THE PSYCHIATRIC SOCIETY OF VIRGINIA

VIRGINIA NEWS

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SPRING 2007

Lawrence J. Conell, MD
PSV President

A MESSAGE FROM THE PRESIDENT

It is with mixed feelings that I write this final column as President of the Psychiatric Society of Virginia (PSV). While there have been significant responsibilities, the rewards have far outweighed any sacrifices, which pale by comparison.

It has been an honor to work with so many bright, committed people on the PSV Board and our new management company, Ruggles Service Corporation. I have learned much, including how lucky we are to have so many people working in so many different ways through our society, to protect and improve the future of our profession, and by extension, the care of our patients.

While no organization can meet every constituent's needs all of the time, I must say that the PSV is among the most responsive groups of which I have ever been a part. We are actively striving to learn of our members' diverse needs throughout the different regions of the state. The board is comprised of members throughout the state to help give broad voice to all members. If ever there is a sense that there are areas we should be addressing either through our CME activities or our legislative efforts, please communicate with us either through your local society representative, or directly to the President or any member of the Board. We want to be responsive, but we can only be as responsive as our members are active.

At the time of this writing, we have just concluded our Spring meeting that was held March 23-24. It was extremely successful and very well attended. Dr. Brasington did a brilliant job organizing the educational component, entitled *Family Psychiatry*, with great speakers on a broad range of topics, including Childhood Depression, Postpartum Depression, Sleep Disorders and Domestic Violence. Each of the presentations were incredibly clinically relevant and applicable to day-to-day practice. There was wonderful participation from our members, with enthusiastic Q & A sessions, which reflects how positively received the presentations were. A big thank you to Dr. Brasington for coordinating such a diverse program, within a cohesive theme of *Family Psychiatry*, with such broad appeal to such a diverse audience. Likewise, Ruggles Service Corporation did an equally stellar job with the administrative and logistical side of things, guiding us through our second meeting since being hired as our management company. It is hard to imagine the administrative complexities in arranging such a meeting with the new Pharma regulations for grant money, and the intricacies necessary to obtain CME accreditation through the APA. All of these processes have become much more proscriptive and complex over recent years, and Ruggles has done a great job in adapting and responding to the changing regulatory environment, and putting on a meeting with top notch amenities, including a wonderful reception with cocktails and great food, as well as an opportunity to meet and talk with our friends and colleagues across the state and also with a number of our Virginia Legislators on Friday evening, March 23.

I guess the reason I'm spending so much time speaking of the meeting is to let people know what a great member benefit this is. Coming to the meetings is a great way of meeting colleagues throughout the state, making new friends, rekindling old relationships, and getting extremely high quality APA endorsed free CME. It's a deal that's hard to beat! It's also a great way to begin getting better known by your fellow members, and becoming more involved in the society and its activities, which are geared toward trying to preserve and improve the status of our profession and our patients. In short, it's a way to have fun and do good things at the same time. Aren't we all looking for those type of opportunities?

In our continuing efforts to rotate the meetings throughout the state, the Fall 2007 Meeting is scheduled at the Hotel Roanoke & Conference Center, October 19-20. Please mark your calendars and plan your call responsibilities now, so when you get the formal mailings, you just have to call in your reservations.

For now, I bid farewell as President, but look forward to serving on the Board in the capacity of Immediate Past-President, and welcome Dr. Steve Brasington as our new President, and Dr. Jim Krag as our President-Elect.

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Letters to the editor and editorial contributions are welcome. Submissions may be sent to James L. Krag, MD via email at jkrag@vacp.net. Paid advertising is accepted on a first-come, first-served basis. To place your advertisement or to request a rate sheet, contact Beverly Bernard at PSV Headquaters via email at beverly@societyhq.com or by phone at (804) 565-6321.

A Message from the Editor

It's None of Their Business

By James Krag, MD

As physicians, how we deal with pharmaceutical reps and pharmaceutical companies in general is controversial. Currently, I don't mind meeting with a rep to learn about a new product or to obtain information about a current product. I also don't mind accepting some funds to support educational meetings. Maybe I'll change my opinion later. But I resent them profiling my prescription information.

A few years ago, I didn't realize that pharmacies collect information on what drugs I prescribe and that reps are able to access this. I haven't taken the time to understand fully how this works, but I don't like it and feel that what I prescribe is none of their business. Of course, from their point of view, it is their business because they are trying to influence my prescribing practices.

