



2011 FALL MEETING RECAP

By Adam T. Kaul, MD, FAPA

First of all, thank you to all of you who attended the PSV 2011 Fall Meeting. It was a wonderful, well-attended meeting, and I have heard many compliments regarding speakers and exhibits. The meeting was held at Wintergreen Resort, which is always beautiful, even with the fog! We were fortunate to have over 30 young researchers' presentations on display, which made for a fabulous poster session. Kudos to all of the researchers, faculty, and judges who helped make this a very successful part of our program.

Saturday's committee breakfasts were well attended, and the program started well, (in spite of the current President's hoarse voice). Dr. John Shemo started our looking forward meeting by presenting a twenty-five year old report on the future of psychiatry. It was interesting to see how present this report was in many areas, especially regarding the changing roles and financial trends of the "psychiatrist of the future."

Dr. Paul Spector then presented "Psychiatry and Pain Management." Along with a good primer on neuropsychiatric and multimodal evaluation and treatment strategies of pain management, Dr. Spector also discussed medical-legal aspects of the usage of narcotic pain medications.

Our morning session ended with an update on community focused services in Virginia, presented by the Commissioner for the Department of Behavioral Health and Developmental Services, Mr. James Stewart. Mr. Stewart discussed the "Creating Opportunities" plan, which identified the goals of improving statewide behavioral health services in many areas, including emergency response, peer support, substance abuse, developmental disabilities, autism, state hospitals, housing, employment, and case management services.

At our lunch business meeting, we recognized the guests from the Northern Virginia Chapter of the Washington Psychiatric Society; it was nice to have the chapter President, Dr. Valerie Buyse, join us, and we hope to reciprocate soon. We also recognized Drs. Rizwan Ali and James Krag, our newest Distinguished Fellows of the APA.

The business meeting was concluded with a presentation of awards by the panel of judges for the poster session.

Dr. Varun Choudhary opened our afternoon session with "Crossroads of Psychiatry and the Law." He presented an excellent overview of the legal system and tort law, and then gave a refresher course on confidentiality, duty to warn, capacitance, informed consent, and the insanity defense.

Returning to Virginia, from Charleston, South Carolina, Dr. Kevin Spicer presented "The Role of Psychotherapy in Private Practice." He presented a cohesive practice model of psychotherapy in the current financial and teaching environment. Dr. Spicer also presented meta-analysis data showing efficacy of psychodynamic psychotherapy. He made a very good case for continued usage of psychodynamic therapy for all ages, and for the need for continued teaching in our training programs.

Our program ended with Dr. Jack Hettema's presentation "Will Modern Genetics Research Contribute to Psychiatric Practice?" Dr. Hettema discussed the history of genetic research, and how it has evolved over the past few decades. He discussed some of the genes currently identified that are associated with multiple mental illnesses, including autism, schizophrenia, bipolar disorder, and depression. He also discussed the challenges of current genetic research, which is "still in its infancy," and that the practical clinical usage of much of our knowledge is likely another decade away.

Again, I would like to thank all of you who helped make this meeting a success, and wish all of you to have safe and happy holidays.



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A MESSAGE FROM THE EDITOR

Broadening Perspectives May Improve Treatment Options

By Kathleen M. Stack, MD, DFAPA

There have been several recent reports of research findings which piqued my interest. The findings offered possibilities for treatment in areas I had little to offer my patients.

For example, we can all recognize symptoms of dementia. We are trained in the evaluation of dementia to find and eliminate the possible treatable causes. Far too often, there is no cause I can treat. We work to slow the progression of the disease and to provide support to the care givers.

I have more treatments to offer with a diagnosis of schizophrenia; I find, however, that I set goals related to reduction of symptoms or improvement in functioning, but not goals related to "recovery."

The multi-faceted precursors to suicide attempts was something I was trained to assess with every patient. I learned to identify facilitating or risk factors and remove them, while identifying protective factors and supporting them. Never did I consider a parasite as risk factor for suicide.

Anxiety, irritable bowel, asthma and the more nebulous opposite, resilience, were in the psychotherapeutic arena and were impacted only at the margins by the treatment I could offer in a med-check appointment.

However, some new research has infused hope into these diagnoses for me. Or quite possibly, infused hope into me for these diagnoses.

I will give only the briefest overview of the studies for the purposes of this editorial. A full review would require dozens of pages and exceeds my ability to accurately summarize. I selected four examples which intrigued me and required that I adjust my professional views to integrate the implications of each. Each example highlights novel potential treatments for "amorphous" and un- or under-treatable mental health conditions.

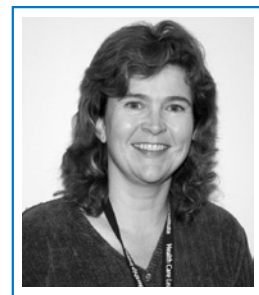
First, the *New York Times* (6/17/11) reported that "Scientists have designed a brain implant that restored lost memory function and strengthened recall of new information in laboratory rats. This is a crucial first step in the development of so-called neuro-prosthetic devices to repair deficits from dementia, stroke and other brain injuries in humans." The article continued with, "While still a long way from being tested in humans, the implant demonstrates for the first time that a cognitive function can be improved with a device that mimics the firing pattern of neurons."

