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ABOUT THE COVER

The cover photo was snapped by Patricia H. Troy in Cape May, New Jersey.



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FROM THE EDITOR

WASHINGTON PSYCHIATRIST



Dear WP Readers,

In this issue of *Washington Psychiatrist*, President Steve Epstein, MD gives us the rationale and the process for the Maintenance of Board Certification requirements in psychiatry. This is required periodically of all psychiatrists who received their Board Certification after September 30, 1994 (p.3). I was fortunate to attend the installation of James L. Griffith, MD as Chair of the G.W. Department of Psychiatry and Neurology. His acceptance speech moved me deeply and I was grateful when he agreed to allow me to publish it in WP. Dr. Griffith combines his personal story with a scholarly overview of some of the opportunities and challenges to psychiatry in today's world (p.5). An excellent multidisciplinary article on the

critically important but often underfunded and unaddressed problem of the homeless mentally is provided by, among others, WPS members Michael Morse, MD and Alan Dyer, MD, PhD (p.7). Ms. Pat Troy, WPS Executive Director and President of Next Wave Group, LLC gives us a behind-the-scene view of how her group does such an excellent and efficient job of managing the Washington Psychiatric Society (p.7). Ms. Troy brought to my attention an article that I turned into a brief WP piece about a study showing what many of us in clinical practice know only too well to be true: that it is often difficult to impossible for patients to use their health insurance to get an appointment with a psychiatrist. Patients can, however, as the article points out, sometimes order a Big Mac instead (p.13). Brian Doyle, MD, regular WP contributor, provides us with another engaging story about his experience of becoming a doctor (p.14). Finally, Jason Emejuru, MD, G.W. psychiatric resident, shares his experience of a winter night in the emergency room with a seriously ill young man, pondering at the end of their encounter, the effects of his intervention (p.17).

Please send your articles and your stories to enews@dcpsych.org.

Thank you.

Cordially yours,

Gerald P. Perman, MD
Editor, *Washington Psychiatrist*



By Steven Epstein MD, FAPA
WPS President

As everyone knows by now, the American Board of Psychiatry and Neurology requires that all psychiatrists who wish to remain board-certified must maintain certification. Full disclosure: As a long-standing member of an ABPN test committee for Psychosomatic Medicine and a new MOC ambassador, I am fully in support of MOC.

I will briefly review the requirements for maintenance of certification, but first: **why is MOC essential?**

To answer a question with a question: why would it not be? As physicians we are entrusted with maintaining standards of patient care. We are no different than other medical professionals or, for that matter, pilots. Would you want a surgeon or a pilot who was certified twenty years ago to tell you that she was trained at an excellent program and often reads journal articles, so why should she have to demonstrate MOC? In addition, maintenance of licensure already depends to some extent on MOC, e.g. CME credits.

What possible argument could there be against MOC? It appears that the majority of complaints focus on the actual procedures, not the necessity of MOC per se. In fact, the ABPN is responsive to feedback from the profession. For example, the Performance in Practice requirements have recently been lessened.

Here is an abbreviated summary of MOC. In addition, we all should check the website periodically for updates (abpn.com/moc): As mandated by the American Board of Medical Specialties, the Maintenance of Certification programs include four components:

1. Professionalism and Professional Standing
2. Lifelong Learning and Self-Assessment (SA)
3. Assessment of Knowledge, Judgment, and Skills
4. Improvement in Medical Practice (PIP)

1. Professionalism and Professional Standing

All Diplomates must continuously hold an active, full, and unrestricted allopathic and/or osteopathic license to practice medicine.

2. Lifelong Learning and Self-Assessment

A. CME

Diplomates of the ABPN are required to complete an average of 30 specialty or subspecialty CME credits per year averaged over three years.

B. Self-Assessment (SA)

Each SA activity must cover new knowledge and/or current best practices in one or more of the competency areas and provide feedback that can be used by the Diplomate as the basis for focused CME, lifelong learning, and/or career development. That feedback must include the correct answer and recommended literature resources for each question, and comparative performance to peers. At least eight CME credits per year (averaged over three years) should involve SA.

3. Assessment of Knowledge, Judgment, and Skills

Passing the MOC cognitive examination at least once every 10 years fulfills the cognitive expertise component of the program.

4. Improvement in Medical Practice (PIP)

There are two components to a PIP unit: a clinical module and a feedback module. Each component must be done twice to complete the unit. One PIP unit should be completed every three years.

A. Clinical Module (Chart Review)

- Diplomates are required to collect data from at least five patient cases in a specific category (e.g., diagnosis, type of treatment, treatment setting) obtained from the Diplomate's personal practice over the previous three-year period.
- Diplomates must then compare data from the five patient cases with published best practices, practice guidelines, or peer-based standards of care (e.g., hospital QI programs, standard practice guidelines published by specialty societies), and develop and carry out a plan to improve effectiveness or efficiency of individual clinical activities.

- Re-measurement: within 24 months, Diplomates must collect the same data from at least another five clinical cases in the same specific category and review that data to see if improvements in practice have occurred.

B. Feedback Module (Patient and Peer Review)

- Diplomates must solicit personal performance feedback from at least five peers or five of their own patients concerning the Diplomate's clinical activity during the previous three years.
- Diplomates must then identify opportunities for improvement in the effectiveness and/or efficiency in their practice as related to the general competencies and take steps to implement improvements as needed.
- Re-measurement: within 24 months, and using the same forms, patients or peers are surveyed again and the results are used to compare to the original survey to see if practice improvement has taken place.

One final thought: why shouldn't the requirements be even more stringent? I would not be surprised if in the coming years we need to present data on actual outcomes similar to mortality rates for cardiac surgery, or incidence of central line infections. Shouldn't our patients know whether we are successful in treating our patients with depression, psychosis, and chemical dependence? Stay tuned, and please be happy (or at least proud) that our profession cares that we maintain high standards for our patients.



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James L. Griffith, MD's remarks on being installed as the **Leon M. Yochelson, MD Professor and Chairman of the Department of Psychiatry and the Behavioral Sciences** at the George Washington University Medical Center, Washington DC ~ Monday, August 11, 2014

Good afternoon. I want to express gratitude to Provost Lerman and to Dean Akman for your confidence in me and for your leadership. I want to thank Natalie Allgier and Dennis Narango for preparing this event today. I also want to acknowledge Dr. Lynne Gaby, my wife and partner in much of my work, and my children, Van and Devin, who are here today, and Noah and Marianna who could not be, as well as my sisters, Marie and Margaret. I can only wish that my Mother, who was herself Chair of a Department of Education and Psychology, and later a Dean, could be here, but she is too ill to travel.

