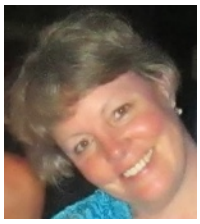
THE MARYLAND PSYCHIATRIST

Winter 2014

THE MARYLAND PSYCHIATRIST was



first published in electronic format last spring. With this current issue, enabled by the electronic format, the Editorial Advisory Board (EAB) offers an updated graphic style for The Maryland Psychiatrist (TMP).

This is my first issue as Chair of the EAB, and it is with great pleasure that I accept this role. I am fortunate to be surrounded by the continued support of the many esteemed members of the MPS Editorial Advisory Board, and I look forward to receiving continued contributions from these members as well as from a diverse range of other individuals in the Maryland psychiatric community.

I want to express particular gratitude to Bruce Hershfield for the promise of his guidance-- I look forward to benefitting from his many years of experience, including his service as a past Editor. I am also grateful to MPS President Scott Aaronson for providing me this opportunity to lead the continued growth of TMP. The EAB will continue to strive to provide meaningful and timely articles of both breadth and depth, and I hope to inspire contributions from the full spectrum of practitioners we are so fortunate to have here in Maryland.

Contributions (article submissions) as well as letters to the Editor (regarding content and/or format) are welcome. Commentary and/or contributions may be addressed to the Editor c/o nwahls@sheppardpratt.org

Selected commentary may be published in future issues.
I hope you enjoy this issue!

Nancy K. Wahls, MD
Editor

Teaching Psychiatry... in Malaysia
a cross-cultural experience

Jessica Merkel-Keller, MD, Msc

Travel makes the world a smaller place. When we venture out from our homes and see a new part of the world, we appreciate the similarities and differences in cultural worlds. I recently had the opportunity to teach psychiatry to medical students at a new American-styled medical school, Perdana University Graduate School of Medicine, in Kuala Lumpur, Malaysia. I had the pleasure of working with Dr. Andrew Monhanraj from the World Health Organization, in teaching the Psychiatry Clerkship to the first MS3 inaugural class.

DR. JESSICA MERKEL-KELLER AT KLINIK PSIKIATRI, PERDANA UNIVERSITY GRADUATE SCHOOL OF MEDICINE, KUALA LUMPUR, MALAYSIA, 2013.

Immediate warmth and hospitality filled the office on my first day of work. An office party was underway for a woman returning after a protracted sick leave. The campus of Hospital Kuala Lumpur (HKL) was shaped like a "T" and contained a mixture of new and old buildings. The older buildings were one-to-two stories high and had crumbling pastel facades. They housed major clinical departments and patient wards, such as orthopedics and OBGYN. These concrete buildings were constructed to be open on one side with bars as dividers and a concrete overhang to keep out the rain; fans kept the tropical air circulating. The new spaces were constructed from glamorous marble. As their double doors opened, air conditioning poured out. The sidewalk had a strip that allowed blind people to stay on course by feeling its texture. Meanwhile, cars and mopeds zipped past, and pedestrians made an effort to get out of the crosswalk in time. HKL had a centrally located mosque, and clinical activities ceased for prayers. In Malaysia a surname was not used-- so I was "Dr. Jessica".

Once a week, there were Grand Ward Rounds-- discussions in which diagnostically difficult cases were presented, and decisions were made regarding transfers of patients to a free-standing psychiatric hospital for a longer stay. The cases were similar to what we see in academic centers in Baltimore and were managed pharmacologically in a similar fashion. One case stood out. The team was struggling to discharge a patient. The medical officer presenting the case stated that, "The family was preparing for the patient's arrival home." I thought that the preparation was supportive and positive; but when everyone in the room grimaced, I sensed that I had misunderstood. The department chair announced that this was a "return to the old ways." The family was preparing a cage! The team felt that the patient was improved enough to be discharged from the hospital but still needed additional outpatient care. Ultimately, the patient was transferred to the free-standing mental

hospital until the family was able to feel more comfortable having the patient home without shackling him. The free-standing mental hospital had a home- and community-feel. Patients liked it, and often requested it.

