

To Candidates for APA President Elect:

The Academy of Psychosomatic Medicine represents psychiatrists who specialize in psychosomatic medicine and those who serve as consultation-liaison psychiatrists. We have a long history of working with the APA on issues that are important to all psychiatrists and specifically those who practice in general health settings. We believe that our relationship with the APA is critical and look forward to an extensive and productive dialogue about how we might work together.

Below are a series of questions from our leadership and members.

1. We are interested in stronger collaboration between the APA and the APM; what plans do you have to improve the collaborative relationship between affiliate organizations and the APA? How would you plan to assure that committee assignments and the functioning of the Council on Psychosomatic Medicine benefit from the contribution of experts in psychosomatic medicine?

Carol Bernstein: *I believe that close collaboration between the APA and APM is absolutely essential. As the APA moves towards reorganization and restructuring, I plan to work with the subspecialties to eliminate duplication of our efforts on behalf of our patients and our field. I will turn to APM leadership to represent the interests of patients and specialists in psychosomatic medicine. I will certainly consult with APM regarding appointments to the Council on Psychosomatic Medicine and other components related to your work to insure appropriate representation.*

Michael Blumenfield: *Thank you for the opportunity to respond to the concerns and interests of the members of Academy of Psychosomatic Medicine. As a long term member of APM and as someone who strongly advocated for subspecialty designation, I was very proud to be certified in Psychosomatic Medicine. If I am elected President of the APA there will be an excellent collaborative effort between the APA and the APM. I know the leaders of APM very well and will be able to easily work with them in discussing and planning projects of mutual interest. As the co-editor with Jim Strain of a major textbook Psychosomatic Medicine, we brought together close to 100 experts in our field to collaborate on this book so I am sure that between those whom I personally know and suggestions that I would receive from APM leaders, we would have outstanding people to fill committee assignments and other APA liaison activities. In addition, I was impressed with the increasing numbers of younger APM members making presentations and posters at the last APM meeting in Miami. I am sure that many of them would also be excellent candidates for such assignments.*

Roger Peele: *Carolyn Robinowitz, Paul Fink and I were the major advocates of including allied organizations in the APA's governance, leading to APM having a seat in the Assembly. In the mid-1990s, some Presidential candidates have agreed with my request that they ask APM and other key organizations for names as to appointments, but Presidents have not followed through. Should I be elected, the Council on Psychosomatic Medicine vacancies will be filled by whoever APM recommends to me. Secondly, I have successfully made motions this decade to remove the limits as to how many Corresponding Members can be appointed to a components, and this month I had a motion passed by the APA Board of Trustees that Corresponding Members can vote. With these motions, we are in a position to have APM also make appointments to other key components, such as the Committee on Graduate Education, where APM's selection would have a vote.*

2. How do you plan to develop coordinated efforts with other medical specialties- especially primary care disciplines (Family Medicine and General Internal Medicine) to better identify and treat psychiatric disorders?

Carol Bernstein: *This is an extremely important topic since the majority of patients with psychiatric disorders are treated by internists and primary care and family medicine physicians. I have always believed that close collaboration between psychiatry and other specialties is critical to providing "state-of-the-art" medical care. As President of the APA, I pledge to personally meet with the leadership of Family Medicine, General Internal Medicine and Pediatrics to expand the work the APA is already doing with these groups to develop the best models for collaborative treatment. I am particularly interested in developing rapid response telephonic or telemedicine connections with our colleagues where we could provide immediate consultation to the non-psychiatrist with a difficult patient sitting in the office. Furthermore, I will work to increase membership of psychiatrists in the AMA so as to foster more effective partnerships in this regard. I will invite the leadership of Family Medicine, Pediatrics and General Medicine to the APA annual meeting I will chair. These types of cooperation will also assist us in advocating that outpatient clinics in particular employ psychiatrists trained in psychosomatic medicine to work alongside physicians in other medical specialties to provide psychiatric care that is fully integrated with the rest of treatment.*

