

# THE PSYCHIATRIC SOCIETY OF VIRGINIA VIRGINIA NEWS



A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SPRING 2011

## A MESSAGE FROM THE INCOMING PRESIDENT

By Adam T. Kaul, MD, FAPA

I would like to thank all attendees of this year's PSV Spring Meeting. Our attendance was more than 100, and the participation and feedback were very positive. The meeting took place in Midlothian, Virginia on March 26th and the theme was "Looking at Psychiatry in an Evidence-Based World." The breakfast sessions were well attended, representing the committees of Membership, Legislative/Public Psychiatry, Child Psychiatry (AACAP), Ethics, Members-in-Training, and the Psychiatric Foundation.

The program was opened by outgoing PSV President, Dr. Cheryl Jones. Dr. Nassir Ghaemi, from Tufts University, presented a lecture on *Evidence-Based Applications in Psychiatry*. Dr. Ghaemi gave a thought provoking discussion on statistics and research practices and discussed evidence-based data on bipolar disorder. Continuing with the theme of the interplay between evidence-based medicine and the APA Practice Guidelines, Dr. Rochelle Klinger then presented an overview of *HIV and Psychiatry*. After lunch, the new officers for the 2011 year were announced, and Dr. Jones gave several words of thanks to many in the PSV as she ended her term.

Representing another APA Evidence-Based Guideline, Dr. Bela Sood then presented an overview of *ADHD and Disruptive Disorders in children*, and was followed by Dr. James Levenson, who discussed several psychopharmacologic and psychosomatic topics in the medically ill. The program ended with a rousing panel discussion on the DSM-V. The panel included Drs. Levenson, Sood, and Ghaemi, and was rounded out by Dr. John Shemo, who works with the APA Guidelines Committee. Dr. Levenson graciously moderated a question and answer format, with the questions

coming from the audience.

I would like to thank the planning committee for their assistance and advice for this meeting. I would also like to send very special thanks to our lecturers, who presented a fabulous program and were all very open in their support and valuable advice regarding the planning and structure of this meeting.

As I assume the office this year, I would like to offer a challenge to each member of the PSV. I want each of you to join me in a commitment to the membership of this organization. We need to reach out to our colleagues and encourage them to attend a meeting at the state or chapter level. I want each of our members to make a phone call, and bring one non-member with you to a meeting. We need to reach out to our Members-in-Training and Early Career Psychiatrists and educate them about the benefits of being an active member of the Society. I encourage those of you who do not have very active local chapter, to work together to strengthen those groups. To that end, I hope to visit each local chapter and each residency program in the state during my term as President. I encourage any feedback, suggestions, or ideas. Please feel free to email me at [atkaul@hotmail.com](mailto:atkaul@hotmail.com). I hope to see you all at the meetings.



Adam T. Kaul, MD, FAPA  
President



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## INSIDE THIS ISSUE

A Message from the Editor.....	2
Virtual Reality into Real Recovery...	3
The Medical Home Model.....	4
NAMI Virginia .....	4
Medical School News.....	5
In the News.....	6
Oral Case Presentations .....	7
Thank you to our Supporters .....	7
Legislative Update .....	8
Welcome New Members.....	8
2011 Spring Meeting Highlights ..	10



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## A MESSAGE FROM THE EDITOR

### Using Virginia's Felon DNA Database to Look for Relatives of an Unknown Criminal. What Should We Consider?

By Kathleen M. Stack, MD, DFAPA



Kathleen M. Stack, MD, DFAPA

What are the considerations in using the Virginia's DNA database of felons? I do not know. I had not even thought about it until a recent article caught my attention.

The article reported that Virginia did not need new laws to begin using the DNA database of Virginia felons. I understand the support of law enforcement and victims' families in supporting this new process. Yet, it troubled me that none of the articles I read commented on the concerns this might raise from the perspective of a person included in the database or their family members.

Like most psychiatrists, I have treated many people with a history of a felony and more who have first degree relatives who have felony records. I have also treated people who have been victims of brutal crime directly or indirectly. I am humbled to witness what people can endure emotionally and personally.

I summarize the articles below on the topic of using familial DNA, then pose a few questions.

