THE WASHINGTON PSYCHIATRIC SOCIETY News

JULY/AUGUST 2008

Perinatal Psychiatric Prevention

by
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Established in 1989, the Washington Psychiatric Foundation, under the leadership of Dr. Ralph Wittenberg, created a major referral and information resource for people with psychiatric illnesses throughout the Washington metropolitan area. When the referral program closed in 1998, the Foundation took the lead in implementing a perinatal preventive screening program that is now being employed throughout the Navy and is very likely to be extended to the other military services and to other major clinical settings nationwide. We want to review this development and its implications in this article.

Perinatal psychiatric disorders impact about one in five pregnant women, ten times the number impacted by perinatal diabetes and twenty times those of women who are HIV positive. Yet, in most settings in the United States, only 15% of that one fifth get treatment. Fear of law suits, stigma, and time constraints inherent in OB-GYN practices contribute to the low identification and management of perinatal psychiatric disorders. However, universal depression screening can identify over 92% of cases.

Early identification and management of perinatal psychiatric disorders is major secondary prevention for mothers and substantial primary prevention for newborns. It is both primary and secondary prevention for husbands and for the other children in the family. The impact on society is also large. It has been shown that disturbed families, whose members receive treatment, are 60% less likely to have children incarcerated by their 15th birthday. The opportunity for prevention is staggering: there are four million births a year in the United States and 800,000 of those women giving birth could have psychiatric disorders or warning signs.

In 2000, the renamed Family Mental Health Foundation began working on a grant from the Health Resources and Services Administration's Bureau of Maternal and Child Health, with Dr. Wittenberg as the Senior Investigator, to establish the feasibility of perinatal screening programs in primary care settings. After attaining an $800,000 grant, spread over four years, the Foundation conceptualized and demonstrated that universal screening for depression of perinatal women in primary care settings worked. Programs were developed at the Bethesda National Naval Medical Center, the Eastern Shore of Maryland, and the Healthy Start and Healthy Families components of Mary's Center for Maternal and Child Health for underserved mothers in DC. The protocol used a ten-question postpartum depression screening instrument that was called a "health questionnaire," deliberately not using the words "mental" or "psychiatric." The approach was both mother-friendly and OB-GYN friendly: 998 out of 1000 women took the test. Of the first 1000 women screened, about 300 were in the positive range. After identifying a potential problem, the next challenge was to access care for these women. The OB-GYN physicians were given a script to tell their patients: "We have some findings that make us concerned. A nurse is going to make some arrangements for an appointment for further evaluation and we will discuss the results together." This approach is now the official standard of care for the entire Navy, and the other major uniformed services may soon follow suit. In dealing with patients and clinicians, an excellent analogy is

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What's Inside . . .

The President's Column

SCREAM BLOODY MURDER

by Harold I. Eist MD, DLFAPA

Dr. Michael Houston passes the gavel to Dr. Harold Eist our new President

THE WASHINGTON PSYCHIATRIC SOCIETY News

The US Senate temporarily delayed stopping a 10.5% decrease in Medicare payments. Most reasonable people deplore this further shredding of our already torn health care safety net, because without this modest adjustment physicians will be unable to continue seeing Medicare patients.

This reduction will interfere with access to care for the poor, the elderly, minorities and children. However, it will do more than exaggerate the disparities in health care.

In the 1980's, I predicted that so called "health insurers" would "medicarize." In other words they would quickly rationalize paying out less because the government paid out less. This is now termed "indexing" to the Federal payout. Who could complain if the "insurers" were simply following the lead of the government?

This copycat action on the part of "insurers" will crimp or deny access to millions of our people, including those struggling to pull themselves out of poverty.

According to Health Care July 2, 2008, a poll by the AMA found that 60% of physicians would limit the number of new Medicare patients they would see because they simply would not be able to afford to see patients at the proposed low rates.

The AMA plans TV and radio campaigns to inform the citizens of Mississippi, New Hampshire, Pennsylvania, Tennessee, Texas and Wyoming that their Senatorial representatives voted against their health care and for the further enrichment of private "health insurers."

Why did these public officials vote to harm those they were elected to represent?

The Center for Public Integrity notes that the health insurance industry, between 1998 and 2004, contributed $ 594,211,834. to Senate election campaigns. Lockhead Martin contributed $429,000,000. during this same period.