I learned of this practice when I honestly told a rep I really didn't prescribe (call it product x) much. He said "I know, that's why I'm here today." Finding out that he already knew surprised me. He also told me he appreciated my honesty and shared his frustration about a doctor he recently visited in Charlottesville that told him he used "product x" a lot. He said something like, "I really had to bite my tongue because I know that he hardly ever uses it and he was just saying that to get rid of me." I couldn't contain my surprise that he would have this information. He said they don't talk much about it but briefly explained the system of large pharmacy chains collecting and selling this information. It really irritated me but I hadn't thought much more about it until I saw a recent article in the APA news talking about a way to opt out of this system.

So I did it! I went to the web site: http://www.ama-assn.org/ama/pub/category/12054.html. On that web page is the ""I want to opt out" button. The site explains the following:

Facts about the physician data restriction program.

If you decide to exercise the physicians data restriction option, all pharmaceutical sales representatives will be denied access to your individual prescribing profiles. Pharmaceutical companies will be required to check the prescribing data restriction list on a quarterly basis, at a minimum. Upon checking the list, it may take a pharmaceutical company up to 90 days to restrict the individual data from their sales representatives.

The data restriction option is valid for a three-year period. The AMA will notify physicians prior to the termination to give them the opportunity to reinstate their decision. Physicians can remove this option at any time by contacting the AMA.

The AMA's Physician Data Restriction Program does not affect the use of prescribing data by managed care providers or pharmacy benefit managers because they use their own proprietary data and are not subject to AMA data licensing rules and regulations.

Based on the previous paragraph, I really don't know if reps will find some way to gain access to prescribing information about me, but at least it will be limited. I timed the entire process of opting out and it took about five minutes. So, I encourage you to opt out as well, since what we do individually really is none of their business. That web site again is: http://www.ama-assn.org/ama/pub/category/12054.html

This is the last issue of PSV News with me as editor. I have enjoyed the past couple of years as editor and will be passing this on to Dr. Nieves.

Thank you.

The Case for a National Health Plan

By Joseph T. Mason, MD, FAPA

I am a member of Physicians for a National Health Program (PNHP); a nonprofit organization of 14,000 physicians, medical students and health professionals, organized in 1987, who support single-payer national health insurance (see www.pnhp.org). According to the Physician's for a National Health Program, the U.S. spends twice as much as other industrialized nations on health care - $7,129 per capita. Yet our system performs poorly in comparison, leaving 46 million without health coverage and millions more inadequately covered.

This is because private insurance bureaucracy and paperwork consume up to 31% and commonly 20-25% of every health care dollar. Streamlining payment though a single nonprofit payer would save more than $350 billion per year…enough to provide comprehensive, high-quality coverage for all Americans.

The PNHP endorses a fundamental change in America's health care - the creation of a comprehensive National Health Insurance (NHI) Program. Such a program, which in essence would be an expanded and improved version of Medicare, would cover every American for all necessary medical care.

For a nation that prides itself on having good business sense, we're getting a very poor return on our investment. So what's the answer? The best one so far is the single-payer system, originally sponsored by James McDermott (D-Washington), a psychiatrist, and John Conyers (D-Michigan) and endorsed by Physicians for a National Health Program. It was introduced in 2003, has 80 co-sponsors so far and is likely to gather momentum with the new Congress and with a growing number of states finding it necessary, but impossible, to provide their own universal care.

HR676I would be federally funded through a payroll tax of approximately 5.8% for employers and 2.9% for employees and would provide for expanded coverage for all citizens, without being tied to employment. It would have neither co-pays nor deductibles, since their only purpose is to discourage care, leading to noncompliance, more expense, and poor outcomes. Essentially, the approximately 15% savings on unnecessary administrative expenses covers the additional 46 million with dental, long-term and home health included for all.

What about the notion that we shouldn't expand government with its perceived inefficiencies? The fact is that Medicare is an extremely efficient system economically when compared to private insurance systems, having only 3% of its budget go to administrative overhead. However, there are legitimate concerns about the way the machinery operates. Another large government system, the Veterans Administration, even with the recent controversies, was recently ranked higher than Johns Hopkins, the Mayo Clinic, and many other prestigious institutions in its hospital care delivery system. For example, it uses its size to negotiate drug prices 40% lower than the private sector and is similar to what Canada pays.