Last week, Governor Bob McDonnell announced that Virginia would begin using DNA to identify first degree relatives of those who commit serious crimes. Peter Dujardin of *The Daily Press*, Julian Walker of the *Virginia Pilot* and several blogs reported on the decision to use "familial DNA." The process involves searching the state DNA database of known felons (over 330,000) and comparing to a sample found in a case with no leads. As reported in the media, Peter Marone, Director of the Department of Forensic Science said, "The protocol will be rare, because it's a time-consuming affair. We're only going to do this in the case of these major-type crimes when the police department has exhausted all other options." The process involves narrowing the pool to about 100 samples. Then, looking for those which match more closely before it is connected to identities. The goal is to use the relatives to identify and locate the person who committed the crime. This resulted in an arrest in a serial murder case in California. The ACLU did not contest the use of this technology. Kent Willis, Executive Director of the Virginia Chapter of the ACLU said, "The ACLU here is OK with the testing so long as it's used rarely, and only in the most violent and difficult-to-solve crimes. Then it may be worth the sacrifices of privacy to serve a greater good." But he raised the point that, over time, it will be less expensive and the process may be more frequently used. Some states have decided that the privacy concerns outweigh the benefits and consider it an "unreasonable search."

What seemed to be missing was discussion about the use of a database collected for one reason, to identify a felon, and then used for the different use of finding their relatives, who may or may not be a suspect in a crime.

I thought of the DNA database as a 21st century finger print library. DNA is the best way science could correctly identify the person who left this "fingerprint." It is nearly 100% accurate, unlike the number of point matching on a fingerprint. DNA analysis allows for people convicted unjustly to be freed. It removes doubt that the person was present.

This new use of the database utilizes exclusionary information; it was definitely not the people in the DNA database. The authorities then use the information to generate possible leads. For example, one person's DNA in this database may come up as a first degree relative to the person who left DNA at a crime. Their parents, children and siblings would all be considered possible suspects. Each would need to be ruled out as the perpetrator. I imagine this process might include contact with the person's

*Continued on page 10*

# CHANGING VIRTUAL REALITY INTO REAL RECOVERY: NEW THERAPIES IN PSYCHIATRY

By Kathleen P. Decker, MD

Most of our children are technologically comfortable with 3-D glasses. Many of us play with Wii sets or electronic games and as our virtual play expands so, too, does our work! I'm going to briefly describe and discuss virtual reality treatment in psychiatry. Virtual reality is an environment which attempts to simulate reality by means of technology, in which the individual becomes immersed. The basic set-up includes a visor (a pair of glasses with tiny screens in them), a set of headphones to hear sound, and the environment is generated by a computer program. In virtual reality therapy, the therapist is in control of software which generates a virtual world in which the patient moves about. The goal is to recreate a traumatic or difficult setting for the patient so that their imagination doesn't have to work as hard to generate the environment. This allows the patient to focus even more on their responses, while keeping her/him grounded in the office, where she/he knows she/he is safe.

The history of use of this modality in psychotherapy began with software which was developed for treating the fear of flying in the 1990s, by Barbara O. Rothbaum (Emory University) and Larry F. Hodges (University of North Carolina). Most patients could not afford to go to airports (and now security prohibits them) to experience in vivo treatment for "aviophobia or aerophobia" (fear of flying). So, once the individual had reached a plateau with imagined exposure therapy, there was a major gap between conquering flying in the imagination and reality. Investigators used computer simulations reminiscent of Microsoft's Flight Simulator™ to begin to close the gap between imagining flying and experiencing it. Of course, NASA predated this with true flight simulators, which use capsules and centrifuges but even early virtual reality investigators found that putting an individual in goggles and showing them virtual airplanes and landing strips was very successful in provoking panic in those

with aviophobia. Such programs are now much more detailed and sophisticated. In a newer application, as the U.S. became involved with an increasing number of wars with a new wave of tech-savvy warriors, the Army began collaborating with private companies to assist with virtual reality for treatment of PTSD. There are already facilities using virtual reality for active duty personnel with PTSD, as well as VA medical centers in Virginia caring for vets with PTSD.

One irony here is that whether we're talking about aviation or war, the same modality is now being used to train individuals as is used to treat them for trauma engendered by that setting! In other words, you can become a better pilot by using virtual reality, OR if you crash, learn to get over your aviophobia! The same applies to war. You can become a better soldier by playing war games, but when the real thing traumatizes you, you can get desensitized to the trauma and re-adapt to civilian life by using virtual reality instead of re-experiencing the real thing until you become numb to it. It's a strange world!

Virtual reality therapy is basically a Prolonged Exposure (PE) model. It has similarities to traditional PE – it still features therapist-guided imagery and the patient can still stop and debrief at any point and the therapist can de-escalate the session (Rizzo). It uses "SUDS (Subjective Distress Scale)" and "PCL" scales to monitor effects and uses graduated exposure to accomplish its goal. The differences include: virtual vs. imagined recreation of trauma, it is more suitable for patients who are less abstract, less verbal, and more action-oriented, so it is more popular with



Figure 1. Virtual airplane for treating fear of flying



younger or more video/electronically-oriented patients. These patients can actually control the situation better than in their imagination.