Currently, there is a vicious cycle operating that should be criminalized. Legislators vote to protect "private insurers" that they "coddle" (NYT, July 5, 2008) who in turn make large contributions of monies leeched from health care to those same legislators to aid, if not assure, their re-election. This is blood money.

If we, individually, and through our organizations clearly and repetitively describe this vicious cycle to the public, those who struggle daily with health care benefits denied will rise and scream bloody murder. ■

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Pawns in the Game

By Stephen A. Green, M.D., M.A.

Dr. Eist's musings in the May/June *Newsletter* [Notes from the Bureaucracy], which lampoon pitfalls inherent in the profession's relationship with the pharmaceutical industry, distract from more serious matters.

Partnerships between drug companies and psychiatrists have undoubtedly yielded benefits, such as the current spectrum of psychoactive medications. These advances, however, have been linked with the industry's growing influence over professional activities, fostering an interdependency whose practices and policies raise disturbing ethical questions. As examples:

Are clinicians fully and accurately informed about a medication's therapeutic and side effects, the way drug companies influence the design of clinical studies and how research data are reported and employed in marketing? If not, can we claim to uphold the Hippocratic tradition of "First do no harm"?

Are patients afforded true informed consent when subjected to direct consumer advertising (DTC) or enrolled in clinical studies without knowing that financial benefits might accrue to their physicians?

Has the profession fulfilled a primary responsibility of educating its members or, as three former editors of the *New England Journal of Medicine* assert, largely abdicated that role to continuing medical education (CME) endeavors supported by pharmaceutical companies? If the latter, has this been a net benefit or harm, given its effect of promoting widespread use of more expensive medications, imposing financial burdens on individual patients and escalating health care costs for society?

The answers to these, and more nuanced questions, suggest that our collaboration with industry has promoted commercialization at the expense of professionalism. One consequence is the emphasis on pharmacologic treatment of mental illness over psychosocial interventions, advancing what Steven Sharfstein terms the "bio-bio-bio" model. As a result, a well-entrenched system now exists that financially advantages major stakeholders—pharmaceutical companies, practitioners, researchers, academic centers, the Federal Drug Administration (FDA) and universities holding licenses on products they helped develop—placing ethical care at risk.

How did we get to this juncture? Being human we continually have to reconcile conflicting interests. In the medical environment they arise when professional judgments concerning a primary interest (e.g., a patient's welfare or the validity of research) are influenced by a secondary interest (e.g., financial gain). The severity of a conflict generally depends on the likelihood that professional judgment will be influenced, or appear to be influenced, by the secondary interest, as well as the degree of harm that may result from such influence or its appearance. Whether such conflicts violate standards of medical ethics depends on the degree to which they detract from the quality of health care and its cost (e.g., prescribing expensive medications whose effectiveness is unproven), the integrity of research (e.g., withholding studies that fail to reflect favorably on a product), and the profession's integrity (e.g., publishing or presenting ghost-written material).

As Jerome Kassirer (1) notes, "without the willing engagement and active involvement of physicians" the effects of many complicated conflicts between the medical profession and pharmaceutical industry would be diminished or eliminated. His opinion is justified in certain circumstances, as when physicians receive thousands of dollars for publicly advocating the virtues of a specific medication. However, there exists ample evidence that even when individuals attempt objective judgment they often respond to self-serving bias; notably, a consensus view among physicians is that small gifts and free meals do not affect prescribing patterns despite clear evidence to the contrary. The pharmaceutical industry has provided a fertile environment for conflicts of interest to flourish, but we must acknowledge our contribution to the situation through continued acceptance of a system whose policies and practices chip away at professional values. The potential consequences of continued complicity cannot be ignored; to do so would compel us to re-visit circumstances that accompanied the advent of managed care when the profession's autonomy and welfare of patients increasingly came under industry's control. Whether knowingly or unwittingly we are, in the words of Bob Dylan, "pawns in the game". We can no longer accept that role. As others have suggested, specific steps must be taken to reverse the trend.

First, the profession must educate itself about the nature of the pharmaceutical industry and the influence it wields. Programs dedicated to this goal have been introduced into medical schools.

Second, gifts, meals, payment for participation in online CME, and for travel to and time spent at meetings should be prohibited. Provision of drug samples should be eliminated because they incur physicians' obligations, inclining them to prescribe newer, more expensive medications. (Moreover, the rationalization that samples are given to the needy has been disproved; most are distributed to wealthier, insured patients.)

