President’s Column: Covid-19 and the SPMI patients
By: Richard McCarthy, M.D.

The Covid-19 vaccines are now being made available in New York state. The New York State Health Commerce web site has promulgated lists of who can get the vaccine and when they can get it. While there have been significant delays and problems in the initial phase of vaccine use, these are likely to be largely contained by the time you read this. This has led to a dramatic increase in e-mails and phone calls from patients who are concerned about whether they should get the vaccine or not. They have been watching the TV news and listening to the radio in an effort to learn about and understand what they should do. Unfortunately, they have picked up a lot of contradictory opinions and are more confused than they are clear-headed about all of this.

My response in all of these calls has been largely the same. I very strongly recommend that they get the vaccine and when they can get it. While there have been significant delays and problems in the initial phase of vaccine use, these are likely to be largely contained by the time you read this. This has led to a dramatic increase in e-mails and phone calls from patients who are concerned about whether they should get the vaccine or not. They have been watching the TV news and listening to the radio in an effort to learn about and understand what they should do. Unfortunately, they have picked up a lot of contradictory opinions and are more confused than they are clear-headed about all of this.

As a result, I have started to see some of them in my office. Both the patient and I wear masks, and the patient sits in my waiting room as I sit in my office. This permits social distance to be maintained. This has resulted in an apparent decrease in symptoms in many of these individuals. While this has been helpful, it is only a stop-gap action. These patients need to return to some degree of community activity as soon as possible. The only way for this to happen is for them to receive the vaccine. As of this time, I am unaware of any program that would be made available to the population with Severe and Persistent Mental Illness (SPMI) to make sure that they get vaccinated. I suspect that this would be most easily done in our psychiatric hospitals and clinics where these patients could most easily get their shots without the hassle of scheduling on the internet. I intend to raise this option with the hospital where I work and strongly recommend that you do so as well. ■
2021 Medicare Update Webinar - Reported by Jerry Liebowitz, MD

On December 16, 2020, the Psychiatric Society of Westchester hosted a webinar on the new Evaluation & Management (E/M) Code Documentation Requirements effective 1/1/2021. The presenters were Rachel A. Fernbach, Esq., Deputy Director and Asst. General Counsel of NYSPA, and Seth P. Stein, Esq., Executive Director and General Counsel of NYSPA.

Rachel Fernbach introduced the topic noting that it is “a simplification of documentation for CPT E/M codes,” not a change in the codes themselves. With the new RVU changes established for the codes, “enhanced reimbursement is available for the combination of E/M and psychotherapy codes.”

The CMS moved away from elements that had to be established and documented to a simpler system based more on the condition of the patient and the doctor’s intervention, making it more patient-centered and doctor-centered. These changes apply to outpatient office visit codes only (99201-99205 for new patients and 99212-99215 for established patients).

Under the new framework, she explained, there are two methods for selecting the proper E/M code: either the level of medical decision making, or the total time spent providing the E/M service. This new approach will replace the prior guidelines for documentation based upon elements of history and psychiatric examination, leaving such documentation to be determined by clinical judgment based on what is clinically relevant. This change will simplify documentation, particularly for higher level E/M codes.

For combined E/M and psychotherapy codes (which have not been changed and are based on time), the CPT E/M code chosen is based on the level of Medical Decision Making (MDM), which is based on three elements (and 2 out of 3 are needed): 1) Number and Complexity of Problems, 2) Amount and/or Complexity of Data to be Reviewed and Analyzed (not usually relevant for psychiatry), and 3) Risk of Complications and/or Morbidity/Mortality of Patient Management. [See Table 2 below for a summary from the APA member’s website.]

To determine which level to use, four definitions are important:

1) A stable, chronic illness is a problem with an expected duration of at least one year. “Stable” for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.

2) A chronic illness with exacerbation, progression or side effects of treatment is a chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does (Continued on page 4)

THE APA AREA II COUNCIL MEETING FALL 2020
By Karl Kessler, MD

The Area II Council of the American Psychiatric Association (also known as the New York State Psychiatric Association or NYSPA) Fall Meeting was held on October 24, 2020. This was a virtual meeting, held under the shadow of the coronavirus pandemic. Some of the highlights of the meeting are given below.

