THE PSYCHIATRIC SOCIETY OF VIRGINIA

VIRGINIA NEWS

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION SUMMER 2011

A Message from the President

Make That Call: Being a Political Advocate

By Adam T. Kaul, MD, FAPA

One of the interesting roles that the President of the PSV has is being the politically active "face" of the Society. I have recently attended a number of political functions at the state level, and also was in Washington during the APA Advocacy Day. The latter was as a representative from the PSV, and it would be nice to have some of our newer members attend this annual activity in the future. It provides a wonderful introduction to the role that we play as resources for our decision makers. Several "talking points" were noted this year, including funding issues on the psychiatric workforce, parity issues regarding inpatient care, returning military psychiatric care, and the perennial Sustained Growth Rate issue of Medicare.

Adam T. Kaul, MD, FAPA
President

The PSV is very fortunate to have many active political advocates; and to those members I wish to say thank you for making phone calls, attending functions, and supporting candidates and causes that promote the message of mental health. We are also very fortunate to have Cal Whitehead and Whitehead Consulting as the representative for advocacy for the PSV. Cal, and Ralston King, work overtime to advance our opinions, and they keep their finger on the pulse of political issues and trends that may directly or indirectly effect psychiatry in Virginia. Cal also manages the PsychMD PAC. I ask each of you to support this very effective tool for directly promoting the message of psychiatry in Virginia.

For those who may be new to the idea of being advocates, allow me to offer a few points of advice. First, do not be afraid! Discussions with politicians should not feel daunting. We are a valuable resource to those at every level of government. There are many decisions to be made and the legislators or executives need information in order to make an informed decision. Second, remember your message. It is good to be yourself and be comfortable, yet it may be easy to go off on tangents. Remember that you are a resource with a message to convey. Finally, make that call. Attend a political function, write a letter, visit your legislator's office, or even host an event. You can locate your legislator by looking on the PSV webpage (www.psva.org) on the left column. If you're looking for ideas, and/or issues to discuss with your legislator, Cal and many PSV members (including myself) will be happy to get you connected.

PSV WOULD LIKE TO THANK THE FOLLOWING EXHIBITORS

SILVER LEVEL

American Professional Agency

Eli Lilly & Company

Sunovion Pharmaceuticals, Inc.

COMMERCIAL SUPPORTERS

PSV was supported by educational grants from

Eli Lilly & Company

Merck and Co.

EXHIBITORS

American Professional Agency
Angelini-Labopharm
AstraZeneca
Bristol-Myers Squibb
Central State Hospital
CFG Health Net-Insight
Contemporary Insurance Services
Eli Lilly & Company
Janssen Pharmaceuticals, Inc.
Merck & Co.
Neuronetics
Pfizer, Inc.
Somaxon Pharmaceuticals
Sunovion Pharmaceuticals, Inc.
The Psychiatrists' Program
US Army Healthcare Recruiting Team
Welligent, Inc.

Inside This Issue

THE PSYCHIATRIC SOCIETY OF VIRGINIA
VIRGINIA NEWS

Psychiatric Society of Virginia
2209 Dickens Road
Richmond, VA 23230-2005
Phone: (804) 754-1200
Fax: (804) 282-0090
Email: psv@societyhq.com
www.psva.org

Letters to the editor and editorial contributions are welcome. Submissions may be sent to Jose Edwin Nieves, MD, DFAPA, or to Kathleen M. Stack, MD, DFAPA, via email at jose.nieves@med.va.gov or to kathleen.stack@med.va.gov. 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 Headquarters via email at beverly@societyhq.com or by phone at (804) 565-6321.

A Message from the Editor

Prescriptions And Marketing: Whose Data Is It Anyway?

By Kathleen M. Stack, MD, DFAPA

Kathleen M. Stack, MD, DFAPA

I was surprised to learn that my prescribing patterns are a commodity which can be bought and sold by others without my permission. I was aware that my credit card company, internet provider and grocery store track my purchases, shopping sites and favorite toothpaste. However, they provided me with information about how my information would and could be used. I admit, they did so in very small print or in a "legalize" link, so I am inclined to make myself read them for this very reason. Some even provided me the option to "opt out" of having my data shared. However, I make the choice to use these services, understanding that my information was going to be used and how. It will be used to try and sell me other things.

The situation with the prescribing practices seems different to me. I did not engage in a transaction with the pharmacy, my patient did so. The information is sold for a profit. It was gained without my consent or any parameters of its use.

The Supreme Court did not support any protection of this data. I was reviewing the APA Office of Communications & Public Affairs email on Friday, June 24, 2011, and was surprised by the following information:

USA Today (June 24, 2011, Biskupic) reports that the Supreme Court "struck down a Vermont law Thursday that prevented pharmacies from selling prescription information for drug marketing purposes, by a 6-3 vote in a closely watched data-mining dispute." The court ruled that the Vermont law "violated the First Amendment by targeting certain information and particular speakers, specifically pharmaceutical manufacturers and so-called detailers who visit physicians' offices and engage in marketing on behalf of drug companies. In an opinion by Justice Anthony Kennedy, the court said, "such pharmaceutical marketing deserved heightened free speech protection that could not be overcome by Vermont's arguments about medical privacy or marketing that may lead to more costly prescription choices."

In a separate article, the *New York Times* criticizes this ruling. They editorialize, "Pharmaceutical companies, which spend billions of dollars a year promoting their products to doctors, have found that it is very useful to know what drugs a doctor has prescribed in the past. Many use data collected from prescriptions processed by pharmacies -- a doctor's name, the drugs and the dosage -- to refine their marketing practices and increase sales." The court's ruling "made it harder for states to protect medical privacy with laws that regulate such practices. The court's majority unwisely narrows the gap between commercial and political speech, and makes it harder to protect consumers."

The same day, National Public Radio reported on the topic. Their report on the ruling focused on the planned use by tobacco companies to fight the new more graphic warning labels. They would be using the "free speech" of their advertising. While I disagree with this, it made as much sense to me as the Court's decision. The rational is the same. They would be protecting the free speech of cigarette makers and their vendors.

I reviewed several other national and trade publications that discussed the implication of the ruling. Neither those in support of, nor against, the ruling mentioned that the physician may have some concern about this process.

If the opportunity was given, I would "opt out" of this.