Later in the week, students presented interesting cases of patients suffering from Conversion Disorder and Borderline Personality Disorder. The borderline case was classic, containing polysubstance abuse, cutting behavior and multiple suicide attempts. In the distant past, the patient had poisoned her brother, who was the perpetrator of abuse. The standards of confidentiality, mandatory reporting, and duty-to-warn existed but were not universally applied in the same fashion as in the United States. In instances of duty to warn, the family was more likely to be informed than the police. Perpetrators of abuse would have had to admit to the abuse for there to be consequences. The family was much more involved in the care and had the ability to consent for the patient regardless of his or her wishes. When patients did not desire ECT or other medical procedures, family consent allowed the intervention to proceed. It was assumed that doctors and families knew what was best for the patient.

Malaysia was a cultural melting pot with a large Chinese, Indian, and indigenous Malaysian population, with land rights referred to as Brahmaputra. Malay, English, Cantonese, and Indian dialects were widely spoken. The locked psychiatry wards were divided into zones by zip code to allow for continuity of care for the outpatient and home visit teams. I was amazed to have traveled so far to interview patients who communicated in English. My experience informed me that psychiatric practices were more similar than different. This drove the point home to me: disease is disease, with patterns for clinicians to follow, diagnose, and treat. Even the ECT machine was the same as the ones we used at Johns Hopkins, but treatment started with bilateral electrode placement instead of right unilateral.

Pharmacologically, a full complement of agents was used. I learned that Invega Sustenna was more widely used than Risperidal Consta because the latter was recently pulled from the South Asia market due to lawsuits. Psychiatric services included day hospital programs, occupational therapy, social work, methadone programs, community psychiatry and psychiatric home visits by a team that functioned very similarly to an ACT team. Psychotherapy was not widely practiced in the country. Most of it was performed by clinical psychologists. From the reports of the HKL Community Psychiatry Program, it seemed that insight–oriented therapy and cognitive behavioral therapy were the dominant treatment modalities.

DR. JESSICA MERKEL-KELLER, KUALA LUMPUR, MALAYSIA, 2013.

One of my favorite experiences was going out with the psychiatric home visits team. The nurses and social workers had the most patient contact and knew the patients best. On the day we went out, we had an hour–long meeting to discuss patients and care plans prior to seeing seven cases before noon. I was informed that the HKL team was based on Co–Star at Johns Hopkins; the issues it faced were the same as those I have confronted in the Baltimore program. For example, the HKL team was afraid of dogs, afraid of being bitten by a psychotic patient's pet during a home visit. No one liked to give depot shots in public places such as restaurant bathrooms

or by the side of a dirt road as we were about to do. We all preferred to administer care privately, but we knew that getting the neuroleptic to the patient was more important than where it was given. The team saw patients from all rungs of the socioeconomic ladder. In the seven cases we saw, I was impressed by the patients' ADL's and how clean the apartments were regardless of economic circumstances. Patients lived with their families and did not fall as far with their ADL's as they would have if they had lived alone. In Kuala Lumpur, patients had tidy places for us to sit even when they lived in poverty with homes built of "found" materials and blue tarps.

Another cherished experience occurred while I was teaching. I interviewed a manic Buddhist, back-to-back with a manic Hindu and a manic Muslim. They all were able to speak English. They spoke of their symptoms, their special powers, and their connection to God, and how God works through them. The challenge was to parse out standard religious practices from psychiatric signs and symptoms.

This experience reminded me that practicing psychiatry and providing psycho-education means practicing human rights. As I saw the bruising on hands and ankles of recently admitted psychotic patients, I was eerily reminded that not too long ago we faced similar practices in the United States. Our work is never finished. Our expertise and advocacy can liberate patients from the shackles of mental illness-- at home and abroad.

