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In This Issue



This issue of *The Residents' Journal* features articles on patient decision-making capacity as well as the resident's on-call experience. First, Nishi Bhopal, M.D., provides information on tools to aid the psychiatry resident in assessing patient capacity. Next, Dawn Flosnik, M.D., discusses both historical and empirical findings regarding an association between lunar phases and psychiatric hospital admissions. Finally, Patrick Gresham, M.D., shares with us a compelling and reflective personal experience involving a patient's capacity to make a life or death decision.

Tobacco Cessation

Joseph M. Cerimele, M.D.
Editor-in-Chief

Tobacco use is common among patients with psychiatric disorders (1). The prevalence of smoking in the general population is 19.8%, while the prevalence among patients with a psychiatric disorder ranges from 40%–60%, especially in those with major depressive disorder, to as high as 88% in patients with schizophrenia (2). Many trials examining the effectiveness of tobacco cessation techniques exclude patients with chronic psychiatric disorders (particularly schizophrenia), which clouds the clinical decision making for physicians treating patients who use tobacco and have a psychiatric illness.

Because of the high prevalence, psychiatry residents frequently encounter patients with tobacco use disorders. Most on-call residents have been paged to assess and order nicotine replacement for patients admitted to smoke-free hospitals, and most residents have explained no-smoking policies to patients. Although some educational programs have addressed psychiatry residents' ability to diagnose and manage tobacco use disorders (3), many patients continue to be discharged from psychiatry wards without interventions directed at tobacco use and many resume tobacco use subsequent to discharge.

Interventions for tobacco use disorders include motivational interviewing and other psychotherapeutic approaches, nicotine replacement therapy, and medication therapy specifically targeting smoking cessation (bupropion and varenicline). Although these medication treatments are generally safe, adverse

events have been reported with varenicline use in patients with psychiatric disorders. In a recent clinical case conference, Patel and Parvinchiha (4) reported on two patients who experienced onset or worsening of psychiatric symptoms during treatment of tobacco dependence with varenicline. One patient reportedly developed anxiety, suicidal ideation, irritability, insomnia, and other psychiatric symptoms associated with abrupt varenicline discontinuation, while the other patient experienced psychosis associated with varenicline use. Other case reports have demonstrated the association of varenicline and exacerbation of psychiatric symptoms, but a recent Cochrane Review on the effectiveness of nicotine receptor partial agonists in treating tobacco dependence noted that "possible links with serious adverse events, including depressed mood, agitation and suicidal thoughts, have been reported but are so far not substantiated" (5). Residents could spend hours interpreting the results of case reports and systematic reviews on this medication's safety alone, adding an additional hurdle to the treatment of tobacco use.

The Residents' Journal is looking to publish articles on tobacco use and tobacco cessation strategies. We hope to receive articles describing the clinical use and different formulations of nicotine replacement therapy and the pharmacological interplay between tobacco smoke and antipsychotic medications. Other topics would also be welcome, including review articles on evidence supporting

the use of bupropion or varenicline in the general population or in patients with schizophrenia, descriptions of the clinical management of patients with co-occurring substance (e.g., alcohol or cocaine) and tobacco use disorders, the assessment and treatment of smoking in adolescent patients, or the use of psychotherapeutic techniques or phone-based interventions to reduce tobacco use in specific populations. We look forward to seeing your submissions.

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Medical Decision-Making Capacity: An Overview

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Between 3% and 25% of requests for psychiatric consultations in general hospitals involve the assessment of a patient's capacity to make decisions about medical treatment (1). The number of requests for psychiatrists to evaluate decision-making capacity has grown over the past 20 years (2) for many reasons, including increasing appreciation of patient autonomy, advancement in medical treatments, barriers to the physician-patient relationship (1), and legislation.

What Is Capacity?

Capacity can be viewed as a measure of how much autonomy a patient has or how much that autonomy should be respected (3). Capacity is question and situation and time specific and clinically determined, whereas competence is a legal judgment determined by a court.

There are four elements to decision-making capacity: 1) understanding the information relevant to the decision, 2) retaining the information and appreciating its application to the situation, 3) using the information as part of the decision-making process, and 4) expressing a consistent choice (4).

Lack of Capacity in Inpatients

Historically, the presence of a diagnosis alone often determined whether or not a patient had capacity (5). Now, there is greater emphasis on patients' abilities and an understanding that diagnoses are not the sole determining factor in medical decision-making capacity.