So, now I'll paint an imaginary picture (see photos at the top for some real ones). The patient is in a chair or standing on a platform with a set of goggles and headphones holding either a mock gun (for war scenarios) or a joystick that allows them to "walk" in the virtual environment. The therapist sits at a desk with two monitors and a computer (either laptop or desktop), mouse and keyboard. Although this set-up looks very artificial, any of us who has ever tried the system can tell you that the virtual environment does not need to be an exact replica of what the individual has experienced. However, it triggers memories just as imagined exposure does, including a journalist who went on TV and had a panic attack because the virtual reality reminded him so much of when he was embedded with the Army.

So how does it work for smoking or substance use cessation? First, virtual reality software allows the individual to enter a party or a bar, brimming with temptations of various sorts. (Guess what's coming?!) A nice young thing will approach you and invite you to partake of whatever sin you are trying to quit-smoke, drink, etc. This affords the patient the opportunity to practice

*Continued on page 12*



## Virginia's Voice on Mental Illness

By Farleigh Fitzgerald  
Special Project Coordinator  
NAMI Virginia

Sharon and her husband have just finished taking a *Family-to-Family* course through NAMI Virginia. For the first time in their lives, they feel that they have the skills, information, and hope they need to deal effectively with their son's mental illness. "We have all bonded, made new friends, and shared our stories of our sick relative. We have learned so much. I have taken a different view on mental illness. We do not feel so alone and can be more compassionate."



*Rashida Gray, MD, receives a certificate of appreciation on behalf of PSV from Mira Signer, Executive Director of NAMI Virginia.*

When mental illness strikes, individuals and families are often faced with an array of questions. How do you support a person who is experiencing a mental health problem or has dealt with mental illness in the past? What resources in the community exist to support families dealing with mental illness and help people regain their lives from a mental health problem?

One place to turn for resources is NAMI, the National Alliance on Mental Illness. NAMI Virginia is the state organization of NAMI, a non-profit grassroots organization dedicated to improving the lives of people affected by mental illness through support, education, and legislative advocacy. NAMI Virginia offers individuals and the community information and education through a variety of activities, including a toll-free helpline, free support groups, and a variety of free educational programs.

In 2010, NAMI Virginia and its affiliates reached 520 family members through their family education programs, 132 persons living with mental illness through *Peer-to-Peer*, a consumer education program, and 2,292 people through *In Our Own Voice*, an outreach presentation offering insight and hope for recovery from persons experiencing recovery in their own lives. Martha, a trained *In Our Own Voice* presenter from Roanoke claims "*In Our Own Voice* changed my life. I am speaking before large groups of people, telling my story, taking part in discussions, and deftly answering questions. I am not the same person I once was. The impact of *In Our Own Voice* is truly powerful and empowering." NAMI Virginia has also just introduced *Basics*, an educational course for parents and other caregivers of children and adolescents living with mental illnesses. The course is designed to give parents/caregivers the basic information to take the best possible care of their child, their family, and themselves, provide tools for future use when making decisions regarding their child's care, and support to help the parent cope with the impact of mental illness

on the child and the entire family.

To help support our programs and advocacy efforts, NAMI Virginia holds its annual fundraiser, NAMIWalks Virginia. NAMIWalks is a family and community event to raise awareness, educate people about mental illness, and celebrate hope and wellness. The Walk relies on funds raised by individuals and the ongoing generous support from sponsors like the Psychiatric Society of Virginia. This year's Walk is scheduled for Saturday, October 8 at Innsbrook in Richmond. Over 1,000 individuals from across Virginia are expected to be a part of this festive event with face painting, clowns, kid's activities, exhibitors, food, and live music.

For more information about  
NAMI Virginia or NAMIWalks please visit:  
**[www.namivirginia.org](http://www.namivirginia.org)**  
or call  
**1 (888) 486-8264**

## THE MEDICAL HOME MODEL

### Where We Have Been, Where We are Now, and Where We are Going: Where will the Psychiatrist Fit In?

By W. Victor R. Vieweg, MD, DLFAPA

The Medical Home concept has evolved since being introduced by the American Academy of Pediatrics in 1967. In 1992, that Academy published a policy statement defining a medical home, and in 2002 they expanded and operationalized the definition. That year, seven U.S. national family medicine organizations created the *Future of Family Medicine* project to "transform and renew the specialty of family medicine." Every American should have a "personal medical home" by which to receive acute, chronic, and preventive services with such service "accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians".