I'd rather take my chances with a system that is not primarily profit driven and does not stand to benefit from intentionally deceptive policies, as is currently the case in the self-regulated private sector. As physicians, the prohibition of our unionizing makes it difficult to wield power, but a public system would allow our input into how the system is administered.

What happens to physician income in countries with such a system? Prices for procedures would be negotiated by our designated representatives, with regional boards created to administer the plan, but the bottom line is physicians pay overall may change very little, if at all, and savings on expenses will be significant. National health systems in other countries are geared more to generalists and less to specialists, which leads to criticism for "rationing." But, the fact is, rationing is already going on with choices being made by those who have no interest in healthy outcomes.

Stephen Sharfstein, Immediate Past President of the APA, endorsed the concept of a single-payer system in his outgoing editorial, saying it is simply the fairest way to cover everyone. The private model is more about serving the insurer rather than the insured and it is time to replace it with an affordable system which acknowledges health care as a basic right, similar to education. The difficulties involved with doing the right thing should not prevent us from doing it.

Please consider endorsing the national health plan, supporting legislators who do, or becoming part of the solution by contributing your own ideas to the debate. Check out pnhp.org for much more information and, hopefully, to join. A new state chapter has been formed, Virginia Health Care For All. For more information contact me at jmason54@earthlink.net.

Save the Date!

2007 Fall Meeting

October 19-20, 2007

Hotel Roanoke
& Conference Center
Roanoke, VA

PLEASE NOTE

PSV Elected a New Board of Directors in May 2007

Visit
www.psva.org
to see your new officers!

In The News

An Invitation to Help with a National Problem

By Dominic Ferro, M.D.
President, American Society for Adolescent Psychiatry

Adolescence is a unique period of life. It is also the stage of development during which major mental illnesses often begin, and often can go undiagnosed and untreated until later in life. The demand for psychiatrists to diagnose and treat these disorders in adolescents is outstripping the supply of child and adolescent-trained psychiatrists. The American Society for Adolescent Psychiatry is an organization that can support general psychiatrists in obtaining the skill and confidence to do so.

Adolescents with psychiatric conditions are an underserved population. Psychotropic medications are being prescribed by practitioners with inadequate training and experience, such as pediatricians or primary care physicians. Recognition of the need for trained psychiatrists is also evident in efforts by several states to encourage the practice of tele-psychiatry to fill the void.

Despite the obvious need, a shortage in child and adolescent psychiatrists has long been recognized, and is likely to persist. The United States Bureau of Health Professions projects a 100% increase in the use of child and adolescent psychiatrists, compared to an increase of 19% in the use of general psychiatrists. However, during the 1990's, the number of child and adolescent psychiatry residency positions and training programs actually decreased.

Since child and adolescent psychiatry has been recognized as a subspecialty by the American Board of Psychiatry and Neurology, some general psychiatrists have been reluctant to work with minors. However, general psychiatrists can help to fill the need by obtaining training and experience in the assessment and treatment of adolescents. One avenue is to complete a fellowship in child and adolescent psychiatry. Another avenue is to take advantage of professional organizations which offer continuing medical education opportunities. The American Society for Adolescent Psychiatry is the only organization dedicated to adolescent psychiatry, and it offers membership to general psychiatrists, as well as to child and adolescent psychiatrists. Its annual meeting provides approximately 25 hours of CME credit in adolescent psychiatry. The *Annals of the American Society for Adolescent Psychiatry,* published annually, provides a more in depth treatment of some of the subject matter of the annual meeting.

The American Society for Adolescent Psychiatry offers a supportive, collegial atmosphere in which experienced clinicians and researchers readily share their expertise. It is a particularly valuable resource for the general psychiatrist who has the temperament and the inclination to work with teens and young adults. Many of the Society's senior members can attest to the personal and professional satisfactions of caring for these youngsters, and setting the tone for how they will cope with the challenges of mental disorders throughout their adult lives. Interested psychiatrists can learn more about the Society at www.adolpsych.org, or can contact me directly at drferro@opton-line.net.

