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Reflections on the Spade/Bourdain Suicides

By: Somya Abubucker, MD
Resident, Johns Hopkins

Somya Abubucker, MD

When Kate Spade died by suicide on June 5, 2018, and Anthony Bourdain three days later, I felt shock and grief as if I had lost people close to me. After all, I—along with millions of others—owned Kate Spade bags, dreamed in Kate couture, and experienced more of the globe with Anthony Bourdain than with anyone else. They were cultural icons and role models and epitomized the American dream. Kate Spade made her first prototype hand bags out of scotch tape and paper and went on to launch a brand that would define New York fashion in the 1990s . Anthony Bourdain started as a dishwasher and transformed himself into a world-renowned chef and writer, hailed as the "Hemingway of gastronomy" and someone who spoke truth to power and delighted in marginal subcultures. In the vernacular, they were "living the life."

Both also suffered from psychiatric disorders. Bourdain was public about his, writing openly about his previous substance use disorders. He was also frank about his depression. In the 2016 Bueno Aires episode on Parts Unknown, Bourdain expressed a fascination with Argentina, a country with one clinical psychologist for every 696 people in 2012. (The USA in 2014 had one psychologist for every 3,376 people.) It is one of Bourdain's best episodes, weaving together the tango, midnight soccer matches, and paeans to red meat to create a nostalgia so authentic and severe that even the first-time viewer feels homesick. The vibrantly colored scenes of Buenos Aries life are interspersed with black-and-white cuts to Bourdain sitting in the office of his psychoanalyst. The camera returns obsessively to an airplane landing strip, where families gather to watch planes take off and land. It is an idyll of the rustics that Bourdain cannot take part in. Just as persistently, the camera returns to the psychoanalyst's office, where Bourdain says, "I feel like Quasimodo." When I first watched the episode, the psychotherapy was darkly jocular with more than a touch of theater, but when I watched it again, Bourdain's courage at self-disclosure and at seeking help brought tears to my eyes.

Kate Spade also suffered from depression. After her death, her husband revealed that she had been under medical care for depression and anxiety for five

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In This Issue

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Spade/Bourdain Suicides

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years. Her sister stated that Spade "refused to seek help lest word get out and sully the brand's upbeat reputation". The Facebook tribute by Claudia Herrera the day of Spade's suicide captures a lot of my bewilderment. She posted, "I knew when Patrick Swayze was battling pancreatic cancer. I know that Cynthia Nixon is a breast cancer survivor. I know that Selena Gomez has lupus and recently had a kidney transplant…. I know that Lance Armstrong is a testicular cancer survivor. But I didn't know that Kate Spade suffered from depression…. Somehow society has made it more acceptable to talk about breasts and testicles than about the mind…". There is much truth to Herrera's indictment. The stigma about psychiatric disorders runs deep in American culture.

The Spade/Bourdain suicides tore at the fabric of the everyday. Spade and Bourdain have ignited a national conversation about suicide. This opportunity comes not a minute too soon. On June 7, 2018-- sandwiched between the two suicides-- the Centers for Disease Control and Prevention published a press release; between 1999 and 2016, suicide rates rose across the US by 25.4%. According to WHO data, globally a suicide occurs every 40 seconds, and that "[t]here are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide". In the US, suicide is the 10th leading cause of death; globally it is the 17th.

What can we do? First and foremost, we can become better clinicians-- better able to take care of suicidal patients. As Spade and Bourdain make clear, how people appear is an unreliable index of their suicide risk. We can improve how we detect self-harm potential, becoming experts in its causes and its risk and protective factors. We can beware of stereotypes, avoid myths, and forge therapeutic alliances with special-risk populations. We can help patients and families recognize warning signs and create safety plans. We can advocate restricting access to lethal means of suicide. All of us can continue to improve our listening skills. Finally, we need to learn more about the genetics, etiologies, management, and prevention of suicide. We have to improve screening tools, develop algorithms for predicting suicide risk, and find bio markers. We need to be mindful of our social media presence, which can reach a much larger audience than our academic journals can. Even seemingly trivial acts such as "liking" posts about people with suicidal ideation who sought help and did not attempt suicide can make a difference in which stories reach vulnerable people. As suicide rates continue to skyrocket, we need to apply all these anti-suicide strategies and re-commit to the goal of zero suicides.

Note: A version of this article was first published in The American Journal of Psychiatry Residents' Journal.

How I Came to Write the Letter to the Editor in the Baltimore Sun

by Steven S. Sharfstein, MD

Steven Sharfstein, MD

Fewer and fewer people read *The Baltimore Sun*. What was once an important source of information and commentary for local, regional, and national news now is a shade of its former self, a thin local paper with an editorial page and Op Eds that can occasionally cause some ripples. This has been the fate of many newspapers around the country as our source of information and opinion has shifted to cable news and the Internet.

But I am old fashioned. My wife and I are throwbacks, as we read 4 print newspapers every day, not only the *Sun*, but also the *Washington Post, New York Times* and *Wall Street Journal*-- newspapers with some continuing heft.

So, on September 23, *The Sun* published an Op Ed by Patrick Hahn, arguing that the increased suicide rate for patients with schizophrenia in the 20th century is due to the antipsychotic medications we use in everyday practice. Provocative. Distressing. Anti-psychiatry.

Having fought these wars with Scientology and others for many years-- as APA President and in my role as President of Sheppard Pratt-- and now that I'm "retired", I thought someone else could respond this time. Then I got an e-mail from a NAMI family member I love: "Steve, what are you going to do about this?"

Me?? Why me? That night I woke up at midnight, after a dream about water and tsunamis, and, silently cursing, began typing a letter to the Editor that I sent the next morning. The following morning, two days after the Op Ed piece appeared, I thought about calling the Editor of the editorial page to urge prompt publication. Then I saw that my letter had been published that day, 24 hours after I wrote it.

You never retire or leave an old job. "They always keep "pulling you back." (The Godfather).

To The Editor:

Patrick Hahn argues in his essay ("Schizophrenia and suicide: is there a drug connection?" Sept. 23) that an increase in the suicide rate for patients with schizophrenia since the 19th century may be due to the use of anti-psychotic medications in the 20th century. An alternative hypothesis would examine the impact of de-institutionalization of tens of thousands of these patients from the long-stay state hospitals into the community unprepared to treat and care for them.

The well-documented increase in homelessness and incarceration of these patients is a public health crisis today. Suicide is only one bad outcome that may be attributed to the neglect of these patients. Dramatic decline in the number of, and access to, inpatient beds accompanied by inadequate resources devoted to community treatment has led to the failure of the public mental health system nationwide.