As of 2004, a study hypothesized that if the *Future of Family Medicine* recommendations were followed (including implementation of personal medical homes), "health care costs would likely decrease by 5.6%, resulting in national savings of 67 billion dollars per year, with an improvement in the quality of the health care provided." A review of the literature published the same year determined that medical homes are associated with better health, lower overall costs of care, and reductions in disparities in health.

By 2005, the American College of Physicians had developed an "advanced medical home" model that involved the use of evidence-based medicine, clinical decision support

## VCU UPDATE

By Joel J. Silverman, MD, DLFAPA  
James Asa Shield, Jr., MD Professor and Chair, Department of Psychiatry, VCU

The Department of Psychiatry at Virginia Commonwealth University is a large, diverse, academic department. We have 84 full-time faculty, strongly supported by 110 community clinical faculty who provide wonderful education and supervision for our house staff. Our doctors treat 32,000 patient visits a year on campus and many faculty are involved in serving community mental health centers and their clients. Our doctors are routinely recognized on both "Top Doctors In America" and "Top Doctors in Richmond".

Our residents and faculty participate in the Psychiatric Society of Virginia and often provide lectures and presentations. Our residents participate regularly in the PSV poster session and our faculty serve in executive positions.

We have many research strengths, including brain stimulation, women's mental health and the highly-recognized Virginia Institute of Behavioral and Psychiatric Genetics, headed by Dr. Kenneth Kendler. Our research extends beyond Virginia to Finland, Ireland, India and the People's Republic of China. Dr. Kendler and Dr. Sam Chen recently identified a new candidate gene for schizophrenia, the CMYA5 gene. Dr. Jack Hettema was recognized by *Science Watch* for his paper on anxiety disorders, which was the most widely quoted paper in psychiatric literature. Dr. Kendler is serving as Chair of the APA's DSM V Oversight Committee. In the past year, our faculty published almost 350 peer-reviewed publications and seven books. Grant funding is vigorous.

We are proud to announce that Dr. Susan Wallis is Interim Chair of our Division of Ambulatory Psychiatry. Dr. Cheryl Jones is Interim Chief of Service at the Hunter Holmes McGuire Veterans Administration Medical Center and Dr. Ananda Pandurangi was appointed Vice Chair of the department. Dr. Pandurangi is heading our brain stimulation program and our new Transcranial Magnetic Stimulation clinic which is both an intervention and research clinic.

We have taken a leadership role in designing and implementing the recently opened Child Mental Health Resource Center, which is a community effort to provide social support, information, multidisciplinary evaluations and treatment plans for families and children with psychiatric issues.

We teach required courses in the first three years of our School of Medicine and are very proud that the Senior Associate Dean for Medical Education is Dr. Isaac Wood, a member of our faculty. Dr. Bela Sood chairs the State Board of Social Services and Dr. Ananda Pandurangi serves on the State Board of Behavioral Health.

*Continued on page 10*

tools, the Chronic Care Model, medical care plans, "enhanced and convenient" access to care, quantitative indicators of quality, health information technology, and feedback on performance. Payment reform was important for implementation of the model.

IBM and other organizations started the Patient-Centered Primary Care Collaborative in 2006 to promote the medical home model, and, as of 2009, its membership included "some 500 large employers, insurers, consumer groups, and doctors."

In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association (the largest primary care physician organizations in the United States) released the *Joint Principles of the Patient-Centered Medical Home*. Principles included:

- **Personal Physician:** Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician Directed Medical Practice:** The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole Person Orientation:** The personal physician is responsible for providing for all the patient's healthcare needs or taking responsibility for appropriately arranging care with other qualified professionals.
- **Care is Coordinated and/or Integrated,** for example, across specialists, hospitals, home health agencies, and nursing homes.
- **Quality and Safety** are assured by a care planning process, evidence-based medicine, clinical decision-support tools, performance measurement, active participation of patients in decision-making, information technology, a voluntary recognition process, quality improvement activities, and other measures.
- **Enhanced Access** to care is available (e.g., via open scheduling, expanded hours and new options for communication).
- **Payment** must appropriately recognize the added value provided to patients who have a patient-centered medical home. For instance, payment should reflect the value of work that falls outside of the face-to-face visit, should support adoption and use of health information technology for quality improvement, and should recognize case mix differences in the patient population being treated within the practice.