This occasion presents a challenge, which is to answer in 12 minutes two ancient questions: *Whence, and Wither?* From where, to where?

My own story in Medicine must have begun as a small child in a South Mississippi Baptist Sunday School where I encountered one of Jesus's parables that read like this: "*The kingdom of heaven is like a merchant seeking beautiful pearls, who, when he had found one pearl of great price, went and sold all that he had, and bought it.*" (Matthew 13:45-46). As a child, I pondered that parable and asked myself what, for me, would be such a pearl of great price? What for my life would be worth that kind of devotion? That was one current that moved me as I grew and developed.

Another current was our greatest Mississippi author and Nobel Prize Winner – William Faulkner – who wrote in his short story, *Tomorrow*, that any man's life can be summed up in eight words — "He was born, he suffered, and he died." I grew up in Faulkner's Mississippi, and I saw what he witnessed, that suffering was all around me — my father's World War II head injury, Brown-Sequard Syndrome, and neuropathic pain; poverty and disease; an impoverished society built on religion and racism. It was where Jesus's tracks were crossed by Faulkner's tracks that I made a decision to become a doctor. Doctors are healers. Healing is sometimes about curing disease. More often it is about relieving pain and disability. Healing is about alleviating suffering.

Eventually, after a neurosurgery internship, a neurology residency, and graduate studies in laboratory neurophysiology, this would bring me to Psychiatry. Much human suffering is from disease, but only Psychiatry among the disciplines of Medicine, both treats disease and reaches beyond disease to impact other sources of suffering I saw around me, particularly abuse, neglect, and exploitation of other human beings. In time I would understand that my mission was not just to become a healer but to learn how to teach healing. At no point have I ever considered any job other than teaching in a medical school.

At his installation as the Walter Bloedorn Professor of Administrative Medicine, Dr. Akman spoke about the lessons he had learned in his years at GW. He said this: "*In Medicine, it is said, first do no harm. However, what I learned is first to do what is right.*" That is the kind of Psychiatry department Jeff and I sought to build during our twenty years serving together on this faculty.

"Doing what is right" gives a straightforward mission for our Psychiatry department, into its future, that I will briefly outline. First, is the creation of mental health policy and advocacy, both in the U.S. and around the world. This is the political. Second, is the translation of neuroscience research into practices that can both treat mental illnesses and relieve human suffering more broadly. This is the science.

Psychiatry is unique in that healing means promoting basic human rights as much as it does treating symptoms of disease. Our nation's largest psychiatric hospital is the Los Angeles County jail that houses 1,400 mentally ill individuals, many arrested for petty crimes that supported living homeless on the streets. Three-fourths of incarcerated women in our country have psychiatric diagnoses.

Patients are not arrested for disabilities due to diabetes or kidney disease. Arresting a person due to symptoms of mental disease is wrong. It was never right.

Internationally, the picture is the same. 2011 marked the year when psychiatric illnesses, mainly depression, schizophrenia, and alcoholism, surpassed cardiovascular diseases as the world's leading cause of disease burden and work disability. Thirty-seven percent of the world's disease burden is due to mental illnesses, yet only ½ of 1% of health care expenditures in low-income countries, and only 5% in high income countries, are spent for mental health. This is stigma.

If this sounds like passing judgment on those who stigmatize, it is — and it isn't. Discrimination against the mentally-ill merits moral judgment and political action, but the fact that stigmatization of mental illnesses exists doesn't. We now know from social psychology and social neuroscience research that stigmatization is an evolutionary byproduct of the way normal brains process social information and is akin to racism, anti-Semitism, moral and contagion stigma against HIV patients, all of the same fabric. The human brain is evolutionarily designed for its remarkable capacity to form tightly cohesive groups, including the extrusion of those perceived as too different or too likely to impede functioning of the group.

After reviewing 8,200 journal articles over two years, the World Psychiatric Association concluded that mental illnesses are stigmatized in every society studied and that there are essentially no evidence-based interventions that do anything about it. Education does no harm but accomplishes surprisingly little. The answer to stigma will come from a new generation of research that utilizes an understanding of the brain's systems for social cognition to guide practices that re-humanize those who are stigmatized.

Dr. Brandon Kohrt, a graduate of our psychiatry residency last year, has been in Liberia field-testing interventions to counter the stigma of mental illness, interventions that originated in large part in our department and are based on a social neuroscience model, rather than our traditional psychological theories. The findings from his research we hope to bring back to the U.S. This May we published the first of a series of articles that will attempt to ground psychiatric residency training in neuroscience research, rather than our historic nosology, in an effort to bring new solutions to old problems, such as stigma.

Our department is serving, and will continue to serve, a significant role in translating basic neuroscience research into clinical practice and interventions that can treat mental illnesses more effectively, more efficiently, and with greater portability across cultures.

Our context is global, anchored by the Charles and Sonia Akman Professorship in Global Psychiatry that we received last year. Our GW psychiatry residents and faculty have conducted training, research, and human rights projects in ten low- and middle-income countries during the past two years. Our department has become a national leader for both the training of clinicians and treatment programs for individuals who have been politically tortured in their home countries around the world. We are nearing closure on an affiliation agreement between our medical school and an NGO directed by our fourth year resident, Michael Morse, that, with good fortune in fund-raising, will create community-based training for Palestinian mental health professionals in Bethlehem and Jerusalem. Promoting mental health promotes a civil society. This becomes our contribution to peace-building.

So this is our future — to engage fully in mental health policy, advocacy, and political action to restore humanity to our patients, to translate neuroscience research into treatment innovations at bedside and in office practices, and, through our programs in global mental health, to carry these innovations beyond our borders.

To chair this department as the Leon M. Yochelson Professor of Psychiatry is a privilege for which I am grateful. We have a mission that I believe we can accomplish. For this I continue to work more hours and sleep less each week than I did when I was a resident in training. It is a calling.

Assisted Outpatient Treatment for Homeless Individuals with Severe and Persistent Mental Illness: An Interdisciplinary Conversation

By Michael Morse, MD, MPA and Allen Dyer, MD, PhD

A Frontline View by Gunther Stern, Executive Director, Georgetown Ministry Center

Chris walks his route through Georgetown every day, picking through the various trash cans looking for half eaten sandwiches or pizza. He picks off his finds and eats them right there to the horror of any nearby witnesses. In the nearly thirty years that I have been working with homeless people I have learned that many of the people who live on the streets can be diagnosed with various types of brain disorders that drastically impair their ability to function in modern society.