ON THE ROAD TO GIVE DEPOT INJECTIONS. DR. JESSICA MERKEL-KELLER, KUALA LUMPUR, MALAYSIA, 2013.

"I am very impressed that the folks on the Board and the staff are interested in doing the right thing."

Interview with Robert Roca, MD

Member of the Maryland Board of Physicians, MPS Representative to the APA

Bruce Hershfield, MD

Q. "Please tell us about your activities in the MPS and the APA."

Dr. R. "I was initially involved with the MPS Geriatric Psychiatry Committee in the late '90's and was elected to Council in 1999 and continued to make an effort to make the committee more meaningful for a number of years. I was then elected to join the leadership of the MPS. I had not started out with any political ambitions in organized medicine, but I had been impressed with the caliber of people who were in the MPS leadership-- so I thought that would be an enriching experience in some way, and it definitely was. I went through the ranks and had a Presidential year. By that point I had become the Medical Director at Sheppard Pratt."

Q. "What has being Medical Director been like?"

Dr. R. "It was an honor to be asked to play that role there. It is a wonderful place. It was an opportunity to learn what it is like to run a place like that- to be in a room when important issues are discussed. You see people struggling with the complexities of decision-making."

Q."What was it like to make the transition from clinician to administrator, even while you continued to see patients?"

Dr. R.: "The focus of a clinician is always on the patient. When you are in a different kind of role, your vision has to be different. As a Medical Director you are looking at how lots of doctors deal with lots of patients. Your responsibility is to ensure that they do the best possible job. As you know, I trained in Internal Medicine. I attended medical school at UCLA. When I was there, because I was interested in the big picture as well as with the individual patient in the consulting room, I got a master's degree in public health. As far as I was concerned, that was part of my general medical education. I was very interested in Psychiatry, but I was not ready to make that commitment—to any specialty, for that matter—so I did Internal Medicine because it seemed the best way to learn the most about the most things. While I was doing that I became reacquainted with my interest in Psychiatry, not only as a personally rewarding specialty, but also as the most fascinating one."

Q.:"I remember when you would moonlight at the Highland Health Facility in East Baltimore, when you were a Resident at Hopkins."

Dr. R."There were a lot of memorable experiences there. I remember coming on call one evening and being told that a patient was feeling sick to his stomach. I walked into his room, not expecting anything in particular, and just happened to ask him if he also had pain in his chest. He mentioned he had severe, crushing substernal chest pain. Half an hour later he was in the ICU; he was having an acute MI. Those were the moments I was grateful for having had the internal Medicine background."

Q.:"Did you go directly from your residency at Hopkins to Sheppard Pratt?"

Dr. R. "I finished my training in 1985, then I ran the C-L service at Hopkins Bayview until 1993. I had become a "de facto" geriatric psychiatrist over those years because a lot of the Geriatric Medicine in the Hopkins system was stationed there. Geriatrics was the subspecialty in Psychiatry that seemed the most challenging and stimulating because of the co-morbidities you have to deal with. The patients were perhaps the most grateful ones I had encountered. There was a certain kind of gratification that came with treating them that you did not necessarily see with other patients."

Q."What do you see as Sheppard's future?"

Dr. R.: "It is anticipated that there will be incentives created to avoid hospital care. So, what is the role of a psychiatric hospital in that kind of world? I believe very strongly that there is going to continue to be a need for containment—the sort that occurs in concert with treatment in a psychiatric hospital. At the most problematic stages of their illnesses people may be the most dangerous to themselves. They may need the kind of supervision and support that occurs in a hospital. I think there will always be a need for that. We need to be alert to whatever arises in the community, in terms of medical homes or accountable care organizations. I chair the Council on Geriatric Psychiatry, and integrative care is one of the potential innovations we will be rolling out when the Affordable Care Act is fully implemented. A lot of demonstration projects are aimed at finding ways to do this better. Geriatrics has been at its best, for decades, when doing integrative care. I think we are going to see greater access to care. I think there will be opportunities for people to practice in different ways. I think trainees need to be prepared to work in teams. They need to be prepared to be consultants. I think those kinds of roles will increase."