A survey of 3,535 U.S. adults released in 2007 found that 27% of the respondents reported having four indicators of a medical home. Furthermore, having a medical home was associated with better access to care, more preventive screenings, higher quality of care, and fewer racial and ethnic disparities.

Less clear is the role that psychiatrists will play in the Patient-Centered Medical Home. That is, will the psychiatrist be an integral member of the team or a consultation to the team playing a role similar to other consultants?

We hope to address issues related to this question and the model in March at the Psychiatric Society of Virginia 2012 Spring Meeting in Richmond.



# IN THE NEWS

## VIRGINIA PSYCHIATRISTS NAME DELEGATE TAG GREASON LEGISLATOR OF THE YEAR



Cheryl Jones, MD, DFAPA, presents Delegate Thomas A. "Tag" Greason with the PSV Legislator of the Year Award. He is accompanied by his wife Mary Elizabeth Greason.

The Psychiatric Society of Virginia (PSV) has named Delegate Thomas A. Greason (R-Loudoun) the organization's Legislator of the Year for his work on autism treatment coverage and gambling addiction treatment. Tag Greason is completing his first term representing the 32nd House District. His award was announced and presented at the PSV 2011 Spring Conference on March 25 in Richmond.

PSV President Cheryl Jones MD said, "Delegate Greason's efforts to tackle challenging issues like insurance coverage for autism spectrum disorders and treatment for gambling addiction is a service to all patients, their families and physicians."

Delegate Greason was a co-patron of HB 2467, a bill which would extend limited insurance benefits for children ages 2 to 6. It is awaiting action by Governor Bob McDonnell. He also introduced legislation to establish a fund to address the prevention and treatment of gambling addiction and other problems related to gambling. HB 1977 did not advance but Delegate Greason will continue to pursue the concept.

"Tag's work not only advances important new policy that will help families struggling with these conditions, it also raises awareness about mental illness and addiction for everyone," added Dr. Jones, a Richmond area psychiatrist who concludes her term as PSV President this Spring.

Please join us in making  
a contribution to PSYCHMD-PAC  
by visiting [www.psva.org](http://www.psva.org).



## AMERICAN ACADEMY OF LAW MANFRED S. GUTTMACHER AWARD RECIPIENT

Liza H. Gold, MD is the recipient of the 2011 American Psychiatric Association and American Academy of Law Manfred S. Guttmacher Award for her book, *Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis* (Springer, 2009), co-written with Daniel W. Shuman, J.D. This award is given for the previous year's most outstanding contribution to the literature of forensic psychiatry.

Dr. Gold, a clinical and forensic psychiatrist, and Daniel W. Shuman, a renowned legal scholar, collaborated in exploring this topic from both clinical and legal perspectives. Clinicians are often asked to provide opinions on an employee's fitness for duty or to document psychiatric disabilities for insurance purposes or purposes of accommodation. Their text proposes a model for assessment of psychiatric disability in the workplace, reviews practice guidelines for conducting workplace mental health disability evaluations, and closely examines legal and ethical aspects of employment evaluations. In addition, detailed review and explanations are provided about the basics of disability compensation systems, and the role of the psychiatrist in these systems, as well as disability evaluation in relation to the Americans with Disabilities Act and Fitness for Duty evaluations.

Dr. Gold joins a small handful of authors who have received the Guttmacher Award more than once, and she is the only woman to have been so honored. In 2006, she received the Guttmacher Award for her book *Sexual Harassment: Psychiatric Assessment in Employment Litigation* (American Psychiatric Publishing, Inc., 2004). Dr. Gold is also the co-editor of *The American Psychiatric Publishing Textbook of Forensic Psychiatry*, 2nd edition (American Psychiatric Publishing, Inc., 2010). She is a Clinical Professor of Psychiatry at Georgetown University School of Medicine and has a private practice in Arlington, VA.

## VOLUNTEER AWARD PRESENTED

Dr. Helen Foster, DFAPA, thanks the Psychiatric Society of Virginia for supporting the nomination of Jessica and Ray Burmester for their many years of service for the Coalition for Citizens with Mental Disabilities and for their service in the three disability areas of Mental Illness, Intellectual Disability, and Substance Abuse. On Thursday April 28, 2011, Governor Bob McDonnell presented the Burmesters with an award recognizing their 45 years of volunteer service. Congratulations!