New PSV Members

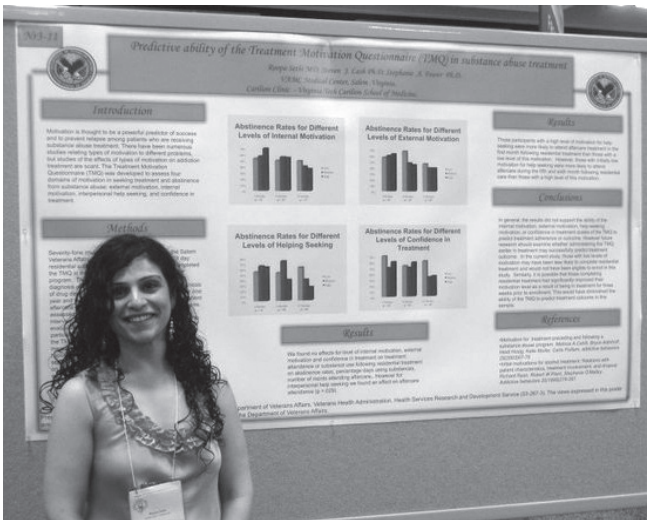
Laura L. Harvatine, MD.....Chantilly, VA
David H. Millis, MD.....Gainesville, VA
Mark R. Vanelli, MD .....Dulles, VA, VA
Constantine D. Elliott, MD Chesterfield, VA
Saba Syed, MD.....Roanoke, VA

APA Annual Meeting Recap: A View from a Resident

Roopa Sethi, MD
MIT Representative to PSV Board

Excited about going to Hawaii from Virginia, I hopped onto the aircraft with three other co-residents to attend the APA meeting. However, because of some technical difficulties in the plane, we were emergently landed at Atlanta and ended up missing the connection to Hawaii. I panicked as I had two of my poster presentations the next day. I could not get a connecting flight as they disclosed that there was a psychiatric conference in Hawaii with 19,000 attendees (of course, the APA) and they were totally booked. I felt sad as I thought that I had missed the poster presentations that I had been working on for months. In my desperation, I called the APA helpline. A very co-operative female representative answered my call and stated, "No problem doc, we will move your posters to the next day." I felt comforted and remedied.

I did not use the free poster printing option that APA offered for all residents. I envisioned that others had used that and were travelling light. I then learned that the poster printing service at APA is an excellent and sophisticated approach to traveling gracefully.



Roopa Sethi, MD PGY IV, Chief Resident, Carilion Clinic-VTC School Of Medicine, pictured in front of her poster during the APA Annual Meeting.

We eventually made it to Hawaii. The warm breeze, the floral outfits and the smiling and beaming Hawaiian faces welcomed us. I went promptly to the conference where I presented my posters. The conference hall was capacious and was packed with hundreds of people. The registration kiosks were there just like an airline check in. You could print your badge on the various printers attached. A blue APA bag, along with a detailed book of the schedule, was provided to all on registration.

Attending the APA Annual Meeting in Honolulu, HI are from left: Echezona Anunobi, MD; Imran Hassan, MD; Roopa Sethi, MD, Chief Resident and Yuri Simonenko, MD, from the Carilion Clinic-VTC School Of Medicine.

The poster hall was huge, with about 100 posters exhibited. I quickly displayed my poster and realized that attendees had started pouring in. The detailed schedule book had the list of the posters with the sub-specialties, the title and the poster number and physicians with an interest would stop by the poster with queries. There was a committee of psychiatrists who judged the posters. Engaging and appealing research posters were awarded the Best Resident Award. The list of the awarded posters is on the APA website. It was a distinguished learning experience, as I met psychiatrists from all over the United States and also from different regions of the world. This was the first resident poster competition that APA ever had.

The consecutive day, APA organized a Chief resident's conference. Chief residents from all over the United States had arrived. At the beginning of the conference, we all completed the Myers-Briggs personality evaluation forms and our personalities had been determined. This was an entertaining conference to attend and included sessions about knowing your personality, dealing with the difficult resident and dealing with conflict, etc. Savory breakfast and lunch was provided. This program was sponsored by Eli Lilly and each chief received $1,000 to travel and attend the conference. This was held in the Ala-Moana Hotel.

Besides this, APA had bountiful seminars and lectures. There were lectures on motivational interviewing, mindfulness, yoga meditation, and compulsive hoarding, which were all interesting and informative. Some of these seminars and lectures were free and others were paid courses. I also attended a few lectures on buprenorphine. The main hall also had a virtual hallucinations machine, where you could experience the hallucinations similar to what our patient's experience.

I stayed about four days in Hawaii and, in addition to attending two poster sessions, a chief resident's conference and multiple lectures, I experienced the feel of the Hawaiian life as well. The beach was walking distance from the conference center. I took a Hawaiian cruise, with loads of Hawaiian dancing and food that was delicious. I also took a bus tour and saw the beautiful beaches, Dole factory, along with the famous Buddhist temple of Hawaii. I personally think this trip was full of education, learning and entertainment.

An APA conference is a must for all residents to attend before they graduate from their residency programs. The next APA conference is in Philadelphia, another interesting place to visit and another opportunity for residents to participate in workshops and poster competitions. We hope to see you there.

Maintenance of Certification

John P. D. Shemo, MD, DFAPA
PSV Assembly Representative

As most of us are aware, as part of the last election for APA officers, there was a referendum included which addressed the issue of the American Board of Psychiatry and Neurology (ABPN) attempting to significantly increase both the requirements and the expense for maintenance of certification. This referendum arose out of the Assembly, with assembly members gathering the required signatures to ensure that the issue was put to a vote.

Eighty percent of those APA members who voted in the election supported the referendum, which was worded to require the Board of Trustees to confront this issue with the ABPN. This was a higher percentage and absolute number of votes than any of the winning candidates for national office received. Unfortunately, the by-laws require that 40 percent of all those eligible to vote do so for a referendum to pass, regardless of the plurality of those actually voting who vote for the referendum. Obviously, the same standard does not apply for officers to be chosen in the same election. Since 40 percent of eligible voters never vote in an APA election, it would be extremely difficult to change the by-laws, as such a change would itself require a referendum again needing the 40 percent turnout.

In response to this dilemma, a number of assembly members established an assembly caucus entitled "The APA Caucus on Certification, Licensure, and Professional Regulation" to monitor both the ABPN and the actions of the Board of Trustees, reemphasizing that we are very serious in our intent that our concerns be heard and that both these groups understand the necessity that they only "govern with the consent of the governed."

Several key points that contribute to the understanding of the dynamics of this interaction include:

• The ABPN is a for-profit corporation that for most of its existence had only one opportunity to make money from board certification candidates.

• The ABPN now and in the past has charged the highest fees of any specialty board, including the surgical boards, for initial certification. In the past, they have attributed this to the existence of the oral boards. It is noted, however, that they are not lowering the fees with the phasing out of the oral portion of the boards.

• Around 1990, the ABPN expanded its role with the requirement that psychiatrists need to repeat a cognitive exam every ten years for both their specialty board certification and all subspecialty certifications they have attained.

• Now, the ABPN proposes a "continuous process" that will be far more onerous or us and fee generating for them, than that which presently occurs. They are currently proposing a fee of $1,500 for the maintenance of certification exam, or the alternative option of $175 each year ($175 times 10 years equals $1,750).

• There have been further concerns expressed that this expansion is being supported by some psychiatrists who are in position to obtain CME credit availability for programs of continuing medical education they will prepare and wish to "sell" to clinicians to replace CME credit programs that used to be supported by the pharmaceutical industry, as CME requirements are expanded.

• As psychiatrists, we have particular concern about the requirement for what are in fact "patient testimonials" which will have to be solicited. While the ethics committee of the APA has judged that they do not view these requirements as a boundary violation, many, probably a clear majority, in the assembly believe that a boundary violation is exactly what this is.