Third, medical training should limit the degree to which industry influences educational activities. This requires greater transparency regarding the content of CME courses (e.g., the degree to which an academic center has been involved substantively) and the sources of their financial support. Other proposed measures include banning pharmaceutical representatives from academic centers, eliminating industry-sponsored symposia from conferences, and making profes-

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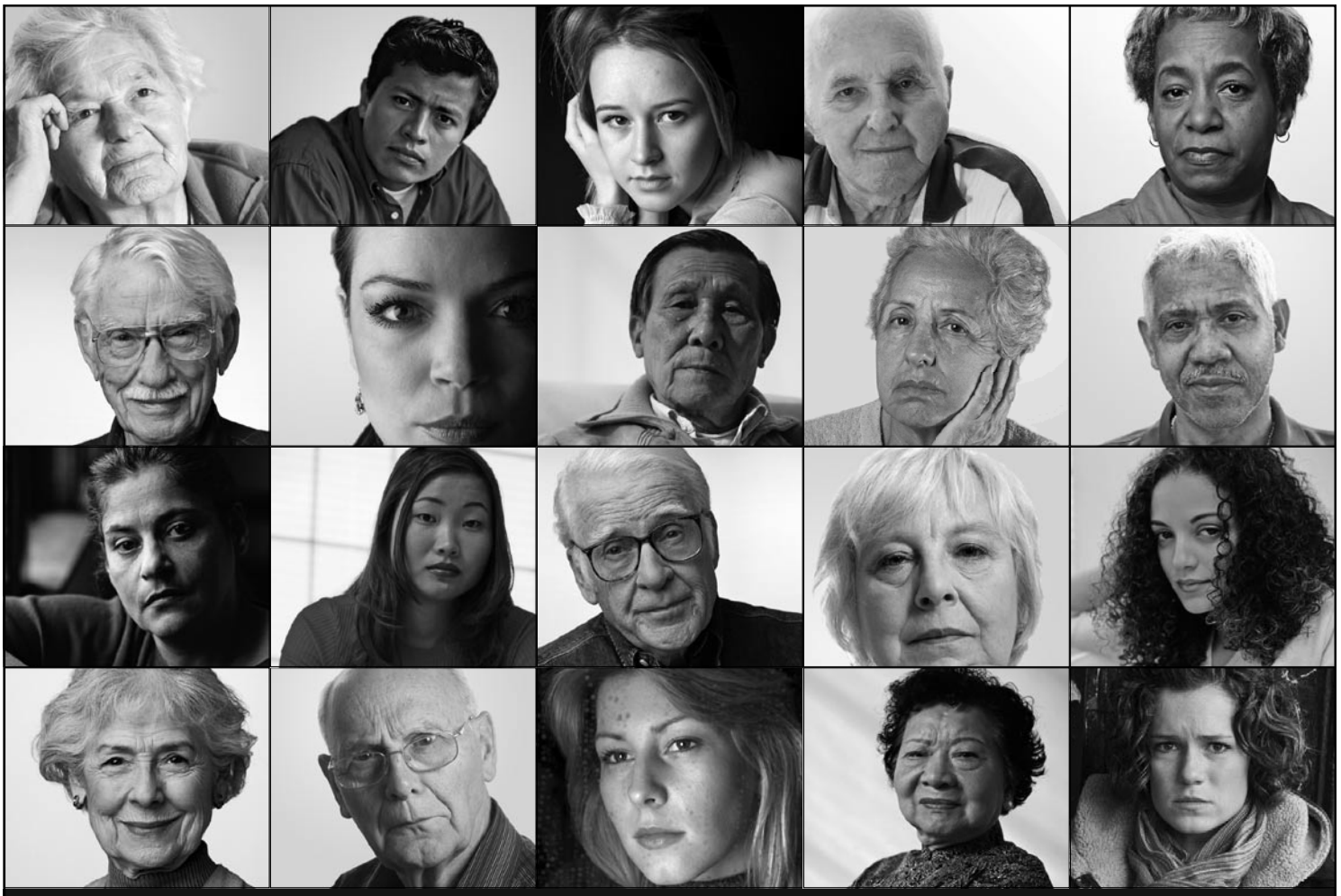

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Answers That Matter.

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sional organizations completely independent of industry support.

