THE WASHINGTON PSYCHIATRIC SOCIETY News

MARCH / APRIL 2008

How I Was Able to Do a Research Study as a Lowly Resident

Amy L. Harrington, MD PGY-3, Georgetown University

Since the first time I entered a science fair in middle school, I have enjoyed research. I love the creative process involved when I am trying to figure out the answer to a question.

I knew I wanted to be involved with research at some point during my residency training, and that there were several ways I could go about doing it. One option was to get involved with a faculty member's on-going study, use their data or create my own little sub-project. However, the science fair geek in me wanted to come up with something I could call my own. So I kept my eyes open for an opportunity.

Last summer, I was rotating through the Kolmac Clinic, and had the opportunity to observe addiction treatment patients in group therapy situations. I often heard patients describing "using dreams" they had experienced since starting treatment. One patient wondered if the addition of a sleep aid to her medication regimen might be making her dreams more intense. I thought this was a great question, but the medical literature did not contain much information on the subject. I realized this was a topic in psychiatry where not much is known, but where patients are thirsty for information and context.

I decided to design a study to see if there is an association between what medications patients are taking and whether or not they experience "using dreams." I did not know where to go next,. This was the point in the process that intimidated me the most, and that I think most residents find daunting. Most of us have never conducted research at this level, let alone designed our own study.

The first thing I did was ask Dr. George Kolodner, medical director of the Kolmac Clinic and a Georgetown faculty member, if I could recruit study participants from his clinic. He was more than accommodating: he was enthusiastic and excited to give me access. I looked through patient charts to see what kind of information was available to me. I also talked with patients about their experiences with "using dreams" and their questions about this phenomenon.

I devised a preliminary study design, and consulted Dr. Joyce Chung, a faculty member at Georgetown. I knew that she also was a researcher at NIH; and, therefore, would be a good resource for me. She, too, was eager to help. She showed me how to broaden my study to make it more publishable. It was a valuable lesson that I had not learned in middle school, but that I realize is important to learn if I want to be an academic psychiatrist.

I have just finished all of the design aspects of the study, as well as the mountains of paperwork that go along with submitting a study proposal to an Institutional Review Board. Hopefully, the committee will not find too many problems with the consent form, and I will soon get started with data collection. The study has expanded beyond what medications can exacerbate using dreams. I am also looking at demographic information, co-morbid Axis I and II pathology, and specific pre-treatment drug use. It will be a descriptive study of a clinical phenomenon that I hope will yield more questions that I can pursue more deeply later in residency.

I am glad that I made the decision to create my own study. We residents have such little time, but I have found this to be a good use of the few free moments I do have. I have learned so much, without even having begun to collect data! I have learned how to think when designing a study and how to ask the right questions. I have learned how to navigate the IRB process and how to keep myself organized. Maybe if I had gotten involved with a faculty member's NIH-funded study, I could have had my name in JAMA or something. But, hopefully, I will be able to get published somewhere, and I'll be proud to see myself as first author. Let's face it, when you are a resident, much of your life does not belong to you. This is something that I truly feel is mine, from beginning to end. It has brought me a lot of happiness. ■

What's Inside . . .

The President's Column

By Michael J. Houston, M.D..

Despite the talk of recession in the larger economy, it is my great pleasure to notify the membership that, for the first time in several years, WPS is forecast to complete our financial year in the black. Those who have followed our financial ups and downs over the last decade know how hard the board has worked to balance our budget. Payroll and real estate costs have risen dramatically throughout the country, but especially in Washington. The basic costs of running our society headquarters had risen to nearly seventy percent of our annual budget. As the Board reviewed these figures, it was clear to us that this was not how we wanted to spend the money that all members pay as dues.

After a hard look at the financials and some thoughtful discussions among the Board, we began last summer to steer the ship in a different direction. Contracting with the Next Wave Group, an association management firm run by Pat Troy, we were able to eliminate our payroll and office expenses while bringing a higher level of services to our members. The changes have not been seamless, but we are now clearly seeing the positive results that we envisioned last summer.