Welcome to our New Members

NEW

Karl W. Northwall (GM) ..... *Catawba*
Joseph M. Frieben (GM) ..... *Charlottesville*
Bankole A. Johnson (GM) ..... *Charlottesville*
Kimberly T. Ellis (GM) ..... *Williamsburg*
M. Angela Catolico (GM) ..... *Richmond*
Zaigham H. Ansari (GM) ..... *Chesapeake*
Elizabeth A. Yager (DF) ..... *Christiansburg*
Timur C. Akinli (MT) ..... *Charlottesville*
Ajay Kuchibhatla (MT) ..... *Charlottesville*
Melissa C. Stokes (MT) ..... *Charlottesville*
Elizabeth A. Yoder (MT) ..... *Chesapeake*
Grant L. Yoder (MT) ..... *Chesapeake*
Sharma Santher (MT) ..... *Chesapeake*
George L. Cowan (MT) ..... *Portsmouth*
Aileen Kim (MT) ..... *Portsmouth*
Harjot Sekhon (MT) ..... *Charlottesville*
Meenakshi Parmar (MT) ..... *Chesapeake*
Mark D. Kilgus (GM) ..... *Roanoke*

TRANSFER IN

Ajay Kuchibhatla (MT) ..... *Charlottesville*
Thomas Noga (GM) ..... *Troutville*
Sharad D. Sawant (GM) ..... *Virginia Beach*

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Access to affordable medications is a top priority for Eli Lilly and Company. This commitment is exemplified by Lilly's various patient assistance programs, which provide access to our growing portfolio of best-in class and first-in-class medications that help people live longer, more productive lives, and reduce overall healthcare costs. (Medicines are generally less expensive than other forms of health care, such as surgery and hospitalizations.)

Ensuring access to medicines requires that many organizations and individuals work together, including the government, insurers, healthcare providers, patients and pharmaceutical manufacturers. Lilly continues to lead and support efforts to improve access to medications.

That is why we are proud to introduce our newest patient assistance program, **LillyMedicareAnswers™**. This initiative is designed to give needy Medicare recipients the help they need to maintain vital continuity of care for bipolar disorder, schizophrenia, growth hormone deficiency and osteoporosis. To be eligible for this new program, individuals must enroll in Medicare Part D and meet certain eligibility requirements. For more information, call 1-877-795-4559 or visit www.lillymedicareanswers.com.

To learn more about all our patient assistance programs, call toll-free 1-800-545-6962, or visit our Web sites at: www.lillycares.com and www.lillymedicareanswers.com.

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Conference Highlights

Dr. Sood: Childhood Depression

Among adolescents, 15% report symptoms of depression, while 5% meet criteria for major depression and 3% meet criteria for dysthymic disorder. By age 14, the rate of depression is two times greater for girls compared to boys. Seventy percent of patients do not receive appropriate diagnosis and treatment. Eight out of ten times, the treatment plan does not include psychotherapy support, including cognitive behavioral therapy and family therapy.

Dr. Sood discussed developmental aspects of grief and reaction to loss, reporting that at concrete levels of operation, the child sees death as reversible. Later at the pre-operational stage of Piagetian cognitive development, children tend to personify death and ask illogical questions, such as how can the deceased breathe buried under the ground. She added that grieving children do not like to be comforted, but wish to play or participate in the ritual wake/funeral. Typically, children have a very short period of grief.

Quotable quote: "Adolescents will not tell you things until you spend time with them."

Dr. Pantierre: Understanding Sleep Disorders

Ninety percent of sleep disorders are related to disordered breathing. An example of disordered breathing is snoring at least five times an hour. Risk factors for Disordered Breathing included BMI > 25, advanced age, male gender, African American descent, Neck Size >17 and family history of first degree relatives using Continuous Pressure Positive Airway. The Differential Diagnoses include PTSD, REM Disordered Behavior, Night Terrors, Panic Attack and Depression.

Improve the time sleeping compared to time in bed (sleep efficiency), by turning the lights off, the TV off and the talk off. Ask the patient to keep a sleep diary. Next, restrict when the patient can get in bed to build sleep pressure and improve continuity of sleep. For instance, under sleep restriction, the patient cannot retire until 12:30, then after a week, 12:00, etc. Exercise is encouraged to promote deep sleep. Use hynoptics as a back up, rather than first line. For travel across time zones, one day for every hour of time change is needed for recovery.

Quotable quote: "Ninety-five percent of patients evaluated in my sleep lab have abnormal studies and these are young non-obese patient serving in the military."