Michael Blumenfield: *As you know this is an ongoing project of APM but it is important to all members of the APA. As President of the APA I would be in a position to meet with my counterparts in Family Medicine and General Internal Medicine to discuss the mutually beneficial goal of identifying and treating psychiatric disorders. Where appropriate joint work-groups could be formed. We need not only to educate our medical colleagues but also need to educate the public about the importance of identifying and treating psychiatric disorders. As someone who has had a syndicated newspaper column, a radio program and a podcast with this goal I appreciate the value of such an approach. The APA has an excellent communications division which can be mobilized towards this end and coordinated with the communications and public relations components of the AMA and other medical organizations.*

Roger Peele: *This is an extremely important question, and reaches the reason I joined APM. I agree with a number of recent APA Presidents who have noted that core to addressing this nation's mental health needs is to increase the capacity of other medical specialties to treat and help prevent psychiatric illnesses. This declaration is echoed by many healthcare policy-makers, but the huge challenge this presents, while well known to APM members, is often not explicated by policy-makers. The devil is clearly in the details, and APM must provide the leadership to the APA's effort to enhance the capacity of other physicians to treat people with psychiatric illnesses. Earlier this year I was part of a motion, adopted this month by the APA Board [Eliot Sorel was the primary author], that the APA develop a position and strategy as to how to enhance the ability of primary care physicians to treat the psychiatrically ill. The APA must have APM leaders bring their knowledge and skills to this fundamental issue facing the care and treatment of this nation's people with psychiatric illnesses.*

3. What role would you expect the Academy of Psychosomatic Medicine and the COPM to play in the development and updating of treatment guidelines for specific psychiatric disorders such as Delirium, Dementia, Somatoform Disorders, Psychiatric Disorders Affecting Medical Conditions, and Factitious Disorders?

Carol Bernstein: *I believe that the Academy and the Council should have primary roles in the development and updating of treatment guidelines as they relate to psychosomatic medicine. Although the memberships of task forces and work groups for DSM V have already been identified for the most part, I am committed to assisting The Academy and the Council in continuing to work closely with the Somatic Distress Disorders Work Group, the Neurocognitive Disorders Work Group, and the Psychiatric/General Medical Interface Study Group in particular as they move forward with their recommendations for the DSM.*

Michael Blumenfield: *Not only is input by experts in Psychosomatic Medicine needed and required for updating of these treatment guidelines but it is also essential for the development of DSM V. The psychiatric guideline program and process for upgrading it was designed mainly by Jack McIntyre, a past APA President and a long time member of APM. It involves a method of extensive review and feedback by all relevant APA components which of course includes COPM as well as by Areas, DBs and any interested members of APA. They have been very responsive to making changes. They also were receptive to suggestions I made in the past to updating some of the disorders that you mentioned. Similarly, the DSM process while based on scientific research and ongoing studies will allow for review by interested components and will be interested in suggestions for wording and other nuances by clinicians. In addition all APA products such as guidelines and DSM do come through the Board of Trustees. If at any time, as APA President I am made aware of any concerns by APM, COPM or any other psychiatric subspecialty, that deliberations and the development of the final product is not taking into account our best expertise, I will be sure that the Board of Trustees investigates the situation.*

Roger Peele: *Ron Shellow and I wrote the successful motion that called upon the APA to develop Practice Guidelines. While the quality of the Guidelines has been fine, the ability to keep them current has not. The one on delirium is nine years old, and there have been about 4,000 publications on delirium since then. So, I have suggested in the past that we turn to APM to update the delirium Guideline. Your question points out that I should be more ambitious and think of other Guidelines APM might want to undertake [the one on dementia might be done with APM and American Association of Geriatric Psychiatry working together]. Keeping the APA Guidelines current is core to the APA retaining its advocacy strength, returning to the reason the APA was formed 164 years ago: To explicate, to promulgate and to advocate for the specific clinical needs of people with psychiatric illnesses.*

4. The focus on training in Consultation-Liaison Psychiatry in General Psychiatry residency programs has steadily eroded over the past decade, and now comprises only 1 month of the 36 month total time, or less than 3 %. This is despite the recent recognition of the importance of the field with the granting of sub-specialty status of Psychosomatic Medicine by the ABPN. The Council on Psychosomatic Medicine recently emphasized the complexity of the training for residents in this area, and recommended to the Council on Medical Education, as well as the RRC, that Consultation-Liaison rotations should be a minimum of 2 months in length and preferentially occur in the PGY 3/4 years. These recommendations were not accepted. What message will you encourage APA to convey to the Council on Medical Education and the RRC about Psychosomatic Medicine training during residency?