Fourth, physicians should be prohibited from participating in industry-sponsored speaker bureaus and publishing articles and editorials ghost-written by industry staff.

Fifth, physicians should not be permitted to conduct research in which they have a financial interest. As for reporting research data, journal editors should require information about authors' conflicts of interests. The editors themselves should be free of financial conflicts, as should officers of professional medical organizations and faculty of academic centers. The Institute of Medicine has advocated the public dissemination of all trial data whether or not they have been published, to insure that all studies contribute to scientific knowledge, and that selective reporting is minimized. Published data should be available for independent analysis.

It would naïve to think that the profession alone can curb the negative impact industry has on the psychiatric care of patients. Government, for example, should reform the FDA and better guarantee the safety of medications by decreasing its financial dependency on pharmaceutical companies and increasing post-production oversight. The public has a responsibility to advocate, both in the political arena and with individual practitioners, for needed changes. But the profession must lead the charge because we are knowledgeable about the existence and effects of conflicts of interest, and capable of neutralizing their impact simply by retreating from participation. We must stop being pawns and assert greater power--Dylan also believes "the loser now will be later to win, for the times they are a-changing." ■

1. Kassirer, J.: *On the take: how America's complicity with big business can endanger your health.* New York, NY, Oxford University Press, 20005.

Join a WPS Committee

If you wish to join a WPS committee or help structure one, please contact Harold Eist, MD, President of WPS, at 301 530-0510 or email Patricia Troy at admin@wdcpsych.org.

Committees that need volunteers are as follows:

1. Disaster
2. Child and Adolescent
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6. Awards
7. Membership
8. CME
9. Nominating
10. Committee on Committees
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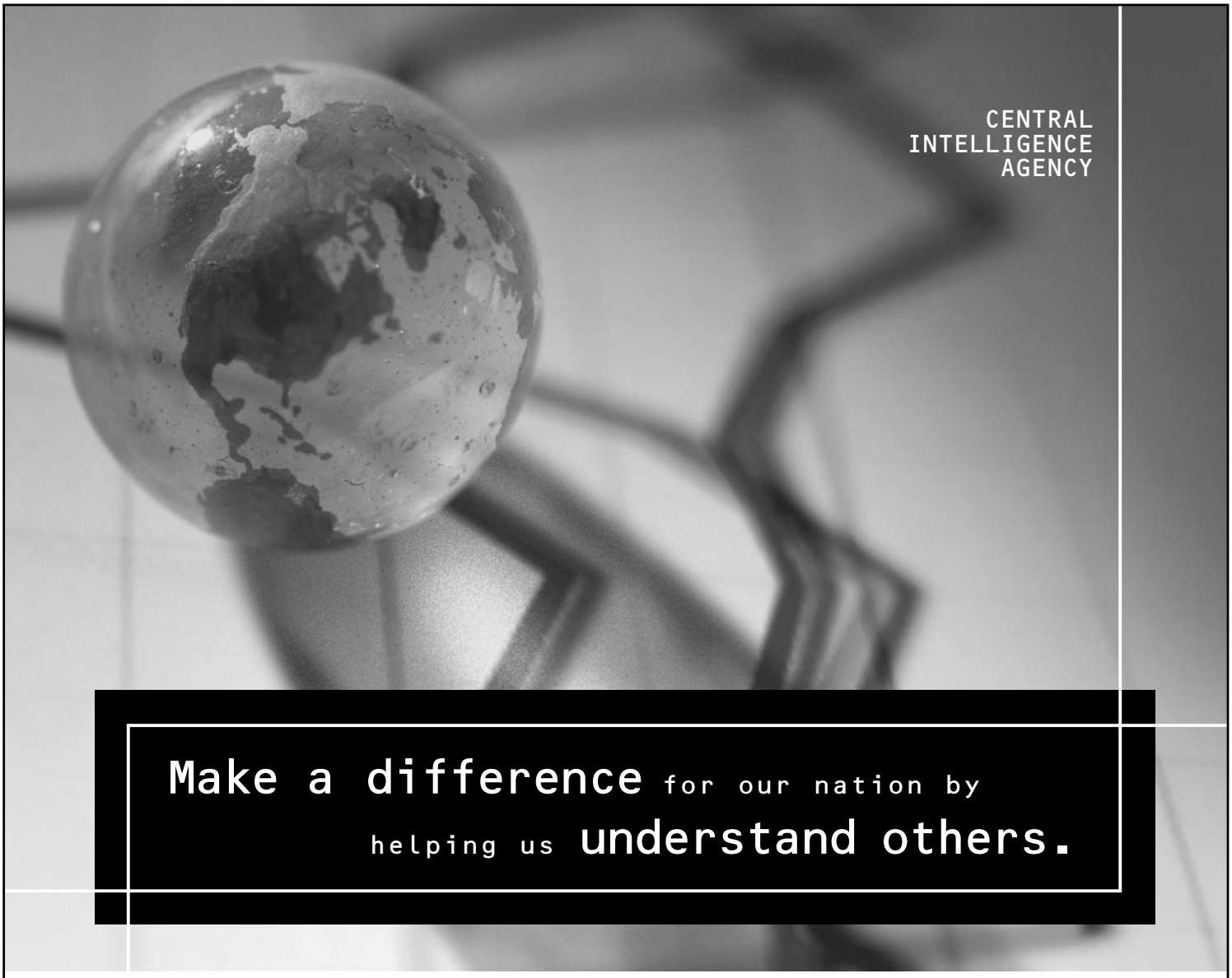
12. Mentors
13. Corporate Relations and Social Action ■