In contrast, there are thousands of patients who have benefited from the medications designed to treat the severe symptoms of schizophrenia who have a life in the community but need additional resources devoted to housing, employment and support for families who are the primary caregivers. I have seen many lives transformed by these medications that reduce the most disabling symptoms of schizophrenia. There are many positive outcomes today thanks, in part, to the medications we have available. Without them, our patients would be worse off.

Steven S. Sharfstein, MD

Cheers From The Chair

Geetha Jayaram, MD Becomes Full Professor

by Jimmy Potash, MD, MPH


Jimmy Potash, MD, MPH

Eds' Note: This is a version of the article sent to Hopkins faculty members by Dr. Potash on 9/27/19.

The Advisory Board of the Medical Faculty voted yesterday to approve the promotion of Dr. Geetha Jayaram to Professor. I want to congratulate her on reaching this lofty height, the top rung of the ladder of academic achievement.

This means, oddly enough, that in my third year as Department Director, I have seen more women psychiatrists promoted to Professor than has any other Phipps Director in our 106-year history. Dr. Jayaram is the second woman to earn this distinction during my tenure, with Dr. Meg Chisolm having been promoted last year. Before that there was only Dr. Susan Folstein, former Director of the Division of Child and Adolescent Psychiatry, in 1989, and Dr. Una McCann, who directs our Anxiety Clinic at Bayview, in 2008. It's not that we haven't been promoting women to our highest ranks. Since 1990, we have elevated 16 women with PhDs in the department to Professor. Most of these women have been research-focused, and because promotion has traditionally depended on writing research papers and getting research grants, they probably have had an advantage over psychiatrists, who typically have substantial clinical responsibilities.


Geetha Jayaram, MD

One more point on the issue of who has made it to Professor over the years: before 1959 only one woman in the *entire* School of Medicine was named a Professor (physician-anatomist Florence Sabin in 1917). I believe part of the reason is that until that time Hopkins only allowed one Professor per department, and that title was reserved for the Department Chair.

Dr. Jayaram grew up in India and did her medical school training there. She arrived at Hopkins in 1978 for residency, just three years into Dr. Paul McHugh's tenure as Department Chair, and she became Chief Resident under him and Residency Program Director Phillip Slavney. She then went on to do a fellowship in Community Psychiatry. Early in her career, she was the first author on a paper about patients with chronic schizophrenia treated with the long-acting anti-psychotic medication, fluphenazine decanoate, which showed that relapse in this group was associated with low levels of the drug in the patients' blood. She went on to co-author several more papers on schizophrenia. She served as Medical Director of our Hopkins Hospital Community Psychiatry Outpatient Clinic, and then as co-leader of our inpatient Community Psychiatry (Short-Stay) unit. Dr. Jayaram developed expertise in quality of care and patient safety on our inpatient units, and became the department's leader in that area for 20 years. She worked successfully to decrease the need for the use of seclusion and restraints, to reduce medication errors that caused harm, and to diminish the risk of suicide on our units. Eventually, she would Chair the Patient Safety Committee for the APA, serve as President of the American Association of Psychiatric Administrators, and publish two books on patient safety in Psychiatry.

When I spoke to Dr. Jayaram about her promotion yesterday, she expressed pride in being a foreign medical graduate who was able to make it to Professor. While she is not the first such graduate to accomplish this, she is among the very few from less industrialized countries. This is noteworthy because Dr. Jayaram has been keenly aware of the need for building up access to mental health care in the rural parts of her native India. In 1997, she set up a rural community psychiatric clinic (The Maanasi Project) that is integrated into primary care in Southern India, focused on the care of women and children. This clinic continues to thrive, treating a caseload of 1,900 active patients, with a reach of 206 villages and a household population reach of several million. The project includes the use of female indigenous caseworkers, data entry workers and outreach, teaching and training of resident medical officers, nurses, junior faculty and visiting scholars from many countries. Her impressive work with The Maanasi Project has led to international invitations to teach and speak about low-cost models of psychiatric care in Lithuania, Romania, and Canada, and at the World Health Organization and the World Bank.

Dr. Jayaram broke new ground here with us, and has made a difference for patients both in our local community and in another community on the far side of the globe. Let us continue to widen our embrace of people with talent and of people in need, here in our department and in our institution, in Baltimore and in our region, and around the country and the world.

The Standard of Care for Prescribing Practices and Documentation: Opinion of the Maryland Board of Physicians

By: Joanna Brandt, MD


Joanna Brandt, MD

Earlier this year, the Maryland Board of Physicians (the "Board") published a Consent Order (2218-0136 A), which should be of interest to members of the Maryland Psychiatric Society. A Consent Order is a voluntary agreement between the Board and a Licensee ("Respondent"). In this Order, the Board produced a lengthy list of specific deficiencies in prescribing practices and in documentation relevant to all practitioners, including psychiatrists. The Board also referenced the AMA Code of Medical Ethics opinions about self-treatment and the treatment of immediate family members. This case illustrates how the Board investigates complaints and is a reminder that an investigation into a complaint about the treatment of one patient may lead to a review of many patients' files.

The Board received a written complaint from the father of a patient of a Maryland psychiatrist. The complaint alleged that the Respondent "had been overprescribing amphetamines [to the patient], who lived out of state, without 'meaningful contact,' resulting in a psychotic episode with suicidal ideation. [The patient] overdosed on amphetamines and was hospitalized." The Board sent a subpoena to the Prescription Drug Monitoring Program (PDMP) for a list of all controlled substances written by the Respondent for an 18-month period.

Relying on the information from the PDMP, the Board requested records from the Respondent for *ten* patients including the one whose father generated the initial complaint. The Respondent provided the Board with *nine* charts and told the Board there were no records for one patient listed on the PDMP because that individual was a family member. The Respondent reported that the prescriptions written for the family member were renewals of prescriptions written by other providers. He further reported "the prescriptions provided were with the knowledge of and in consultation with" the family member's primary care providers. He denied initiating any new medications for the family member, and reported that office records were not maintained because he was not the treating doctor. Regarding the patient in the initial complaint, he reported providing treatment to that patient intermittently for 15 years and stated he had no reason to suspect the amphetamines would be misused.