In the study conducted by Raymont et al. (3), it was estimated that at least 40%—and up to 48%—of medical inpatients lacked decision-making capacity regarding treatment. However, only 24% were deemed by the primary team to lack capacity to consent to treatment at the time of the study. Rates of impaired medical decision-making capacity in patients with

An Algorithm for Capacity Assessment^a

- 1) Do the history and physical examination confirm that the patient can communicate a choice?
If yes: Proceed to the next question.
If no: Defer to an advance directive or surrogate decision maker for further direction or seek guardianship for decision making.
- 2) Can the patient understand the essential elements of informed consent?
Ask the patient the following questions:
What is your present medical condition?
What is the treatment being recommended?
What do you and your doctor think might happen to you if you accept the recommended treatment?
What do you and your doctor think might happen if you decide not to accept the recommended treatment?
What are the alternatives available (including no treatment), and what are the probable consequences of accepting each?
If the patient demonstrates understanding of the essential elements of informed consent, proceed to the next question. If not, defer to an advance directive or surrogate decision maker.
- 3) Can the patient assign personal values to the risks and benefits of intervention?
If yes: Proceed to the next question.
If no: Defer to either the advance directive or the surrogate decision maker.
- 4) Can the patient manipulate the information rationally and logically?
If yes: Proceed to the next question.
If no: Defer to an advance directive or surrogate decision maker.
- 5) Is the patient's decision-making capacity stable over time?
This can be examined by repeating a question several minutes later.
If yes: Accept the patient's decision.
If no: Defer to an advance directive or surrogate decision maker.

^aThis series of questions was created by Miller and Marin (7) to assess capacity more systematically (adapted from Jones and Holden [8]).

dementia vary. Yet it is estimated that between 44% and 69% of older adults who are hospitalized or in nursing homes have impaired capacity to consent to treatment at any given time (5).

Among patients with psychiatric illnesses, capacity is more often impaired in patients with psychotic versus nonpsychotic disorders. One study showed that approximately 53% of inpatients with schizophrenia lacked decision-making capacity for treatment at the time of the study, relative to 20% of inpatients with depression (6).

Other than advancing age and cogni-

tive impairment, there are no individual sociodemographic factors that are associated with mental incapacity (6).

Tools to Aid Assessment of Capacity

Consultations to assess decision-making capacity are requested commonly when patients refuse treatment in inpatient settings or disagree with treatment recommendations. Thus, lack of capacity may be overlooked when patients simply accept treatment (3) or not be called into

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question until they express disagreement with the treatment plan.

Interrater reliability varies and is close to chance for evaluations of patients with dementia (5), but it has been shown that reliability improves with the use of standardized assessments (4). Several instruments have been developed to aid clinicians in evaluating capacity, although only a few evaluate all four dimensions of capacity (4). Of the instruments available, the MacArthur Competence Assessment Tool for Treatment is a semi-structured interview that evaluates the four components of capacity, has extensive training materials available, and has been validated in a variety of populations. However, it is intended to act more as a tool to help evaluate capacity rather than to make a final determination regarding treatment. It requires formal training and takes 20–30 minutes to administer and score, and thus it may not be a feasible tool for many clinicians.

The Mini-Mental State Examination may be of use in evaluating medical decision-making capacity, particularly among elderly patients. Scores of ≤ 19 are strongly correlated with impaired decision-making capacity, but higher scores are less specific (1).

The Aid to Capacity Evaluation can be downloaded, complete with instructions and clinical examples, and is a useful tool for initial capacity screening. Limitations are that it evaluates the domain of understanding only and requires further validation for clinical use (4).

For patients with cognitive impairment, the MacArthur Competence Assessment Tool for Treatment, the Competency to Consent to Treatment instrument, and the Hopemont Capacity Assessment Interview may be of use. All three instruments have training materials available, and the former two assess all four domains of capacity (4).

