pads, but each State will define which features it will require to meet those characteristics in order to be considered tamper-resistant. The baseline characteristics must: (1) prevent unauthorized copying of a completed or blank prescription form; (2) prevent the erasure or modification of information written on the prescription by the prescriber; or (3) prevent the use of counterfeit prescription forms. By October 1, 2007, States must require at least one of these baseline requirements. By October 1, 2008, States must require all three characteristics on prescription pads in order to be considered tamper-resistant.

The letter to State Medicaid Directors outlines situations where the new requirement does and does not apply. The requirement does not apply: when the prescription is communicated by the prescriber to the pharmacy electronically, verbally, or by fax; a managed care entity pays for the prescription; or in most situations when drugs are provided in certain institutional and clinical facilities. The letter also allows emergency fills as long as a prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours. For detailed information on the requirements, please refer to the State Medicaid Director letter.

What to think about to begin

States may need to act quickly to implement this requirement by October 1, 2007. To prepare for implementation, State health policymakers should begin by asking the following questions:

- Does your State already have rules that require some prescriptions to be tamper-resistant? If so, do those rules meet or can they be expanded to meet the requirements outlined by CMS?
- Will your State need to pass legislation or make regulatory changes to its Medicaid pharmacy reimbursement procedures?
- Does your State have an e-prescribing initiative? Electronic, faxed, and verbal prescriptions do not need tamper-resistant prescription pads.
- Will your State supply providers with tamper-resistant prescription pads that comply with the State's requirements? If not, will your State identify suppliers of tamper-resistant prescription pads that comply with the State's requirements for providers?
- Can your State apply model practices from States that already require tamper-resistant prescription pads?
- How will your State communicate this new requirement to pharmacists and prescribers?

Deadline for Tamper-Proof Prescription Pads

President Bush has signed legislation that delays the required use of tamper-proof prescriptions for Medicaid patients by six months. The new deadline is April 1, 2008. The vote came in response to strong concerns expressed by the MMS, the AMA and other physicians' groups working with pharmacists, who contended that they weren't given enough time to obtain the new prescription pads. Manufacturers also said they were getting so many orders that they could not keep up with the demand. On April 1, 2008, all Medicaid prescriptions must be written on pads that contain at least one industry-recognized feature to prevent copying, erasing, or counterfeiting. By October 2008, all such pads must prevent all three forms of tampering.

2007 APA Ethics Workshop

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Also there was an excellent presentation about Correctional Psychiatry and affirmation that we should not participate in a legally authorized execution.

There was an informative presentation regarding: Soliciting Patients to Advocate And Contribute Funds, of course the consensus was that we do not and should not have any role in this touchy issue, repeatedly the HIPPA was cited.

There was a presentation titled DSM V: Ethical Challenges, we were informed about the extremely strict criteria used in the selecting the authors of this important text.

The meeting concluded with a presentation by Dr. Carolyn Robinowitz APA president

Regarding Pharma: Friend or Foe?

Even though I did not agree with every single opinion and conclusion, I am very pleased to be a member of an organization that include and promote differing opposing positions as long as our patients' rights and dignity are respected and protected.

Incidentally the most recent issue of Focus (the Journal of life long learning in psychiatry) has a collection of articles devoted to most of these ethical topics.

Calendar of Professional & Clinically-Oriented Events

April 17-19, 2008
WPA Annual Spring Meeting
Intercontinental Hotel
Milwaukee, WI

November 15, 2008
WPA Annual Fall Meeting
A day with Glen Gabbard, M.D.
Location TBD

WPA Website

The Wisconsin Psychiatric Association will be joining the APA in a pilot project to host our district branch's web site. One of the major goals is to have a members' only section where protected information may be kept, such as a member's directory. We would also like the ability to conduct online meeting registration. Initial planning discussions have been held and it anticipated that the transition will take place over the next year.

SAVE THE DATE!

Wisconsin Psychiatric Association Annual Meeting

April 18-19, 2008
Intercontinental Hotel
Milwaukee

Featuring:

Phillip J. Resnick, MD, Forensic Psychiatrist, *Case Western Reserve School of Medicine*

Fred Goodwin, MD, Professor of Psychiatry & Director of The Center on Neuroscience, Medical Progress and Society *George Washington University Medical Center*

Jeff Jefferson, MD, Distinguished Senior Scientist, *Madison Institute of Medicine*
Clinical Professor of Psychiatry, *University of Wisconsin*

Program will include updates on medical/legal issues and bipolar disorder and a panel discussion on "The Mind of the Serial Killer: Lessons from theJeffrey Dahmer case" featuring former Milwaukee District Attorney E. Michael McCann, former FBI agent, Neil Purtell, forensic psychologist Ken Smail with Ken Robbins, moderator and Phil Resnick, discussant."

Note to readers and publicists: If you wish to have a professional meeting listed in future issues of the *Wisconsin Psychiatrist*, please send it to the WPA Office, 6737 W. Washington St., Suite 1420, Milwaukee, WI 53214, FAX: 414-276-7704

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