Jessica and Ray Burmester



## ORAL CASE PRESENTATIONS

By J. Edwin Nieves, MD, DFAPA



J. Edwin Nieves, MD,  
DFAPA

It is 6:15 am, on the 7th Floor West Hospital MCV, the night nursing shift is ending, and incoming nursing day shift is rolling in. Medical students and interns rotating through the psychiatry service crowd the nurses' station. You can smell the fresh coffee and hear the night shift nurse dictating reports. Reading and re-reading records, blood work and other pertinent patient clinical information, both medical students and interns prepare to answer questions that are sure to come later in the morning. In about 30 minutes, residents will come in and ask, "Any new admissions, anything overnight?"

"Well, we have this new admission..." and then you would start "presenting the case." In mid-sentence, a resident would stop you to ask a question, stop.....start. Then about 30 minutes later, the attending physician would come in, and you would start "presenting the case" all over again.

Sounds familiar? I bet it does. For all of us, the reading, memorizing and preparing of a strong differential diagnosis is the daily bread of being post call. It was hard for me to imagine I would be able to hold so much information in my mind then and hard to imagine that some of the people I presented cases to would be reading this article today.

The widespread use of electronic communication tools and ready access to reference databases has substantially influenced the clinical environment and the initial presentation of patient clinical material. How many times have you all received a rambling recitation of lab values, mixed with diagnostic tests and other clinical information from a trainee without learning much from the patient themselves?

A recent brief paper in the August issue of *Current Psychiatry* brought back a lot of memories, along with the realization that case presentation may be a dying art.<sup>1</sup> The authors spell out something previously taught by example over and over every morning. For the most part, this was taught by role modeling. I do not recall reading any journal article at the time about case presentation. Practice, practice and more practice with your colleagues and supervising

attending was the norm.

Another useful article; "Oral Case Presentation Guidelines" by Dr. S. McGee, has excellent tips and guidelines for any trainee on the basic elements of oral case presentation. I condensed them below:<sup>2</sup>

1. The oral presentation is always brief, ideally under 5 minutes.
2. It is delivered from memory.
3. It contains those elements essential to the understanding of the current, most pressing issue.

In addition, this article contains a graph at the bottom of the first page delineating listener's attention plotted against the content of the presentation. As I look back on those Friday afternoon consultation/liaison rounds with Dr. Levenson, where he honed case presentation skills, I realize the importance each one of us have in teaching the art of medicine.

### References:

- 1 "Rediscoverig the Lost Art of the Oral Case Presentation" Querques, J. Freudenreich O. Kontos N. *Current Psychiatry*, Aug. 2010 page 56.
- 2 "Oral Case Presentation Guidelines" McGee, S. Department of Medicine Student Program University of Washington. <http://depts.washington.edu/medclerk/student/presentation.html>, accessed 11/08/2010.

## PSV WOULD LIKE TO THANK THE FOLLOWING EXHIBITORS

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### COMMERCIAL SUPPORTERS

PSV was supported  
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grants from

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## LEGISLATIVE UPDATE

### PSV Partners with Physician Allies for Successful 2011 Session

By Cal Whitehead  
PSV Advocacy Coordinator

#### Additional Medicaid Cuts Avoided

Improving state revenues and tenacious lobbying by the physician community allowed us to avoid an additional 4% reimbursement reduction that was scheduled for July 2011. Governor McDonnell and the General Assembly recognized that they will have to reverse recent payment cuts that are driving physicians and other providers away from Medicaid.

#### Long-term Medical Malpractice Cap Compromise

MSV and specialty societies supported passage of legislation which will incrementally increase the medical malpractice cap over the next 21 years, capping at \$3 million. This agreement reached by physicians, hospitals and trial attorneys satisfies key goals by retaining Virginia's total cap, establishing an agreement for a long period of time, minimizing the risk of large premium increases, and delaying the effective date of any increases. Overall, the agreement is expected to help strengthen the long-term predictability and stability of medical liability insurance, while having a nominal effect on insurance premiums. The agreement preserves potential avenues for further tort reform beyond the medical malpractice cap.

The bills had overwhelming bipartisan support from the General Assembly but, unfortunately, Governor McDonnell vetoed the legislation. The General Assembly decisively overrode the Governor's veto, sending a message that long-term stability is desired for the medical malpractice insurance market.

#### Insurance Coverage for Autism Treatment

Delegate Tag Greason (R-Loudoun) and Senator Janet Howell (D-McLean) patroned legislation to extend limited insurance coverage for autism treatment for children ages two to six. PSV supported the bills which benefitted greatly from endorsement by Speaker of the House Bill Howell (R-Stafford). Delegate Greason, who also introduced unsuccessful legislation that would help with gambling addiction treatment. Delegate Greason was named PSV Legislator of the Year and presented an award at the PSV 2011 Spring Meeting in Richmond.