Carol Bernstein: *The current ACGME requirements stipulate that residents must have a minimum of 2 months experience in consultation-liaison psychiatry and that at least one of these months may be met with an experience in pediatric consultation-liaison psychiatry. However, I would strongly support the preferential occurrence of the c/l experience in the PGY 3 or PGY 4 year as residents need both the medical and psychiatric maturity to learn maximally and function most effectively in this arena. Furthermore, in the general hospital, the significance and value of psychosomatic medicine to the overall care of patients cannot be underestimated. I will work vigorously to get that message across to AADPRT and to the ACGME.*

Michael Blumenfield: *As a former Director of C/L Psychiatry and as someone who developed a Psychosomatic Medicine fellowship program at New York Medical College, I certainly appreciate the value of there being a 2 month Consultation-Liaison rotation preferably in the PGY 3 or 4th year. At this time I am not familiar with the decision process of the Council on Medical Education and the RRC about Psychosomatic Medicine training during residency. One of the potential roles as President of the APA would be to bring together interested parties for a discussion about contested issues as well as asking for scientific information to be brought forth from our various components and research division which might be helpful in such decision making. These discussions and this type of information can influence the message and the impact of the APA on other groups such as the RRC and the Council on Medical Education.*

Roger Peele: *It has been disappointing to see the decrease in the C&L requirement. I am pleased to note, however, that the largest residency programs in Washington, which I chaired for 16 years, continues to value the importance of C&L: THREE full months of C&L in the program. APA Presidents, however, do not set policy. The Board and Assembly do. What a President can do is what I said I will do supra, give APM a seat in the Committee on Graduate Medical Education. I'm open to other appointment suggestions that would enhance APM's thinking as to residency training.*

5. We have long been concerned with several issues regarding access and reimbursement for psychiatric services for patients treated in medical settings. Many of these problems have occurred as a result of the carve-out of mental health reimbursement from general health care reimbursement. We would like to know specifically what the APA can and will do to aggressively address this issue. Specifically, what APA resources would you be willing to commit to helping to address these reimbursement concerns?

Carol Bernstein: *I am hopeful that with the passage of the federal parity bill, psychiatric reimbursement will move out of the realm of "carve-outs." However, it will require serious efforts to communicate this to human resource administrators and employers in an effective way. I believe that APA and APM should identify key leaders in psychosomatic medicine at major facilities across the country to serve this advocacy role in their home institutions. I will turn to the Committee on APA/Business Relations and the Corresponding Committee on Access to Care and Reimbursement and ask that they work collaboratively with the Academy to insure that the critical interface between psychiatry and the rest of medicine is protected. I will do everything in my power to have the APA use all of its legislative strength to move towards benefits parity which will not just provide co-pay parity and parity in terms of coverage but true parity in funding psychiatrists for their work in a way that is comparable to and appropriate to funding of other specialists in medicine.*

Michael Blumenfield: *There should be no area more important to the APA than access and reimbursement for psychiatric services and that of course must include psychiatric services for patients treated in the medical setting. If there is not proper reimbursement there will not be treatment available for our patients as resources will not be available. We now have irrefutable data demonstrating the relationship between the development or exacerbation of medical conditions and psychiatric conditions. There is no excuse for denying psychiatric care to patients in the medical setting. The APA's COPM and the APA Research Division can provide the facts and the APA Government Relations and Communications/Public Relations Divisions should be fully committed to addressing these concerns.*

Roger Peele: *The Washington Psychiatric Assembly team [Kline, Sack and myself] was the major voice within the APA that insisted in the 1990s that the APA condemn all carve outs. Finally, it became APA policy in 2001, and we have fought back efforts since to modify that position. Unfortunately past parity bills had encouraged carve-outs. Last winter, Harold Eist, Steve Sharfstein and I testified before Patrick Kennedy congressional hearing that all forms of discrimination must be abolished. Will the new parity bill do so? I have spoken with Nick Myers of the APA Government Relations office, and he indicated that he would encourage the DHHS regulation writers to prohibit carve-outs, as it is up to the regulators' wording since the last parity bill is not clear on that point. If we do not get the regulatory wording we want, then the APA must go the legislative route to meet our goal of being an equal member in the house of medicine.*