The second report (Arch Neurol. 2011 Sep 12) showed improvement in cognitive functioning in those with mild cognitive dysfunction and Alzheimer's with the use of low dose inhaled insulin. This human trial made the mainstream news. It was even more exciting to me as these results give hope where we had none.

Third and fourth are environmental factors previously either not considered, or undervalued in their implications on mental health.

Studies have associated *Toxoplasma gondii* antibody titers with a history of suicide attempts. I recall *toxoplasma gondii* as a risk to the fetus if a pregnant woman was exposed to it via cat feces. I did not recall it was an obligate intracellular protozoan parasite infecting one-third of the world population. It resides relatively silently in the brain of the immunocompetent host. Seropositivity and serointensity are associated with having a history of attempting suicide and, in those attempting suicide, a greater number of attempts.

My last example is a report from the National Institute of Health. Their findings said that "disturbances in the "microbial ecosystem" of the human body may be disrupted by modern life style behaviors. For example, modern trends -- diet, antibiotics,



Kathleen M. Stack, MD, DFAPA

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CENTRA'S UNIQUE DEDICATION

By Paula M. Dubay
Director, Mental Health Marketing
Centra Mental Health Services

Did you know that right here in Virginia there is a small hospital system that provides an unrivaled range of mental health services? If you look across the country, it would be difficult to find any not-for-profit organization that has placed an emphasis on and made a major commitment to the mental health care of children, adults and families. Yet, Centra Health has done just that.

Based in Lynchburg, Centra's three hospital system (Lynchburg General, Virginia Baptist and Southside Community Hospitals) employs 12 psychiatrists and several hundred allied mental health professionals who provide services in its outpatient and inpatient settings.

Over the past 40 years, Centra Mental Health Services has slowly, but continually expanded its programming, primarily in response to community and statewide demands. Its next endeavor to address area needs will be a partial hospitalization program for children and adolescents, scheduled to open in early 2012.

For more information about Centra or to apply for a position, contact: Paula Dubay Director of Mental Health Marketing at 800-947-5442.



HIV/AIDS AT 30: A PSYCHIATRIC PERSPECTIVE

By Rochelle L. Klinger, MD, DFAPA

On June 5, 1981, the first five U.S. cases of what came to be known as Acquired Immunodeficiency Syndrome (AIDS) were reported in homosexually active men in Los Angeles who presented with *Pneumocystis carinii* pneumonia and other opportunistic infections. Within months, cases were reported in people with histories of injection drug use and recipients of blood products. Neuropsychiatric manifestations were noted from the early days of the epidemic. In 1986, AIDS Dementia Complex was first described, affecting 50% of patients prior to death at the time. As we all know, HIV has evolved into a global pandemic, with approximately 35 million cases worldwide, and an estimated 1.2 million cases in the U.S.¹

In 1981, I was an M-3 at Boston City Hospital and saw one of the first cases of AIDS there. A few years later, an openly gay resident in my program died of the disease. As a member of the gay community, I felt a sense of mission about addressing AIDS as a psychiatrist. I came to MCV/VCU in 1986 as a psychosomatic fellow, and started a liaison with the HIV program that is now in the able hands of Chris Kogut, MD. In the 1980's AIDS was nearly universally fatal and few health professionals were willing to care for people with AIDS due to fear of contagion (see Abraham Verghese's 1995 memoir *My Own Country* for an account of this era).² The excitement we felt when combination antiretroviral therapy came out in 1996 was akin to that of physicians first utilizing penicillin in the 1940's. In 2011, antiretroviral therapy is available to most patients including those in the developing world, the risk of HIV-Associated Dementia has dropped to about 2% of patients, and the rate of perinatal transmission is essentially zero with maternal treatment.

Some of the potential interactions between HIV and mental illness are

outlined below:³

- Psychiatric Disorders (including substance abuse) can increase an individual's risk of acquiring HIV up to eight times that of the general population;
- Conversely, the proportion of mental health and/or substance abuse disorders among people living with HIV/AIDS is nearly five times greater than the proportion found in the general population;
- Neuropsychiatric complications and psychiatric illness can affect adherence to antiretroviral therapy regimens;
- New antiretroviral treatments and combination therapies can affect the CNS and/or contribute to the development of psychiatric side effects/symptoms;
- Individuals with waning immunity and high viral loads may be at particular risk for the HIV-related CNS complications that can cause acute mental status changes;
- As HIV/AIDS becomes increasingly a chronic disorder with the improvement of treatments and longer survival times, the need for comprehensive psychiatric care and services is expected to rise.

Given the above, psychiatrists can contribute to the ongoing HIV/AIDS epidemic through primary and secondary prevention in children, adolescents and adults with mental illness and substance abuse, and can take an active role in treatment. On World AIDS Day, 2011, this is a worthy goal not just in specialty clinics, but in every clinical setting in which we find ourselves.