The Board arranged for an independent peer review to be conducted by two board-certified psychiatrists. The reviewers concluded that the Respondent "failed to meet the appropriate standards for the delivery of quality medical care" in eight of the nine cases, and "failed to keep adequate medical records" in nine. The Board cited the following deficiencies:

Documentation Deficiencies

- Respondent's medical records, which are hand written, are only approximately 80% legible;
- Did not indicate the type of patient encounter (i.e. Initial assessment, follow-up visit, telephone contact, refill called in)
- Did not provide patients' identifying information on individual pages of the record;
- Often omits the year in documenting the date of appointment;
- Did not document the amount of time spent in appointments;
- Did not document when the next follow-up visit should occur; and
- Did not sign his notes.

Clinical Content of Documentation

- Respondent failed to obtain and document a clinical history;
- Notes are generally quite brief, quite sketchy, and contain little detail. They usually contain little or no interim history and little or no information about social, occupational or relationship status or functioning. Some are so brief as to be essentially meaningless;
- Failed to document a regular clinical assessment. The history section of the progress notes was largely followed by prescriptions without a notation of what Respondent thought the clinical assessment was and why the changes, or ongoing medications, were indicated;
- Failed to perform mental status examinations other than at the initial psychiatric evaluation. Most notes, which are apparently follow-up visits, do not document the patients' mental status examination at the time of the appointment;
- Mentions diagnoses in some notes, but most notes do not indicate Respondent's diagnostic impressions or working diagnosis, which should be in every note;
- Failed to adequately assess suicidality, an essential task of a psychiatrist;
- Failed to assess bipolarity. This is important as the use of antidepressants can severely negatively impact the clinical course of this disease;
- Failed to take vital signs despite use of stimulant

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medications, and/or failed to document coordination with the patients' family doctor in obtaining vital signs;

- Failed to obtain adequate laboratory monitoring for metabolic syndrome despite use of second-generation antipsychotics; and
- Failed to document monitoring for tardive dyskinesia in patients who were on antipsychotics.

Documentation of Prescriptions

- Respondent nearly always abbreviates the name of the medication which is often not identifiable from the abbreviation;
- Did not document the strength or include units (i.e., mg, micrograms);
- Did not clearly indicate the number of refills and did not include the directions for taking the medications being prescribed; and
- Did not adequately document patients' medication regimens. Many progress notes have lists of medications (names abbreviated) that look like records of prescriptions it is often impossible to tell exactly what medications the patient should be taking.

Prescribing Practices

- Respondent's "overall prescribing practices" fall outside of usual community practices because of the extreme frequency with which unusual combinations of controlled substances are prescribed. The most common situation is prescribing a combination of a benzodiazepine (sedative) medication and an amphetamine (methylphenidate or modafinil) (stimulants) simultaneously;
- Records do not document a justification for these medication combinations, and whether patients were using controlled substances as performance enhancers. Review of the PDMP report shows that numerous other patients whose medical records were not reviewed were prescribed a combination of sedative and stimulant medications; and
- Records document that controlled substances were prescribed in high amounts with inadequate assessments of the patients, who were sometimes prescribed controlled substances for years without being seen.

The Board also learned from the PDMP that the Respondent wrote 40 prescriptions for his family member, primarily for benzodiazepines. The Board concluded the Respondent engaged in unprofessional conduct in the practice of medicine in the treatment of a family member and noted the following:

- Objectivity is compromised when Respondent is treating a member of his own family;
- Quality of care is diminished when treating a family member;
- Physician/patient confidentiality is impacted because family members do not have the opportunity to discuss alternative treatment and make private disclosures that otherwise would be made to a primary psychiatrist or primary care physician to whom they are not related;
- Family members' ability to give meaningful informed consent is limited because family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending Respondent;
- Family members are placed in a position of dependence on Respondent to continue to prescribe their medications;
- Respondent may be inclined to treat problems that are beyond his expertise or training; and
- Respondent failed to maintain documentation of the prescriptions he was writing for his family member and the medical indication for each.

According to the AMA Code of Medical Ethics (Opinion 1.2.1), there is not an absolute prohibition against self-treatment or the treatment of family members. However, this should only be done “limited circumstances” such as ”in emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available” or “for short-term, minor problems.”
The psychiatrist in this case was reprimanded by the Board and agreed in the Consent Order not to renew his license. A second Consent Order (2217-0082A) involving a psychiatrist was also published this year. Similar documentation deficiencies were addressed indicating the Board considers these issues to be important.

I hope this summary will clarify the position of the Board with respect to psychiatric record keeping and appropriate prescribing practices.

https://www.mbp.state.md.us/bpqapp/Orders/D3510406.069.PDF

https://www.ama-assn.org/delivering-care/ethics/treating-self-or-family and https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/coet1-1205.pdf

https://www.mbp.state.md.us/bpqapp/Orders/D4563906.249.PDF

Why We Need More Horses

By: Stephen Warres, MD

Stephen Warres, MD

In August, Dr. Johanna Paulino-Woolridge asked a straightforward question on the MPS e-mail list. She reported that a government agency had decided to reduce the time-allotment for child psychiatry follow-up appointments from 45 - 60 minutes to 30. She wanted to know whether and how psychiatrists might be able to do this.

Here is what I believe needs to be done in a follow-up appointment:

1) Review past notes, psychological evaluations, teacher evaluations, discharge summaries, and relevant lab results. If the psychiatrist is not the child's psychotherapist, talk with whoever it is.

2) Talk with the child/adolescent alone. With older children and adolescents, this may need to precede meeting with the parents in order to protect the therapeutic alliance. With younger children, talking with the parent(s) first is usually better in order for the child to feel that the psychiatrist has been approved and informed.

3) Establish rapport with all parties and provide enough temporal and emotional space for everyone to explore sensitive underlying issues.

4) Talk with child/adolescent and parent(s) together so that all will know that the psychiatrist does not speak “with forked tongue”.

5) If parents are separated, divorced or disagreeing with one another, talk with them separately and/or together in order to negotiate a mutually acceptable plan. (Any treatment intervention that omits this step is useless.)

6) Contact a teacher or school clinician, especially when ADHD medication is involved, since response to medication varies across the day (so a parent may not see medication results or side-effects at their peak).

7) If medication is involved (as is often the case), contact the pediatrician so that you are not prescribing behind the primary doctor's back. Review other medical issues and do a drug-interaction check. This is an obvious safety issue.

8) Establish and secure lines of communication with all parties.

9) Check PDMP if there is a question of substance abuse or medication abuse. Write prescription, if indicated---which may immediately trigger a time-consuming preauthorization process.

10) Write progress note and any letters needed for implementation of the treatment plan.