• The PSV Board recently supported a resolution presented to the AMA House of Delegates regarding maintenance of certification issues. The resolution stated that: "our American Medical Association representatives to the American Board of Medical Specialities (ABMS) urge that specialty societies obtain membership endorsement for any changes in the maintenance of certification requirements." Resolution 321 failed to pass based on the spurious argument that even though specialty societies appoint members to the ABMS, these representatives on the Board of ABMS have a fiduciary responsibility only to the Board. That is like saying that elected members of congress don't represent their constituents. Nonetheless, the debate on the resolution did raise awareness on an issue that will not go away.

• The above occurred in the context of the fact that the CEO of the ABPN receives a yearly salary of $500,000 for doing a job with none of the pressure or liability of patient care. Other members of their equivalent of an executive committee are also paid quite well. It is an economic reality that when a price is being paid, especially a high price, something is being bought and something is being sold.

• A final concern being expressed by many practitioners has to do with "Board splintering" of specialty groups. That is, more and more subspecialty certifications are being created by the specialty boards with the knowledge that managed care organizations increasingly use specialty and subspecialty board certification as a prerequisite for reimbursement for the provision of certain services or the provision of any services to specified patient populations. This, or course, more and more limits the general specialist's ability to obtain reimbursement for the provision of specific services to specific populations despite years of experience in doing so when such services were considered a "core competency" of the general specialty. It is noted that this is as large a problem for other medial specialty areas, such as cardiology, as it is for us.

• This approach allows the managed care organizations to limit access (they do not need to deny care when no "properly credentialed" specialists are available, even as they continue to reimburse primary care physicians for treated the same patients). It also expands the scope of the specialty boards as specialists need to obtain and pay for the certification, recertification, and "continuous learning" in more and more subspecialty areas to maintain a diversified practice.

• To end where I started, the ABPN is a privately held, for-profit corpora-tion. It apparently has a business plan to increase its profits. Like Enron Corporation, the mortgage industry and the banking industry, we can expect them to tenaciously hold to their business plan until and unless enough push-back is exerted by those who are their profitability targets – us and our patients.

• As a disclaimer, neither I nor the Assembly caucus is in any way opposed to maintenance of competency for all physicians, including psychiatrists. What we oppose is what has been described and discussed above.

APA Assembly Update

APA ASSEMBLY MEETING Spring 2011 • Honolulu, HI

John P. D. Shemo, MD, DFAPA
Ram Shenoy, MD, DLFAPA
Assembly Representatives

The Assembly Meeting, held prior to the scientific meeting in Hawaii, addressed a variety of important issues critical to the APA membership. Unfortunately, a segment of the assembly representatives made the choice not to attend the meeting in protest of the selection of Bishop Desmond Tutu as convocation speaker by current APA President, Carol Bernstein, MD. While I certainly understand these members' reasoning in the matter, I personally think that, as elected representatives, should have attended the assembly meeting and then, if they chose, boycott either the convocation or the entire scientific meeting.

As feared, the attendance for the scientific meeting in Hawaii was rather low. Traditionally, the best attendance occurs when the meeting is held in New York, San Francisco, or Toronto. Given the importance of the scientific meeting, as both a revenue source and a "tribal gathering," it has been argued that the meeting should rotate among these three sites.

I will, however, note that holding the meeting in Hawaii was the end product of years of lobbying by Jeffrey Akaka, MD, who has provided great service to the APA and American Psychiatry by using his political knowledge and connections (he is the nephew of U. S. Senator Akaka) to help block the signing into law of a psychologist prescribing bill in Hawaii. The meeting had the benefit of allowing the APA to present a certificate of appreciation to Hawaiian Representative Ryan Yamane, Chair of the Health Committee and Vice-Chair of the Consumer Protection Committee of the Hawaiian House of Representatives. He is a strong supporter of adequate training for clinical privileges. Additionally, Neil Abercrombie, the Governor of Hawaii, and the person able to veto further psychologist prescribing bills, also addressed the assembly.

Reports related to electronic health records in psychiatry were presented to the assembly, including the challenges of expense and implementation, especially for small practices, of issues related to privacy and security and the reduction in documentation quality due to cut and paste templates. A recent large study demonstrated no difference in prescriptive errors between handwritten prescriptions and e-prescribing systems.

The finances of the APA are in overall good health. Revenues for last year were below budget by $4.6 million, but expenses were below budget by $8 million. Revenues for the Annual Meeting will be down due to the relatively low turnout in Hawaii. However, it is interesting that revenues from DSM-4 have been increasing despite the fact that it will be replaced by DSM-5 in 2013. Reserves are around $60 million, which is about one year's operating expense for the APA. One year of revenue reserves is a benchmark of financial health for non-profit groups.

Rebecca Patchin, MD, past Chair of the American Medical Association Board of Directors, addressed the assembly. It was reported that the strength and influence of the APA delegation to the AMA has never been greater. Dr. Jeremy Lazarus, former Speaker of the APA Assembly, is running unopposed for AMA President. It has been almost 100 years since a psychiatrist has been AMA President. Patrice Harris, MD, from Georgia, is running for a seat on the AMA Board of Trustees.

A report was presented on the Partnership for Workplace Mental Health, a very effective initiative, that came out of the efforts of the Assembly. It was pointed out that many businesses are concerned about too many employees getting care for psychiatric disorders from primary care practitioners by the wish of their insurance companies, but to the detriment of the company's workforce. Obviously, these companies need to be telling this to the managed care organizations with which they or their contracted insurance companies outsource.

Finally, a variety of action papers were considered and debated by the Assembly. This included papers that:

• Opposed legislation in several states that would allow guns to be carried on college campuses. It is interesting that Florida has passed legislation barring physicians from asking patients about firearm possession.

• Opposed the use of automatic prescription refills (APR's) except where approved by both the patient and the prescribing physician.

• Advocating for the position that the use of the diagnostic and statistical manual multiaxial system for the purpose of determining "medical necessity" (denying reimbursement if the GAF is above a certain level) is incompatible with the concept of parity.

• Urge the APA Board of Trustees to very clearly communicate to the American Board of Psychiatry and Neurology (ABPN) Board of Directors about APA member dissatisfaction with the proposed maintenance of certification requirements.

• Urge the APA Board of Trustees to advocate with the ABPN regarding the excessive cost of certification by the ABPN. It is noted in this regard that the cost of board certification in psychiatry is the highest of any specialty, including the surgical specialties.

• Request that the APA develop a "train the trainer" program for psychiatrists who are interested in doing DSM-5 training for other psychiatrists and allied health professionals.

• Request that the principle that there should be no restriction for psychiatrists on the use of E/M (evaluation and management) codes inform the APA's efforts to reform CPT codes. It is noted in this

Continued on page 6

Coventry/Southern Health/MHNet Update

John P. D. Shemo, MD, DFAPA
PSV Assembly Representative
Chariman, PSV Managed Care Liaison Committee

Visit the PSV website (www.psva.org) for the latest iteration of the dialog between Coventry/SouthernHealth/MHNet and the Psychiatric Society of Virginia/American Psychiatric Association regarding our efforts to encourage them to begin to comply with the mental health parity law, which they seem to wish to ignore.

As you may be aware, Coventry has been rated as the worst health insurance company in the country in regard to physician relations by the UVA sponsored journal, *Physicians' Practice*. It is interesting to note that now they rate only the "best in the country" and no longer rate the worst.