References

- 1 2011: http://www.unaids.org/en/resources/unaidspublications/2011/#c_60139.
- 2 Verghese, Abraham, *My Own Country*; New York: Simon & Schuster, 1994.
- 3 <http://www.psych.org/Resources/OfficeofHIVPsychiatry.aspx>

MSV Annual Meeting Updates

By Varun Choudhary, MD, FAPA
PSV Representative Delegate to MSV

The Medical Society of Virginia's Annual Meeting was held at the Homestead Resort this year October 28-30, 2011. This historic landmark hotel, known for its beauty and hospitality, was further transformed into a winter wonderland when the snow began to fall on Friday evening.

MSV organized a very effective policy driven meeting with two pertinent educational sessions. There were several delegate sessions designed to assist new delegates in understanding their role and position in the House of Delegates. There were a number of social activities including a 5K run and a reception on Saturday night.

Dr. Kent Bradley, a former Deputy Commander of the 30th Medical Brigade in Operation Iraqi Freedom and Dr. James Roudebush, a retired Lieutenant General of the USAF, led a discussion and presentation on team-based care. They outlined the principles of team-based care and the importance of physicians to take a leadership role in incorporating it into patient care within the health care system.

Another educational symposium was on Virginia's Prescription Monitoring Program (PMP) led by the manager of the system, Ralph Orr. He outlined the purpose of the program as well as its goals to serve as a state wide resource to decrease prescription drug abuse.

MSV enumerated its legislative victories and accomplishments in the past year including the new medical malpractice cap agreement that the General Assembly voted into law in April 2011. MSV was actively involved in brokering the deal along with the Virginia Hospital and Healthcare Association (VHHA) and the Virginia Trial Lawyers Association (VTLA). The new cap will allow for graduated increases of the malpractice cap by \$50,000 a year until 2031. Another successful negotiation involved the protection of peer review and quality assurance documents from discovery in litigation.

MSV highlighted and praised Delegate Chris Stolle, MD for HB 2218, which ensured that physicians would not be forced to accept Medicaid or any other third-party reimbursement program as a condition of obtaining their license to practice medicine in Virginia. This was a preemptive strike to protect physicians in Virginia from suffering the same fate as physicians in some other states.



Varun Choudhary, MD

MSV was able to successfully lobby the General Assembly to eliminate a scheduled 4% cut in the budget for Medicaid provider rates, although the rate cut for hospitals was still passed.

There were a number of policy votes presented for delegate votes. MSV presented a policy compendium update as required by the Ten Year Policy Review Report. The items pertaining specifically to psychiatrists included scope of practice issues and psychologists' prescriptive authority. MSV reaffirmed their belief that physicians needed to oversee, assist and advise legislators and regulatory agencies on any scope of practice issues. They also reaffirmed their opinion that MSV is opposed to any legislation allowing psychologists to prescribe medications in Virginia.

The meeting, however, was not just focused on regulatory, legislative and policy matters and allowed for participants to enjoy all that the Homestead had to offer. Quite a few physicians took advantage of their luxurious spa services, mineral baths, indoor pool and fine restaurants. The meeting alone was worth the price of membership to MSV!

MEDICAL SCHOOL NEWS

EASTERN VIRGINIA MEDICAL SCHOOL

Outpatient Clinical Trials Unit to Test Promising Lead Compounds for the Treatment of Autism Spectrum Disorders in Older Adolescents and Young Adults at Eastern Virginia Medical School

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

I am delighted to have the opportunity to describe two innovative clinical trials that are in the process of implementation by EVMS' Department of Psychiatry and Behavioral Sciences, targeting the older adolescent and young adult population with autism spectrum disorders (ASD). The first trial evolved out of preclinical work conducted with the genetically-inbred Balb/c mouse, which displays quantitative deficits of sociability and serves as a model of ASD. For example, as opposed to the outbred Swiss Webster comparator strain, the Balb/c mouse shows diminished locomotor activity in the presence of an enclosed or freely-behaving salient social stimulus mouse. Moreover, compared to the Swiss Webster mouse, the Balb/c mouse spends less time exploring and in the vicinity of an enclosed social stimulus mouse, in addition to making fewer discrete episodes of social approach when the Balb/c and social stimulus mouse are allowed to interact freely with each other. Because the Balb/c mouse has altered endogenous tone

of NMDA receptor-mediated neurotransmission, as reflected in its heightened behavioral sensitivity to MK-801 (dizocilpine), a noncompetitive NMDA receptor antagonist, we examined the effects of D-cycloserine and D-serine, a partial and full glycineB site agonist, respectively, on the impaired sociability of the Balb/c strain. Quite remarkably, these NMDA receptor agonist interventions improved several quantitative measures of the Balb/c mouse's impaired sociability. The NMDA receptor is a glutamate-gated ion channel receptor, whose channel is more likely to assume an open configuration in the presence of glutamate and glycine, the latter amino acid is the receptor's obligatory co-agonist. Interestingly, the heightened behavioral sensitivity to MK-801 and ability of glycinergic interventions to improve the impaired sociability of the Balb/c strain occur even though expression and processing of NMDA receptor subunits themselves in cerebral cortex and hippocampus of Balb/c mice do not appear to differ from that in an outbred Swiss comparator strain. The data suggest that the efficiency of synaptic transmission within circuits containing NMDA receptors that mediate aspects of social behavior may be reduced in Balb/c mice, relative to the Swiss Webster strain. Based on these data and an earlier provocative open-label, dose escalation trial of D-cycloserine in children with autism that reported a positive therapeutic effect on social withdrawal, Dr. Maria Urbano, an Associate Professor of Psychiatry and Director of the Autism Disorders Program at EVMS, designed a comparative study of two dosing strategies of D-cycloserine in adolescents and young adults with good expressive language and normal or near-normal IQs. Currently, there are five active patients enrolled in this exciting trial and many more waiting to be screened for participation.