It is impossible to do this in 30 minutes. Moreover, inpatient stays for children and adolescents trend ever shorter, so outpatient follow-ups increasingly shoulder the burden of what used to be done in the hospital. When I was a Child Fellow, we had time to address the components described above, to make referrals, negotiate differences, and so on. Now, however, children and adolescents are discharged ASAP, essentially defenestrated by administrative fiat---the emotional equivalent of throwing infants out of NICUs and hoping the receivers catching the pass know which way to run. So, at the very time that outpatient psychiatrists should be allotted *more* time to do what has not yet been done, they are given *less*.

And no one has time to listen. Anton Chekhov wrote a short story, variously translated as "Grief" or "The Lament." A horse-carriage driver in Russia has recently suffered the death of his son. He picks up one fare after another and repeatedly tries to talk about his grief, but none of the passengers, for varying reasons, has time to listen. Finally, the driver takes his horse back to the stable, sits down on a stool, and tells the whole story to the horse.

This is the way our mental health system works. One person is populating the fields on a history form; another is administering a questionnaire; another is writing for medications, and so on. What we really need are more horses.

Why do clinicians have to plead with *administrators* for the resources (time) necessary to do their work? How have we gotten here? You may have read that Boeing, after having lost two planes and hundreds of lives this year, is revising its organizational structure. Heretofore, Engineers (substitute "Doctors") had been reporting to Administrators. So engineering (clinical) concerns were trumped by *administrative* concerns. And guess what happened?

Who is being *served* and who is being *sued*? We like to think that we are serving the patient. Is that so? If we are pressured to cut corners at the expense of patient care, whom are we really serving? One likely answer is the Organization and its bottom-line.

And who is being sued? Decades ago, I was on the MPS peer review committee. I remember one case in which a physician was covering a ward of more than twenty patients for a weekend. Utilization Review told him that a

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Why We Need More Horses

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particular patient no longer met criteria for continued hospitalization, so he discharged that person. The patient went home and killed a family member. Somewhere in a handwritten note earlier that week, an aide had documented that the patient was angry at the relative. Elsewhere, there was a note about firearms. I reviewed the chart and found that it took me about 30 minutes to read the chart and find those two notes. Extrapolating, it would take about ten hours to review notes on everyone that the hapless doctor had to cover that weekend before even seeing any of the patients. Do you think the Utilization Reviewer was sued? Do you think the hospital changed any of its procedures? Of course not. The doctor was sued. That solved the problem.

In my opinion, when psychiatrists agree to do follow-ups in arbitrarily curtailed times, they offer their bodies as shields to the organization. The doctor bears the responsibility and takes the hit. The organization takes the profit.

So, what can be done? Here is where organizations like MPS, APA, AACAP and others can step in. Dr. Paulino-Woolridge asked a good question, and a professional organization composed of clinicians, not administrators, could provide consensus-approved guidelines. As a passenger, I prefer to fly on airplanes designed by engineers who can plan without the interference of administrators. As a patient, I prefer to be treated by clinicians who can use their best judgment undistorted by administrative priorities.

Finally, I believe the psychiatrist should do her or his own scheduling. Some patients require less time than others; others, much more. The psychiatrist and the therapist are the only persons in a position to know---not the scheduling clerk responding to administrative pressures. Who constructed the procrustean bed of 30 or 45 minutes? Are patients wheeled out of operating theaters with their incisions un-sutured because they have exceeded an administratively allowed surgical time limit?

To paraphrase Shakespeare's Cassius in his *Julius Caesar*...." The fault, dear Brutus, is not in our stars/But in ourselves, that we are underlings."

REMEMBRANCE:
Robert Trattner, MD

By Bruce Hershfield, MD

Robert Trattner, MD

Dr. Robert E. Trattner, who had a private practice at 11 E. Chase St. in Baltimore from 1959 until he retired in 1990, died on May 23rd of pneumonia at age 98.

Originally from Cleveland, he entered dental school and served in the Pacific during WWII as a junior dentist. He completed his dental studies, then enlisted in the Naval Reserve before entering the University of Chicago Medical School. He was Chief Resident in Psychiatry at what is now the University of Maryland, where he served as a Fellow the following year.

In addition to his private practice he taught counseling to Jesuit priests and also worked at a clinic in Hagerstown.

Fluent in French, German, and Italian, he had a personal art collection, supported cultural institutions in Baltimore and Washington, and enjoyed collecting palindromes—words or sentences that read the same either forward or backward.

(From article in the Baltimore Sun)

MPS ADVOCACY DAYS IN ANNAPOLIS

February 4, 2020
8:30AM-1:00PM

We invite all MPS members to join us in Annapolis to meet with House and Senate leadership to discuss current and future legislation affecting psychiatry and mental health in Maryland.

RSVP: Contact Meagan Floyd (410-625-0232) or email.

DL v Sheppard Pratt:

The Collateral Consequences of Civil Commitment

By: Erik Roskes, MD


Erik Roskes, MD

In September 2019, the Maryland Court of Appeals (COA) decided *DL v Sheppard Pratt*.

DL, age 14, was evaluated in an emergency department, having cut her arms superficially with a blade. She was certified for involuntary admission by two physicians and transferred to Sheppard Pratt for inpatient care. By the date of her involuntary commitment hearing, she had already been referred to a residential treatment center (RTC), but no beds were available. At her hearing, her inpatient psychiatrist testified that she was dangerous to herself, though not to others, and that there was no less restrictive intervention because no RTC beds were available. Based on this testimony, she was retained by the administrative law judge (ALJ) after a finding that there was clear and convincing evidence that she met criteria for civil commitment. The ALJ commented that while there is a "possibility that something might or might not be available today [,] that is not clear and convincing that [a less restrictive form of] intervention is available."

DL filed for judicial review in the Circuit Court for Howard County. While her review petition was pending, she was discharged to the RTC when a bed became available a few days after her hearing. Later that month, the review hearing was held in Circuit Court on the question of whether or not a less restrictive form of intervention was available, and the Court granted Sheppard Pratt's motion to dismiss, based on mootness.

"Mootness" refers to a situation in which the legal controversy being litigated at the time of filing is no longer present by the time the case is heard. That would appear to be the case here, given that the review and appellate hearings occurred weeks, months and years after DL's commitment and release. But there are exceptions to the mootness doctrine, most notably related to controversies that are capable of repetition, yet, because they are short-lived, typically will evade review. Involuntary civil commitment is a classic example of such a controversy; the typical length of stay for an involuntarily admitted patient is measured in days or weeks, while appellate review often takes months or years. Another rationale for hearing such "moot" cases at the appellate level is when there is a "public concern" that warrants review, even though the individual controversy would appear to no longer exist. Finally, there are cases in which mootness is overridden when it can be established that there are collateral consequences that have not been resolved by the termination of the initial deprivation or injury.