The PSV is in the forefront of APA district branches in confronting the problem of managed care organizations that are trying to avoid compliance with parity legislation and the collusion of both political parties with their doing so since the health insurance industry is the largest contributor to both political parties.

In any case, this above-referenced letter, which is a product of the APA Work Group on Health Care Reform and Parity, is an excellent example of the efforts of the APA to advance the interests of both our patients and our membership. I think you will find this letter both highly informative and, in its own way, amusing.

APA Assembly Update

Continued from page 5

regard that the SRG code for psychotherapy is 1.6 – the same as a nurse taking a blood pressure with no physician supervision.

As always, Ram and I are continuously open to feedback from the PSV membership regarding potential action papers designed to address the concerns of the membership, our patients, and their families.

Area 5 MIT Deputy Representatives

Area 5 MIT Representatives:
Nina Kraguljac, PGY-3
University of Alabama-Birmingham
E-mail: **nkraguljac@uab.edu**

Molly Ryan, PGY-3
University of Miami-Jackson Memorial Hospital
E-mail: **Mryan@med.miami.edu**

To all Residents and Fellows:

I'd like to introduce your Member-in-Training Representatives from the APA Assembly. The APA Assembly is an elected body of representatives who are charged with representing, serving, and bringing to the attention of the APA Board of Trustees the needs and concerns of the association's district branches. The U.S. and Canada are divided into 7 Areas, and the Psychiatric Society of Virginia is within Area 5. Each Area selects two members-in-training (MITs) to serve as MIT Representative and MIT Deputy Representative.

Your MIT representatives serve on the Assembly Committee of Members-in-Training (ACOM), and serve the vital role of making sure that the MIT voice is represented in the governance of the APA. MITs represent 12% of the membership of the APA, and your opinions and positions on various issues facing the organization are important. In the past year, ACOM has worked to:

• Advocate for a strong position statement by the APA on the management of potential conflicts of interest between psychiatrists and the pharmaceutical industry;

• Begin work on developing a guide for residents new to the United States as they navigate the transition from medical school to residency;

• Ensure that the American Board of Psychiatry and Neurology is aware of general MIT dissatisfaction with the disproportionately high fee structure for the new Initial Certification Exam;

• Increase the involvement of medical students interested in psychiatry within the APA.

In the coming year, many important issues are facing psychiatry, and we want to hear from you to ensure that we are accurately representing MITs on the issues that are important to you. In particular, we will be working to enhance APA resources for the transition to practice from residency training, survey members-in-training to determine how relevant the APA is to you, provide comments and feedback to the DSM-5 committee in the development of the new DSM, and advocate for psychiatry and our patients in important legislative issues that arise locally and nationally.

Please do contact your representatives to let them know how they can best represent your needs, or if you'd like information on how to be more involved with the APA. We'd love to hear from you!

WHY BECOME AN APA FELLOW?

- Being a Fellow is an honorary designation that was created by the APA Membership Committee and Board of Trustees to recognize early career members who have demonstrated allegiance to their profession and commitment to the on-going work of the Association.
- Fellows are permitted to use the FAPA designation on all of their professional documentation.
- All newly appointed Fellows are publicly recognized at the Convocation of Fellows and Distinguished Fellows, which is held every year during APA's Annual Meeting.
- Fellows receive a lapel pin as a symbol of their status and an embossed Fellow certificate to display with pride in their office.

The deadline for Fellowship applications is September 1.

How Do I Apply? Visit **http://www.psych.org/Resources/Membership/FellowsDistinguishedFellows.aspx**

Beyond the Agonist Recognition Site: Reinventing Psychiatry as a Translational Discipline of Clinical Neuroscience

Stephen I. Deutsch, MD, PhD
Ann Robinson Endowed
Chair in Psychiatry
Professor and Chairman
Department of Psychiatry
and Behavioral Sciences
Eastern Virginia Medical School
Norfolk, Virginia

Although we must aggressively eschew becoming a "mindless" discipline, I feel strongly that Psychiatry's best chance for survival as an economically-viable academic medical specialty will depend on successfully redefining itself as a clinical discipline of translational Neuroscience. Clearly, lectures, seminars and required readings on modalities of psychotherapy, empirically-derived principles of psychosexual and psychosocial development, psychoanalytic constructs, and the influence of cultural and social factors on development and personality, among other topics, must be represented in the curriculum of our medical students and residents. However, this representation must be balanced with sufficient room and time allotted for formal and required classes in topics that may have equal or more relevance to the future of our field, such as molecular genetics, neurochemistry, neuropharmacology, functional brain imaging and functional anatomy of the cerebral hemispheres, and cognitive neuroscience. Increasingly, we will be challenged as a specialty to demonstrate our effectiveness and value, which may require us to more sharply differentiate our portfolio of professional activities from that of our nonphysician mental health colleagues. Importantly, we must be prepared to demonstrate favorable effects of our interventions on functional outcomes. I also think that a changed emphasis in our undergraduate medical student curriculum may make our specialty more attractive to graduating seniors; of course, current choice of specialty is confounded by the enormous burden of educational debt incurred by so many of our medical students. However, our patients deserve nothing less than recruiting larger numbers of the best and brightest graduating medical students into our field; also, our field would be invigorated with the infusion of larger numbers of graduates, whose thinking is informed by the relevance of basic neuroscience to clinical practice. In fact, the curriculum has changed both in terms of content and emphasis over the past 34 years that I have been in Academic Psychiatry; however, my recent participation as a panelist in a Symposium at the annual meeting of the APA dealing with the teaching of psychopharmacology to residents convinced me that this is occurring too slowly and our field still has a long way to go!

As an example, medication development over the next several decades will include focus on pharmacological targets beyond the almost exclusive current focus on the "agonist recognition site" that is located on the extracellular surface of the cell, and will be informed by the explosion of information arising out of molecular genetics and bioinformatics. Although small molecule candidates that mimic the ability of endogenous ligands, such as neurotransmitters, to bind with selectivity, high-affinity and saturability to agonist recognition sites have certainly been developed as effective medications for many indications, they have limitations and are often less than fully effective. Importantly, the electronic architectures of "druggable" agonist recognition sites that recognize these exogenously, usually orally administered, small molecules are similar across classes and subtypes of receptors that are widely distributed in both the brain and periphery; for example, there are many kinds of ligand-gated ion channel receptors and G-protein coupled receptors (GPCRs) that recognize the excitatory amino acid glutamate. The agonist recognition sites for many of these classes and subtypes of "glutamate receptors" have conserved structures. Thus, competitive glutamate agonists and antagonists may lack sufficient selectivity, which can cause severe and frequent adverse medical side effects and intolerance, outweighing any desired therapeutic effects. Also, most small molecule drugs that are administered orally achieve steady-state blood levels and provide tonic stimulation of the drug's binding site, which can result in changes in "sensitivities" of diverse receptor populations throughout the body. Importantly, orally administered medications do not mimic the normal physiological patterns of spatial and temporal release of the endogenous ligands they are designed to "compete" with; most often, neurotransmitters are released in bursts in a depolarization and calcium ion-dependent manner as trains of action potentials moving along axonal projections invade the nerve terminal within specific neural circuits. Therefore, newer medication strategies are trying to more closely model the physiological spatial and temporal patterns of an endogenous ligand's release, in addition to more selective interactions with specific receptor complexes and signal transduction pathways located within specific neural circuits. A popular strategy involves development of positive and negative allosteric modulators (PAMs and NAMs); these are small molecules that bind to sites distinct from the agonist recognition site itself (usually sites located within the receptor's transmembranous hydrophobic domain) that act only in the presence of the endogenous ligand to increase (i.e., a PAM) or decrease (i.e., a NAM) the likelihood that the endogenous ligand will have a receptor-mediated biological effect. Specifically, these allosteric modulators affect the efficiency of coupling between binding of endogenous ligand and biological effect (e.g., channel opening or cAMP production). Other strategies include taking advantage of "cross-talk" between receptors that are functionally coupled to each other on the surface of the cell. Thus, a metabotropic glutamate receptor, which is a specific example of a class of GPCR, may influence the sensitivity of an NMDA receptor, which is a specific example of a glutamate-gated ion channel receptor, by regulating the extent to which specific serine residues on a subunit of the NMDA receptor are