Q.:"It sounds like you have been pretty busy. How did you decide to apply for the position on the Maryland Board of Physicians?"

Dr. R : "I had worked for some time in the county medical society and had done some work with Med Chi as well. I got to know the leadership of Med Chi, and when there was a vacancy it was suggested to me that I would be a good candidate-- so it is not something that I sought. I have been on the Board since July. It has been an eye-opening experience, in the best sense of the word. I did not go into it with any particular prejudice about the sorts of people I would meet and their commitment to what they are doing. I am very impressed that the folks on the Board and the staff are interested in doing the right thing. They are trying to be fair to clinicians about whom there have been complaints and also to be mindful of their duty to protect the public. No process is perfect, but I think they make an effort to be fair and thorough, and to help physicians to remain in practice.

Q."What is it like to be the only psychiatrist on the Board?"

Dr. R.: "They certainly turn to me when certain kinds of issues come up. We meet once a month for a day. In preparation for that meeting there are hundreds of pages of material to review—1200-1500 i-pad screens of all kinds of material to be reviewed in relation to the individual cases. There are also policy documents to review."

Q.:"Do you have some advice about how psychiatrists can stay out of trouble?"

Dr. R.: "It is important to be wary of boundary violations. It is important to document thoroughly. It is important not to get caught up in providing informal care to friends. These are the kinds of things that you would counsel anybody you were supervising to be mindful of and to avoid. There certainly are instances in which patients who are ill will make groundless accusations against psychiatrists and other physicians. At those kinds of times it is your documentation that may spare you consequences—at least, support you in your defense. Psychiatrists should keep current with CME's. There are still a lot of physicians who neglect to get their CME's or sometimes claim to have gotten their CME's without actually having fulfilled the requirements. Practicing in the way that you would counsel somebody else to practice is probably a good general rule to follow."

Q.: "What experiences did you have earlier in your career that have helped guide you?"

Dr. R.: "All through my clinical training what struck me again and again was how critical vigilance is. There are a lot of patients who come to grief because of small things that were overlooked. I learned that when I was in Medicine and watched what happened around me. It became clear that you could never be too confident that you know enough. You can never be too confident that you understand what a patient needs. You need to listen to what the patient tells you. Osler said, 'Listen to the patient. He will tell you the diagnosis.' That stuck in my mind as good advice. Listen to the families. I think the people who know the patients well are invaluable sources of information. Listen to your colleagues. Being connected, being open, not being over-confident, not being smug are critical for physicians. It is hard to imagine ever retiring, given the privilege of taking care of patients."

Online Ratings of Psychiatrists
An ethical way to defend ourselves?

Mark S. Komrad MD

The following was a major issue of increasing concern expressed by colleagues at the open ethics consultation with the APA Ethics Committee at the San Francisco meetings in May.

You have read about people having a "cyber footprint" --the places and ways your name shows up on the Internet-- so you decide to Google your own name. Like most doctors, you find your name on pages of numerous sites where people can rate or review their doctors, like they do for movies and books. Somehow, these sites mine databases listing doctors' names and addresses. If you click on them they will ask you something like, "would you like to rate this doctor and write a review?" But wait, there on the first page of the Google search is one site where someone did rate you! So you click on it and read:

One out of five stars in every area: knowledge, helpfulness, punctuality, staff. Review: "Please do not use this doctor. He was totally wrong; his advice is the opposite of what other doctors and books advise. He is only interested in money. Extremely uncaring and aloof. He never got my medication correct. I felt that he did me harm." [excerpt from an actual online review]

You are shocked. You cannot imagine who wrote this. No angry patient comes to mind in recent memory. You certainly know not everyone you have treated has had a wonderful outcome. Of course you have made more progress with some more than others, but devoted your best to them all. You look to see if there are any other ratings of you at this site that are more positive. There are no other ratings here or on the other numerous sites where doctors can be rated. This is it? This one disgruntled patient? What can you do about this within the bounds of ethical practice? Some rating sites let the rated doc write a response; others do not. Yet, what response could you make that does not sound defensive and reactionary?