#### General Assembly Rejects Licensure of Naturopaths

The physician community defeated HB 2434 (Kilgore, R-Gate City) allowing for the full licensure of naturopaths, who want to practice as physicians. The naturopath bill did not even get a hearing because of the concerns that were voiced by organized medicine.

#### Protection for Providers of Emergency Care

PSV was pleased by the passage of HB 1690, patroned

by Delegate Chris Stolle MD (R-Virginia Beach), which will increase the penalty to a mandatory two days in confinement for those who assault a healthcare provider in the emergency room setting.

Please contact PSV Advocacy Coordinator Cal Whitehead at [cwhitehead@whiteheadconsulting.net](mailto:cwhitehead@whiteheadconsulting.net) for more information about these issues and other legislation addressed during the General Assembly session.

## WELCOME NEW MEMBERS

### GENERAL MEMBER

Maha M. Abdel-Kader, MD ..... Ashburn, VA  
Imran Akram, MD ..... Manassas, VA  
Valerie Buyse, MD ..... Vienna, VA  
Sireesha Chimata, MD ..... Glen Allen, VA  
Eleanor L. Gagon, MD ..... Maidens, VA  
Brian D. Krause, MD ..... Front Royal, VA  
Phillip B. Marshall, MD ..... Richmond, VA  
Ellen Perricci, MD ..... Vienna, VA  
Justin D. Petri, MD ..... Chesapeake, VA  
Vasu Venkatachalam, MD ..... Midlothian, VA  
Ann E. Walling, MD, MSc ..... Staunton, VA  
David A. Weis, MD ..... Virginia Beach, VA

### MEMBER IN TRAINING

Tracy Das, MD ..... Roanoke, VA  
Sharron Jones-Daggett, MD ..... Roanoke, VA  
Sreekant Kodela, MD, MBBS ..... Roanoke, VA  
Neeta Kumari, MD, MPH ..... Norfolk, VA  
Chadrick Lane, MD ..... Charlottesville, VA  
Nirupama Natarajan, MD ..... Roanoke, VA  
Peter S. Oliver, MD ..... Charlottesville, VA  
Stephanie L. Peglon, DO ..... Norfolk, VA  
Karamjit Singh, MD ..... Roanoke, VA

### STUDENT

Jeffery Conley ..... Norfolk, VA  
Ashley Jenkins ..... Norfolk, VA  
Jeremy Kidd ..... Boston, MA  
Lindsey Prochaska ..... Scottsburg, VA  
Elizabeth Spencer ..... Norfolk, VA  
Christopher Wright ..... Salem, VA

## CALL TO ACTION

**Please Submit Your Poster Abstracts  
for the PSV 2011 Fall Meeting!**  
**Poster Submission Deadline  
August 13, 2011**

Visit [www.psva.org](http://www.psva.org)  
for Application Submission Information



SOME THINGS **NEVER** CHANGE



**BUT, SOME THINGS DO.**



The American Psychiatric Association after many years with the same company has changed to a new medical malpractice insurance carrier – and if you are currently enrolled in the old program, it is important that you know your renewal is not automatic. We also think you should be aware that there is only one malpractice program in the nation endorsed by the American Psychiatric Association where the coverage is extensive and the rates are low—American Professional Agency, Inc.

To remain enrolled in the only APA-endorsed program monitored by the Association, you must contact American Professional Agency, Inc to do so. If you are not currently enrolled or perhaps considering a change in malpractice insurance carriers, there is no better opportunity or time to change to American Professional Agency, Inc. than now.

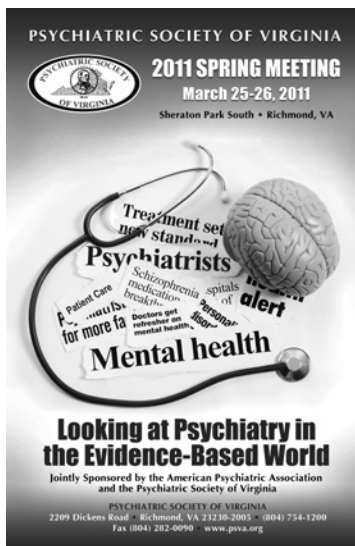
So, regardless of when your renewal date is, or who your current carrier might be, we urge you to please visit us on the web at [www.apamalpractice.com](http://www.apamalpractice.com) or call us toll free at 877-740-1777 and make a change for the better to American Professional Agency, Inc.