Continued on page 12

In The News

IN MEMORIUM

Catherine Woods Richard Smith, MD

Catherine Woods Richard Smith, MD, age 98, passed away peacefully on January 7, 2011. Dr. Smith was a graduate of Handley High School in Winchester, VA, and attended Virginia Intermont College in Bristol Virginia. She went on to graduate from the George Washington University School of Medicine in 1941 and completed her medical internship at Garfield Memorial Hospital in Washington, DC. While her husband, Charles Willoughby Smith, whom she married in 1939, was called to active duty during World War II, Dr. Smith took special training at Bethesda, MD in order to join the U.S. Public Health Services. She lived in Virginia, serving first in Richmond and then in the southwest part of the state. She was the first female physician to be named Director of Public Health, serving Bristol, Washington and Smyth counties. In 1946, she took a general residency at Johnston Memorial Hospital in Abingdon and practiced Gynecology and Obstetrics for nearly 20 years, delivering hundreds of babies across southwest Virginia. In 1964, she went to New York City to complete a residency in psychiatry at New York Medical College. Returning to Abingdon in 1968, Dr. Smith became the first Director of the Mental Health Clinic in Marion, VA. In 1980, she began a private medical practice in Abingdon, where her focus was holistic and mental health. She retired in 1993. Dr. Smith served as President of the Washington County Medical Society and was a founding member of the American Holistic Medical Association.

Frederick G. Woodson, MD

Frederick G. Woodson, MD, 95, of Norfolk, VA, died peacefully surrounded by his loving family on Friday, September 24, 2010. He was a native of Covington, VA.

Dr. Woodson graduated with a Doctor of Medicine degree from the University of Virginia in 1938. His Internship training was at St. Elizabeth's Hospital, Richmond, VA from 1938-1939 and his Residency at the University of Virginia, Department of Neurology and Psychiatry from 1939-1942 and Residency at Boston City Hospital, Neurological Unit 1942-1943. He entered the United States Army Medical Corps in 1943 and attained the rank of Major at his discharge in 1946.

Dr. Woodson was in private practice from 1947 to 1985 in Norfolk, VA in Neurology and Psychiatry.

He was a Past President of the Neuropsychiatric Society of Virginia, and a member of the American Medical Association, American Psychiatric Association, American Academy of Neurology, Southern Psychiatric Association, Psychiatric Society of Virginia, Medical Society of Virginia and the Norfolk Academy of Medicine.

Help for Veterans, Service Members & Their Families

Every day, about 3,000 veterans and military families separate from military service. The rate of unemployment and homelessness among this group is much higher than for civilians. *Community Blueprint*, a new tool and initiative, can help local leaders improve their communities' support for veterans, service members and their families in the areas of education, employment, mental health, reintegration, and financial and legal services. *Community Blueprint* was developed by a coalition of national organizations including American Legion Auxiliary, American Red Cross, America's Promise Alliance, Armed Forces Services Corporation, Blue Star Families, Give An Hour™, Military Child Education Coalition, Military Officers Association of America, National Military Family Association, Operation Homefront, Points of Light Institute, ServiceNation: Mission Serve, the Tragedy Assistance Program for Survivors and the Veterans' Innovation Center. On June 21, this coalition signed an agreement with Points of Light Institute to lead and administer the *Community Blueprint* initiative. Points of Light Institute will lead this coalition to further refine the tool and roll it out to community leaders in the service sector. Two national organizations that serve on the coalition, Give an Hour™ and Military Officers Association of America (MOAA), are testing the tool at demonstration sites in Norfolk, VA; at Fort Bragg in Fayetteville, NC; Tyler, Texas; Huntsville, TX; and Valdosta, GA. At these locations, the organizations are exploring how to best support the community in their efforts to meet the needs of service members, veterans and their families.

Tidewater Academy of Psychiatry

Charles Devitt, MD
TAP Chapter President

Twenty psychiatrists and their guests attended the "resurrection" party of the Tidewater Academy of Psychiatry. Jerry Blackman and his wife, Susan, graciously opened their home for this social event, held on Saturday, June 25. The gathering brought together psychiatrists across a range of practice settings, including residents from EVMS and the Naval Hospital, private practitioners and CSB physicians. The "seasoned" psychiatrists among us had the opportunity to become reacquainted. We look to build on this event as we decide among the various social, educational, networking or service purposes TAP may evolve.

Coalition Board Meeting

The next board meeting of the Coalition for Citizens with Mental Disabilities will be in September. Please contact Dr. Helen Foster at HFoster160@aol.com with inquiries.

The New APA-Endorsed Medical Malpractice Program

The American Psychiatric Association has changed malpractice insurance carriers.
If you are not already insured with the American Professional Agency, Inc.
don't get left behind!
Join your fellow members who have found their protection with the
APA-endorsed insurance product that best serves their needs.

Program Enhancements

- **New LOWER rates**
- **Years in APA's prior program count towards tail coverage**
- **Fire Damage Legal Liability included**
- **Occurrence and Claims-Made forms available**
- **Information Privacy Coverage (HIPAA) included**
- **Internet/Telemedicine included**
- **Licensing Board Coverage with no aggregate**
- **Interest Free Quarterly Payments/Credit Card payment is available**
- **10% Discount for New Insureds who are claims-free for the last six months**
- **10% Claims Free Discount if you have been claims free for the last ten years**
- **No Surcharge for Claims**

To go to our Website
Scan Here

American Professional Agency, Inc.

877-740-1777

www.apamalpractice.com

Legislative Update

PSV Brings Issues to MSV Legislative Summit

Cynthia C. Romero, MD, FAAFP
President, Medical Society of Virginia

Cynthia C. Romero, MD, FAAFP

Each Spring, the Medical Society of Virginia (MSV) hosts a legislative summit during which any member, local or specialty medical societies, may present proposals that they would like to be considered as a part of MSV's legislative agenda. At the Summit, these ideas are debated and discussed, allowing members to present multiple perspectives as to how MSV can serve the interests of physicians and patients. This event presents an excellent opportunity for physicians to influence the future legislative agenda of MSV and to network with colleagues.