The worst part is they usually do not understand that the bizarre thoughts and suspicions they perceive are not reality. I cannot tell you how many times I have heard from mental health professionals in DC, “If he doesn’t want help and he isn’t holding a gun with his finger to the trigger there is nothing I can do.”

When I talk to Chris about treatment he becomes angry, hostile and sometimes enraged, but never violent. Everything about his behavior seems dangerous but he never threatens to hit me or anyone else and so he is never considered a danger. Our hands are tied. We need tools to reach people like Chris, whose mental illness prevents them from understanding that they need help. Their lives would be so much better with treatment.

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A Legal View by Kathryn Cohen, Attorney, Treatment Advocacy Center

The District has a shortage of public psychiatric beds. Community-based services are in short supply, and those that exist are often accessible only to those psychiatrically and physically well enough to seek them voluntarily.

DC’s laws make the problem even worse by restricting access to treatment for the most severely ill, often until it is too late. We see the consequences of this abandonment too often in our headlines and we then learn that predictable and preventable tragedies have been committed by people as a result of their untreated severe mental illness. But even more suffer out of the media’s notice, languishing on our streets, in homeless shelters and in jails. Many of these tragedies could have been prevented by commonsense laws already in place in many states throughout the country.

Instead, DC relies on well-intentioned but misguided laws that protect the right to be ill. These laws ignore those too sick to seek treatment voluntarily and abandon them to a life of torment by the symptoms of their illness.

As an attorney at the Treatment Advocacy Center, I frequently hear from DC residents living with the heartbreak that these laws impose because they can’t get their loved one into treatment. The key to eliminating this heartbreak is getting those people with severe mental illness into treatment involuntarily until they are well enough to do so voluntarily. We know, for example, that people who are receiving treatment for severe mental illness are no more likely to engage in violence than anyone else and that treatment is the key to maintaining strong bonds with friends and family, as well as a key component to avoiding hospitalization, victimization, and incarcerations. But in DC, families are often powerless to help their loved ones unless they are found to be “likely to injure” themselves or others. Until that point, the person in crisis must volunteer for care.

Why can’t the severely ill volunteer for care? Mental illness often affects the very organ that would allow a person to make an informed treatment decision, making voluntary treatment impossible. This condition, called anosognosia or “lack of insight,” renders a person unable to recognize his or her own illness, no matter how painfully obvious it may be to outside observers. And so they reject all offered treatment.

While anosognosia is a term that had previously been used primarily in neurology, extensive research since the early 1990s has found that it affects many people with severe and persistent mental illness, especially those with schizophrenia and bipolar disorder.

WASHINGTON, DC

Since 2010, homelessness in DC has increased by 18 percent, even as it has declined by six percent nationally. Those who work directly with the homeless recognize that most people who are homeless in DC have severe mental illness and struggle with anosognosia. As a result, many of the homeless with severe and persistent psychiatric problems cannot access needed treatment within the existing systems of care.

How do inpatient and outpatient commitments work in Washington, DC and how would they help someone like Chris?

Despite the obvious need for psychiatric treatment, these people frequently fail to meet DC's standard for involuntary commitment to a hospital, i.e. posing a "likelihood to injure self or other persons." In DC, this standard has been understood to mean a person needs to be actively trying to hurt himself or someone else in order to get inpatient treatment. DC courts have already interpreted the standard to encompass a broader set of criteria, but, without formal adoption by statute, psychiatrists are unlikely to apply the broader set of criteria in clinical practice. As a result, individuals are rarely admitted involuntarily to a hospital on grounds other than imminent risk of violence to others or suicide. What this means in practice is that individuals are allowed to deteriorate without care until they are violent. For someone like Chris, this means a life of eating out of garbage cans and other symptomatic behavior. DC must update its laws to address this obvious failing to help Chris and those suffering as he is.

DC should also reinvigorate its committed outpatient treatment ("CMOP") program. CMOP, known nationally as assisted outpatient treatment ("AOT"), that allow people who struggle to adhere to treatment voluntarily to receive treatment under court order while remaining in their homes and communities. These people have to meet strict legal criteria to qualify for a CMOP/ AOT order.

CMOP assigns a treatment team to provide necessary care and allows the team to work with the court to facilitate more consistent adherence. AOT's combination of court order and comprehensive treatment plan improves treatment adherence, the lack of which is the single largest reason that people get caught in the revolving door of repeated hospitalizations, incarcerations, and homelessness. For those whose anosognosia impairs their ability to seek and voluntarily comply with their medication, AOT/CMOP can be the solution they need to remain well in the community. Multiple studies show that AOT significantly reduces these consequences and saves public mental health systems money in the process. As people with severe mental illness are better able to maintain their treatment, evidence suggests significant decreases in both expensive inpatient hospitalization and emergency room use.

AOT works for two key reasons. First, the impact of judicial oversight cannot be overstated. Individuals in successful AOT programs report that the judge is able to impress upon them the need to comply with treatment. Second, an AOT order ensures that public mental health system and treatment providers are aware that the person is at high risk for relapse and requires consistent care and monitoring. Effectively, AOT ensures the system takes responsibility by obligating mental health providers to execute a comprehensive treatment plan. With judicial oversight, it is much less likely the person will be allowed to fall through the cracks.

Does DC's assisted outpatient treatment law work?

Discussions with providers point to a problem with the law, specifically that the statutory language is not robust enough to ensure that individuals are receiving high quality services. For example, it does not mandate the DC Department of Behavioral Health develop a treatment plan for each patient — a key component to any successful AOT/CMOP program. As a result, AOT orders in DC lack effective oversight and planning.

The practical result of DC's failure to utilize AOT/CMOP effectively is that community mental health services only serve the people who are well enough to seek and accept services voluntarily. By not using this life saving tool effectively, we are denying people with severe mental illness a less-restrictive alternative that would allow them to recover and live successfully in the community.

Some people argue that AOT impedes civil liberties. But there is no liberty in the torment of the hallucinations and delusions that result from untreated severe mental illness, or eating out of the trashcan like Chris. Rather than impeding civil liberties, AOT/CMOP actually restores liberties and ensures that people with severe mental illness receive care until such point that they are well enough to again make treatment decisions voluntarily.