The second study is a translational clinical trial based on recent genetic data that emerged from Array-Comparative Genomic Hybridization (ACGH) studies of specially referred populations of persons with an array of developmental disabilities, including persons with autism, intellectual disabilities and facial dysmorphic features, and idiopathic epilepsy. Although they occur rarely, microdeletions of the q13.3 region of chromosome 15, which contains the locus of the gene coding the alpha7-nicotinic acetylcholine receptor subunit, are associated with developmental disabilities, including ASDs. The ACGH data suggest that diminished expression of this nicotinic acetylcholine receptor subunit can be causally-associated with presentations of ASD. These ACGH data complement converging evidence of pathological abnormalities of cholinergic nuclei and their projections in post-mortem brain samples of persons with autism. Even in the absence of pathological abnormalities, because alpha7-subunit-containing nicotinic acetylcholine receptors are involved in normal processes of attention and cognition, this specific subtype of nicotinic receptor would be an important molecular target to interrogate in ASDs. Because of these data, Dr. Urbano and her collaborators also designed a clinical trial examining the effects of galantamine on measures of sociability and cognition in adolescents and young adults with ASDs. Galantamine has two important pharmacological properties: it is an acetylcholinesterase inhibitor that will

increase the concentration and lifetime of acetylcholine within the synaptic cleft of cholinergic synapses, and it is a positive allosteric modulator (PAM) of nicotinic acetylcholine receptors. Thus, galantamine should preserve the spatial and temporal characteristics of depolarization-dependent acetylcholine release locally in the areas of cholinergic synapses; specifically, galantamine will act when and where acetylcholine is released to increase the efficiency of coupling the binding of acetylcholine by nicotinic receptors to their channel opening.

Because preclinical models and genetic research are going to identify promising molecular targets for medication development, there is an urgent need to develop efficient clinical trials methodologies that will facilitate the rapid testing of promising compounds. The goals include obtaining data on safety, tolerability and preliminary evidence of an efficacy signal. Unfortunately, in almost all instances, a therapeutic signal will not be found, but, inevitably, these rationally-based trials will lead to a "hit," which may hold promise for improving the outcomes and quality of life of persons suffering from highly-prevalent ASDs. EVMS's Department of Psychiatry and Behavioral Sciences is committed to developing these important clinical trials methodologies that will facilitate discovery of these novel medication strategies, while it is engaged in caring for these patients and their family members.

EARLY CAREER PSYCHIATRY

By Daliborka M. Danielson, DO & Kelly Sullivan, DO

As an early career psychiatrist (ECP), one ventures out into the medical world away from the stable arms of residency and faces the challenges of not only a new population of psychiatric patients, whether it be inpatient, community, private practice, or a combinations, but facing them alone. This presents unique challenges as may early career psychiatrists venture into new communities and new state mental health care systems different from where one may have practiced. Whether or not your patient population has transitioned from urban to rural or from high functioning patients to the severely mentally ill, early career psychiatrists are eager, adapting to new mental health care systems, and are doing this a time of extreme change in mental health care as we know it with growing popularity of fee for services, medical home models of treatment, polypharmacy backlash, and growing culture of economic downturn that is affecting our delivery model of medicine, but it vastly increasing utilization of emergency services, increasing numbers of mentally ill, and depleting limited services within mental health. Given all of these items on the horizons, as we face these challenges together as well as on our own, often our greatest insights are found in our lessons learned or more aptly the first post-residency years. Some residencies have in their curriculum transitioning to practice, however, the specificities for each care system that early career psychiatrists enter can not be fully covered.

These are some of the lessons we learned during our transition from residency to early career psychiatry:

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IN THE NEWS

DR. JOHNSON HEADING UP NEW GROUP ON BEHAVIORAL CARE AND PRIMARY CARE

Dr. Robert Johnson, the IT Chairperson of the Northern Virginia Chapter, is heading up a group of mental health providers in Fairfax County who have begun to explore ways of improving and increasing communication and accessibility between behavioral care and primary care in our community. Dr. Johnson has accumulated a database of over 235 providers including 80 psychiatrists, 70 psychologists, and 65 other degree mental health providers. These providers are connected by at most three degrees of separation with traceable connection and recommendations. The model being used is developing communities of practice that is, like-minded, interacting people who filter, amplify, invest and provide, convene, build, learn and facilitate to ensure more effective creation and sharing of knowledge in their domain. These are peer-to-peer collaborative networks that are driven by the willing participation of their members and are focused on learning and building capacity. They are engaged in sharing knowledge, developing expertise, and solving problems. Initial efforts are focusing around using a closed social media, completing the database with information that might be of value to primary care doctors and designing the content of the site. Dr. Johnson has been working with the Fairfax Family Practice group teaching psychiatry there for over 20 years and initial efforts will be with that group to test out the model. Our goal is to increase our understanding of natural referral networks that exist in the county and how they could be changed to work more effectively for both behavioral care providers and primary care providers. There is also an interest in finding out who would like to participate in developing an electronic community around shared interests, integration with primary care, psychopharmacology, psychotherapy, "health behaviors, non-compliance, super-utilizers," child psychiatry research, etc. It is possible that there may be other people in our district who are interested in similar projects with their own acquaintances, and we would be more than willing to share our ideas and results.

Drs. Robert Johnson and Valerie Buyse will be presenting their experiences at the APA meeting in May 2012 at the Lifer's Workshop on "Integrated Care: Civilian and Military Models."

INTERNATIONAL COLLEGE OF PSYCHOSOMATIC MEDICINE

Dr. Thomas Wise, Chairman of Psychiatry at INOVA Fairfax Hospital and Professor of Psychiatry at VCU has been elected President-Elect of the International College of Psychosomatic Medicine.

VCU MEDICAL CENTER SELECTED TO ADMINISTER A DBS STUDY FOR REFRACTORY DEPRESSION

Dr. Anand Pandurangi's Brain Stimulation Therapy program at Virginia Commonwealth University Medical Center has been selected as one of 15 centers in the country to administer a deep brain stimulation (DBS) study for refractory depression.

The BROADEN™ clinical study for severe major depressive disorder involves stimulating subgenual cingulate white matter area 25 (Brodmann Area 25) with a surgically implanted deep brain stimulator.

If you would like to refer a patient, would like study-related materials, or have questions, please call 804-628-8520 or visit the study website at www.BROADENStudy.com.

JOAN A. TURKUS, MD BOARD CERTIFIED PSYCHIATRIST AND FORENSIC PSYCHIATRIST, FALLS CHURCH, VA

This has been a busy and eventful year with my roles as Co-Founder and Psychiatric Consultant, The CENTER: Posttraumatic Disorders Program at the Psychiatric Institute of Washington, DC. At the American Psychiatric Association's meeting in May, I was inducted as a Distinguished Life Fellow. In August, I was elected President-Elect of the International Society for the Study of Trauma and Dissociation (ISSTD) and presented three presentations at the annual conference in Montreal, Quebec. Presentations included: (1) Ethics of Technology in Clinical Practice, (2) Psychopharmacology of Complex Posttraumatic Stress Disorder, and (3) Risks for Women in the Military.

IN MEMORIAM

Ruth W. McDonough

Ruth W. McDonough, age 82, of Richmond, passed away Wednesday, September 14, 2011 after a short battle with cancer and heart ailments. She was the executive secretary for the Psychiatric Society of Virginia from 1981 to 1996 and was an avid Boston Red Sox fan. She was preceded in death by her loving husband of 35 years, Dr. William W. McDonough. She is survived by her daughter, Amy M. Griesse and her husband, Slider, of Fairfax Station, VA; and her son, Kevin W. McDonough and his wife, Lisa, of Roanoke, VA; four grandchildren, Amelia and Andrew Griesse and Eric and Alex McDonough; and two brothers, Richard Weir and Robert Weir.

CHANGES IN PSYCHIATRIC TRAINING

By J. Edwin Nieves, MD, DFAPA



J. Edwin Nieves, MD,
DFAPA

A while back I wrote about the art of case presentations and it made me nostalgic about psychiatry residency training then and now. The PGY 1 year was a broad experience that included inpatient rotations in medicine, emergency room and inpatient psychiatry. During that first year and part of the second, we focused on doing a complete evaluation of the patient, obtaining a complete history, detailed family and social history along with a physical examination. Making a differential diagnosis, beginning a treatment plan and following one or two symptoms progression, and thus monitoring if you had the correct treatment plan, was the bread and butter of those first two years of training no matter the specialty. The process was repeated several times a day, each one of my colleagues developing their own "script" of questions. Especially valuable experiences were the taping of some of these interviews, watching some other trainees take a detailed history and in my case the "Med-Psych" team, which always had a diagnostic dilemma. Lectures on the biology of psychiatry, the different modalities and indications of psychotherapy rounded up those first two years. The call schedule usually

included anywhere from 2 to 4 nights a week in Randolph Minor with periodic interruptions and visits to the ER or clinical floors for consultations (I wonder if those tunnels still exist).

I recall one of my supervisors, (I think it was Dr. John Russell) saying that it was between your second and third year of training that you started "becoming a psychiatrist." The shift to outpatient experiences centered on different psychotherapies, the identification of defenses (many never master this difficult requirement), learning the different therapeutic interventions and perfecting your clinical persona.

It seems impossible that I could hold that much information in my mind then when it takes me three to five minutes to find my car keys in the morning now a days.

In the recent years the training of psychiatric residents has maintained some of these "core requirements" but there have been changes in the training in psychological and social aspects of the patient.