Conclusions

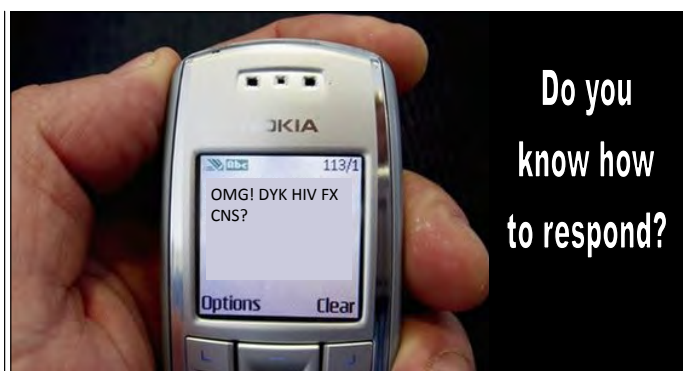
Capacity involves four dimensions. Many patients who lack capacity are not identified, particularly when they acquiesce to treatment. Clinicians should be aware that capacity may be lacking even when patients are compliant. Since interrater reliability varies, standardized instruments or algorithms should be used, particularly in ambiguous or complex cases.

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Lunar Madness: Does the Full Moon Guarantee a Bad Call Night?

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On a brisk autumn day last year, I found myself walking into a call night that happened to fall on the evening of a full moon. Among many superstitious beliefs held by psychiatric residents, the idea that a full moon will increase the number of inpatient hospital admissions while on call remains one of the most popular. Upon reviewing the literature regarding this phenomenon, I was surprised at what I found.

It has been a long-held belief that the phases of the moon have an effect on human behavior just as they influence the rise and fall of the tides (1). The English term *lunacy*, an obsolete term for insanity and mental illness, is derived from the word *luna*, meaning moon in Latin. Popular culture, news sources, and the beliefs of some medical staff have linked the full moon to an increase in psychiatric admissions and violence (1–3).

However, empirical evidence regarding this lunar hypothesis shows otherwise. A literature review conducted in 1978 by Campbell and Beets (1) examined the results from 16 studies that attempted to link lunar effects with mental disturbances. Some of the studies included in this analysis examined the relationship between the number of psychiatric hospital admissions and the phase of the moon. Campbell and Beets concluded that despite popular belief, the lunar phase is not related to human behavior and does not have an effect on psychiatric hospitalizations, suicides, or homicides (1).

Regardless, many members of the scientific community were still convinced that the moon had to play a role in the psychiatric behavior of humans and increased psychiatric hospital admissions. This prompted the completion of a large meta-analysis conducted in 1985 by Rotton

and Kelly (4), which examined the relationships of the phases of the moon, lunar cycles, patient gender, and geographical features with psychiatric hospitalizations, mental illness exacerbations, “crisis” calls, and homicides and other criminal behavior (4). Thirty-seven empirical studies were examined in the meta-analysis, eight of which specifically addressed the relationship between moon phases and hospital admissions. Lunar indexes were developed by the authors’ via a mathematical equation in order to quantify the relationship between the phase of the moon and the reported activities. Despite a few statistically significant findings, it was concluded that the moon accounted for no more than 1% of the variance in the rise in mental illness emergencies (4). Another more recent study concluded that no part of the lunar phase (including the full, quarter, waxing, or waning moon) was associated in any significant way with psychiatric admissions or emergency room presentations (5).

Although no actual modern-day link between the phases of the moon and psychiatric disturbances has been reported, this may not have been true prior to the advent of indoor lighting. One study hypothesized that the moon used to be a significant source of nocturnal illumination, leading to a state of relative sleep deprivation around the time of the full moon. This sleep deprivation, in turn, may have led to an increase in hypomanic, manic, and psychotic states (6). However, with modern-day advances in electricity, our sleep-wake cycles are less heavily dependent on the natural lighting provided by the moon.

In summary, we cannot blame the full moon for a rough call night with regard to inpatient admissions. However, as any

resident can attest, bad call nights consist of many other factors than simply the number of emergency room evaluations and inpatient admissions. Hospital consultations, episodes of agitation, and patient elopements are examples of just some of the challenges faced by on-call residents. It should be noted that many of the aforementioned studies did not move beyond attempting to link moon phases with initial patient presentation to the hospital. Perhaps further studies would be useful for elucidating the lunar effects on call nights as a whole.

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Capacity to Make Foolish Decisions

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At a busy urban hospital, seldom does a call shift pass in which the psychiatry resident achieves rapid eye movement sleep. Close as I was, the pager still summoned me to task. A frantic intensive care unit resident firmly insisted on an urgent consult for a young man who demanded to leave against medical advice. After a splash of water on my face, I headed to the fifth floor.