In this case, the COA found that, in fact, DL was subject to possible collateral consequences that far outlived the brief period of her involuntary commitment.

The word "possible" is important here. In the law, "probable" is defined as "more likely than not", often mathematically derived as a 51:49 ratio. "Possible" is less than "probable", so it can include events that are more likely NOT to occur, but which might occur. This is a very low bar indeed.

After reviewing relevant case law, the COA turned to the possible collateral consequences that DL may suffer as a result of her brief civil commitment. At her oral argument, DL argued that she was subject to the following possible consequences:

Her civil commitment may affect

1. her ability to obtain a driver's license;
2. her employment prospects by preventing her from obtaining certain certifications, licenses, or security clearances;
3. her standing in future child custody disputes;
4. her immigration status;
5. her ability to serve on a federal jury.
6. her ability to defend against future civil commitment proceedings, and
7. her ability to possess or own firearms.

Additionally, her civil commitment may cause stigma by labeling her legally and in the public record as a person with mental illness.

After reviewing these assertions in detail, the COA concluded that DL was subject to most of these possible collateral consequences, rendering her appeal not moot.

So, in 2019, what is the implication of this ruling vis-à-vis a civil commitment lasting two weeks in 2015?

The main point is this: At the initial hearing, the Circuit Court did not hold a hearing on the merits of DL's argument that there was in fact a less restrictive intervention that could have allowed her to avoid being committed. Because these collateral consequences are possible, and her discharge does not erase them, this means that review hearings, in those cases when patients seek them, are to be held on the merits of the argument raised by the patient, even if the hearing takes place after release. What the remedy would be if the Circuit Court found, weeks or months after the end of the civil commitment, that the commitment was invalid for some reason, is not clear. Perhaps such

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Civil Commitment

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people would be able to petition for an "expungement" – that is, a legal erasure of the commitment. But the current case did not reach this decision.

Why does this matter to clinicians? In my view, the most important thing for us to remember is that our actions in hospitalizing or otherwise treating patients over their objection have possible consequences for them. While we may have the best of intentions, all treatments have side effects, and civil commitment certainly does. It is important that we are as mindful of these "collateral consequences" as we are of the potential for tardive dyskinesia, metabolic syndrome, liver or renal failure, myocarditis, or any of the other myriad side effects from the medications we use. That such side effects are rare does not make them any less real when they happen to a patient.

REMEMBRANCE: Robert F. Ward, MD

By Bruce Hershfield, MD

Robert Ward, MD

Dr. Robert F. Ward, a Life Member of the MPS, died on September 28th.

Originally from New Jersey, he attended medical school and did his training at Johns Hopkins, where he was Chief Resident at the Baltimore City Hospitals. He then directed an inpatient unit and served as a faculty member in the sexual behaviors outpatient clinic.

He had a private office at the Rotunda in Baltimore. He was particularly interested in family therapy and ran a family therapy clinic for employees of General Motors. He was an opera lover who also enjoyed cooking and traveling.

Dinah Miller, MD commented about the way he inspired his colleagues, "Bob's office was across the hall from mine at the Rotunda. He was a kind and gentle soul. Everything about him was elegant, and yet he still was a bit of a teddy bear. When I first moved into the Rotunda, I wanted to tell him something and I walked into his waiting room -- there were Oriental rugs and antiques. I walked back into my own waiting room with the two chairs, fluorescent lighting and white walls, and realized I had it all wrong and I went out shopping that same afternoon. "

No Shows

When Prospective Patients Don't Show Up

By: Robert Herman, MD

Robert Herman, MD

In my busy psychopharmacology practice near Annapolis, prospective patients often have to wait months to get an initial appointment. This is very frustrating for me and for them, as many of them are quite ill, have been hospitalized, or are doing very poorly. Therefore, it is extremely frustrating when new patients do not show up, even though my staff calls to remind them on the day before their appointment.

This problem is common in all specialties and in all practices. Most folks will charge patients who miss an appointment and want to reschedule. Some charge a full fee, while others charge less. Very few practices, I have found, will ask for payment in advance and collect the fee even if the person does not show up.

I recently attempted to diminish the number of "no shows" by personally contacting new patients two days in advance, asking them to call me personally (or my voice mail) to confirm they were coming. Some folks said, "I was thinking that I wanted to reschedule some other time". It was clear that they were not planning to keep their appointments. I told my staff not to reschedule these folks

When I cut down on "no shows" this way, I have less free time to catch up on prescription renewals, prior authorizations, returning patient messages, and other tasks. Recently, I got so busy that I did not have time to call the new patients in advance, and--sure enough -- I had another "no show". I was happy at the moment that I had an extra hour to catch up on paperwork, and to call the new patients who were due to see me in two days.

We will never completely eliminate "no-shows", although I am still interested in figuring out what is best to do. Perhaps it's better that we don't eliminate them completely so we can get a break and catch up on all the other work we have to do.

What I've Learned

By: Brent Pottenger, MD
Resident, Johns Hopkins

Brent Pottenger, MD

Prior to starting my psychiatric training at Johns Hopkins, I had formed impressions about psychiatry both from my rotation during the 3rd year of medical school and from my two years as a Resident, first in internal medicine and then in physical medicine & rehabilitation. I had seen firsthand, while caring for medically ill patients, that mental disorders can impair their functioning significantly. From these experiences, I recognized that I needed specialized training to learn how to provide effective, empathic care to them.

Now, after training in psychiatry this past year, I have learned that I can help them face challenging problems of mind and body. For example, while working with Dr. Glenn Treisman, a psychiatrist, on the inpatient Pain Treatment Program, I realized that improving their quality of life required me to be a *doctor*. Every day I had to think about the *whole* patient and then advocate for his or her unique needs. Often, these patients, dependent on opioids and benzodiazepines for chronic pain, suffer from co-morbid medical disorders that have gone either unrecognized or under-treated for years. I had to re-think the differential diagnoses and to consider the possible etiologies. This is where being a doctor comes in. For instance, a patient with a chronic pain syndrome who is anxious from years of battling recurrent kidney stones who presents on large doses of opioids and benzodiazepines. He could wean off them if the underlying problem--generation of kidney stones--is addressed. The more I learn about mental health, the more I learn about physical health, and vice versa.