This year's Summit took place on Wednesday, May 11 at MSV's Richmond Headquarters. I was pleased to see nearly 70 MSV members, local and specialty medical societies representatives and the current class of the Claude Moore Physician Leadership Institute, gather to present and discuss proposed issues for MSV to consider for its 2012 agenda.

This year, the Psychiatric Society of Virginia (PSV) was represented by PSV lobbyist, Cal Whitehead. Your Society brought forward the following issues:

- Exploring ways to ensure that insurance companies cover prescriptions for patients on stable, effective regimens
- "Physician title" protection for those who have earned an "MD" or "DO"
- Preventing health plans from rejecting the use of certain E&M CPT codes, particularly those used by psychiatrists and other physicians for claims submitted for psychiatric care

Delegate O'Bannon and Frank Royal, Jr, MD continue their debate on healthcare while Owen Brodie, MD, PSV Past President is introduced to Delegate Garrett, MD.

- Prior authorization reforms to address the increased demands from health plans for prior authorization for medications and procedures in recent years

Other issues that colleagues from other specialty and local societies presented include:

- "Truth in Advertising" for health professionals to ensure patients know which provider is caring for them (i.e., physician, nurse practitioner, psychologist, physical therapist, etc.)
- Ensuring third party-payers meet their responsibilities to insured members
- Development of a strategy to protect patients from the threat of inadequately trained providers performing outpatient surgery
- Certificate of public need reforms
- Extension of malpractice reporting requirements to all health professional licensees
- Continued opposition to cost controls in workers' compensation cases

MSV's legislative committee will review the collected input and forward its recommendations to the MSV Board as to what should be included on MSV's legislative agenda for 2012. To inform its decision-making, legislative committee members will rely upon feedback from the summit participants, review of existing MSV policies, current statutes, and other research prepared by staff.

The legislative committee will meet on June 30. The MSV board will review the committee's report at and forward its recommendation to the MSV House of Delegates which meets during MSV's annual meeting. If you are interested in attending as a delegate and participating in this process, please contact your PSV leadership or your local medical society.

Collaboration leads to success

MSV's legislative accomplishments this year were significantly influenced by the collaboration between MSV and specialty societies. Specialty society lobbyists met with the MSV government affairs team each week during session to discuss strategies for advancing shared health care issues in the General Assembly.

This year, we successfully worked to pass legislation that preserves the medical malpractice cap and codifies the agreement between MSV, the Virginia Hospital and Healthcare Association (VHHA) and the Virginia Trial Lawyers Association (VTLA). The agreement maintains a total cap for the next 20 years with $50,000 annual increases beginning July 1, 2012. This legislation will ensure a fair and reasonable medical tort system in Virginia and will help the commonwealth attract and retain physicians.

The subject of additional negotiation between MSV, VHHA and VTLA was the privilege and discoverability issues stemming from the 2006 Virginia Supreme Court case Johnson v. Riverside. The legislation establishes needed protections for the peer review and quality assurance processes in physicians' offices and in-patient and out-patient hospital care that result in patient safety improvements while allowing facts and incident reports that are included in a patient's medical record to be discoverable in litigation.

Delegate O'Bannon (left), Delegate Garrett, MD (center) and Frank Royal, Jr., MD discuss mental healthcare issues.

In addition MSV and our specialty partners were able to:

- Work with a coalition of organizations this year to successfully prevent the scheduled four percent cut to Medicaid physician payments that was scheduled for July 1
- Prevent legislation that would require the Board of Medicine to license and regulate naturopaths
- Advance legislation that prohibits tying physician licensure to health plan participation
- Reach an agreement with the Virginia Council of Nurse Practitioners to explore team-based models that would allow all providers to work to the full extent of their education and training. These talks are aimed to ensure patient safety through appropriate physician supervision and efficient delivery of care.

Also resulting from the 2011 General Assembly session is a partnership between MSV, other provider groups and a community-based coalition in Southwest Virginia to offer four free substance abuse forums this summer. These will educate health care providers, prescribers and pharmacy professionals on current best practices on how to prevent, identify, and treat prescription drug abuse. Registration and more information at http://www.etsu.edu/com/cme/.

Other Resources for Physicians

On September 21, 2011, MSV will host its second *eHealth Roundtable* with new content and speakers. This event will be held in Norfolk in conjunction with the Virginia Medical Group Manager's Association Fall Meeting. Attendees will have access to the most up-to-date information on meaningful use and health information exchange. Featured speaker is David Hunt, M.D., CMO, of the Office of the National Coordinator. For more information, visit www.msv.org/ehealthroundtable.

I hope you will consider getting involved with MSV in some capacity. We are the only organization in Virginia that represents all physicians and we want your involvement and input. Attending events like the Legislative Summit, Annual Meeting or educational events are great opportunities to see what MSV has to offer. I think you will be excited to learn about our vision for the future and encourage you to join us in our work to make Virginia the best place to practice medicine and receive care.

2011 General Assembly Primary Summary

Cal Whitehead
PSV Advocacy Coordinator

The lineup of candidates for General Assembly elections will be set August 23, when primary elections will be held in 18 House and Senate districts. The House of Delegates is expected to remain in GOP control; not even the optimistic Democrats are predicting a change in partisan control in the 100-member chamber.

That puts the focus on the Senate of Virginia, where Democrats hold a 22-18 majority. If enthusiasm counts, Republicans appear to have momentum. Consider this – even though challenging a sitting incumbent is one of the most thankless tasks in politics, GOP candidates are lining up for the chance to take on sitting Democratic Senators.

Pictured from left: Varun Choudhary, MD; Cal Whitehead, PSV's Lobbyist and Frank Royal, Jr., MD after the MSV Legislative Summit.

Two or more Republicans are vying for the GOP nomination in these five Democratic-controlled districts:

- Northern Virginia: Democrats Toddy Puller (Senate District 36), George Barker (Senate District 39) and David Marsden (Senate District 37)
- Southwest Virginia: Democrat John Edwards (Senate District 21)
- Tidewater: Democrat Ralph Northam, MD (Senate District 6)

(You can find a complete listing of primary candidates in your area at http://www.vpap.org)

At least one Republican has filed against ten other incumbent Democrats and there are two open seats that were previously held by Democrats. The result is a very busy Summer and Fall for the Democratic Party in Virginia. By late August, Democratic officials say many of the 18 Senate Republicans will have challengers in the November election. For now, however, there is no district where more than one Democrat has signed up for the task.

This year, Republicans running in Senate primaries appear more focused on defeating Democrats. In the last two cycles

Continued on page 12

Legislative Update

2011 General Assembly Primary Summary

Continued from page 11

(2007 and 2003), the primary season was dominated by efforts by Conservatives to topple moderate GOP Senators. This year, only one Republican incumbent, Sen. Tommy Norment (James City), faces a Tea Party-inspired challenge. Stay tuned - the primary field will be decided on August 23.