Conclusion

The District needs to update its laws to allow for earlier inpatient care and to make active use of its AOT/CMOP program. These changes will allow for more timely treatment for individuals in need and reduce the consequences of non-treatment on people with severe mental illness, their families, and their community. Once these changes are made, the Department of Behavioral Health must be committed to properly implementing the law. Improving the law and insisting on the proper implementation is a necessary predicate to a successful system of care for our most severely ill.

A Clergy View by Rev. John Graham, Rector, Grace Episcopal Church

Over the past decade, as Rector of Grace Episcopal Church and a board member of Georgetown Ministry Center, I have been intimately involved with caring for and ministering to homeless persons with mental illness. As a member of the Christian Clergy, I feel that we have a societal obligation to respond to the suffering of those most in need in our community. Assisted outpatient treatment is one opportunity to do so.

Biblical stories portray that human beings may not initially be aware of their need for healing. Take, for example, the story of the Gadarene demoniac in Mark's gospel, chapter 5. This nameless, possessed man "...lived among the tombs; and no one could bind him anymore, even with a chain; for he had often been bound with fetters and chains, but the chains he wrenched apart, and the fetters he broke in pieces; and no one had the strength to subdue him. Night and day among the tombs and on the mountains he was always crying out, and bruising himself with stones."

Certainly "anosognosia" would be a reasonable diagnosis for the Gadarene. Jesus does not enlist the man's cooperation or ask his permission, but rather "gives (the demons) leave" to depart from him and enter a herd of pigs. Interestingly, the demons – in contrast to the man himself – know that Jesus' arrival requires their departure; with this awareness, they ask not to be banished from the area, but to enter the swine nearby. It's a plausible interpretation that they represent an alien power, like mental illness, that has stolen the man's own self-awareness, that can re-emerge once they are gone. In the story of the Gadarene, healing takes place through the intervention of an external spiritual force. This force does not deprive the man who is healed of his selfhood. Rather, it bestows agency.

In the Hebrew and Christian scriptures, such interventions proceed from divine authority and power. Assisted outpatient treatment, in contrast, is undertaken by flesh and blood human beings, with all our flaws and limitations. Nonetheless, the Bible also tells us that human beings are made in God's image, invested with a measure of God's authority and power. Properly hedged and constrained by court procedure and judicial and medical oversight, assisted outpatient treatment, in my view, has the capacity to effect healing for those most in need.

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A Medical Ethics View by Michael Morse MD MPA, Psychiatric Resident, George Washington University and Allen Dyer MD PhD, Attending Psychiatrist, George Washington University

As psychiatrists with a background in medical ethics, we believe that using the lens of principle-based ethics can shed some additional light on assisted outpatient treatment.

As articulated by Beauchamp and Childress in *Principles of Biomedical Ethics* (2001), four primary principles guide ethical decision making: respect for the patient's autonomy, beneficence, non-maleficence (first do no harm), and justice (especially the socially just distribution of scarce healthcare resources). Ethical problems arise when these principles come into conflict.

When applying these principles to cases of homeless persons with severe and persistent mental illness, it is immediately apparent that the problems raised by Ms. Cohen (see above) regarding autonomy are a foremost consideration. It is common for a homeless patient with severe and persistent mental illness to lack the following insights: (1) that she has a psychiatric illness, (2) that the psychiatric illness was likely the primary proximate reason for her homelessness, (3) that if left untreated the psychiatric illness will put her at high risk for sustained homelessness, and (4) that homelessness strongly covaries both with victimization including physical and sexual assault risk and with death an early age from comorbid medical conditions. In the absence of such an understanding, a homeless person can neither perceive the risks of ongoing untreated mental illness and concomitant homelessness, nor can she accurately estimate the potential benefits of treatment. Autonomy, as it is commonly understood by the general public and by medical ethicists, is quite limited in such cases.

The remaining three principles, beneficence, non-maleficence, and justice must then be considered in turn.

The principle of beneficence clearly requires that we provide effective treatments for patients with severe and persistent mental illness. This includes both pharmacotherapy and psychotherapy. The present system of care provides such treatments to an exceedingly small percentage of mentally ill homeless persons; thus, we are not meeting the principle of beneficence.

The principle of justice and, as we are interpreting it - social justice - requires a fair distribution of mental health resources to homeless persons. As noted above, most homeless persons do not access any mental health services at all. The principle of justice is not being met.

Non-maleficence is more complicated, however, as antipsychotics do have a substantial side effect burden. The risk of both extrapyramidal symptoms and metabolic disturbances is clinically meaningful from the physician's perspective; from an individual patient's perspective, akathisia may be insufferable and diabetes may be unmanageable. The likelihood that some harm will be done if patients are adherent to antipsychotics over the long run must give us pause as we consider our role in assisted outpatient treatment.

I (M.M.) have been working with homeless persons on the streets of Georgetown over the past year. I have heard innumerable stories of functional decline, of the loss of not only housing but also all connections with loved ones, and of assault and victimization in the street. I have witnessed firsthand the pervasiveness of anosognosia among homeless persons with severe and persistent mental illness. It does not seem right to simply leave those who are most at need in our society without the care that they require and deserve.

Contrary to conventional wisdom, assisted outpatient treatment is the most effective way to enhance and respect patient autonomy by restoring patient capability to better participate in shared decision-making.

Concluding Remarks

Our society will need to implement numerous complimentary interventions if we are to fully meet the needs of all homeless persons with severe and persistent mental illness, including housing, general medical care, and case management. While these are all necessary, for homeless persons with anosognosia they are often insufficient. Assisted outpatient treatment enables these persons to access and to benefit from care, often restoring a measure of autonomy and enabling them to maintain housing, to participate in general medical care, and to work collaboratively with case managers to meet their social service needs. We believe that physicians, lawyers, political and government leaders, religious leaders, and other members of the community should work together to advance assisted outpatient treatment initiatives, reducing suffering and improving the wellbeing of vulnerable homeless individuals.



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Managing a Psychiatric Society

By Patricia H. Troy, CAE
Executive Director, Washington Psychiatric Society
President, Next Wave Group, LLC, Organization Management

When I was approached to submit a proposal to manage the Washington Psychiatric Society, I felt confident that we could manage a psychiatric society, in the sense that we were already managing an oncology society. But I have to confess that I was somewhat intimidated by the thought of working for people who would potentially be analyzing me at every turn.

When I was interviewed by the “selection committee,” I was a bit shaky. What would they be thinking? Would they be interpreting everything I said and drawing conclusions about my childhood? Would they want to diagnose me? I wasn’t sure and no doubt my nervousness showed. This wasn’t your typical job interview. I had never been to a psychiatrist as a patient and I had never known one as a friend either. So this was new territory for me — to be interviewed by six of Washington DC’s finest psychiatrists.