This interplay between mind and body came to life in another case on the same unit. For most of his childhood, Mr. L was a "happy-go-lucky" kid who played outside and enjoyed participating in various sports, including karate. At age 3, he had ingested a toxic household cleaning substance that damaged his GI tract. By age 13, the effects of this became functionally impairing: he struggled to keep food down and lost weight, and he passed out frequently and had to use a wheelchair. He spent most of his teenage years in and out of hospitals for abdominal pain and feeding intolerance. He remarked, "What's the point of living like this?" As his peers graduated from high school, he was once again hospitalized, this time at Hopkins. While he was on the GI service, Dr. Treisman was consulted. He noted the patient was unable to eat food by mouth and depended on a J-tube for feeding and on a central line for intravenous fluids and medications. Workup showed significant colonic inertia; he had at most one bowel movement per week. Dr. Treisman transferred him to our program.

By participating in the interdisciplinary Pain Treatment Program over several months, his functioning improved. He was eventually able to eat meals by mouth. His central line, J-tube, and IV' s were removed. After being in a wheelchair for 7 years, he walked again.
His orthostatic intolerance and syncope from dysautonomia were managed with multiple medications. He responded well to immunomodulation therapy. He had bowel movements more frequently, re-gained approximately 25 lbs and, walked more. He was able to go to a baseball game and to travel to Washington to visit the museums. He continues to receive IV-IG monthly as an outpatient, and he faces challenges every day with his medical conditions, but he works on how best to manage them. He is hopeful about the future again.

From mentors like Dr. Treisman, I have learned that being a good doctor--and being a good psychiatrist--requires keeping an open mind about what *could be*--both for etiology and for recovery. I will do my best to consider what *could be* contributing to each patient's predicaments. And, I will simultaneously keep an open mind about how to help when hope wears thins--this is when being a good psychiatrist is most important.

MPS & MedChi Presents:

Public Health Impacts of Gun Violence in our Community

April 15, 2020
5:45 - 9:30PM
MedChi's Osler Hall

This CME activity will include research & strategies that psychiatrists and other providers can use when treating patients and families who are victims of violence. The evening will also include a screening of the film, *Charm City*.

Presenters/Panelists Include:

Damion Cooper
Nathan Irvin, MD
Marilyn Ness
Paul Nestadt, MD
Carol Vidal, MD, MPH

More information coming soon.

Interview:
Gerald Nestadt, MBBCh, MPH

Professor, Johns Hopkins University Department of Behavioral Sciences

By: Bruce Hershfield, MD

Baltimore, October 4, 2019

Q.:" Congratulations on the grant to study post-partum OCD."

Dr. N.:" Thank you. We are going to follow pregnant women throughout their pregnancies from the 22nd week to 6 months post-partum. We want to explore further the high incidence of exacerbations of OCD symptomatology during the pregnancy and post-partum. This is something that few people have paid attention to, nor are there very good data.
There are several aims to the study. One will be to identify the frequency of OCD and another is to identify the characteristics of the OCD during the pregnancy. We also want to identify the consequences—-whether there are substantial disabilities or impairment secondary to OCD."

Gerald Nestadt, MBBCh, MPH

Q.:" Please tell us about your studies of the genetics of OCD."

Dr. N.: "We have been studying genetics since the early to mid '90s. It was known that there was a familial relationship. There had been family studies in the past, but none had gone into depth.

At first, we couldn't get a grant because the NIH and others weren't satisfied about the familiarity of the condition. So, we started out by doing a family study showing that indeed OCD incidence was higher in the relatives of those who suffered from it. We also completed a segregation analysis to see how OCD was transmitted from one generation to another. We then proceeded with molecular studies. We conducted a linkage study to look for a major gene anywhere within the genome. That was very popular at the time. Although we could identify regions of the genome that were of interest, we could not identify an actual major gene for OCD.

We then completed a genome-wide association study, in collaboration with other institutions. Unfortunately, we did not hit a 'home run' and find a significant association. But we did find interesting associations. We continue this work today with an international consortium. We are now completing whole genome and whole exome sequencing studies, looking for rarer variants involved in OCD.

Q.: " You are also involved in clinical care of patients."

Dr. N.:" We have an OCD clinic which we staff together with PGY-3 Residents. This provides the residents exposure seeing and treating patients with OCD. Hopefully, many of those residents will take over the management of the case of a patient with OCD and participate in their care."

Q. "What are your views on the role of the psychiatrist in the diagnosis and treatment of OCD?"

Dr. N.:" I do not support the view that psychiatrists are merely prescription-writers or psychopharmacologists. I think evaluations should be conducted by psychiatrists so that there is a full understanding of the psychiatric issues. We should take care of patients, using both medication and behavioral treatment in addition to supportive psychotherapy."

Q.: "Why do you think so many psychiatrists avoid doing behavioral therapy?

Dr. N.:" I think that's true of many psychiatrists. At Hopkins, the younger generation is actually interested in treating these patients with behavioral therapy and that is because they are getting the training. I don't believe that I got that training when I was a Resident."

Q.:" How did you get involved with OCD?"

Dr. N.: " It was totally serendipitous. In 1986 I was at Hopkins with Dr. Rudolf Hoehn-Saric. He was doing clinical trials with clomipramine or Anafranil. While I was not involved with OCD at the time, I assisted and that sparked my interest in the patients and the experiences they were having."

Q.: "That was an exciting time. Not only clomipramine, but also the publication of "The Boy Who Couldn't Stop Washing".

Dr. N.: " Yes, and it was around then that we changed our perception of the prevalence. As you know, we thought it only affected 0.04% of the population. But the ECA program made a major impact on OCD when it showed it to be as high as 2-3%."

(Continued on p. 13)

Nestadt Interview

(Continued from page 12)

Q.: "Was it hard for you to change your perceptions of what was useful in treating OCD?"

Dr. N.: "At the time there were a lot of interest in dynamic concepts in the development of OCD and there was some interesting work in that regard. With the help of Rudy, I was able to look at other methods of treatment."

Q.:" How can American psychiatrists get more familiar with CBT?"

Dr. N.:" I haven't personally had formal training in behavioral therapy, though I did spend a brief period of time in London with Paul Salkovskis, an expert in that field in the UK. Today there are some excellent clinicians training our Residents in behavioral therapy."

Q.: " Please tell me more about what you are working on."