The evolution of more compartmentalized schedules, less independent time, less psychodynamic involvement and less of what Dr. Weisman calls "the empathic sense of the patient" has had an impact in the transformation of the resident "into a psychiatrist." This "empathic" connection is developed early on and in my opinion, cultivated as the resident gathers information from the patient and family, observes and monitors the evolution of acute psychiatric syndromes, its impact on the patients'

social circle and the response to treatment. This empathic capacity along with interviewing skills, and core medical knowledge completely rounds out the diagnostic capacity of the modern psychiatrist¹.

The advent of multidisciplinary teams, where every discipline makes an assessment, has slowly restricted the area of influence of residents to a more biological review, medication management and medical co-morbid assessments. Other disciplines integrate the social environment (housing), available resources, faith preference and family health or therapy interventions.

In addition to this disciplinary evolution, the Accreditation Council of Graduate Medical Education has approved common requirements that have taken effect this July. These include a 16-hour work day for interns (first year residents), decreased autonomy with direct supervision (or indirect with direct supervision immediately available), fatigue monitors and others². While the main purpose of the requirements are centered on patient safety and ascertain that residents receive an education in medicine with "graduate levels of responsibility" they may have some unintended consequences. The ability of the resident to be around and in close clinical contact with the patient is decreased. The extent to which residents will have the opportunity to make clinical decisions in acute situations such as acute psychiatric syndromes while under direct supervision is unknown. This may delay the development of increased sense of clinical acumen and may delay the development of diagnostic and management aplomb.

We must make sure that residents have adequate exposure and ability to incorporate the psychological and social science elements critical to being a psychiatrist¹.

References:

- 1 "Are we Training Psychiatrists to Provide Only Medication Management" Weismann S. *Psychiatric Times*; June 2011 Vol. 38 #6 page 20.
- 2 <http://www.acgme.org/acWebsite/home/home.asp> accessed August 19, 2011.

CHAPTER UPDATES

The **Richmond Psychiatric Society** kicked off its season of CME lectures in October with Dr. Keyhill Sheorn speaking on the use of psychosis as a defense. Dr. Stan Jennings will present at our November meeting on integrating nurse practitioners into outpatient psychiatric practice. Meetings are held on the first Thursday of each month. For more information on attending, please contact Chris Kogut at cpkogut@vcu.edu.

PSV – SW VA Chapter met on the night of October 5th. There was a lively group of about 25 practitioners which included psychiatrists, nurse practitioners and residents. Ralph Orr, program manager from the prescription monitoring program, gave an overview of this program and the changes that are coming down the pipeline. Agency business included President's & Treasurer's Reports. The chapter also elected its new office bearers who will take over for the year 2012. The chapter continues to be collegial, active and thriving. We look forward to seeing our colleagues at the PSV meeting in Roanoke in 2012.

Early Career Psychiatry

Continued from page 5

Lesson 1: Its never too early to start looking for a job. If you are certain that you will be joining work force after the residency, you can start interviewing for jobs as early as the beginning of your 4th year of residency. That will give you enough time to pick the area where you want to practice, negotiate your contract, plan your time-and then enjoy the rest of your year!

When deciding whether to pursue a fellowship, think about your future goals and how you would like to utilize your fellowship. Might be great if academic psychiatry is your area of interest-if not, consider carefully cost of additional year in training vs benefits.

Lesson 2: Make sure that you carefully review your employment contract. HIRE A LAWYER who is experienced in physician contracts! It's well worth the cost. Some of us have walked away from damaging contracts that employers were not willing to change. Anything that is discussed during your job interview should be in your contract-if its not that should raise a red flag. One thing that we have learned from numerous lectures about medicine and law is that anything and everything can be negotiated, so don't be afraid to ask for contract benefits you would like to have.

Some of the things to consider when negotiating contracts are: sign in bonus, loan repayment programs for psychiatrists working in underserved areas, funds for additional education etc.

Lesson 3: Research the system you are entering before starting.

Whether private or community, learn what the state legislation regarding involuntary inpatient hospitalization, policy and protocol for your local state hospitals and regional jails and their formularies if there is flux between your area of practice and these two systems. Research the strength of mandatory outpatient treatment programs, if mental health or drug courts are available, whether your patient population is uninsured or uninsured and the resource of Patient Assistance Programs for newer non-generic prescriptions.

Lesson 4: Consider financial planning, whether paying off your medical school loan, setting up a 401K, or the need for additional disability consultant. This may be the time that is appropriate to recognize and come out on top of a higher income curve. Ask your employer if they have financial advisors available to you.

Lesson 5: Learn the changing requirements of Medicare/Medicaid reimbursement, including codes for atypical antipsychotic monitoring and how new DSM V codes will be integrated with ICD-9 coding.

Lesson 6: Do not forget to laugh and smile. In those first months of attempting to establish yourself as a respected inpatient attending or as a outpatient psychiatrist, in crisis or not, patients and coworkers respond the most positively when they can identify with you and see that you are still able to lighten the mood as well as navigate academically through psychosis and suicidality.

Lesson 7: Do not exist in a vacuum. Join your local societies.