My firm, Next Wave Group, was selected for the management contract, and in 2007 I began my journey managing WPS. At first I was called Administrator, but soon it became clear that the work we were doing was more than back office support. We were providing governance, guidance and helping the organization grow. My title was changed to Executive Director. We now provide the full spectrum of management and support services for WPS.

Prior to 2007, WPS was managed by “captive staff.” This means that the staff were employees of WPS. There was an Executive Director and an Executive Secretary. At the recommendation of Interim Executive Director, Jackie Van Hook, WPS explored the idea of using an association management firm as an alternative to “captive staff” and a conventional office.

Next Wave Group, LLC, my company, has operated “virtually” since 2006. We find this is a cost-effective way to ensure that our clients have the right people in place for each task and we are flexible enough to meeting changing client needs. We make extensive use of Web-based applications. In the case of WPS, it was clear that a conversion to digital operations would make sense in terms of handling the nearly 1000 records of active members.

The system we use is called MemberClicks. It enables us to maintain an online membership directory, as well as communicate directly with members via email, host a listserv and much more. WPS was actually using MemberClicks when we came onboard, but only in a limited way for a Find a Psychiatrist feature. We have expanded the use of MemberClicks extensively, as well as implemented a process of data integration every two weeks with APA files. This is a totally digital process that saves countless hours.

In the area of accounting, we use a web-based platform that allows simultaneous use by our five member accounting team. Since 2012 all accounting files have been converted to digital, including all accounts payable documents. File sharing is done using a cloud-based platform, and this includes file placement for audit documents. We are pleased to report that we have just received another “clean” audit for the 2013 fiscal year. We shifted to a calendar fiscal year to align with APA and to allow for true accrual accounting.

We also provide support to the board of directors, which includes assimilating agenda items, preparing large (sometimes more than 70 pages) packets for the board meeting. These packets are posted online prior to the meeting. More and more, the board members are viewing the documents on their laptops or smart devices.

Most of the time and energy that our NWG team spends on WPS goes into the broad area of program support. In fact, based on our last audit, roughly 90% of what we are paid goes into program support. Chris Cotter provides support for the Membership and CME committees, as well as coordinating venues logistics for WPS events. We also provide ongoing services to the Career, Leadership and Mentor program, publications, Web site, ethics, and more.

I have learned that psychiatrists are not always working and that they probably have no particular interest in analyzing my deepest thoughts. (If you do, please don’t tell me.) Our conversations are not about deep, weighty issues — they are more about schedules, menus, publications, accounting, etc. There are exactly the same things I discuss with my other clients, whether they be physician spouses, oncologists, dancers or car washers.



“This wasn’t your typical job interview. I had never been to a psychiatrist as a patient and I had never known one as a friend either. So this was new territory for me — to be interviewed by six of Washington DC’s finest psychiatrists.” — Pat Troy

I have learned that first of all psychiatrists are physicians and in that respect they are very similar to the oncologists I work for. Clearly, they want to do what is right for their patients. Like most physicians these days, they are coping with the many changes in the practice of medicine, the requirements for electronic medical records, reimbursement issues and the list goes on and on.

I learned that psychiatrists tend to think more about the underlying implications of taking any action. They also are very “hands-on.” Even when they disagree with their colleagues, they are also always trying to help them “see the light.” I think that is a sign of truly caring and an attempt to create an organization where members can grow. From my perspective, WPS leaders are engaged and want to share their love of the profession and of WPS with their colleagues.

One thing I love about WPS is the way that the senior members want to give back to the profession by mentoring residents. The Career, Leadership and Mentoring program is truly a prototype not only for psychiatry but for medicine. I also am thrilled to see the response of the residents as they learn and grow through new opportunities.

By virtue of being WPS Executive Director, I get to participate in the APA District Branch staff meetings, held in November and May each year. These meetings are really fabulous because they keep us updated on all the important things that are going on at APA. The District Branch staff execs are a close bunch and throughout the year there is an ongoing sharing of ideas and concerns. WPS is stronger as a result of this opportunity to be involved with APA at the national level.

As a professional association manager, I thrive on learning new things. When I first started to work for WPS I didn’t know what the term DSM-IV meant, but I made it my business to find out. Now, of course, we are experiencing the implementation of DSM-5 and preparing for ICD-10 and wrestling with CPT coding, MOC, EHR and more alphabet soup.

I find that the WPS leadership is open to new ideas. When we have made recommendations, such as the one for the *Washington Psychiatrist* magazine, we were taken seriously. The magazine has turned out to be a good thing for WPS, so I am pleased to be asked to make a contribution. Our editor, Dr. Gerald Perman, is to be congratulated for taking this project and running with it!

Getting an Appointment with a Psychiatrist: What We All Suspected...

By Gerald P. Perman, MD

A recent study published in *Psychiatric Services* (October 15, 2014) documented that many patients are unable to get an appointment with a psychiatrist when they attempt to use their health insurance. Researchers in the study telephoned a total of 360 psychiatrists in Boston, Houston and Chicago whose contact information was listed in the Blue Cross Blue Shield provider database. The researchers posed either as (1) patients who had Blue Cross Blue Shield insurance or Medicare or (2) patients who said they would pay out-of-pocket.

The researchers attempted to make an initial appointment with 120 psychiatrists in each of the three cities. In the first round of calling, they were able to reach 119 of the 360 psychiatrists (33%). Of 216 calls in which messages were left, only 35 were returned. After a second round of calling, appointments were made with 93 psychiatrists, i.e. 26% of the total psychiatrists on the BCBS provider database. There was no difference in the number of appointments made based on the type of payment. The authors opined that: “expanding insurance coverage alone may do little to improve access to psychiatrists — or worse, expansion might further overwhelm the capacity of available services.”

This study was picked up and reported on by Reuters Health (October 17, 2014). Senior author, J. Wesley Boyd, M.D., a psychiatrist at Cambridge Health Alliance and Harvard Medical School, was quoted as saying “It’s unfortunately about what I expected given how many patients come into my office on a first visit and say they were on the phone over and over and over.” He noted that 16% percent of the phone numbers listed in the BCBS database were wrong, with calls going to a McDonald’s restaurant, a boutique and a jewelry store. Another 15% of the psychiatrists were not accepting new patients. Dr. Boyd noted that “Although the BCBS insurance database in the study was not accurate or updated, that is the way many patients go about trying to get appointments. Worsening the problem is a shortage of psychiatric providers in the U.S.”