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THE WORK OF A NATION. THE CENTER OF INTELLIGENCE.

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diabetes – part of routine prenatal care is a blood glucose test. The key to avoiding no care is to have a program that is integrated with the rest of prenatal care.

More specifically, in 2008, in consultation with Dr. Wittenberg, the Bethesda National Naval Medical Center screens expectant mothers at their first Ob visit or transfer Ob appointment, at 28 week prenatal visits, and at 6 week postpartum visits. The Pediatric Service screens at 2, 4, and 6 month well baby visits. They use the Edinburgh Postpartum Depression Scale, which they call a health survey and not a depression screening survey in order to help eliminate bias and the stigma barrier. If a mother fills out the form and is positive for suicidal ideation, she is referred to the ER. If the score is 12-13, the patient is referred to social work. If the score is 14 or greater, the patient is referred to behavioral health. There are unresolved problems. One in three mothers refuse care. In the military, the patient records of both soldiers and spouses are sent to the commanding officer and are often prejudicial to advancement. Also, it can be difficult for dependents to access behavioral health resources in the community due to the limited number of Tricare insurance providers. After the patients are referred to social work or behavioral health, no one checks up on them to ensure that the patient has followed through with the referral. There are currently no support groups for new mothers or mothers with perinatal depression at the Bethesda National Naval Medical Center, but these mothers may be able to access support groups in the community.

In conceptualizing this program beyond the military, Dr. Wittenberg has suggested that it may be useful to develop a corpsman care model for women in the civilian world. Corpsmen, medics, and EMS personnel, by being trained in a vital but narrow skill set, have outstanding acceptance and usefulness.

An interesting question for the developers of the DSM-V is: " Would identification and management be enhanced by having a section on "Perinatal Psychiatric Disorders?" A broad range of psychopathology first surfaces during the perinatal period; for example, 60% of women with OCD develop it perinatally.

In summary, the Washington Psychiatric Society should take considerable pride in these ongoing preventive initiatives developed by Dr. Wittenberg. ■

Positions Available

Well qualified, personable psychiatrist interested in working with geriatric/medically ill patients in long-term care facilities in Montgomery and PG Counties, wanted P/T. Flexible schedule. Excellent pay. Opportunity for growth with an expanding consultation practice. FAX CV to: 301-681-4699 or mail to: PsychoGeriatric Services, 11120 New Hampshire Ave. #204, Silver Spring, MD 20904

Fallsgrove JSSA (Jewish Social Service Agency), a fast growing community based non-profit, non-sectarian, social service agency, has an immediate opening in a part-time contract position, for a consulting Board Certified Child/Adolescent Psychiatrist to provide child, adolescent, and adult psychiatric evaluations and medication monitoring. MD license required. Approximately 10-12 hours per week: some evening hours preferred. Send cover letter and resume to: JSSA, 200 Wood Hill Road, Rockville, MD 20850, Attn: HR. Fax: 301-309-2596. E-mail: hr@jssa.org. Visit our website at www.jssa.org. An EOE

An error was made in our last ad for The Psychiatric Institute of Washington. The ad stated that PIW was seeking 4 full time Psychiatrists. The corrected ad follows.