Network. Stay in touch with your residency colleagues. Open dialogue prevents insularity, as this is the goal of this column.

For those of you in practice for 7 years or less-please, join our Psychiatric Society of Virginia Early Career Committee! Let's work together!

2012 PSV SPRING MEETING

By W. Victor R. Vieweg, MD, DLFAPA

We have planned an initial 90-minute session in which an executive in healthcare administration will deliver a 40-minute presentation "Physician Hospital Integration and the Interface of Outpatient and Inpatient Psychiatry." The Private Practice of Psychiatry is largely an outpatient practice. More and more, organizations such as Bon Secours may recruit Psychiatrist Hospitalists. How might they interface with the outpatient practice of psychiatry? Tom Wise, MD, Chairman, Department of Psychiatry Inova Health System, Professor of Psychiatry and Associate Chair of Psychiatry at George Washington University School of Medicine, Professor of Psychiatry at Virginia Commonwealth University Inova Campus, and Professor of Psychiatry at Johns Hopkins University School of Medicine, pointed out to me how important this topic is to the future of psychiatry. He will be one of the discussants for this presentation. The full program is outlined below.

"Preparing for the Future of Psychiatry"

March 23-24, 2012 • Richmond, VA

9:00-10:30 am	"Inpatient-Outpatient Psychiatry. What lies ahead?"
9:00-9:40 am	"Physician Hospital Integration and the Interface of Outpatient and Inpatient Psychiatry" Paul Altovilla, Vice President Behavioral Health, Bon Secours Richmond Health System
9:40-9:50 am	10-minute commentary, Cal Whitehead
9:50-10:00 am	10-minute commentary, Tom Wise, MD, Chair, Psychiatry, Inova, Northern Virginia, and Professor of Psychiatry, VCU
10:00-10:10 am	10-minute commentary, Martin Buxton MD, Clinical Professor of Psychiatry, VCU
10:10-10:30 am	Q&A
10:30-11:00 am	Visit Exhibits
11:00-11:40 am	"Pharmacologic treatment of mixed Anxiety and Depression"- Prakash Ettigi, MD
11:40-12:00 pm	Q&A
12:15-1:15 pm	Lunch
1:30-2:10 pm	"The Role of antidepressant medications in the treatment of Major Depression: What is all the fuss about?"- John Shemo, MD
2:10-2:30 pm	Q&A
2:30-3:10 pm	"Role of atypical antipsychotic drugs in the treatment of Anxiety and Mood Disorders" Anand Pandurangi, MD
3:10-3:30 pm	Q&A
3:30 pm	Wrap-up

FALL MEETING PRESENTATION

Will Modern Genetics Research Contribute to Psychiatric Practice?

By John M. Hettema, MD, PhD

Genetics has gradually become a major research tool in all fields of medicine, including psychiatry. Since genes code for brain structure and function, and gene expression occurs in response to our environment, identifying “the genes” for psychiatric illness can potentially help us address many of the questions that plague our profession today, such as “What are the causes of psychiatric illness?,” “How can we better define psychiatric syndromes?,” and “What new pathophysiological pathways can we target for treatment?”

Family and twin studies performed in the 1970’s to 1990 have confirmed that all psychiatric syndromes have some genetic basis. Over the past several decades, countless molecular genetic studies have attempted to identify specific genetic loci that contribute to that liability, with little firm success. This was likely due to the short list of candidate genes selected and the relatively underpowered sample sizes employed. Most recently, genomewide association studies (GWAS) using millions of markers that interrogate the entire human genome in a single experiment have been conducted in thousands of subjects, with larger studies underway. These have identified a handful

of novel genes that each show some consistent, but quite modest, effects. Such studies hint at the large number of genes that contribute to complex phenotypes like psychiatric and other medical illness. This complexity suggests that, while genetics still holds many potential promises for the future of psychiatry, it will be some time before clinicians will see any practical applications.



Adam Kaul, MD, FAPA, PSV President and Fall Meeting Program Chair with John M. Hettema, MD, PhD.

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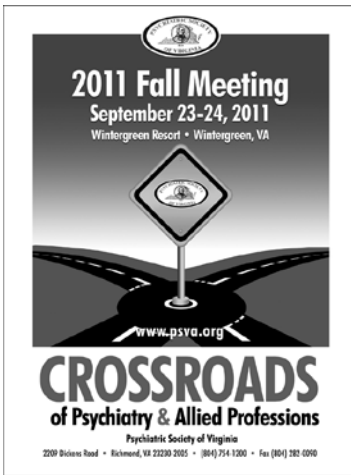
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2011 Fall Meeting Highlights



Adam Kaul, MD, FAPA, PSV President and Fall Meeting Program Chair; Kevin Spicer, MD, presenter; Rochelle Klinger, MD, DFAPA, author of HIV/AIDS article on page 3; Varun Choudhary, MD, FAPA.



James L. Krag, MD, DFAPA, Past President of PSV; Rebecca J. Lindsay, MD, DFAPA, Ethics Committee Chairman of PSV; Cheryl Jones, MD, DFAPA, Past President of PSV.