Dr. N.:" Let's go back to the pregnancy study. In addition to the psychological and functional factors, we are looking at hormonal and immunological factors that may be involved in the development of OCD during pregnancy. We are lucky to have Dr. Lauren Osborne, at Hopkins working in this area. "

Q.:" How can the psychiatric community help you in your work?"

Dr. N.: "I think that the goal is to provide the best treatment for individuals suffering from OCD. This includes the use of appropriate psychiatric medications, appropriately using behavioral therapy, reducing stigma, and continued public education." We would be most grateful for referrals of pregnant patients to our research study. "

Calling All Residents & Fellows!

TRIVIA NIGHT

Join us on **Wednesday January 29th from 6-9 PM** at HomeSlyce Pizza Bar in Baltimore for a **FREE,** fun evening featuring music, great food and open bar. Teams of residents and fellows will vie for cash prizes. For fun we will even throw in a team from the MPS leadership to find out who comes out on top!

The trivia portion of the evening will be run by Charm City Trivia. This event is open to members, non-members and their guests.

More information coming soon!

Nurse Practitioners as Medical Directors (SB 1122/ HB 944)

By: Kim Jones-Fearing, MD


Kim Jones-Fearing, MD

In the June issue of The Maryland Psychiatrist I wrote an article addressing the "Nurse Practitioners as Medical Directors of Outpatient Mental Health Centers" law that was recently passed and implemented. Since that time, I have met with various stakeholders and legislators about our concerns. A teleconference with the MPS administration and psychiatric leaders—including Dr. Anne Hanson and several other MPS and WPS members-- took place on September 3rd. We were able to review the hearings regarding this bill and discuss possible future steps, including receiving full support from our lobbyists at the MPS, and from Med Chi, and some legislators. We were able to meet with State Senator Brian Feldman (D- Montgomery County), Senator Clarence Lam (D-Howard County, Senator Katie Fry-Hester (D-Howard County), and Delegate Terri Hill (D-Howard County). Delegate Hill has agreed to assist in writing and supporting a corrective bill.

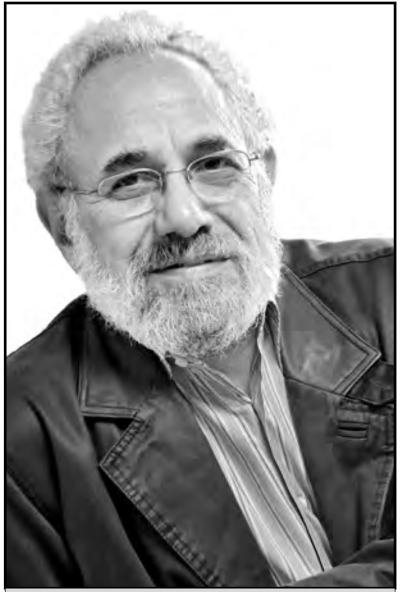
Quite a few concerned Maryland psychiatrists attended the Med Chi House of Delegates meeting held on November 2nd. The keynote speaker was Dr. Patrice Harris, the first African-American president of the AMA. She addressed current obstacles to health care, including prior authorization, administrative barriers to care, physician shortages, EMR burdens, loss of autonomy and physician burnout. During the meeting, resolution 24-19 was presented as a corrective remedy to the Nurse Practitioners law. Details can be reviewed on the Med Chi web site under the Events, House of Delegates, and Resolutions Tabs. The resolution, entitled "Outpatient Mental Health Clinic Medical Directors" states that "…the Medical Director of an Outpatient Mental Health center should be required to be a licensed and appropriately trained physician." We will follow legislation about this in the 2019-2020 general assembly.

It is more important than ever for all psychiatrists to show up for these legislative meetings, and to express opposition to bills that worsen access to quality mental health care and further burden the workload of psychiatrists.

We must disrupt the status quo!

Do Not Use Mass Murder as the Reason to Improve the Mental Health System

By: Michael B. Friedman, MSW



Michael Friedman, MSW

(Ed.'s Note: Mr. Friedman has been a mental health policy advocate for over 40 years. He recently retired from teaching at Columbia U. and moved to Baltimore.)

Whenever there is a highly publicized mass murder in the United States, there are calls to fix America's "broken" mental health system. How should mental health professionals respond?

It is tempting to take advantage of the attention given to mental health after such tragic events and to ask for increased funding and other policy changes to improve America's inadequate mental health system.

But using mass murders as an opportunity to advocate for a better mental health system gives the false impression that mental illness is a major contributor to violence and that a better system will result in a significant reduction of these terrible events.

Yes, the mental health system is inadequate. And yes, mental health is mostly a matter of political indifference. But taking advantage of false and stigmatizing beliefs about people with mental illness in order to draw attention to the importance of mental health perpetuates the myth that people with mental illness are violent, and it spreads baseless fears.

The Truth Is That:

- People with mental illness rarely commit homicide, and few homicides are committed by people with mental illness. About 5% of homicides are committed by people with psychotic conditions.
- People with serious mental illness are far more likely to be victims than perpetrators.
- Most mass murders are committed by people who are not seriously mentally ill* including:
  - Terrorists
  - People who commit purposeful acts of murder or manslaughter or who commit crimes that result in unintended deaths
  - Perpetrators of domestic violence
  - People seeking revenge.
  - People with mental illness are far more likely to take their own lives than the life of another person. This is becoming an increasingly serious problem. The rate of suicide has increased 22% since the beginning of the 21st century and is now more than double the rate of homicide, which has declined 10%.

Would a better mental health system reduce homicide? Maybe a little. No one really knows.

But there are more important reasons to improve the mental health system, especially its failure to serve 60% of Americans with diagnosable mental disorders, its failure to provide easy access to treatment and community supports, and its failure to provide even "minimally adequate care" more than 1/3 of the time.

More and better mental health and substance abuse services probably won't affect the rate of mass murder significantly, but they can reduce the suffering of people with mental and/or substance use disorders and perhaps reduce the incidence of suicide and drug overdoses—goals eminently worth pursuing.

So, when politicians who oppose gun control argue that it is not guns but madmen who commit mass murder, psychiatrists and other mental health professionals should strongly counter their false claims with the truth about the near irrelevance of mental illness to murder. And we should advocate persistently for critical changes that have little to do with violence towards others.