Dr. Harsh K. Trivedi, chair of the American Psychiatric Association Council on Healthcare Systems and Financing, when asked to comment on the study, said: “We need to make sure we’re training adequate numbers of psychiatrists. What the study did not look at is, right now, that the providers providing most prescriptions are primary care doctors.” He was not involved in the new study. Trivedi also said that: “Previous research has found that even primary care doctors struggle to refer patients to psychiatrists. Instead, they often end up prescribing medications themselves. That’s actually not a bad system as long as primary care doctors and psychiatrists collaborate effectively.”

In my own out-of-network psychotherapy practice, I have often heard the same story as reported by Dr. Boyd: many patients have tried unsuccessfully to find an in-network psychiatrist before contacting me. I often email new patients information about my fees, billing and insurance and I provide them with the CPT codes for the initial consultation and subsequent psychotherapy sessions that they can use to find out how much reimbursement they can expect to receive from their insurance company when they submit my invoice. I sometimes will use one of several listserves to help a caller find a provider within their network, or I will give them a list of places where they can seek low-fee treatment.

It would be useful to know the consequences of patients not being able to obtain treatment from psychiatrists because of the broken health insurance referral system. This would need to be measured in suicide rates, alcohol and substance abuse relapses, and the burden of untreated depression and anxiety, as well as the emotional cost among those suffering from schizophrenia and bipolar disorder.

The *Psychiatric Services* study, of course, only addressed patients who have so-called good health insurance, and not those with Medicaid or without any health insurance at all. The Affordable Care Act will greatly increase the number of patients with health insurance coverage, but many of these patients will run into the problems encountered in Dr. Boyd’s study. Dr. Boyd concludes by saying that: “The larger backdrop is we need to rethink the way psychiatric care is delivered here in the U.S. As for patients, if they are very, very persistent, hopefully they can get an appointment.”





HE'S TELLING YOU THE DIAGNOSIS

By Brian B. Doyle, MD

I shifted from foot to foot as I waited for the exam at the end of my Junior clerkship in Medicine at McGill's medical school. I knew I had to examine a patient and present my results, including a diagnosis, to a faculty internist. The clinical dictum of the great McGill internist, Sir William Osler, resounded in my brain: "Listen to the patient. He's telling you the diagnosis."

My patient damn well better tell me the diagnosis, I thought, because There's so much Internal Medicine I don't know.

The Medicine clerkship at the Montreal General Hospital had been a bitch. For eight weeks, we worked long hours with patients on the ward. Clinical questions frequently arose that required us to read "Harrison," as we called our textbook. Our medical bible, *Harrison's Principles of Internal Medicine*, was several pounds of densely-written material, a multi-authored book that had dozens of chapters and hundreds of pages. As well as working on the ward and reading Harrison, we had to submit exhaustive (and exhausting) write-ups on our patients. I learned a lot, yes, but I was not the only med student who felt overwhelmed by the volume of material.

I glanced at my watch. Ten-fifteen already and the exam was supposed to start at ten.

"Where the hell's the chief resident?" I asked my classmate, Arnie Matlin.

As my three friends and I milled about in the hall, around us the ward staff went about their tasks. Trim in their white uniforms and perky little caps, the nurses ignored us, as usual. Med students were the lowest form of life on the wards of the teaching hospitals. Arnie and the other two students in our little quartet looked less nervous than I did, but then, I always assumed that everyone was less anxious and more knowledgeable than me. Arnie shrugged. "They can ask us anything, Arnold. Do you realize that?" I said. He nodded, rolling his eyes and arching his eyebrows. I kept talking. "All I've seen on this service are congestive failures or MIs. I don't care if I never see another one." "Congestive failure" is the term for a heart struggling futilely to maintain proper blood circulation. "MI" is the acronym for "myocardial infarct," med-speak for "heart attack." I didn't know much Internal Medicine, but I could sling acronyms with the best of them.

I couldn't stop talking. "I saw Mr. Gagnon, the farmer from Trois Rivieres, who had an esophageal carcinoma." I shuddered. When I examined poor Mr. Gagnon I knew his diagnosis and its grim prognosis, and he didn't. "They'll never give me another

patient with that diagnosis,” I said. “What if they give me a pulmonary or rheumatology or GI patient? What if they give me some zebra?” “Zebra” was medical slang for a patient with an unusual diagnosis. It came from the clinical axiom, “When you hear hoof beats, don’t assume it’s a zebra.” That in turn was a version of the simpler axiom, “Common things are common.” In other words, don’t jump to the conclusion that the patient has a rare disease until you have ruled out the common diagnoses. “Brian, I don’t know,” said Arnold, “Would you please shut up? You’re making me more nervous. Here’s the chief resident anyway.”

Dr. Frank Carter strolled up to us with a piece of paper in his hands. Pale, skinny, and prematurely bald, Dr. Carter had a way of looking away from us when he talked to us, as if medical students were beneath his notice. I could sympathize with him somewhat. Like all of the residents, he was chronically fatigued, since his schedule required him to be on duty every third night and every third weekend. In addition to his clinical duties, though, he had teaching and administrative responsibilities, one of which was getting patients for us to examine. It wasn’t my fault that you became Chief Resident, I thought. You knew what you were getting into. Still, getting patients for med student exams was a chore. Dr. Carter had to find patients who spoke English, and many of the patients in Montreal hospitals only spoke French. He had to find patients who would agree to have a med student examine them. Many patients, whether or not they spoke English, weren’t keen on having us doing that. Patients didn’t have to agree to us examining them, but they were in a teaching hospital and under not-so-subtle pressure to contribute to our medical education. Some patients enjoyed bringing along “the young doctors,” as they called us. So, would my patient cooperate?

Carter said to us, “You have 45 minutes with the patient. At the end of that time you will present the results of your history and physical, your diagnosis and differential diagnosis, to one of the attendings waiting here in the hall. Questions?” His tone suggested that he wouldn’t welcome any. My only question was, how the hell am I going to pass this exam? I was ruminating about my inadequacies when Carter said, “Doyle?” I nodded. “See Mr. Owen McLeod, in 2248.”

I found Mr. McLeod near the window on the left hand side of his room. Too big for his bed, his sheets rumpled around him, he sat looking grumpy and uncomfortable. He was a stocky man with a big belly. Especially in this setting, he made a colorful impression. The Montreal General Hospital was bland. Everything was quiet, immaculately clean, but boring. Grays and tans and off-whites prevailed on the walls and floors. Even the curtains that we pulled around patients’ beds had beige and white vertical stripes.