The patient's gut contained over 5 grams of plastic-bound crack cocaine, swallowed in an effort to conceal it from police. When stomach pain ensued, he headed for the emergency room. So why did he now decide he needed to leave before he was medically cleared of danger?

I went to his room to find him calmly sitting on his bed, still dressed in his gown. His brother stood at his side, fielding whispered calls on his cell phone. I went into my usual routine.

"Why do you want to leave?"

With a calm even tone, he answered,

"I got some business to take care of."

Right away, given the context of his admission and the whispered calls, I determined the said "business" to be drug

related. Unwavering, I continued.

"Can you tell me what could happen if you leave before they can get the bags out of your system?"

"Yeah, I could die."

Again, he remained calm, cool, and—most importantly—accurate. Before I finished writing down his quote, he added to his statement,

"But if I don't take care of this business, I will die."

I paused and considered my next question carefully.

"Are you afraid that someone is going to harm you?"

In our game of psychic chess, he countered accordingly.

"All I'm saying is that if I don't get out of here now and take care of something, I'm gonna end up dead, and that's a fact."

I went through the remainder of the template, still unable to substantiate a reason to hold him against his will. I reviewed the case with my attending for 20 minutes.

Same conclusion. No psychiatric his-

tory, a mental status examination that rivaled mine for that time of night, and a genuine understanding for the risks he faced in leaving the hospital. With a deep foreboding, I returned to the patient and made a final plea.

"What good are you going to be to your family if you walk out of here and drop dead?" Think of your kid, man.

He turned his head away.

"I am..."

I gave him the news. Even as I sat at the nurses' station writing my note, "*patient has decisional capacity to leave against medical advice*," he was on the phone with whatever mysterious force posed a greater threat than the ticking bomb within him.

Despite the remainder of the evening being uneventful, I found myself unable to return to sleep. Like my attending said in the final part of our phone call:

"He has capacity to make an informed decision, even a foolish one."

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A Resident's Guide to Tarasoff

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Psychiatric residents are frequently tasked with assessing patients who threaten violence against others. In managing such patients, residents need to be aware of any existing doctrine legally obligating them to protect others from a patient's violent intentions. While residents may have heard the phrase "duty to warn and/or protect" used in reference to patients who pose a physical safety threat to others, they may be less familiar with the context in which this concept developed. Appropriate clinical application of this concept requires a working understanding of the landmark case *Tarasoff v. the Regents of the University of California* (1–3) as well as the current state-specific interpretations of the *Tarasoff* rulings.

Facts of the Case

Tatiana Tarasoff and Prosenjit Poddar met around the fall of 1968 while students at the University of California Berkeley. Poddar was a graduate student from India. After kissing on New Year's Eve, Poddar believed a serious relationship existed between them. However, Tarasoff did not similarly interpret the kiss and informed Poddar that she was

seeing other men. Subsequently, Poddar lapsed into a severe and persistent depression and became obsessed with Tarasoff. In the summer of 1969, after she traveled to South America, his symptoms improved somewhat. A friend encouraged him to seek help, and he began seeing psychologist Lawrence Moore at the University's Cowell Memorial Hospital. He informed Moore of his plans to "kill an unnamed girl, readily identifiable as Tatiana" (1), upon her return home. Concerned, Moore recommended that Poddar be civilly committed and detained by campus police. Psychiatrists Dr. Gold, who previously examined Poddar, and Dr. Yandell, assistant to the Director of Psychiatry, agreed. Whether Poddar was detained after Tarasoff's return home from South America (2) or months prior to her return (1) is debatable. Nevertheless, at some point campus police briefly detained Poddar but released him because they believed that he posed no danger. Dr. Powelson, Chief of the Department of Psychiatry, ordered that Poddar not be detained further or committed and requested that Moore destroy therapy notes related to him. In October, Tarasoff re-

turned home, and later that month Poddar fatally stabbed her. He had discontinued his therapy sessions with Moore prior to Tarasoff's death.

Tarasoff's family filed a law suit citing negligence to warn Tatiana or them of Poddar's threats as well as failure to confine him. The case reached the California Supreme Court.

People v. Poddar

In a separate trial, *People v. Poddar*, Poddar was convicted of second-degree murder (2). This conviction was later overturned on appeal due to failure to properly instruct the jury (2). Poddar was not retried and returned to India.