Meeting of the NYSPA Committee on Legislation

1) The waivers allowed by the federal and state government regarding video and telephone sessions with patients will be continued, likely for as long as the pandemic continues. The Federal HHS waiver regarding telehealth was extended for 90 days on October 23 and it is expected that the waiver will continue as long as needed. How many of the telehealth changes will be continued after the pandemic is an open question.

Three points from the Federal HHS waiver are given below. More information is on the NYSPA website.

1) The Medicare and Medicaid program will provide reimbursement for audio-only telephone evaluation and management (E/M) services during the public health emergency.

2) HHS will continue its enforcement discretion of the HIPAA security rule in connection with the good faith use of telehealth communication services that are not HIPAA compliant. Providers may continue to use certain non-public facing remote communications products, including Apple FaceTime, Google (Continued on page 3)
THE APA AREA II COUNCIL MEETING FALL 2020 —cont’d.

By Karl Kessler, MD

(Continued from page 2)

Hangouts, Whatsapp, Zoom, and Skype during the public health emergency.

3) During the public health emergency, the DEA will continue to waive the requirement for an in-person exam prior to prescribing of a controlled substance.

II) The possible merger of NY OASAS and OMH

New York State is considering merging the Office of Addiction Support and Services (OASAS) and the Office of Mental Health (OMH). New York State officials were doing a “listening tour” in October to obtain opinions regarding the possible merger. NY State hopes that the merger will save some money, in light of the expected State budget deficit. NYSPA has formed a task force to examine this matter.

III) Scope of practice laws regarding who can prescribe medication and what training is necessary for a healthcare worker to make a psychiatric diagnosis (i.e. who is permitted to make a diagnosis) require continuing vigilance. NSYPA keeps track of this situation.

IV) The pandemic has adversely affected inpatient mental health and substance abuse treatment. At the end of October, it was estimated that 199 psychiatric beds in New York State had been closed due to the pandemic. A Wall Street Journal article said there were approximately 400 combined psychiatric and substance abuse beds closed in early October. [https://www.wsj.com/articles/a-hidden-cost-of-covid-shrinking-mental-health-services-11602255729] Also see the comments by OMH commissioner Sullivan below.

She reported that 540 inpatient beds had been closed throughout the State: 340 of these were in New York City. It is expected that the majority of these will reopen.

Dr. Sullivan also mentioned possibility of merging OMH and OASAS.

New York State received a FEMA grant of $108 million dollars for crisis counseling for covid19.

V) The Legislative Report from our government relations advocate, Richard Gallo and Jeff Borenstein, MD, NYSPA President

1) The pandemic is having a serious negative effect on the New York State budget. A large budget deficit is expected but the numbers are uncertain. The NY State fiscal year runs from April through March. The hope is that the federal government will help the states, including New York State, with their budget problems.

2) There is a new State law that requires all physicians to post a sign in their offices about how to report suspected physician misconduct to the NY Office of Professional Medical Conduct. NYSPA sent out a sample sign.

3) New York State has increased access to opiate antagonists.

VI) Executive Director’s Report: Seth Stein

1) There will be CPT code changes going into effect on January 1, 2021. These will decrease the burden of documentation. E+M

(Continued on page 8)
not require consideration of hospital level of care.

3.) A chronic illness with severe exacerbation, progression or side effects of treatment refers to the severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

4) An acute, uncomplicated illness or injury is a recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

CPT codes 99202 and 99212 are for straightforward situations with minimal risk: one self-limited or minor problem, such as bereavement.

CPT codes 99203 and 99213 are for situations with low levels of complexity and risk: two or more self-limited or minor problems, one stable chronic illness, or one acute, uncomplicated illness.

CPT codes 99204 and 99214 are for situations with moderate levels of complexity and risk: one or more chronic illnesses with exacerbation, progression, or side effects; two or more stable chronic illnesses; one undiagnosed new problem with uncertain prognosis; or one acute illness with systemic symptoms.

CPT codes 99205 and 99215 are for situations with high levels of complexity and risk: one or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or one acute or chronic illness or injury that poses a threat to life or bodily function.

Total time spent in one day (not just face-to-face) may be used instead of MDM for standalone E/M codes without psychotherapy codes. For new patient visits, use 99202 for 15-29 minutes, 99203 for 30-34 minutes, 99204 for 45-59 minutes, and 99205 for 60-74 minutes. The CPT code or initial psychiatric visit (90792) is still available. But, based on the new RVUs, reimbursement is greater for a 60-minute visit if 99205 is used instead. For less than 60 minutes, 90792 should be used.