This past month, each member should have received, along with their ballots for the annual election, instructions for accessing their account and membership information through our website. This will allow you to view and edit your personal information online: such as your practice address and patients and illnesses you work with in your practice. It also enables you to search for and find other members by location and type. You will soon be able to register and to pay for WPS CME events online. The software we are using will allow us to organize topic specific list serves so that members who share a particular interest will be able to communicate easily with each other.

The Board hopes that these changes are the merely the first steps in a developing plan that will result in a more efficient and effective society. The WPS has a long and proud tradition of being a service to our community, a resource to our members, and a leader within the APA. I am quite certain that this mission will continue for some time to come. ■

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DC Medicaid Program Issues Guidance for the Use of Tamper Resistant Prescription Pads

Starting April 1. 2008, all hand written or computer generated prescriptions for fee-for-service DC Medicaid recipients must be on tamper-resistant paper. The Medical Assistance Administration (MAA) outlined three (3) baseline characteristics of the tamper-resistant prescription pads. They are:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

The implementation will be in two phases. The first phase requires that prescriptions carry at least one of the three characteristics by April 1, 2008. The second phase requires all three on October 1, 2008. ■

NPI Deadline

The APA;s Office of Healthcare Systems and Financing reminds all APA members that, as of March 1, 2008, Medicare will be rejecting any claims filed without a National Provider Identifier (NPI) in the appropriate spaces on the claim form.

To access more information from the Centers for Medicare and Medicaid Services (CMS) about the NPI go to http://www.psych.org/MainMenu/PsychiatricPractice/MedicareMedicaid/Alerts.aspx.

If you still have questions, e-mail them to the Office of Healthcare Systems and Financing at hsf@psych.org.

P450 and Others

By Anne Sagalyn, MD

"Doctors pour drugs of which they know little, to cure diseases of which they know less, into patients of whom they know nothing" Voltaire.

"A physician without physiology and chemistry flounders along in an aimless fashion, never able to gain any accurate conception of disease, practicing a sort of popgun pharmacy, hitting now the malady and again the patient, he himself not knowing which" Sir William Osler.

Like most of you, I've practiced psychopharmacology with an eye on P450 enzymes, taking note of rapid and poor metabolizers in my practice, and adjusting medications accordingly. Several years ago, when it became possible to test for P450 polymorphisms, I began having the more dramatic metabolizers tested-just so I'd know.

What I found surprised me. Only 30% of my predictions were accurate; the majority of my patients on drug doses well above or below recommended guidelines should have done well on standard doses. What else could account for this? Inquiring minds want to know, and I began to look further into Drug-Drug Interactions (DDIs) and pharmacogenomics to find out.

Pharmacodynamic interactions are arithmetic and predictable: opiates+benzodiazepines=respirator y depression, MAOI+SSRI=serotonin syndrome. Pharmacokinetic interactions occur when drugs interfere with each other's metabolism. Pharmacokinetic DDIs cause thousands of drug deaths each year in this country.1 Where mortality goes, morbidity follows: DDIs are responsible for treatment failures and what may appear as worsening disease. Regrettably, it is not uncommon for another drug to be added at this point.

Pharmacogenomics is the study of inherited variability in drug response, a variability that almost certainly conferred evolutionary advantage. For instance, multiple copies of CYP2D6 genes exist in many persons of Ethiopian and Saudi Arabian origin, presumably to cope with the high load of toxic alkaloids in their diet. These CYPs chew up a variety of drugs (antidepressants, antipsychotics) making them ineffective. Conversely, prodrugs will be extensively activated: codeine will be turned into vast amounts of morphine! 2