PSV Participates in Physician Roundtable with U.S. Senate Candidate George Allen

Ralston King
PSV Advocacy Assistant

This month PSV President Adam Kaul and PSV Legislative Representative Varun Choudhary joined a group of other physician leaders in Richmond to meet with U.S. Senate Candidate George Allen in a roundtable forum on healthcare. Former Governor Allen requested the meeting to discuss the current challenges that Virginia physicians face in providing care and managing practices. The discussion included topics ranging from health savings accounts and medical liabil-ity reform to patient access to care and the purchase of health insurance across state lines. Dr. Kaul specifically voiced his opinion on defensive medicine, which should to be addressed through tort reform. Dr. Choudhary expressed the need to reform healthcare by allowing patients to purchase health insurance across state lines to create more choices and value for the patient. The open forum has led to receptive communication between Governor Allen, PSV, and other physician specialities. All parties appreciated this occasion and PSV will look for additional opportunities with other candidates and public officials.

Former U. S. Senator & current Senate Candidate George Allen discusses current challenges and issues that Virginia doctors face with a roundtable of specialty doctors from across the Commonwealth.

Varun Choudhary, MD, FAPA, PSV's representative to MSV and Adam Kaul, MD, FAPA, PSV's President, listen intently to former Governor and Senator Allen.

NAMI Virginia
National Alliance on Mental Illness

2011 NAMI Virginia/Virginia CIT Conference!

September 11-12, 2011 • Virginia Beach, VA

NAMI Virginia and the Virginia Crisis Intervention Team (VACIT) Coalition are teaming up to hold a two day joint conference, being held in conjunction with the 2nd Annual CIT International Conference!

Don't miss out on this exciting opportunity to collaborate and learn from each other on how to build and develop CIT in your community!

To register and for more information please visit:
http://namivirginia.org/get-involved/state-convention
or call **(804) 285-8264**

Beyond the Agonist Recognition Site...

Continued from page 7

phosphorylated. The phosphorylation state of the NMDA receptor can affect the likelihood that glutamate will be effective in promoting channel opening and calcium ion conductance across this ligand-gated ion channel receptor. There is enormous current interest in developing medications that can stimulate specific metabotropic glutamate receptors, whose downstream actions may be mediated by an affect on the phosphorylation status of the NMDA receptor. Other medication strategies may have less to do with the cell surface and much more to do with affecting steps along a cascade of intracellular protein kinase mediated tyrosine phosphorylations that are triggered by transduction of endogenous ligands (such as neurotransmitters or growth factors) at the cell surface, which ultimately leads to activation and translocation of transcriptional factors into the cell's nucleus. Thus, signal transduction often affects transcription and gene expression and new medication strategies may target gene expression; approaches of this type include strategies that affect the availability, lifetime and processing of messengerRNA. Potential targets are emerging from molecular genetic studies of large samples of referred populations. Thus, there is interest in the rare association of microdeletions of chromosome 15q13.3, which contains the locus of the gene encoding the alpha7 subunit of the nicotinic acetylcholine receptor (α7 nAChR), and a variable syndrome whose components may include idiopathic generalized epilepsy, intellectual disability, subtle facial dysmorphism, autism spectrum disorders (ASDs) and schizophrenia. Although very rare, this association supports strategies for targeting the α7 nAChR for the treatment of ASDs and schizophrenia.

The future of Psychiatry is bright, but the profession must be willing to broaden its horizons and, possibly, reinvent itself as a clinical discipline of translational neuroscience that doesn't eschew the mind, but is grounded in the brain. Just a thought!

Indian Sikh Professional Taking Care of Psychiatric Patients

Baljit Singh Gill, MD
Board Certified in Psychiatry, Geriatric Psychiatry and Addiction Psychiatry

I came to this country as a young physician, fresh out of Medical School in India, in 1982. I was looking for better opportunities provided by this great nation on earth. I grew up in the villages and small towns of India. My mother had never been to school as girls in the village were not encouraged to go to school. My father rose from a small village and ultimately ended up as a renowned Agriculture Scientist, and contributed to the Green Revoluation in India. At that time, he was the only boy in the family who had gone to school with the help of the people from his native village. He had to walk over 10 miles daily to go to an elementary school located in another town. My parents and elders guidance helped me to finish medical school in India and later on I expressed the desire to come to America, which they fully supported. Upon entering this country, I had trouble understanding English as it was not my mother tongue. However, my strong faith and desire to succeed helped me to adjust in this environment.

I have been blessed to be working as a Psychiatrist for over 25 years, serving my patients in both community setting and at V.A. Medical Center, Hampton. I remember coming to Eastern State Hospital Residency Program (Oldest program in the State of Virginia) in 1983 as a young physician from India trying to seek training. The Director of Residency Program conducted my final interview, but felt reluctant to keep me due to the physical appearance of a practicing Sikh. I remember having finished the interview process and as I left the office of the Director, he called me by name while looking keenly at my turban, and said, "Dr. Gill, I liked you and am impressed with your interview, but I wonder if you would look more American". I was little perplexed but having had a strong faith inspired by my parents, I replied, "Sir, if you like me, please give me a chance to serve the patients and if my appearance in any way interferes with the patient care, I will leave the program in six months on my own". He immediately stood up from his chair and took me personally to the Human Resources Service so that I can get the necessary contract. At the end of the day, he advised me, that while I am working there, to keep my car windows up during my rounds on the hospital grounds. I am indebted to him for having put his faith in me to serve as a young Psychiatrist at a state facility which housed some of the most difficult to treat patients at that time. The same Director ultimately selected me to be the Chief Resident Physician and also offered all his personal books and notes for me to use or take with me. Interestingly, during those years, I was the only person with a turban living in the Williamsburg area. Due to the recent Iranian crisis, I was often mistaken for an Iranian Mullah by the people. It would have been easy for me to change my appearance by shaving my hair and taking my turban off, but my strong faith encouraged me to be "who I am." However, there were also many times, when people genuinely asked me about my background and I was happy to tell them about my culture and faith. This was my first reminder in the service field that you can make a difference in the lives of people if you trust in them and look for the positives in each other.

Baljit Singh Gill, MD

Over the years, my neighbors, patients and fellow workers have gained understanding of my faith and culture. This provided me the opportunity to serve the community along with other things, as a Rotarian, and to this day I am still an active member of Rotary Club. I served as Club President and currently I am an Assistant District Governor, Rotary District 7600. It provided me the opportunity to participate in the Rotary International Projects such as having youth exchange students from different countries and to build bridges in other countries such as Ethiopia, Peru, Costa Rico, Honduras etc. Thus, I had more opportunity to share my faith and culture with others.

Some of my patients were curious to know about my faith and culture. I did not hesitate to explain them as opportunity arose. I have found that it has built better therapeutic alliance among us. Most of the patients responded positively to this interaction and they showed better response to the therapeutic interventions. Of course, they always remembered me and were keen to comment on the provided care. They were happy to refer more patients to me.

Upon the tragedy of 9/11, the passions towards me became harsher and patients would mistake me for an Arab. I heard more comments and there were times when I sensed that patients were not at ease with me. This was understandable and I continued to serve the patient population. In fact, I ended up working in the Post Traumatic Stress Disorder Clinic, which was quite a challenge. We introduced an orientation session for the patients, in which we will talk about the treatment team members who had different faiths and cultures. It did help to alleviate some of the illogical fears held by patients and their families. Interestingly, lot of my patients started talking about their way of life over the years and how it was for them to be grown up in different cultures and different belief systems.