This is a version of articles published in "Medpage Today" and "Social Work In Mental Health"

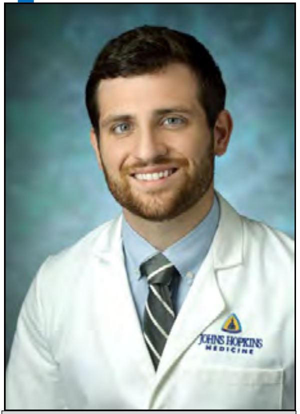
MARK YOUR CALENDAR!

2020 MPS Annual Meeting
Thursday, April 2nd

Martin's West
Baltimore, MD

Center for Psychedelic Research Opens at Hopkins

By: Andrew Flagg, MD



Andrew Flagg, MD

In September, Johns Hopkins announced the opening of the Center for Psychedelic and Consciousness Research, a privately-funded center for investigating the effect of hallucinogenic compounds like psilocybin. Directed by Hopkins professor of psychiatry and neurosciences Roland Griffiths, Ph.D, it is designed to improve the understanding of the benefits and potential risks of hallucinogens and to explore how they can be used in the treatment of psychiatric disorders.

While research into the risks and benefits of psilocybin for psychiatric illness has a long and complex history, the new center hopes to vastly expand on existing work. Funded by $17 million from private donors and investors, Griffiths plans to use the funds to hire additional faculty and cover the costs of running new trials. Federal funding cannot be used to fund research into psilocybin, which is a Schedule I controlled substance, making such a private investment into hallucinogen research particularly groundbreaking.

In a grand rounds presented at Johns Hopkins on October 7, he described some of the recent work in psychedelics. Numerous small studies have taken place already at Johns Hopkins, with promising results. Since it is hard to “blind” research subjects against the effects of psychedelics, studies typically incorporate a variety of high and low-dose or placebo crossover designs. During each trial, subjects first meet with two staff monitors who “guide” them through the psilocybin experience. After getting to know the monitors, patients take psilocybin while being observed and directed in a living room-like setting. During each trial, after taking the psilocybin capsule, the volunteer lays on a couch wearing a blinder and with relaxing music playing, with verbal reassurance from the monitors.

During grand rounds, a patient who had been a subject in an earlier one of Griffith’s studies spoke briefly about his experiences in psilocybin research. He described years of depression for which antidepressants and therapy provided incomplete relief. He subsequently underwent two sessions in a psilocybin study. He, along with Griffiths, stressed the importance of the comfortable environment and reassurance of his monitors during the psilocybin sessions. Several months after these two day-long events, his mood was still much better than before, and he felt the experience was highly transformative.

This positive anecdotal experience appears to be common among patients in Griffiths’ studies, based on the preliminary data. Psilocybin and other hallucinogens like LSD are being investigated for a range of mental conditions, including depression, addiction, and eating disorders. Data show remarkable improvement in some populations: in a study of 24 patients with major depression that was resistant to existing pharmacologic treatment, 69% reported significant improvement at 12 weeks post-treatment, with many of them reporting a return to baseline. In another study involving 51 cancer patients, 78% reported an improvement , 6 months after psilocybin treatment. Subjects report significant increases in so-called “mystical-type experiences”, which they describe as spiritually significant, transcendental, or related to greater feelings of unity, as measured by one of several standardized scales.

Much of the criticism of hallucinogens for psychiatric use has revolved around safety-- particularly long-lasting psychological side effects. Griffiths stressed the great emphasis on safety and scientific method in his trials, briefly mentioning the harm done to the field by the public behavior of Timothy Leary in the 1960s. Trials involve monitoring of vital signs, side effects like nausea or restlessness, and negative experiences such as anxiety. Cognitive testing is done to reduce confounding that could be due to delirium.

The work that will be done at the Center for Psychedelic and Consciousness Research by Griffiths and his team is promising and offers some hope for difficult- to- treat patients. It has received a great deal of media publicity. Still, there is much work to be done. One challenge is the need to identify those patients whom it can help. Previous studies used subjects that Griffiths and his team selected themselves, but there are still no objective criteria for selecting patients or ways to determine who may and may not benefit from treatment. Many patients in these studies had had prior psychedelic experiences -- another confounding factor. Even if good guidelines are published, Griffiths estimates that it would be at least 5 years before the FDA would approve psilocybin for patient use.

LETTER FROM THE EDITOR

Something's Gotta Give

By: *Bruce Hershfield, MD*

Bruce Hershfield, MD

Two adjacent articles in this issue indicate we are heading for a crisis. Thoreau observed, "Wise men avoid desperate circumstances". We should do something about it now.

When I noticed that Steve Warres commented on the MPS e-mail list that it was becoming impossible to do everything that was required of him in a brief session with a child or adolescent, I asked him to expand on that. You can read his comments on page 7.

Shortly afterwards, Joanna Brandt sent me an article explaining a decision the Board of Physicians had made in a case several months ago. In it, the Board criticized the care the respondent psychiatrist had delivered and set guidelines for what psychiatric outpatient notes should contain. As Dr. Brandt lays out in her article, this included listing the diagnosis each time (even when there is no reason to change it), recording vital signs, asking whether the patient is suicidal, and other features.

My insurance company recently published an article that suggests each progress note include the start and stop time, have an assessment of risk not only of suicide but also of violence, list treatment options and medications with their potential risks and side effects, speak about boundary issues, and include discussions with family members.

However, as Dr. Warres points out, there's not enough time in the first place. Time does not expand. A brief visit lasts no more than 30 minutes ; a traditional one lasts 50.

I see at least three problems with this impending collision. Almost none of the charts I examine meets the standards. For example, only electronic health records do list the diagnosis, etc. each time. Diagnoses are important; if you change one it should be for a good reason. Listing the same diagnosis in every note for what may be a treatment course that lasts for decades makes no sense.

I am also concerned by the process. Psychiatrists must set our own standards; it is one of the defining qualities of a profession. The MPS Peer Review committee should be involved. In a democratic society, decisions are made by the majority and with "the consent of the governed". Members of our profession should not have standards imposed on us by other professions or by for-profit businesses.

My third concern is that if indeed these are the standards, everyone should know them. It is not right to set standards that are not well known and then punish those who have failed to meet them. How many of our members even knew about these ones?

Our profession is being slowly eroded by others who set standards for us without coordinating them with each other or with us. I believe it is an important reason why so many clinicians are complaining of "burnout". The APA, MPS and our Peer Review Committee should clarify what standards reasonable practitioners are expected to meet.

Otherwise, Psychiatry will crack as the pressure increases. As Johnny Mercer wrote in the song, in 1955, "Something's Gotta Give, Something's Gotta Give, Something's Gotta Give".