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# 2011 Spring Meeting Highlights



Cheryl Jones, MD, DFAPA, accepts the outgoing President's Award for her PSV leadership for the last 12 months from Incoming President, Adam Kaul, MD, FAPA.



Portsmouth Naval residents Aidith Flores-Carrera, MD and Jennifer Shippy, MD join EVMS resident, Kapil Chopra, MD for lunch.



Delegate Thomas "Tag" Greason speaks after being named PSV Delegate of the Year.



Attendees enjoy thoughtful and provocative presentations from Nassir Ghaemi, MD on evidence-based applications in psychiatry.



Cal Whitehead, PSV's Advocacy Coordinator, gives a Legislative Update and makes a plea to support the PsychMD-PAC.



A. Bela Sood, MD, MSHA, FAACAP, a Saturday presenter.



John P.D. Shemo, MD, DFAPA gives the APA Assembly Representative update.



Brian E. Wood, MD & J. Bobby Miglani, MD enjoy the Friday night reception with Exhibitors and Legislators.



Cheryl Jones, MD, DFAPA presents a check to NAMI Virginia's Special Projects Coordinator Farleigh Fitzgerald in support of their efforts with the mentally ill.

## A Message from the Editor

Continued from page 2

employer, spouse or neighbor who would worry about this. The genetic relatives being considered may or may not even know each other such as in cases of adoption or an unknown parent.

If one agrees that the potential benefit of finding relatives of a serious violent offender is a proper reason to search a database, why not search military or hospital DNA databases? If solving violent crimes is a reasonable use of a DNA database, why don't we use this same process to try and identify those who are "Jane or John Doe" fatalities of violent crimes? If leads are what is being looked for, why not look at extended family, rather than just first degree relatives? These are just a few of the questions to consider. I do not know the answers, but I do know that many of us will be dealing with the consequences.

## VCU Update

Continued from page 5

We are continually strengthened by collaborations with community psychiatrists and other mental health providers. We encourage individuals to contact us if they have interests in teaching and helping us form partnerships with individuals, foundations and businesses to achieve our long-term goal of conquering mental illness. We believe the future of medicine is brain science and that psychiatry is brain science.

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## VIRGINIA NEWS

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### Virtual Reality

*Continued from page 3*

– over and over and over – all the possible ways to say no. Think this sounds hokey or fake? No way. Experiments have already shown that smokers who stub out virtual cigarettes develop more confidence and have a higher quit rate than those who perform a placebo task (Girard). Similarly, if you have a fear of public speaking, the virtual world offers several options. You can have a supportive audience, or the therapist can have the audience throw tomatoes at the speaker.

Another use of virtual reality that benefits pain patients was developed by Dr. Hunter G. Hoffman and Dr. David Patterson (University of Washington). In 2004, they published a groundbreaking article on the use of virtual snow/ice worlds to assist burn patients with pain control by lowering the (imaginary) temperature of their surroundings. Of course, this is a variation on traditional biofeedback techniques, which can also now use virtual worlds. Finally, therapists are now using virtual reality programs to teach patients with Attention Deficit Disorder to learn to control impulses and pay attention better.

Much of the hardware equipment is beyond the range of affordability for an individual therapist this year (\$10,000 for a set-up), but as all technology becomes cheaper with time, it will surely reach individual offices. Actually, the average civilian clinician will spend far more time taking care of phobias

(either specific or social) and substance use disorders than war PTSD. And all doctors need more tools to assist with management of chronic pain. So don't ignore the uses of virtual reality. Your next generation of patients will expect it. It's virtually here to stay!

Here are some links to companies that feature hardware/software systems:

<http://www.virtuallybetterclinic.com/VRtreatment.html>  
<http://www.vrphobia.com/AboutUs/overview.htm>  
[http://www.pixel-age.com/progettovret/eng/pixel\\_age.htm](http://www.pixel-age.com/progettovret/eng/pixel_age.htm)  
<http://www.hitl.washington.edu/projects/vrpain/>

The above links do not suggest an endorsement of any specific company. Use the term "virtual reality therapy" in your favorite internet search engine to find more links.

#### References:

- Girard B, et al. *Cyberpsychol Behav.* 2009 Oct;12(5):477-83.
- Rizzo AA, et al. VR PTSD exposure therapy results with active duty OIF/OEF combatants. *Stud Health Technol Inform.* 2009; 142:277-82.
- Hoffman, HG. Virtual Reality Therapy. *Scientific America.com*, July 2004.