If P450 enzymes and DDIs account for only some of the surprises we encounter prescribing, what else might be responsible? UGTs and P-glycoproteins are two families of genetically-mediated metabolic (UGT) and transporter (P-Glycoproteins) enzymes. Cytochrome P450 enzymes, in phase I metabolism, use iron to oxidize toxins found in food and drugs, making them hydrophilic and more easily excreted. This is the primary means of metabolism for most drugs. UGTs are responsible for phase II metabolism (glucuronidation) rendering drugs even more hydrophilic. Phase II is the primary metabolic pathway for a small, but important number of drugs: Lamotrigine, Lorazepam, Olanzapine, Valproate and many narcotic analgesics. Serotonin is an endogenous substrate of UGTs. 3

P-glycoproteins are extruding transporters, located in gut lumen, where they regulate drug absorption; in renal tubules, where they transport hydrophilic substances into urine, and in capillaries lining the blood-brain barrier, where they prevent toxins from gaining access to the CNS. Like P450 and UGT enzymes, P-glycoproteins have substrates, inducers and inhibitors. P-glycoprotein substrates include Amitryptyline, Nortriptyline, Carbamazepine, Paroxetine, Quetiapine, Risperidone, and Topiramate. 3,4 Information about UGT and P-glycoprotein DDIs and polymorphisms is emerging, and there are other metabolic and transport systems in the wings. We are not yet able to genetically tailor treatments for our patients, but the day is coming.

There are many drug interaction software programs on the market. I use two: oncalldata.com, an electronic prescription service which automatically searches for interactions, and genemedrx.com, a sophisticated P450 interaction program into which prescription and OTC drugs, herbs, foods and genetic polymorphisms can be factored. LabCorp offers FDA approved testing for 2D6 and 2C19. ■

REFERENCES

1. An Overview of Psychotropic Drug-Drug Interactions, Psychosomatics 46:464-494, Oct 2005 Neil Sanderson, M.D.
2. Anaesthetist.com
3. Med Psych Drug-Drug Interactions Update, Psychosomatics 47:1, January-February 2006
4. P-gp introduction, UGT table Jessica Osterheld, M.D. genemedrx.com

American Academy of Psychoanalysis and Dynamic Psychiatry Meeting

By Gerald P. Perman, MD, Chair of Scientific Programs

The annual meeting of the American Academy of Psychoanalysis and Dynamic Psychiatry will be held May 1-4,2008 at the JW Marriott Hotel in Washington, DC. The meeting theme is Nature and Nurture in the XXI Century. Specific information is available on the Academy's website at www.aapdp.org. We are pleased to be hosting this event in our hometown and especially welcome members of the Washington Psychiatric Society to join us.

We will also be hosting a free luncheon and case presentation for all psychiatric residents which will be given by David Mintz, MD, Director of Residency Training and Continuing Medical Education, Austen Riggs Center, Stockbridge, MA. This will be held May 3 from 12:30-2:00 PM at the J. W. Marriott. ■

NAMI of Montgomery County Continues Its Legacy of Family Education, Support and Advocacy

By Cynthia Turner-Graham, MD, President, NAMI-Montgomery County Board of Directors

When the National Alliance for the Mentally Ill was formed, NAMI of Montgomery County (NAMI-MC) - in its former iteration - was one of six family advocacy groups in the nation which came together in Madison, Wisconsin at its historic 1979 meeting. The impact of deinstitutionalization and inadequate psychiatric and social resources continue to be acutely felt two decades later. Families remain ill-equipped to assume caretaking responsibilities of mentally ill loved ones and find available services insufficient to meet their complex needs. It was in a similar setting in 1979 that families and "consumers" recognized their singular voice carried much greater power and weight to effect change when joined with the collective voices of others.

NAMI-MC has maintained this long-standing tradition of joining patient, family and professional communities in providing support and education, and advocating for a more humane and equitable system of mental health care.