Tarasoff I, Tarasoff II, and California Civil Code 43.92

In 1974, the California Supreme Court ruled that "a doctor or psychotherapist" had a "duty to warn" others of any danger that may occur secondary to a patient's medical or psychological state, referred to

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Table 1: Evolution of Tarasoff Ruling

Tarasoff I (1974)	Tarasoff II (1976)	California Civil Code 43.92 (Effective January 1, 1986)	California Civil Code 43.92 AB 733 (Effective January 1, 2007)
"When a doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning... duty to warn. "	"When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. Thus, it may call for him to warn the intended victim or others... the police or to take whatever other steps are reasonably necessary."	A) No cause of action shall arise against, any person who is a psychotherapist... in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims. B) If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.	A) Same as California Civil Code 43.92 (1986). B) No cause of action shall arise against, a psychotherapist who, under the limited circumstances specified above, discharges his or her duty to warn and protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

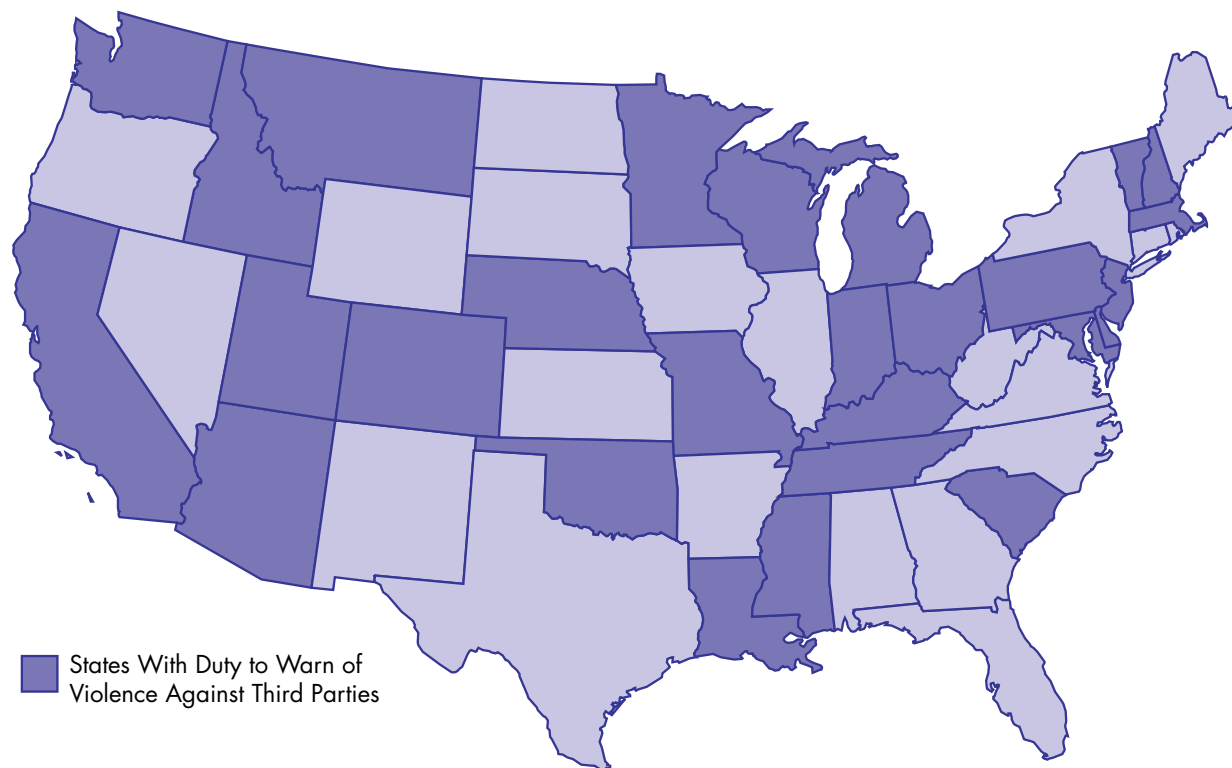
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as Tarasoff I (Table 1) (3). On rehearing the case in 1976, the Court determined that therapists were obligated to “protect” a targeted victim against potential danger if a patient “communicated to the psychotherapist a serious threat of physi-

duty to warn and protect potential victims (5), i.e., when “the patient has communicated to the psychotherapist a serious threat of physical violence” (7) against an easily identifiable individual. Additionally, the code specified how mental health professionals could “discharge” or satisfactorily and legally fulfill their duty,

the interpretation of this duty, in general the duty is triggered when a patient threatens physical harm against a person who can be easily identified (6). Additionally, in these states, mental health professionals can generally discharge their duty by warning the victim and, in some instances, law enforcement (6).