Mr. McLeod, on the other hand, had deep reddish-brownish skin that made him look unhealthily tanned. That’s odd, I thought. What is someone doing with a tan in the middle of the Montreal winter? His unusual skin color was vaguely familiar, but I didn’t know why. His eyes were puffy, with deep blue pupils, the whites muddy. Mr. McLeod had wavy, reddish hair, with a forelock that flopped on his high forehead. Powerful forearms covered with hair whittled down to massive fists. Reddish chest hair curled out of the top of the ridiculous white and pale blue hospital gown he had tied behind the back of his neck. He reminded me of a burly, annoyed kewpie doll.

He doesn’t want to do this, I thought. I didn’t either, but I introduced myself, doing my best to be professional. “I’m Brian Doyle, one of the medical students. Do I have your permission to examine you, Mr. McLeod?” He grunted his agreement, and we shook hands. He had a strong grip. I sat down on the chair beside his bed. I always sat at the bedside rather than stand, because that put me at the same level as the patient. “What brings you to the hospital, sir?”

“I’m weak, and my joints ache.” Weak? I thought. Your grip is much stronger than mine. If this is ‘weak,’ what are you like when you are healthy? He clearly didn’t have an MI, but what did he have? Some kind of arthritis? Hypothyroidism? Anemia? Addison’s disease? My mind was already racing off in all directions. I continued with the safe introductory questions I had been trained to ask. “How old are you, sir?”

“55.” A one word answer. “Where do you live?” “Sherbrooke,” he said, “but I’m hardly ever there.” Why are you hardly ever in Sherbrooke? I thought, as I went on to the my next standard question. “What do you do for a living, Mr. McLeod?” “I’m a Rolls Royce mechanic,” he said. Hot damn, I thought, no wonder you have a strong grip.

“What’s it like to be a Rolls Royce mechanic?” I couldn’t resist asking.

“Been with the company 28 years,” he said. “Worked my way up. I can pretty much repair anything in any model of our cars. I repair Rolls-Royces all over Canada. All over the world.”

“All over the world? Like where?” I was intrigued.

“I’ve been to Saudi Arabia at least ten times. There are dozens of princes in Saudi,” he said, “and you’re nobody if you don’t have a Rolls. I’ve been there so often I know some of the princes by name.” Ah, Saudi Arabia, I thought. No wonder you have that strange tan. “Saudi is a terrible place to have a Rolls,” he continued, “because there’s sand everywhere.” He shrugged. “But if they want service they get service. When there is a problem we go where=ver the problem is, and we fix it.” Mr. McLeod was beginning to relax. “Rolls-Royces are never supposed to have problems,” he said with a chuckle.

Well. I had never met a Rolls Royce mechanic before. “So tell me some more about your work,” I said. Once started, Mr. McLeod was glad to talk, and the conversation flowed easily. He was describing a repair he did in Banff, Alberta, up in the Canadian Rockies, when I glanced at my watch. My god. Twenty-five of my precious minutes had already gone by, I didn’t have a clue about what was wrong with this man, and I hadn’t even started his physical exam.

I sat, stunned. My brain went completely blank, except for the mantra, what am I going to do? It was as if every drop of my blood drained from my body, leaving me an empty husk. I was glad I was already sitting, because my legs would have buckled beneath me.

Noticing my sudden silence and, what was likely, my extreme pallor, Mr. McLeod looked over at me. Then, leaning on his right elbow he whispered, “This is your final examination, eh?”

I nodded. He squeezed his eyes shut, concentrating. “Whatever I have has a long name, but I can’t remember it.” Then he said, slowly, “It begins with ‘heme’ something, ‘hemo’ something ...” Please Mr. McLeod, please, please, please remember your diagnosis, I thought. “Hemolytic anemia?” I took a jab at one diagnosis that I remembered had ‘hemo’ to start with.

“No,” he said. “The diagnosis is one word. Hemo....chro...”

“Hemochromatosis?” I blurted.

“That’s it!” He said. Hemochromatosis! Such an obscure diagnosis. My mind went into overdrive. I had a zebra after all. “It’s odd,” he said. “They tell me I have to get my blood drawn every few months.”

Bingo! Frequent blood draws...too many red blood cells...too much Iron...problem in iron metabolism...reddish skin...reddish skin...I’d seen that kind of skin before...but where?

Yes! Mr. Weed, the headmaster of my secondary school. Frederick R. Weed could not have been more of a WASP, but with his high forehead, dark hair, and dark reddish-brown skin he looked like the American Indian on the back of a buffalo nickel. All that he lacked were the feathers on his head. My physician father told me Mr. Weed had an unusual disease called Hemochromatosis. A disorder of iron metabolism that resulted in too many red blood cells and, presto, dark red skin. I remembered the diagnosis because it sounded exotic, and because it rolled off the tongue like an Indian chant: He-mo-chro-ma-to-sis. He-mo-chro-ma-to-sis.

“What else have they told you?” I asked. “They’ve told me to stop drinking. That’s easy enough in Saudi, but I enjoy a drink from time to time here at home.” Mr. McLeod sounded a little defensive. Sure, Mr. McLeod, I thought. A drink from time to time. I had learned to be skeptical of patients’ self-reports about their drinking. If he was a heavy drinker that might explain the yellowish cast of the whites of his eyes, because a beleaguered liver had trouble metabolizing bilirubin. That accumulated in the blood, resulting in jaundice in the skin and whites of the eyes.

“Anything else, Mr. McLeod?”

“They’re always poking around in my belly. They say I have a big liver and a big spleen.”

Enlarged liver...enlarged spleen...muscle aches...weakness...joint pains...I thought, what else? Damned if I could remember anything else. This was just going to have to do.

Now that I knew the diagnosis, I had clues to the right questions to ask Mr. McLeod. I finished taking his history and whipped through the physical exam. He grunted as I palpated at the edge of his ribs, feeling the telltale bulge beneath my fingertips. Yes, big liver! I couldn’t feel an enlarged spleen on the other side of his abdomen, but that didn’t worry me. What counted more was knowing that splenomegaly, medical-speak for enlarged spleen, was one of the signs of hemochromatosis.