Even if you can guess which patient this is, giving clinical details about the patient (i.e. "this was a severe borderline patient" or "this was a highly paranoid man") would be considered a breach of confidentiality and the standards for maintaining privacy. Ethically, outside of carefully protected clinical contexts, patient information can only be made "public" when needed for educational purposes (e.g. article, lecture) and it must be disguised and used with the patient's permission. So, you cannot fight back against this kind of defamatory review, at least not directly.

An indirect approach would be to have this one review diluted by a flood of positive reviews. However, it is a well-studied phenomenon that Internet ratings are dominated by disgruntled or angry reviewers who are more highly motivated to utilize on-line review sites on which they can vent their ire. How about asking your patients to go online and review you? Can you discuss the problem with the ones you feel would likely give you glowing reviews and would gladly come to your reputation's rescue? Most ethicists would give a resounding "no" to this approach. The concept of "beneficence" is a fundamental principle that is at the core of the doctor-patient relationship. It denotes that the intention, indeed the very purpose of the relationship, is for the benefit of the patient. With the exception of payment for your services, there are no other needs of yours which patients should be asked to satisfy. You may actually be the only person whose needs the patients do not have to satisfy or worry about in their lives. Keeping your needs off their plate is one of the key things for

which they are paying you! Due to the powerful phenomenon of transference, even exposing a patient to knowledge of your needs is tricky. It would be a corruption of this fundamental "beneficent field" to discuss this matter with patients or to ask for their help in addressing it.

Are there any ethically acceptable solutions, or are you completely helpless? A generalized invitation, made available equally to all patients, without direct solicitation, might be ethical. In fact, there are services, like CredentialProtection.com, which provide a large stack of rating forms to be put in the waiting room. Patients can choose to take a form home, not discuss it with their doctor, fill it out on paper or online and send it anonymously to the agency, which will post the ratings and comments. When reminded that there is a world of ratings and online reviews out there, those (typically satisfied) patients who would not have thought to rate, will spontaneously participate. In this way, say polling experts, the number of satisfied patients giving ratings markedly increases far beyond the few disgruntled ones. Research has shown that most patients are actually very satisfied with their physicians. When large numbers of people rate their doctors or hospitals, or even their HMO's, the favorable ratings run 90% or higher. The important thing about this approach is that patients are not directly asked for their participation. The forms in the waiting room simply remind them about the service, should they choose to participate in whatever way they wish. The forms themselves need to avoid solicitation of positive results but give patients equal opportunity to praise or complain.

Whether we have yet reached the age when people choose their psychiatrists based on Internet reviews is debatable. However, if referred to a handful of names, a few moments on Google might be the only way to winnow the list, perhaps based on a single negative review. Judging from the interest shown at the APA convention, psychiatrists are aware of this, and want an ethical way to fight back. Most of us still want our "ethical rating" to be just as high as our "helpfulness rating."

Psycho-Pharm Forum

Clinical conflict...?

Neil Sandson, MD

When it comes to clinical decision-making, why do we ever disagree? Of course, disagreements can arise when specific information or expertise differs between two or more parties. Sometimes there is clearly a correct course of action. The disagreement results because one party has correctly discerned the right course and the other party has not. Such disagreements can usually be quickly remedied. However, other disagreements are more subtle and complex. These disagreements can arise from ambiguous or incomplete available information leading different persons to different interpretations of available evidence. Sometimes, people will fill in these informational and evidentiary gaps with their own personal beliefs. This can lead to wildly divergent beliefs about appropriate clinical decisions, often with a dogmatism and even passion that is not justified by what is truly known.