I currently serve as President of the Board of Directors for NAMI-MC and am excited about the ways we are continuing to make a difference. The needs of our patients and their families for support and education, so necessary for recovery, extend well beyond what we can give. They are best provided in the context of community and this is what NAMI does best. Individuals and families are empowered to build more positive relationships, expand their range of coping strategies and optimize daily functioning through active participation in the following programs:

- SUPPORT GROUPS FOR FAMILIES, PATIENTS, SPOUSES (ENGLISH AND EN ESPANOL) - provides group-specific general support

- FAMILY-TO-FAMILY EDUCATION COURSE - a structured educational program to teach effective behavioral strategies and coping skills

- PEER-TO-PEER RECOVERY EDUCATION PROGRAM - 10-wk course for patients, promoting lives of balance, health and wellness

- IN OUR OWN VOICE - moving testimonies by persons with mental illness describing their experience of illness and recovery. Includes discussion and provides much needed education to the community, conveying an inspiring message of hope.

- PARENTS AND TEACHERS AS ALLIES – program conducted in collaboration with Montgomery County Public Schools which educates teachers, staff and families about signs and symptoms of mental illness.

We thank those who have supported NAMI-MC over the years. Greater involvement of the psychiatric community is welcomed and we believe essential to the ongoing success of this important work. Here's how you can help:

- Go to www.namimc.org, become a member and/or make a donation online

- Obtain patient information brochures describing our programs and services from the NAMI-MC office (301-949-5852), and let patients know they are not alone

- Volunteer to be a speaker at one of our educational meetings

- Contact me directly to explore ways you can get more involved: drcynthia@forsoundmind.com or 301-963-0060 x23

Positions Available

■ Psychiatrists Wanted

We have recently been asked to assist a well-known and highly respected regional hospital in the Midwest region seeking physicians to add to its staff of psychiatrists for their state-of-the-art outpatient facility. The position is extremely lucrative and offers a generous starting salary, plus bonus, paid malpractice, and full benefits. Additional stipends for Directorships in Inpatient and Addiction services are also available to candidates with prior experience. Practice without managed care in a friendly and professional environment.

$250,000+ EARNING POTENTIAL

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If you are interested in learning more about this unique Psychiatry position please email your CV to tnelson@assurgentmedical.com. Please include a phone number where you can be reached. If you would like to speak to me directly, dial my toll free number (877) 842-6833. You may also fax your CV to (877)300-0086. All inquires will be held in the strictest confidence.

■ The Department of Psychiatry and Behavioral Sciences at The George Washington University Medical Faculty Associates, an independent non-profit clinical practice group affiliated with The George Washington University, is seeking a psychiatrist for a full time appointment to begin July 2008. The position will include participation in the department's adult outpatient psychiatry division. **Basic Qualifications:** Applicants must be license eligible in the District of Columbia and be Board Certified or Board Eligible in General Psychiatry. The applicant should have a background and expertise in cross-cultural psychiatry, spirituality and religion in psychiatry, and alternative and complementary healing practices with the potential to gain appointments in the GW Institute for Spirituality and Health and the GW Center for Integrative Medicine. Academic rank and salary will be commensurate with qualifications. Preferred Qualifications: Training in alternative and complementary healing practices including mindfulness techniques. Applicants should allow the Search Committee to contact their training director or more recent menors for references. Review of applications begins April 1, 2008, and will continue until the position is filled. **Application procedure:** To be considered, interested applicants should send a letter of interest, curriculum vitae and two letters of recommendation to:

Jeffrey S. Akman, MD

Leon Yochelson Professor & Chair

Department of Psychiatry and Behavioral Sciences

2150 Pennsylvania Avenue, NW

Washington, DC 20037

Only completed applications will be considered.

The George Washington University Medical Faculty Associates is an Equal Opportunity/Affirmative Action Employer.

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DC Chapter Comments

By Robert Keisling, MD

The article in the Washington Post on 16 February, about the deaths at St. Elizabeths Hospital last year, was welcome and overdue. The Washington Psychiatric Society tried to alert city officials several years ago: a letter was written to the Mayor by Dr. Connie Dunlap in January of 2006.

The Department of Justice released its report in May of 2006, confirming our concerns and citing other problems. Let's not forget about these deaths in our community.