For medication management alone without psychotherapy, the codes and times for an established patient are: 99212 for 10-19 minutes, 99213 for 20-29 minutes, 99214 for 30-39 minutes, and 99215 for 40-54 minutes.

In addition, two new prolonged services codes have been developed to report lengthy E/M care – one was developed by CMS (G2212) for Medicare patients and the other by CPT (99417). The latter is to be added on to 99205 for initial sessions with a new patient in which total time spent that day is over 74 minutes and may be used more than once for each increment of 15 minutes. In other words, you would code 99205 and one unit of 99417 for total time of 75-89 minutes or two units of 99417 for total time of 90-104 minutes. Three or more units can be used for each additional 15 minutes. The same idea applies to established patients, using 99215 plus 99417 in which total time spent is over 54 minutes. One unit of 99417 would be for 55-69 minutes, two units for 70-84 minutes, and three or more units for each additional 15 minutes.

For Medicare patients only, the time used before adding G2212 is calculated using the maximum amount of time for 99205, that is under 89 minutes (74 minutes plus 15 minutes). The same rule applies for 99215, that is under 69 minutes (54 minutes plus 15 minutes). [See table 1 below for a Quick Guide and summary of the coding changes from the APA member’s website.]

Seth Stein introduced NYSPA’s new documentation templates, which were revised in accordance with the new guidelines so that all elements are clearly identified and available to auditors. These templates are available in Microsoft Word® or fill-in format and are posted on the NYSPA website (www.nyspsych.org). You can click here to view them. NYSPA members must use their NYSPA website username and password in order to access the new templates’ and the webinar recording. Please contact NYSPA Central Office at 516-542-0077 if you need any assistance with your username or password.

He also reviewed the new RVUs and the new 2021 NYSPA Medicare Fee Schedules, which are also available on the NYSPA site. He Stein reminded us that these numbers (and the RVUs on which they are based) are for Medicare and that these amounts may vary for commercial insurance.
Quick Guide to 2021 Office/Outpatient E/M Services (99202-99215) Coding Changes

Note that these changes apply only to the office/outpatient E/M services (99202-99215): continue to bill and document as you always have in all other settings.

As of January 1, 2021, codes for office/outpatient medical evaluation and management (E/M) care can be selected on the basis of the complexity of the medical decision making (MDM) or on the basis of the total time on the date of the encounter. For psychiatrists who provide E/M services along with psychotherapy, the appropriate E/M code will be determined by the MDM as newly defined. Time cannot be used to determine E/M when adding on psychotherapy.

See the attached MDM table for a better understanding of the guidelines for selecting the level of E/M service provided. The level of MDM should be driven by the nature of the presenting problem on the date of the encounter. Time is not a factor when code selection is done on the basis of MDM. When billing outpatient E/M on the basis of time, psychiatrists may now use the total time on the date of the patient encounter, not just the face-to-face time. Time spent on the following activities on the date the encounter is included:

- Preparing to see the patient (e.g., review of test, records)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary exam and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals (when not performed separately)
- Documenting clinical information in the electronic or paper health record
- Independently interpreting results of tests/labs and communicating results to the family or caregiver
- Care coordination (when not reported separately)

Documentation has been simplified:

- Code selection based on MDM MUST include information pertinent to that element.
- The extent of the history and exam is not considered for code selection, so history and exam should be documented as medically necessary and as needed to provide good clinical care.
- Code selection based on total time MUST include the total time spent on the date of the encounter and a summary of relevant clinical activities.