Perhaps some of the most vexing and acrimonious disagreements arise when questions of value enter into the domain of clinical decision-making. For instance, I have had several conversations with other psychiatrists and also with a variety of physicians and other health care professionals whose work centers primarily around pain management. These conversations reveal a profound ideological division between most members of these two groups. The disagreement goes as follows.

For any given patient who wants to receive narcotic analgesics for a complaint of pain, let us assume that it is either true or false that it would be appropriate for that individual to receive such medications. We can then use a four-cell decision "table" to delineate the following possibilities:

1) Patient should receive narcotics and does receive them.

2) Patient should receive narcotics but does not receive them.

3) Patient should not receive narcotics but does receive them.

4) Patient should not receive narcotics and does not receive them.

Options 1 and 4 are obviously happy places. The potential for clinical disagreement really centers around navigating between possibilities 2 and 3. Most psychiatrists have a healthy respect for overdose potential; nonetheless they regard option 2 as the most adverse outcome, and their clinical priority in this area is to prevent option 2 from arising. In striking contrast, most pain management specialists seem to regard option 3 as the most adverse outcome, and they orient their practices to avoiding that as the highest priority.

Members of both camps seem to regard the others' position with emotions that range from bewildered curiosity to frank hostility. When charity and resigned disdain finally meld and cool, the most common shared sentiment seems to be "They just don't get it".

Let us look at a real scenario. The patient in question had a history of polysubstance dependence and also a chronic pain issue of an orthopedic nature. Per subjective report, the patient had been experiencing reasonable pain relief with relatively low-dosage Percocet (acetaminophen + oxycodone). Although she had remained generally abstinent from drugs of abuse, it came to light that several weeks previously she had "slipped" and used cocaine once. It bears mentioning that this patient never

abused the Percocet. Upon receiving this news, the patient's non-psychiatric providers immediately instituted a taper and discontinuation of all narcotic analgesics, maintaining that her inability to remain consistently abstinent from drugs of abuse posed a danger of such imminence and magnitude that this was the only safe approach. It additionally bears mentioning that the clinicians who mandated this taper and discontinuation never met with the patient; but rather they arrived at this determination through a chart review and then left it to the PCP to implement this plan. (One doesn't need a degree in semantic analysis to see that I take a dim view of such practices.) Ironically, faced with the prospect of a future with inadequate pain relief, the patient then became suicidal and was hospitalized psychiatrically.

The non-psychiatric providers' position was that the patient's cocaine lapse indicated that continued administration of Percocet was manifestly unsafe, so the only sensible course of action was to cease this practice. The psychiatric providers conversely maintained that her psychiatric crisis was iatrogenic, avoidable, and that the precipitating decision to restrict her access to narcotic analgesia was fundamentally wrongheaded. Dialogue between providers from these two disparate camps was spectacularly unsuccessful in resolving this philosophical impasse. If anything, the impasse deepened, with each party feeling yet more entrenched, self-righteous, and dismissive of the other's viewpoint.

So what is at the heart of this sort of disagreement? When I was first contemplating this topic, my original impulse was to conclude that these differences in clinical decisions arose from differing clinical priorities and philosophies. Specifically, it has seemed that pain management folks elevate *primum non nocere* above all else, and in so doing, believe they are preventing the deaths they perceive psychiatrists are enabling with our more "permissive" approach. Most psychiatrists certainly respect that dictum, but believe that such a single-minded focus on that dictum to the exclusion of all else, ignoring clinical nuances and complexities, often tramples on the needs of our patients, leaving many patients who could have been safely and appropriately managed with narcotic analgesics in needless and avoidable pain. Taken to its extreme, *primum non nocere* would mandate therapeutic paralysis. Responding to our patients' needs places a responsibility on us to engage in active treatment that equally rivals the obligation to avoid harm. Dicta do not provide any safe havens for us clinicians. We must wrestle with each clinical situation on its own terms, although there is hopefully consistency in how we apply our guiding principles in the service of our patients.