The Center for Disease Control estimates that seriously mentally ill people have a life expectancy 20 years less than the general population, due to untreated diabetes, hypertension, HIV disease and mental illness. The Department of Justice has estimated that 64% of local jail inmates and 40-50% of prison inmates are mentally ill. There are 20 times as many mentally ill people residing in jails and prisons as are in state mental hospitals.

The DC Department of Mental Health spends money on programs that lose $14 million per year, according to the court monitor's report. It spends 5 times the national average on administration, according to data from the National Association of State Mental Health Program Directors. Other cities spend their money more wisely.

The Housing First program of Denver has saved that city $4.7 million . It reduced emergency related costs by 72% and incarcerations by 76%. If all chronically homeless mentally ill persons in Denver had been enrolled in this program, the costs savings would have been $16 million.

This model has been duplicated in other sites. You can read about it in a New Yorker magazine article by Malcolm Gladwell, published in February 2006 and entitled: "Million Dollar Murray." DC spends $2.2 billion on healthcare, more per capita than any other city in the US.

We can do better than this. ■

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www.sarcorp.com

■ **Psychiatrist**

The Psychiatric Institute of Washington (PIW), a 104-bed private psychiatric facility, is seeking four (4) (Board Eligible/Board Certified) Adult Psychiatrists to join our professional, stimulating environment serving Washington, DC and Prince George's County, MD. These roles include providing psychiatric services; evaluations and medical management sessions for adult patients on three (3) inpatient and one (1) outpatient settings. We are also seeking Part-time and On-call Physicians.

Desirable qualifications include experience in the techniques of psychiatric diagnosis and treatment and chemical dependency in an inpatient setting. Multi-disciplinary team-based approach.

Excellent salary, benefits and opportunity that provides diverse, comprehensive and innovative treatment and programs. Conveniently located near downtown Washington, D.C. Metrobus and Metrorail accessible.

Interested candidates please send CV to Randy Kellar, Director of Human Resources, Psychiatric Institute of Washington, 4228 Wisconsin Avenue, N.W., Washington, D.C. 20016, by e-mail at rkellar@piw-dc-com, or apply through our website at www.psychinstitute.com.

Office Space Available

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From the APA: DEA Issues Final Rule on Multiple Prescriptions

By Nick Meyers, Director of APA Government Relations

In a win for APA members and their patients, the Drug Enforcement Agency (DEA) has issued a final rule covering multiple prescriptions for Schedule II controlled substances. The final rule became effective on December 19, 2007.

Members will recall that DEA had initially reversed long-standing policy and concluded that multiple prescriptions given to the same patient on the same day for the same controlled substance(s) on Schedule II constituted a refill order and was, therefore, prohibited. In response to statements of concern from the APA and other organizations, as well as from individual psychiatrists and other physicians, DEA proposed in September 2006 to allow physicians to provide individual patients with "multiple prescriptions, to be filled sequentially, for the same Schedule II controlled substance, with such multiple prescriptions having the combined effect of allowing a patient to receive over time up to a 90-day supply" of the controlled substance.

The final rule includes the following important provisions:

Refilling a prescription for a Schedule II controlled substance is prohibited

Individual practitioners "may issue" multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance provided that certain conditions are met. These are:

Each separate prescription is issued for a legitimate medical purpose

Each prescription (other than the first if intended to be filled immediately) indicating the earliest date on which each prescription may be filled

The practitioner determines that multiple prescriptions does not constitute an undue risk of diversion or abuse

Multiple prescriptions covered under the rule are permissible under applicable state laws

The practitioner complies with all other applicable requirements under the Controlled Substances Act, and the regulations, and additional state requirements.

Nothing in the regulations should be construed to encourage practitioners to issue multiple prescriptions or to see their patients only once every 90 days for Schedule II medications. Instead, practitioners should rely on sound medical judgment and established medical standards in making these decisions

It is particularly important for APA members to note that state laws take precedence. Members should therefore be certain that the issuance of multiple prescriptions for the purposes described in this memo is consistent with state laws and regulations. If uncertain, we encourage members to contact their state pharmacy board for additional information. ■

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