The Psychiatric Institute of Washington (PIW), Washington DC's leading full-service 104-bed private psychiatric facility, is seeking a Board Eligible/Board Certified Adult Psychiatrist to join our full-time Medical Staff. We are also seeking part-time and on-call psychiatrists. Desirable qualifications include inpatient experience with acutely ill psychiatric and substance abuse patients. The psychiatrist is the leader of a multidisciplinary team-based approach. Excellent salary, benefits and opportunity. Conveniently located in Northwest DC. Metrobus and Metrorail accessible.

Interested candidates please send CV to Randy Kellar, Director of Human Resources, Psychiatric Institute of Washington, 4228 Wisconsin Avenue, NW, Washington, DC 20016, by email at rkellar@piw-dc.com or through our website at www.psychinstitute.com.

Sheppard Pratt is currently recruiting psychiatrists to provide Electroconvulsive Therapy (ECT) to inpatients and outpatients referred for that treatment at Suburban Hospital in Bethesda, Maryland between 6:30 a.m. and 9:00 a.m on Monday, Wednesday and Friday. Applicants must have specialized ECT training and experience and a focus on quality care. Board certification required.

CONTACT: Barbara Magid, Director, Pr ofessional Services 410 938-3460 or bmagid@sheppardpratt.org ■

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Notes from the Bureaucracy

By Harold Eist, MD, DFAPA
President, WPS

PENS AND STICKIES:

All bureaucracies are the same, whether they are motor vehicle bureaucracies or medical bureaucracies. Lately, we have been warned about accepting pens and "stickies" from pharmaceutical companies because of the dreadful risk of manipulation to which these items expose us.

These pharmaceutical manipulations of us naïve, simple doctors could have irreversible, destructive effects on patients.

Of course, this led me to examine my pens. The one I wrote this with (in long hand: still like to do that as I'm a slow typist) was from the "Med-Chi Insurance Agency." I can assure the reader that I won't prescribe them for any of my patients. I might add the trouble, I've had with them will not begin to be ameliorated by this pen. Curious now, looking over the collection of pens in my desk, I have one from my brothers-in-law. I love them, but I won't prescribe them either. Then, I found a pen from Marriott, which I must have picked up in a hotel or at an Association meeting at the Marriott. In my experience, I remember that Marriott pens are very good but don't last long. I have one from the Minnesota Department of Human Services; it's having almost no impact, positive nor negative. Finally, oops, I have one from Zyprexa - not a very good pen-guess I won't prescribe that medicine.

P.S Full disclosure: I don't use stickies nor do I have any. ■

Obituaries

William Pollin MD

WILLIAM POLLIN MD of Betheda, Maryland and a Distinguished Life Fellow of the APA, died on January 25, 2008. He is survived by his wife, Teresa A. Pollin, his children Josh Pollin, Laura Herzog and Jonathan Amiel, and his grandchildren Samuel, Yoni, Galia, Benjamin, Lilach, Michael and Ayala. Memorial contributions may be made to Magen David Adom.

Robert C. Burnham MD

Robert Burnham, a Distinguished Life Fellow of APA, died peacefully at his home in Chestertown, MD on April 20, 2008. Dr. Burnham was born in Waterbury, CT to parents who immigrated from the Ukraine. A graduate of Yale University, he received his MD in 1941 from New York Medical College and served in the US Navy as a medical officer from 1942-1947, achieving the rank of Lieutenant Commander. He was a Training Analyst at the Washington Psychoanalytic Institute and served a term as President of that Psychoanalytic Society. While continuing his private practice in Virginia until 1993, he was on the adjunct faculty of Georgetown Medical School.

Dr. Burnham, a man of many interests that included sailing, tennis, jazz singing, and the playing of the violin, clarinet, and saxophone, took up tap dancing in his mid sixties. He is survived by his wife of over sixty years, Donna Boyd, and three of their four children: Jeffrey, Timothy, and Janet, and a granddaughter, Megan.

His friend and colleague, Dr. John Kafka, expressed these sentiments: Because Bob moved to Chestertown when he retired, many younger members of our community have been deprived of contact with this outstanding man who loved and profoundly understood psychoanalysis. This psychoanalyst's psychoanalyst was a superb teacher and a subtle clinician who was without pretense and who inspired complete trust. We who worked with him, owe him a great debt and will keep him in our memory. ■

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