However, the more I have considered these conflicts, the more I feel that, while the above considerations are ethically and philosophically interesting and they describe how the conflicts play out, they do not explain why the conflicts occur. It is almost like conducting a family therapy session and watching family members argue with disproportionate vehemence and indignation about an issue that is meaningful but that does not merit all of this affect. Eventually, the question arises, "What is this argument really about?".

My belief is that at its core, this clinical conflict arises from strong differences in identifications with patients and corresponding empathic connections. Generalizations across professions are notoriously unreliable, but some suggestive trends have made themselves painfully apparent to me. As psychiatrists, we are trained to develop appropriate therapeutic empathy for our patients, and hopefully to be aware of both the reality-based grounds for identification with our patients as well as the counter-transferential projections that have more to do with our own unconscious baggage. Although we are generally successful at not becoming too enmeshed and overindulging in rescue fantasies, I think it is fair to say that we experience such

patients as afflicted and on some level in need of our help and protection. Conversely, I fear that many of our non-psychiatric colleagues, usually not trained with these awarenesses and sensibilities, adopt a much more defensive posture. I believe that this defensive posture reveals how many of them regard these patients alternatively as folks from whom they need to be protected, or from whom they need to protect themselves. Let us momentarily leave to the side the objective elements of an appropriate risk-benefit assessment, and the resulting beliefs as to which position is "right" and which is "wrong". It is not difficult to see that on a more visceral level, empathic connection is likely to influence clinicians to take on more risk (to the patient and themselves) in the hopes of alleviating the patient's suffering. Conversely, a lack of such empathic connection makes it emotionally easier to withhold more potentially dangerous pain-relieving interventions in the name of minimizing risk. As much as adherents of each position would regard their choices as rational, and perhaps reasonably so, the foundational underpinnings that nudge us to jump one way or the other are probably more emotionally-based. That would certainly explain why we do not seem to hear each other very well.

There is a part of me that would love to heap further criticism on non-psychiatric providers. And, believe me, I could get in some good licks. However, I will bet that, if they had a turn at bat, they could knock a few out of the park as well. But I have an idea. Maybe the next time I have a complex and problematic patient who leads us to cross paths, perhaps I won't move too quickly to what I think should happen, or to what I think would be the right thing to do. Instead, maybe I will lead with my feelings: talk about why I feel driven to help ease this person's pain, why I am afraid of making specific choices to either initiate or withhold certain interventions, maybe even why I feel frustrated at our seeming impasse. But if I start with feelings, maybe we might communicate on a level that might prevent the impasse from arising.

Hey, I can dream, can't I?

Mental Illness and Gun Violence

Steven S. Sharfstein, MD

A year and a half ago while sitting on the beach in Ocean City on a glorious sunny day, watching my grandchildren frolic in the ocean, I received a call on my cell phone. It was from a friend whom I had known for more than 20 years. He had recently been suffering severe back pain due to deteriorating spinal discs which required major surgery. The surgery did not go well, and he was left with an indwelling urinary catheter, which was painful and very embarrassing to him. A vigorous banker and investor who had retired in his early 60s, this good friend was also an Army veteran who owned several different types of firearms. For the past two weeks, we had been in touch as he was quite despondent over his situation although he was also hopeful that something could be done about his circumstance. The call on the beach, however, informed me that his urologist had said just the day prior that she thought he would never be free of his urinary catheter. As I tried to encourage him to seek a second opinion, he told me that the reason for the call was to thank me and my wife for all the help we had been to him and his wife over the years. I became quite alarmed and tried to keep him on the phone, but he quickly said goodbye. I called another mutual friend, who said he had received a similar call a half-hour before. I then called the house, and his wife answered. She let me know she had just called the police as her husband had just killed himself with one of his personal firearms.