I do believe that keeping up with my faith and culture, has helped me to be a better psychiatrist as it has challenged me to work hard, have faith in the treatment process and to have better understanding of patient's beliefs and misconceptions. I have found my patients to be not only curious and more attentive and better listeners, especially when I interacted with them. I feel blessed and privileged to serve my patients.

Secondary Traumatic Stress in a Veteran's Administration Setting

Rochelle Klinger, MD, DFAPA

I left home a lifetime ago to drive the distance of a marathon "If I can run one, I can drive one," I said, as if distance were the deal breaker.

No one knew what it would be like, 40 years since the last war, and they weren't welcomed back with yellow ribbons and patriotic slogans.

Soldiers and Marines, four deployments in five years, in the deserts of Iraq and the mountains of Afghanistan. Last summer I reached down to rub my black dog as he lay on the floor. Just for a moment, I saw him dead with blood coming from his mouth..
Ten months later, he was dead, "true, true, unrelated."

I used to shake off the images and pain at the end of the day as a dog shakes off fur, but not here, not now.

I wrote the above after weekend call at Hunter Holmes McGuire VA Medical Center where I'd worked for two years. I was the psychiatrist on the Mental Health/Primary Care Team, tasked with evaluating and triaging veterans referred by their primary care providers for mental health services. Referrals are generated by the VA's outstanding screening tools in the primary care setting for mood disorders, PTSD, substance abuse and suicidality; in addition to clinician or self-referral. More than half of veterans referred served in Afghanistan and/or Iraq (Operation Enduring Freedom/Operation Iraqi Freedom), and the MH/PC team triages over 80% of all veterans entering mental health services at the Richmond VA Medical Center. Nearly a decade of combat in Afghanistan and Iraq has produced large numbers of veterans returning from recent and often multiple deployments. The military has launched a strong effort to destigmatize mental health services through education and active screening of personnel. Members of the active duty military and reserves who are diagnosed with PTSD are frequently treated and re-deployed, often on psychiatric medications. The long-term effect of medications such as SSRI's, zolpidem, and mood stabilizers on the assimilation process of combat trauma is unknown.

The above factors have produced an unprecedented influx of veterans seeking mental healthcare at military facilities and VA medical centers. The Veterans Administration has responded with a corresponding increase in mental health personnel, but the growth of veterans needing services continues to outstrip allocated resources, particularly as the Federal Government struggles to address its debt and budget crisis.

I write in the past tense, because by the time this newsletter is published, I will be a former VA psychiatrist.

In an effort to understand my reaction to this work, I scanned the literature. I learned that I had fallen prey to secondary traumatic stress (STS) also known as vicarious trauma.[1] Clinicians exposed to a higher number of traumatized patients with higher empathic orientation are at the most risk.[2] Characteristically, the therapist re-experiences the patients' traumatic experiences in some of the following ways: flashbacks, dreams, intrusive thoughts or frightening recall of traumatic images. The therapist can also exhibit avoidance of further traumatization by distancing him or herself from patients and reminders of their trauma, such as feeling detached, non-empathic, or even angry. Finally, the therapist can experience increased levels of arousal including anxiety, irritability, and increased startle responses.[2]

The process of clinicians' acquisition of patients' trauma is conceptualized differently in various theoretical orientations. Psychodynamic psychiatry emphasizes countertransference, cognitive-behavioral theory cites changes in schemas and worldview, and brain imaging and neurochemistry posit alterations in neuroendocrine functioning.

Voss Horrell, Holohan, Didion and Vance from the Salem, Virginia VA Medical Center explored specific effects of treating traumatized OEF/OIF veterans on mental health clinicians.[4] They noted the interaction between patient, clinician, and organizational factors that predict the development of STS vs. vicarious stress-induced resiliency. While empirical research on clinicians treating this group of veterans is in its infancy, previous literature and clinician experience suggest some of the following.

Patient Factors That May Increase Risk:

- Younger age
- Higher percentage of females (up to 33%)
- More reservists & National Guard (2x more likely to exhibit PTSD)
- Multiple deployments
- Higher treatment dropout rate (may be related to higher levels of employment than other veteran groups)
- High co-morbidity with TBI, substance abuse
- Higher acuity secondary to proximity of trauma, higher risk of suicide and violence
- Possibility of re-deployment after treatment for National Guard and reservists

Clinician Factors That May Increase Risk:

- Civilian background (unfamiliarity with military culture may contribute to fear & revulsion)
- Military background (risk of over-identification)
- Personal history of trauma in clinicians
- Membership in a historically disadvantaged or traumatized group
- Number of hours spent working with traumatized vs. other patients
- Higher caseload

Protective Factors For Clinicians:

- Social support, especially from co-workers
- Spirituality or other frameworks for meaning
- Higher levels of training and comfort with evidence-based therapies for PTSD
- Implementation of self-care strategies

Continued on page 16

THE PSYCHIATRIC SOCIETY OF VIRGINIA
VIRGINIA NEWS
2209 Dickens Road
Richmond, VA 23230-2005

Secondary Traumatic Stress

Continued from page 15

Organizational Factors That May Increase Risk:

- Assignment to a specialty clinic that sees only traumatized veterans
- Time-based mandates without adequate personnel
- Inadequate support (e.g. clerical and scheduling resources)
- Inadequate time for supervision, peer support, educational activities on a weekly basis
- Institutional culture of shame re: admitting vicarious trauma

Voss Horrell and Holohan, et al recommend implementing protective measures for clinicians who treat traumatized OEF/OIF veterans. These include diversifying and modifying workload (they suggest allowing clinicians control over scheduling and selection of patients to balance workload per day and week); normalizing and addressing STS through peer support and supervision; increasing team cohesion; and emphasizing the professional rewards and satisfaction of serving those who serve our country.

In the paper's summary, Dr. Didion states "working with victims of trauma fundamentally and unavoidably changes the way you see the world."

For me, I suspect a combination of factors led to my secondary trauma syndrome: workload (high numbers, acuity and level of trauma in the population); limited nonclinical time for education and peer support despite a skilled and cohesive multidisciplinary team; and developmental factors from having a parent who was a holocaust survivor. I had hoped that my implementation of self-care strategies was adequate: spousal support, wonderful colleagues and friends, animals I love, living in the woods, and a faith community that supplies meaning and support, but it wasn't enough. Of course, we psychiatrists always need to work on practicing what we preach! Here's hoping my colleagues learn from my journey.

References:

1. Jenkins SR & Baird S (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress*, 15,423-432.
2. Figley CR (2002). *Treating Compassion Fatigue*. New York: Brunner-Routledge.
3. Adams RE, Figley CR, Boscarino JA (2008). The Compassion Fatigue Scale: its use with social workers following urban disaster. *Res Soc Work Pract*, 18,238-250.
4. Voss Horrell SC, Holohan DR, Didion LM, Vance GT (2011). Treating traumatized OEF/OIF veterans: how does trauma treatment affect the clinician? *Professional Psychology: Research and Practice*. 42(1), 79-86.