Paul M. Spector, MD, DLAPA presents *ed Psychiatry and Pain Management*.



Eric Rogers, MSW Executive Director of Give an Hour™ gives an overview of the program.



Cheryl Jones, MD, DFAPA, one of the poster judges questions a poster presenter on details, while Thomas Jayne, MD looks on.



Robert S. Brown, Sr., MD, DLFAPA catches up with B.R. Ashby, MD, DLFAPA.

Analysis of Systems

Winner: **Mandrill Taylor, MD**: The Problem and Hope: Analysis of Facilitators and Barriers in Public Mental Health
 Honorable Mention: **Taral R. Sharma, MD, MBA**: Mental Health – Primary care perspective

Clinical Measurement

Winner: **Roopa Sethi, MD**: Prevalence of metabolic syndrome (MS) in veterans with alcohol related disorders alone and alcohol and marijuana related disorders combined.
 Honorable Mention: **Mallory Jones, Pharm D.**: Risk of QT Prolongation and the Assessment of Veterans at Hampton VA Medical Center on High-Dose Citalopram

Case Studies

Winner: **Stephanie Peglow, DO**: Synthetic Cannabinoid Induced Psychosis in a Previously Non-Psychotic Patient
 Honorable Mention: **Adam Daniel Zavodnick, MD**: Amphetamine intoxication or psychostimulant precipitated bipolar disorder

POSTER WINNERS

A Message from the Editor

Continued from page 2

obsession with cleanliness, Caesarean deliveries. They went on to say that these may disrupt the delicate balance, contributing to some of the most perplexing ailments, including asthma, anxiety, allergies, obesity, diabetes, autoimmune diseases, and more. Related to these findings were that mice, given a probiotic solution in their food, believed to restore this balance, had less anxiety in stressful situations and when stressed recovered more quickly.

Imagining even the possibility of restoring memory and strengthening recall is beyond anything I ever hoped scientific research would uncover in my lifetime. While in the recent past, implanting a neuroprosthetic device could sound like science fiction, this insulin treatment has the real possibility of helping insulin dependent individuals in as brief a time as the next few years. A few short years ago, if anyone had suggested a parasite could be involved in the epidemiology of

suicide, this would have been incredulous. The idea that body flora could affect physical health is understandable, but mental health? Once again I was surprised and intrigued. Could this factor contribute to resilience? Might something which before seemed so “minor” be able to ameliorate a vast array of health problems?

The irony that mental health providers may have ignored the interplay of the human being with their “personal environment” is not lost on me. However, when I consider these diverse developments, I feel fortunate to be a psychiatrist. I am part of a profession that revels in the discovery of exploring new frontiers, and in reevaluating paradigms to improve understanding of treatment options for those we serve.

References:

- J Nerv Ment Dis. 2009 Dec;197(12):905-8.
- Schizophr Res. 2011 Sep 2.
- J Pediatr Health Care. 2011 Nov;25(6):355-64.
- J Nerv Ment Dis. 2011 Jul;199(7):440-4.

A message from the president...

Thank you.



Dear Doctor:

On November 1, PRMS celebrated 25 years of serving psychiatrists.

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Throughout the years, there have been many changes in the practice of psychiatry and to PRMS itself. But the one thing that remains constant – and that will never change – is our commitment to protect psychiatrists by helping them manage their risks.

The PRMS Psychiatrists' Program is the single largest source of liability insurance for psychiatrists. As the market leader, we wear that title proudly; and never take it for granted. On behalf of all of us at PRMS, in this season of "thanks" we want to make sure you know how greatly we appreciate the opportunity to be your insurance program.

Again, thank you.

Sincerely,

A handwritten signature in black ink that reads "Martin G. Tracy".

Martin G. Tracy, JD, ARM
President & CEO
Professional Risk Management Services, Inc.

P.S. Questions, concerns? Never hesitate to call me directly at 703-907-3872.

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Elections for 2012 officers are coming.
Are you interested in being an officer or director for PSV for 2012?
Please contact Andrew Mann, PSV Association Manager

VIRGINIA ELECTION RESULTS

By Ralston King, Whitehead Consulting, LLC

It appears that Republicans' aggressive push to take control of the Democratic-controlled Senate this year has paid off. Results are in with two hotly contested contests contributing to a Republican "working majority." Incumbent Democratic Senator Edd Houck (D-Spotsylvania) was ousted by Republican insurance broker and retired Army Ranger Bryce Reeves in a duel over Fredericksburg and surrounding rural, conservative areas. In Southwest Virginia, incumbent Senator Roscoe Reynolds (D-Martinsville) loses to Senator Bill Stanley, which will give the Senate a 20-20 tie and the final vote resting with Republican Lt. Governor Bill Bolling.

In the House of Delegates, Republicans gained its largest majority ever with 68 of 100 seats; this includes conservative independent Lacey Putney (I-Bedford). The GOP expansion included a victory by Delegate Charles Poindexter (R-Glade Hill) over sitting Democratic Minority Leader Ward Armstrong (D-Martinsville).

Please visit the Virginia Public Access Project (VPAP) to check your local races for updates and results: <http://www.vpap.org/>.

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