Medical Decision Making Table

E/M code selection can be done on the basis of Medical Decision Making (MDM) or time. The level of MDM should be driven by the nature of the presenting problem on the date of the encounter. Time is not a factor when code selection is done on the basis of MDM. When billing E/M along with psychotherapy service the E/M must be selected on the basis of MDM. To qualify for a particular level of MDM, 2 of the 3 elements for that level of MDM must be met or exceeded.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems</th>
<th>Elements of Medical Decision Making with Psychiatric Specific Examples</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity/Severity of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>NA/</td>
<td>NA/</td>
<td>Minimal/None</td>
<td>NA/</td>
<td>NA/</td>
</tr>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Low</td>
<td>2 or more self-limited or minor problems (Ex: headache)</td>
<td>Limited (Must meet 1 of 2 categories in this box)</td>
<td>Minimal Risk</td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td>Low</td>
<td>2 or more self-limited or minor problems (Ex: headache)</td>
<td>Limited (Must meet 1 of 2 categories in this box)</td>
<td>Low Risk</td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Low</td>
<td>2 or more self-limited or minor problems (Ex: headache)</td>
<td>Limited (Must meet 1 of 2 categories in this box)</td>
<td>Low Risk</td>
</tr>
<tr>
<td>99213</td>
<td>Low</td>
<td>Low</td>
<td>2 or more self-limited or minor problems (Ex: headache)</td>
<td>Limited (Must meet 1 of 2 categories in this box)</td>
<td>Low Risk</td>
</tr>
<tr>
<td>99204</td>
<td>Moderate</td>
<td>Moderate</td>
<td>2 or more stable chronic illnesses (Ex: chronic pain)</td>
<td>Moderate (Must meet 1 of 3 categories in this box)</td>
<td>Moderate Risk</td>
</tr>
<tr>
<td>99214</td>
<td></td>
<td>Moderate</td>
<td>2 or more stable chronic illnesses (Ex: chronic pain)</td>
<td>Moderate (Must meet 1 of 3 categories in this box)</td>
<td>Moderate Risk</td>
</tr>
<tr>
<td>99205</td>
<td>High</td>
<td>High</td>
<td>1 or more severe exacerbation, progression, or side effects of treatment (Ex: depression, recurrent, severe w/signal functional decline; or Severe akathisia from treatment of schizophrenia with antipsychotic medication)</td>
<td>Extensive (Must meet 2 out of 3 categories in this box)</td>
<td>High Risk</td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>High</td>
<td>1 or more severe exacerbation, progression, or side effects of treatment (Ex: depression, recurrent, severe w/signal functional decline; or Severe akathisia from treatment of schizophrenia with antipsychotic medication)</td>
<td>Extensive (Must meet 2 out of 3 categories in this box)</td>
<td>High Risk</td>
</tr>
</tbody>
</table>
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PRMS Risk Management’s Resolutions
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With the start of a new year, we can likely all agree that we were glad to say ‘goodbye’ to 2020 – a year that has, among so much else, upended healthcare, economies, and mental health. Not only has the pandemic changed the way you practice psychiatry, but it has also created new risks. So, as we begin a new year, our PRMS Risk Managers (or “Mayhem Managers” as they’ve become known) have a few key resolutions to consider in 2021.

Given these tumultuous times, we have reduced the number of resolutions this year. You may already be doing everything suggested below – if so, keep up the great work! And if not, you may find these resolutions useful to your practice – it is never too late to start implementing!

1.) When treating patients remotely, I will check on licensure requirements in the state where the patient will be located at the time of the visit (if different from my state).

Resources:
- Preliminary Analysis Chart to determine if state licensure is relevant
- Telepsychiatry Checklist
- Other telepsychiatry resources, including state waiver information, planning for post-pandemic practice, FAQs, and more at PRMS.com/faq

2.) I will be proactive and create a plan for the unlikely event of my sudden unavailability or inability to practice.

Resources:
- PRMS Contingency Planning Tool

3.) I will continue to address cybersecurity to ensure the confidentiality, integrity, and availability of my patient’s health information.

Resources:
- PRMS Cybersecurity Booklet
- Several practical resources in the Physician Cybersecurity Resources section on the AMA’s Cybersecurity Webpage

4.) I will consider using a suicide assessment tool when evaluating patients’ suicidality.

Resource:
- SAFE-T Card

5.) I will check the relevant state’s Prescription Monitoring Program when prescribing controlled substances.

Great work in 2020, despite the challenges and pivots the year has thrown our way. PRMS continues to be proud of the work psychiatrists and our partners do for the behavioral healthcare community, and we wish you a safe 2021!

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codes added to a psychotherapy code will result in a significant increase in reimbursement from Medicare. NYSPA has provided templates for the documentation required for the new notes. They are also giving webinars on the changes. At this time, these changes apply only to outpatient care, but it is expected that they will be applied to inpatient care in the future.

2) There will be no change in member dues for NYSPA in 2021.

