

Help patients with 'CME fund'

While I agree with Dr. Henry Nasrallah that pharmaceutical companies' policies need to be changed ("Break-through drugs and sponsorless CME: How the FDA can help," From the Editor, CURRENT PSYCHIATRY, April 2008, p. 15-16), I believe he overlooked the larger moral question and a potential intervention. Every dollar psychiatrists accept for personal use—no matter how free from bias—is one that could have been used to benefit our patients.

As physicians we need to set aside our deeply ingrained feelings of entitlement and assume responsibility for our education and sustenance. I can buy my own books, notepads, lunches, and even continuing medical education (CME). I cannot provide expanded patient assistance programs or lower medication costs. A pooled not-for-profit fund is an excellent idea; why not use it to buy generic medications for resident clinics to distribute free of charge or other patient-centered activities?

I recognize that funding CME without industry sponsorship would be difficult and would require fewer creature comforts and more funding from physicians. It likely will require creative use of Web-based teleconferencing, information sharing, or even streamed, prepackaged lectures from recognized experts. In the end, however, I believe a greater commitment to teaching each other and active learning will provide a greater benefit to ourselves and our patients.

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Residents need CME, too

I applaud Dr. Nasrallah's forward thinking regarding encouraging creative new psychotropic drug development and supporting CME. CME programs—although vital for faculty and private practitioners—also are extremely valuable for residents, even though they don't receive credit for completing the courses.

I would like to see your idea for a nonprofit, independent fund for CME activities take into account that all residency programs would need some support for CME and ensure that funding is equally distributed to programs large and small.

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CME: A polarizing issue

I enjoyed Dr. Nasrallah's editorial on sponsorless CME. The issue has polarized different groups, and I thought his ideas were sensible. We have to

start looking for solutions instead of pointing fingers or avoiding accountability. Thanks for speaking up.

Second, CURRENT PSYCHIATRY is a favorite journal to me and a number of my colleagues. It is relevant and clinically focused yet has good evidence-based accountability. And to top it off, the articles can be mastered in a reasonably short period of time. I read more articles in CURRENT PSYCHIATRY than in any other journal, and I definitely am not alone in that practice.

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Patients' plight is no joke

I read Dr. Nasrallah's editorial about the tragic consequences of deinstitutionalization ("Bring back the asylums?" From the Editor, CURRENT PSYCHIATRY, March 2008, p. 19-20) with great enthusiasm. Since 1981 I have devoted my career to treating chronic mentally ill individuals in community settings. For the past 6 years I have worked for a social service agency that provides on-site services to mentally ill tenants in permanent single-room occupancy housing. This agency serves approximately 1,500 tenants in several buildings. I have had intimate exposure to the experiences of individuals who a generation ago would have been placed in long-term institutions.

My private joke is that my agency runs the largest long-term psychiatric institution in New York state. However, over the past few years this no

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longer seems like a joke. Seeing the reality of these severely mentally ill persons' lives—even in this protective setting of supervised housing run by an outstanding agency—is sobering and discouraging. What I see every day thoroughly supports and is living proof of the validity of Dr. Nasrallah's editorial. It is a relief to have my thoughts validated because among community psychiatrists such thinking is viewed as heresy.

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No lobbyists for mentally ill

I heartily agree with Dr. Nasrallah's stance about the treatment of chronically mentally ill individuals, specifically those with schizophrenia. I recently completed my psychiatry residency in Virginia. In addition to the consequences Dr. Nasrallah outlined in his editorial, I have identified



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a few additional disastrous effects of transferring care of severely mentally ill patients from state hospitals to the community service boards (CSBs).

Working in a hospital affiliated with a medical school meant that we took care of all indigent patients who were admitted. It is heartbreaking to spend weeks stabilizing a very ill patient and then send him or her back to

the disastrous circumstances that often lead to the initial hospitalization. I saw patients discharged with appointments to CSBs that they had little chance of finding, getting to, or even remembering. These patients often were prescribed medications that I could not afford even with health insurance.

Discharged patients don't fill prescriptions or they can't remember medication schedules because they are too busy trying to survive. People who most need effective medicines have long ago become nonresponsive because of repeated periods of non-compliance.

Severely mentally ill persons do not have lobbyists in government; they are not likely to organize a march on Washington, DC. They have no voice, which is why their whimpers go unheard and unanswered.

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