"In 2010, the Centers for Disease Control and Prevention reported that there were just over 11,000 firearm deaths related to homicide compared with 20,000 firearm deaths related to suicide in this country."

In 2010, the Centers for Disease Control and Prevention (CDC) reported that there were just over 11,000 firearm deaths related to homicide compared with 20,000 firearm deaths related to suicide in our country. As psychiatrists, we know the mortality of depression is suicide, and our treatments endeavor to create the time and space for healing of this serious medical condition. It is estimated that 80% of suicides are related to serious mental illness, mainly depression; and less than 4% of homicide firearm deaths are related to serious mental illness.

We are all aware of our limitations in predicting whether individuals will try to kill themselves, but we do know that individuals who attempt to kill themselves with firearms are more than 90% successful. This is in contrast to an approximate 2% success rate for overdose attempts. The focus of our efforts to reduce suicide, I believe, needs to be on reducing the means: reducing access to firearms. The Harvard Injury Control Center focuses on this crucial life-and-death issue and how to intervene and prevent suicides. Of the 40,000 suicides in this country, half are accomplished by firearms. Delaying access to firearms would decrease the number of suicide attempts and successful suicides. Although some suicides are planned and deliberate, most are impromptu and related to an acute crisis, such as was the case with my friend. I can only wonder whether he would still be alive today if he had not had this legal (and constitutional) means at his disposal.

Studies that have looked at survivors of attempted suicide by any means (including the rare survivors of a firearm attempt) show they will not likely die by suicide in the future. Only 7% who made a prior serious suicide attempt will succeed in the future;

23% will attempt again; but 70% will make no further attempts.

"What is striking in this country is that the states with the highest rate of gun ownership have quadruple the number of firearm suicides compared to states with lower rates of gun ownership."

What is striking in this country is that the states with the highest rate of gun ownership have quadruple the number of firearm suicides compared to states with lower rates of gun ownership. The number of non-firearm suicides and suicide attempts is equal in states with the highest and lowest rates of gun ownership. This study was reported in the American Journal of Epidemiology. Another recent study showed a dramatic reduction of suicide in Switzerland after decreasing the size of the Army militia by half, which reduced the number of firearms easily accessible in the homes of individuals who served in the Army militia.

It is clear to me that reducing access to firearms for individuals with mental illness, as well as reducing accessibility to firearms overall in our society, will save lives. As psychiatrists, this is what we must support.

In Memoriam: Dr. Ghislaine D. Godenne

In Novermer 2013, at the age of 89, Dr. Ghislaine D. "Ghilly" Godenne passed away from complications of chronic obstructive pulmonary disease. Dr. Godenne was beloved by many—for her warm personality as well as for her many contributions to psychiatry.

After receiving her medical degree in Belgium in 1952, Dr. Godenne completed a pediatric residency at Providence Hospital in Washington, and then did other post graduate work and psychoanalytic training at the Baltimore-Washington Institute for Psychoanalysis. She was founder and head of the Adolescent Psychiatric Clinic at Johns Hopkins Hospital from 1964 to 1973. She was also director of Johns Hopkins

University Counseling and Psychiatric Services-- "The Whitehouse"-- for many years.

Dr. Godenne was the first woman ever to serve as president of the American Society for Adolescent Psychiatry. She was a prolific contributor to psychiatric journals and books. She was consultant to numerous institutions, including Sheppard Pratt Hospital, the University of Maryland Department of Psychiatry, Loyola University Maryland, Catholic Charities, the state Department of Social Services, and the House of the Good Shepherd. She was an active member of the Maryland Psychiatric Society.

In addition to being a Belgian baroness, Dr. Godenne was a world traveler, a sculptor (in wood, alabaster, copper, stone, and plaster), a collector of medieval and modern paintings and of musical instruments from around the world.

Memorial services are expected to be held in the Spring of 2014.

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