REPORT FROM THE APA ASSEMBLY FALL MEETING

Reported by C. Deborah Cross, MD, APA Assembly Representative

The APA Fall Assembly met virtually on Saturday, November 7 from 12:00 noon until 4:00 pm and then again on Sunday, November 8 from 12:00 noon until 2:00 pm.

Several Area Councils met prior to the Saturday Assembly meeting. Speaker Elect Mary Jo Fitz-Gerald acted as Speaker in the absence of Speaker Joe Napoli (absent due to illness). New members to the Assembly were recognized by the Officers and a Quorum was declared by the Recorder.

The Assembly moved quickly to begin discussion of the 13 Position Statements and 22 action papers and Position Statements on the Agenda though the reports of the Reference Committees.

The APA, as explained in prior reports, reviews Position Statements of the organization every 5 years. The Position Statements are assigned to the appropriate Council and/or Committee for review and recommendation. Such recommendations can be:

1) to retire the Position Statement;

2) to approve the Position Statement as is for another 5 years, or to

3) revise the Position Statement. The recommendation of the reviewing body is then passed to the Assembly for review and approval or disapproval. (The vote is up or down only, with no amendments to the Position Statement by the Assembly allowed to be made.) Additionally, new Position Statements are also sent to the Assembly for approval (or disapproval).

The Assembly voted to retain the following Position Statement of the APA in its entirety:

“Involuntary Commitment and Related Programs of Assisted Outpatient Treatment (from 2015).

Two position Statements were revised:
Medical Necessity; and
Ensuring Access to Psychiatric Services for the Elderly.

The Assembly voted to approve the following Proposed Position Statements (either entirely new ones, or revised ones):

Impact of Cannabis on Children and Adolescents;
Suicide Among Black Youth in the United States;
Sexual Abuse of Migrants in ICE Custody;
Growing Fear over Coronavirus Spread and Mental Health Impact in ICE Detention Centers;
Abortion and Women’s Reproductive Health Care Rights;
Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum;
Use of the Terms Client and Provider;
Medicaid Coverage for Maternal Postpartum Care;
Reducing the Burden of Treatment Plan Documentation.

The Assembly did not approve the Proposed Position Statement:
Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness.

The Assembly heard reports on and discussed and voted on 22 Action Papers proposed by Members of the Assembly.

Topics of some of the discussed Action Papers included:
Guidelines for Selection of Seclusion vs. Restraint (Assembly approved to create a resource document that will help guide the choice and use of seclusion versus restraint);

The Assembly also approved:

To create a resource document that will address personal item access/restriction for psychiatrically hospitalized patients;

To develop and promote a position statement in alignment with the AMA’s policy, “Independent Practice of Medicine by Advanced Practice Registered Nurses (H-35.988);

To eliminate barriers and expand use of telehealth;

To explore the process of sub-specialty accreditation to determine the feasibility of granting Emergency Psychiatry certification applying a similar pathway as is done for Addiction Medicine certification by the American Board of Preventive Medicine;

To develop a Position Statement that will address the need for housing and employment opportunities for persons with psychiatric illness to include those with history of criminal activity;

To have the APA expeditiously approve a Position Statement on the Adverse Effects of Misogyny and Gender Bias on the Health of Women;

To create a Task Force to explore member interest, as well as the financial, organizational and public relations implications of changing the name of our organization from the American Psychiatric Association (APA) to the American Psychiatric Physician Association (APPA).

Various speakers also addressed the Assembly over the course of the 2 day meeting, including Dr. Jeffrey Geller who focused on the topic of structural systemic racism and the need to eliminate it within the APA. He explained that a consultant will be selected to assess the entire organization and then key recommendations will be developed and work will begin on implementation.

Dr. Vivian Pender, President –Elect also addressed the Assembly and focused on the specific topic of Social Determinants of Mental Health, such as racism, ageism, sexism, etc. and how the APA can lead on these important issues in the upcoming years.

The APA Assembly will meet again (virtually) on Saturday and Sunday, April 24 and 25, 2021. The dates for the APA Annual Meeting, which will also be held virtually, have not yet been set but will be sometime in April or May 2021.

As always, don’t hesitate to contact me if you have any questions or wish further information regarding the work of the Assembly.

