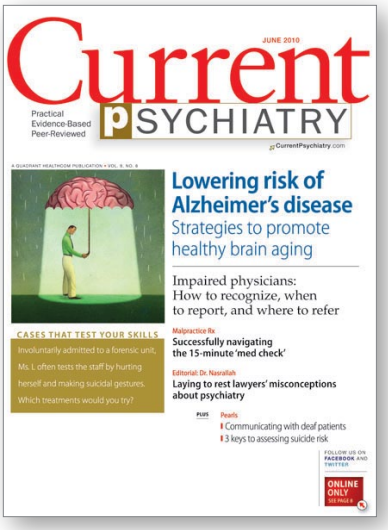
Question BPD outcomes

In Drs. Ali M. Hashmi and Dennis Vowell's article "The manipulative self-harmer" (Cases That Test Your Skills, Current Psychiatry, June 2010, p. 44-48), the authors regard the patient's outcome ("Recently she was placed in a more restrictive setting because her hostile and self-destructive behavior escalated") as characteristic of borderline personality disorder (BPD) ("Ms. L is no different from most axis II Cluster B disordered patients."). In my view, this is the greatest risk of calling a patient borderline—it tends to justify poor outcomes by thinking that it is just characteristic of the illness. Instead, shouldn't we worry that our treatment may be suboptimal? Maybe we are missing something?

For example, Ms. L may have some degree of bipolarity (see the Harvard Bipolarity Index as a characterization of that concept, incorporating but going beyond the DSM-IV-TR) that could account for their observation, "Her mood and behavior continue to oscillate; she is relatively calm and satisfied 1 week, angry and assaultive the next." Instead of concluding, "this stormy course is expected…" the authors should be wondering whether they might be contributing to it by restarting venlafaxine despite simultaneous carbamazepine initiation. Granted, the possibilities of bipolarity and antidepressant-induced rapid cycling are complex considerations, because we lack solid footing for differentiating BPD and bipolar disorder and for determining causality when a patient experiences rapid mood changes while taking an antidepressant. These are controversial issues, but why present the case as though



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it's illustrative of accepted principles? I find it perfectly illustrative of how badly we're floundering as a field.

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The authors respond

Dr. Phelps' contention is that our observation that Ms. L's "hostile and self-destructive behavior" makes her "no different from most axis II Cluster B disordered patients" somehow understates the extent of her illness, perhaps leading to poorer outcomes. Negative countertransference toward such patients is the norm and handling it empathically is an integral part of the treatment relationship. This is true even though the severity of Ms. L's personality pathology, as evidenced by her placement in the "911 program," may not be representative of all patients with BPD.

We agree that "the possibilities of … antidepressant-induced rapid cycling are complex considerations." Even experts disagree on this. In fact, as we pointed out, Ms. L resisted medication tapers, at one point insisting that high doses of fluoxetine and venafaxine be used together for depression, a request we denied specifically for fear of worsening her mood lability. Fluoxetine was discontinued and venlafaxine restarted at a lower dose to treat her persistent depression as well as to help with her chronic back pain. Because by this time she was taking carbamazepine as well, we felt the risk was acceptable. Her positive long-term outcome has validated our approach.

We disagree that psychiatry is "floundering" as a field. In fact, exchanges like this are a core component of placing our specialty on a more solid, scientific basis to position it for future challenges.

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Med check distress

We read with distress "Successfully navigating the 15-minute 'med check,'" (Malpractice Rx, Current Psychiatry, June 2010, p. 40-43). Even if 15-minute med checks have become "standard care," they should not be. Unless a patient is stably medicated, 15 minutes is insufficient to evaluate the situation and make treatment decisions. Psychiatric diagnoses cannot be made by drawing blood or doing physical exams, so information beyond superficial questions must be elicited.

Does it make sense, as Table 2 suggests, that a psychiatrist should "have

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a psychotherapist or case manager present to facilitate communication?" Clearly not. Although theoretically possible, these therapists—apart from the question of their level of competency and training—are overworked and lack time to join psychiatric sessions.

Again, in Table 2, is apologizing sufficient "when a patient truly needs more time"? Clearly not. Although the author notes that intakes should warrant extra time, there is little awareness of the "real-life" difficulty involved in seeing patients who are not new to the clinic but new to a particular psychiatrist. Patients often arrive with as many as a dozen medications and multiple conflicting diagnoses. Charts are voluminous. To become thoroughly familiar with what has transpired takes a competent psychiatrist a minimum of 30 minutes to review. Rapid staff turnover and disconnected care exacerbate this problem.

Having worked in academic settings and in the field, we can state with certainty that dangerous shortcuts are now the norm. Who, if not the psychiatrist, will be addressing the fact that many of these patients have no teeth, out-of-control diabetes, no primary care physician, etc.? This raises more than malpractice issues, this raises quality-of-care issues.

Some days there are "no-shows" and some days every patient comes. In practice, the need for more than 15 minutes per patient exceeds the time gained when a patient does not keep an appointment.

Psychiatrists should serve as purveyors of quality care, not merely signers of prescriptions.

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Dr. Mossman responds

Unlike Drs. Levin and Schwartz, I am unwilling to declare that colleagues who conduct 15-minute med checks are, by that fact itself, doing something psychiatrists should not do. That does not mean 15-minute med checks are ideal. But several psychiatrists feel that despite severe time constraints, they can do many patients much good in 15 minutes—certainly more good than if those patients had no time with a psychiatrist at all. No scientific evidence that I know of contradicts this position.

Drs. Levin and Schwartz and I agree that certain types of patient visits require more than 15 minutes, which is why my column contained suggestions about negotiating for "seeing no more than 3 patients an hour, scheduling longer appointments for new patients, and having some built-in time to return phone calls, do paperwork, review charts, and complete progress notes." The "strategies" listed in Table 2 are ideas about improving care and efficiency that come from psychiatrists with a lot of med check experience. Like most clinical suggestions, the strategies may make sense in some settings, but certainly not all.

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Mainstreaming psychiatry

I commend Dr. Henry A. Nasrallah on his editorial, "Integrating psychiatry with other medical specialties" (From the Editor, Current Psychiatry, September 2010, p. 14-15). I could not agree more with the importance of fully integrating psychiatry into mainstream medical practice, and can attest that this can be accomplished. For the past year I have been part of a family practice where I work closely with the primary care physicians, nurse practitioners, and physician assistants. This practice has electronic medical records, and I have complete access to patients' entire medical records, allowing other practitioners to read my psychiatric evaluations and progress notes. Being in the same location facilitates easy and frequent clinical exchange. The benefits to our patients are real and substantial.

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Following by example

Dr. Henry A. Nasrallah's "Treat the patient, not the disease," (From the Editor, Current Psychiatry, August 2010, p. 13-14) has given me more joy and hope than you can realize. I thought I was alone. I am chair of psychiatry at an academic inner city community teaching hospital, running a dual diagnosis unit as well. I preface each new student rotation by saying, "Medicine is an art as well as a science. You will learn here how to help patients. Do not answer test questions based on my use of psychotropics." Of course, as we move along I offer both sides (or more) to all treatment possibilities, but I use more than the average number of off-label treatments.

I am passing on your words to the students, staff, medical executive committee, therapeutic committee, and anyone who will listen.

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