Dr. Paykel: Postpartum Depression

Postpartum depression is the most common complication following the first year of childbirth. From her research in a population treated at a large military treatment facility, 17 percent of research subjects were identified with postpartum depression. Among the four million children born each year in the United States, 13% of mothers, or one-half million, suffer postpartum depression.

Important risk factors include a previous history of depression (50% recurrent rate), maternal youth, vaginal delivery, permaturity *prematurity* and gravidy. Protective factors include a cultural pattern of social seclusion, mandated rest, assistance from women, and social recognition and community celebration. Prevention involves early identification of women at risk and psychiatric support for the first postnatal year.

Quotable quote: "The largest single cause of maternal death one year after birth was suicide in a British Study."

Ms. Sulivan-Hurst: Domestic Violence

(Hotline 1-800-799-7233) also www.dcjs.virginia

One-third of women report having experienced assault or violence by an intimate partner (IPV) sometime during their lifetime. Domestic violence occurs in one out of four homes. Fifteen to forty-five percent of physically abused women are forced to have sex. Risk factors for violence include high levels of dominance and control; female identity dependent on a successful marriage; coercion based on religious obligation; disparity in job salary; family of origin conflict.

First time offenses are a class 1 misdemeanor. After two-three times, it is a felony. Virginia state Code 161.-228 and 18.2-57.2 includes apprehension of physical harm. Intimate partner violence (IPV), includes forced sex, twisting her words, or disparity in relationships between jobs, education, and income. Prosecution is the most effective intervention to stop family violence. The behavior is criminal, not mental illness. The cost to society to prosecute and manage these cases is 5.8 billion dollars per year (4.1 for direct social, medical and psychiatric services). Three hundred and twenty thousand pregnant women are battered each year.

Quotable quotes: "Twenty-eight percent of homicides are due to intimate partner violence with fifty percent of female homicide victims and 3.7% of male homicide victims are killed in the context of domestic violence."


Fetuses of depressed mothers
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2007 Spring Meeting

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GOVERNOR KAINE CREATES VA TECH REVIEW PANEL

Responding to the April 16 shootings at Virginia Tech, Governor Kaine has appointed a blue-ribbon panel of law enforcement, safety, and healthcare leaders to review the tragedy and make recommendations about how to improve the related systems in the future. The Review Panel includes psychiatrist A. Bela Sood, MD of VCU and emergency physician Marcus Martin, MD of UVA. PSV will actively engage the review panel and other entities to provide expert information and recommendations related to psychiatric care and availability. We expect numerous measures to come from the Governor's office and General Assembly that will attempt to address shortcomings in the mental health system including commitment laws, medical records, background checks and access to services.

For PSV members who wish to share recommendations or expertise in relevant areas, please contact PSV Government Relations Coordinator Cal Whitehead at cwhitehead@whitehead-consulting.net.

For more information about the VA Tech Review Panel, please visit this website: http://www.vtreviewpanel.org/

Friday Night Reception • PSV Spring Meeting

March 23, 2007

Cal Whitehead talks with Reception attendees

Delegate Chris Peace (R-Hanover) with Matt Van Wie, PSV Manager of Corporate & Educational Support

Delegate Frank Hall (D-Richmond) chats with a reception attendee

Helen and Tom Foster visit with Delegate John O'Bannon, MD (R-Henrico)

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YOUR SUPPORT IS NEEDED

We would like to sincerely thank those of you who have already made a contribution to the PsychMD PAC. We are making great progress on rebuilding the PAC; however, we still have a long way to go to reach our $10,000 goal. It is absolutely critical that we reach this goal as many of the House and Senate races are heating up and mental illness issues are going to be one of the most important issues before the General Assembly in 2008. We urge you to strongly consider making a contribution to the PsychMD PAC to help protect you and your industry.

Thanks again.

Hilton Graham
Cal Whitehead

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59TH INSTITUTE ON PSYCHIATRIC SERVICES

October 11-14, 2007

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ABSTRACT DEADLINE SEPTEMBER 7, 2007

2007 Annual Fall Meeting

October 19-20, 2007 • Roanoke, VA

Please visit www.psva.org/poster.htm for an application. All submissions should be returned to Andrew Mann by email at andrew@societyhq.com, mail 2209 Dickens Road, Richmond, VA 23230 or by fax at 804-282-0090. If you have any questions, please feel free to contact Mr. Mann at 804-565-6325.