Behind Our Tears and Joy on This Monumental Inauguration Day
By: Maureen Sayres Van Niel, MD, President, APA Women’s Caucus

[Editor’s note: Since March is Women’s Health Month and International Women’s Day, we thought it appropriate to publish this letter about women psychiatrists from Dr. Maureen Van Niel, President of the APA’s Women’s Caucus.]

Dear Colleagues in the APA Women’s Caucus,

When I witnessed the historic inauguration of Vice President Kamala Harris today, I surprised myself. Like the women psychiatry colleagues I spoke with from all over the country, I felt much more emotion than I had expected: So much joy and exhilaration and also tears—sometimes outright weeping—took us by surprise, arriving at the surface from a suppressed place.

Maybe that’s the place we keep hidden deep inside ourselves where we file painful things so that we can keep going—like when we realized that the “old boys’ network” was working its magic for our male colleagues in their advancement but not for us or noticed the disregard for women’s mental health in our medical school curriculum. It’s the place that allowed us to keep going when we overheard our male fellow interns rank our looks on a one to ten scale, or when we put up with sexual harassment and innuendo from all directions because we thought we had to if we wanted to become a doctor, or when we looked around for women role models at the highest levels of our medical centers only to find the rare professor who had made it through. It’s the place where we have filed away the many times someone asked women physicians of color questions that should have been
THE APA AREA II COUNCIL MEETING FALL 2020 —cont’d.

(Continued from page 9)

directed at the housekeeping staff, and the place where we stored our disappointment when no one seemed curious or motivated to find out why women had twice the rate of depression and anxiety than men. And for some of us, it’s the place where we filed away the painful feelings of impending separation when staring into the eyes of the infant we had just given birth to or adopted, knowing that as mothers in this country we would get no guaranteed accommodation to return to work part time, no break on our academic tenure clock, and no appropriate paid leave to participate in the growth or care of our child.

Each of us woman physicians has had to fit into a system created for men and not designed with our beautiful biology in mind. To some degree or another, we have all had to take a journey that was harder for us than for the men who made the rules and were invested in keeping the system the way it was. Today one of us got through . . . she won one of the prices she had dreamed of. This achievement is cause for great celebration. Just seeing a woman in the role of vice president will give our girls and boys a different world to look to for inspiration.

Amidst our joy is also the sad reminder that many women in our past, including our own mothers and grandmothers, and maybe even ourselves, were denied the opportunities we dreamed of to use our gifts to the highest levels of achievement. Many women psychiatrists have had their own dreams vanquished by just too much adversity.

Meanwhile, women have been tending to the heart of the world for a long time. While we have one eye fixed on the impossible challenges that society has presented to us, we can also acknowledge that some women psychiatrists have managed, in the midst of their zigzagging work and family responsibilities, to weave together a strong, resilient family life. They have helped create a home environment, whatever its composition, suffused with their own personal family values, launching their children into the world every day to face its challenges, bolstered by the love they have received at home.

Hallelujah, Vice President Harris! We are ecstatic that a woman has broken one more barrier. But we are also aware of how much more we must do to make real change for women in psychiatry and achieve equity. We need wholesale structural and institutional changes that will let us reach our full potential—including changes that will let us be promoted and paid equally with our male colleagues.

Let us now remember this day and let it motivate us. Join me in doing all that remains to be done, wherever you are working and whatever district branch you can work through. And remember to take care of yourselves and ask for help when you get overwhelmed.

My instinct was to invite my young grandchildren in the next room to watch the historic inauguration with me, but I thought better of it. What I want for them is a new normal: a world where the high achievements of women don’t seem so unusual to young hearts and minds.

Sincerely,
Maureen

We want to hear from our Members!

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- **5% Risk Management Discount** (for 3 hours of CME)

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- Up to $25,000 for First Party Assault and Battery Coverage
- Up to $25,000 for Information Privacy Coverage (HIPAA)
- Up to $15,000 in Emergency Aid Coverage
- Insured’s Consent to Settle required in the settlement of any claim – No arbitration clause
- Telepsychiatry, ECT, Forensic Psychiatry Coverage
- Risk Management Hotline with 24/7 Service for Emergencies

For over 40 years we have provided exceptional protection and have a reputation for outstanding customer service. Our extensive years of experience and industry knowledge allows us to help you by providing worry free coverage so you can concentrate on what you do best – helping people help themselves. When it comes to caring about people, we have a lot in common.

Visit us at apamalpractice.com or call 877.740.1777 to learn more.