I looked at my watch again. Time almost up. I slung my stethoscope around my neck and shook Mr. McLeod’s hand, saying a heartfelt, “Thank you!” He smiled up at me. “Good luck with your exam.” I hustled out to the corridor, where Carter was standing with one of the attendings. Damn. Wheeler, just my luck. Some of the clinical faculty had been encouraging, but Dr. Wheeler, a grim-faced man in his fifties with unruly gray hair, was a hardass. Looking at his watch, Carter said reproachfully, “I was just coming to get you.” Asshole, I thought.

“Well?” said Dr. Wheeler. I tried to put together everything I knew into a coherent presentation. History...physical findings... “And your diagnosis, Mr. Doyle?”

Pausing briefly, trying to sound as if I was systematically sifting through all my clinical data, I said, “I’d have to put hemochromatosis at the top of the list, sir.”

Carter looked at me with a flicker of surprise. I’ll show you, you SOB, I thought.

“Why are you considering that diagnosis?” asked Dr Wheeler, his tone neutral.

“This is how I put it together, sir,” I said, in my most earnest-medical-student tone of voice. I launched into an exposition of my clinical reasoning, while I thought, Why am I considering it, Wheeler? I listened to the patient, and he told me the diagnosis! ■

On Call in the Winter

By Jason Emejuru, MD

On a crisp winter's night in 2014 I entered the hospital assuming it would be an ordinary Thursday on-call night. This night of the week is usually an anticipated pleasure for residents since being post-call the next day on Friday, with greatly reduced responsibilities, gives them the "holy trinity" quasi-three day weekend. I entered the call room, received the sign-out list from the day-time resident, and relieved her of her duties. I said to myself: "it's show time!"

Being on-call at George Washington usually means averaging 7-8 phone calls from the Emergency Department (ED) over the course of the night and 10-20 calls from the spirited floor nurses on the psychiatric ward. That means that the resident has to review the patient list quickly recognize who are the agitated patients, which patients are at high self-harm risk, which patients would need to be put to sleep (i.e., who needs Trazodone), and, most importantly (!), who is running the grill down in the cafeteria and can whip up a combination of curly fries and sushi, an unpretentious, surprisingly delicious, and efficient combination. Take note, DC foodies!

After coming back up to the call room, I received what I thought was going to be a typical ED call. I picked up the phone and the emergency room resident told me: "We have a 23 year old, African-American, male patient brought in by his family who says that he is hearing voices right that are distressing to him. He is also slightly fatigued." Before going downstairs to see him, I looked him up on our EMR system and learned that he was previously admitted to our unit earlier this winter. He had been admitted then with a diagnosis of new-onset schizophrenia. From the discharge summary, it was noted that he had refused admission earlier in the winter and that it had been difficult for him to engage in the milieu.

As I approach him in the ED, he was lying in one of the ED triage beds outside of the ED proper, that are specifically designated for psychiatric patients. He appeared tired, made little eye contact, but was able to state that "These voices are just too much." I asked him what they were saying and he replied, "Just awful things about me." He then asked, "Could I just get a refill of my medications, that's all I want?" When I offered him admission, he flat out refused. Labs and a urine drug screen obtained by the ED came back as negative.

I remember the ED resident telling me that his family brought him in, so I immediately shifted my focus toward them. His grandmother and his uncle, a DC police officer, were sitting in the visitors section of the ED. After pulling them to the side, the grandmother told me how she had taken care of him since he was a child. "His mother has her own issues," she said. She told me how difficult it had been since he was diagnosed with schizophrenia a few months ago. He had not been compliant with his psychiatric appointments or his medications since discharge. He had been admitted to another psychiatric unit in the city a few weeks after his discharge from GW. She said that his family is "terrified" of him because had been getting violent at home. Three weeks earlier he had swung a baseball bat at his 17 year old brother after believing that his brother had placed a microchip in his head to "steal his thoughts." His grandmother and his uncle made a preemptive decision tonight to take him to the hospital for admission before things escalated in their home.

The uncle was adamant that "he can't live in this house if he is going to continue not to take his medications and be a danger to everyone." I could tell, however, that there was some reluctance in his voice. As I realized that there may not have been enough evidence to involuntary commit him, I asked his grandmother and uncle is they were prepared to let him sleep on the street tonight? This was after telling them that we may not be able to involuntary commit him. Their expressions soon changed and the room's atmosphere quickly became filled with sorrow and uncertainty.

During this time, I noticed that I had become somber also. I too had a dear college roommate who had his own first episode of psychosis but who fortunately experienced his own less-traveled road to recovery. Recognizing this, I consulted with the ED attending, who encouraged me to try for an involuntary commitment. I imagined, if this was successful, the patient would have but a short stay since the justification for commitment was thin. But at least he would get one or two days of necessary treatment, the family could get some peace of mind knowing that he would not be on the street, and they could prepare for him to return to their home.

I went upstairs to the call room and wrote the involuntary commitment letter with which his family was in agreement. I have since asked myself, "Where is he now?" Did this likely brief commitment help, or did it make his situation worse? How does he now perceive the health care system (as represented by me) and his family, and that supported my decision?



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Articles may be submitted to the editor of this magazine by anyone who wishes to write about topics related to psychiatry.

Authors who submit an article to **WASHINGTON PSYCHIATRIST** magazine for publication agree to all of the following:

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4. Articles should be educational, new, informative, controversial, etc. Adequately disguised case vignettes with an informative discussion are welcome.
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 - B. If you want more than one space, use the tab.
 - C. Space once before or after using a parenthesis. For example: (1) Freud or Freud (1)
 - D. Space once before and after using a quotation mark. For example:
John said, "Your epigenetic model was spot on." Then the research ended.
 - E. Any articles that contain pictures of any kind must include the actual picture file in addition to the article.
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DEADLINES FOR ARTICLE AND AD SUBMISSION

- **WASHINGTON PSYCHIATRIST** is published electronically in December (winter issue), March (spring issue), June (summer issue), and September (fall issue)
- Confirmation for submissions are due seven weeks prior to the month of publication.
- Copy (articles) is due four weeks before publication

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- WPS has ongoing CME training with reduced rates for members. This includes the annual Psychiatric Medicine Conference, Salons, and special current needs programs.
- WPS is focusing in 2014 on increasing its involvement the DC Metro mental health community and on focusing energy on initiatives that make a difference to the patients we serve.
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WPS CALENDAR OF EVENTS 2014/2015

Sunday, December 7, 2014

WPS Salon - Update on the Latest Research and Legal Issues on Marijuana

George Kolodner, MD

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Location: Held at member residence, provided on registration

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