Figure 1: States With Duty to Warn of Violence Against Third Parties



cal violence against a readily identifiable victim” (1). This ruling is referred to as Tarasoff II.

The Tarasoff rulings were followed by cases in which the California Supreme Court’s decisions were broadly applied and, in the opinion of many scholars, inappropriately interpreted (4, 5). To limit the growing liability against mental health professionals, in 1985 the California state legislature developed California Civil Code 43.92 (5), which some believe trumped the prior 1974 and 1976 California Supreme Court rulings (6). Unlike Tarasoff I and II, this civil code clearly specified under which circumstances mental health professionals would have a

thereby relieving themselves of legal obligation (Table 1). In 2006, the code was amended to further limit a therapist’s liability (5, 8).

State-Specific Tarasoff Interpretations

The Tarasoff rulings nationally influenced the management of patients threatening violence. Many states were faced with legal cases in which the concept of warning and/or protecting third parties was brought into question. Twenty-seven states have adopted a legal requirement to warn third parties of a patient’s threatened violence (6) (Figure 1). Although there are some state differences regarding

Nine states as well as Washington, DC, permit the breaking of patient confidentiality in order to issue a warning but do not legally impose a duty (6). Thirteen states have no formal Tarasoff-type ruling. Although a Virginia statute (Va. Code 54.1-2400.1) imposes a duty to protect third parties (9), Virginia is still widely cited as the only state to outright reject the concept of the Tarasoff rulings (6). This is because in several landmark cases (Nasser v. Parker and Sage v. U.S.), the Virginia courts ruled that a physician in a traditional doctor-patient relationship is not responsible for limiting a patient’s

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actions (6, 10). The state courts additionally found that a physician could become liable for a patient's behavior if there existed "a higher degree of control over the patient than exists in an ordinary doctor-patient or hospital-patient relationship" (6, 10, 11), such as during involuntarily hospitalization. Therapists in Virginia, as in many other states, are challenged with balancing the duties outlined in the state statute with the implications of case law.

Conclusions

The murder of Tatiana Tarasoff profoundly impacted the management of patients who threaten violence against others. In addition to reviewing the information in the present article, trainees are encouraged to further their knowledge of their state's statutes and case laws. Since

the state-specific Tarasoff interpretations are dynamic and often complex, legal consultation may be necessary if there is uncertainty about whether a particular scenario triggers a duty.

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Rapid Treatment of Psychiatric Symptoms in End-of-Life Patients

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How Should This Case be Managed?

“Mrs. B” was a 54-year-old married, Caucasian woman with a 6-month history of metastatic ovarian cancer that was unresponsive to curative treatment. The patient developed depressive symptoms shortly after placement into a palliative care setting. She had a remote history of major depressive disorder, which was successfully treated with a year-long course of sertraline and psychotherapy, but her symptoms returned after the terminal diagnosis. She developed depressed mood, anhedonia, hopelessness, poor sleep, feelings of guilt (for being a burden on her family), poor motivation, and suicidal ideation, and she subsequently refused to see her children. Within the palliative care setting, what therapies are appropriate in order to optimize the quality of the present patient’s remaining life?

The Psychiatrist’s Role in End-of-Life Care

Within the goal of palliative care is the alleviation of physical, psychological, spiritual, and existential suffering. The psychiatrist may help facilitate this process by treating potential obstacles that may be caused by depression. The World Health Organization states that palliative care is “the active total care of patients whose disease is not responsive to curative treatment” (1). Confronting one’s mortality frequently exacerbates previous psychiatric comorbidity and/or generates symptoms clinically significant enough to warrant treatment interventions to optimize quality of life (2). Unfortunately, mental illness is too often unassessed and undertreated in hospice settings (2, 3). The psychiatrist has an expanding and vital role in managing the mental and behavioral health of this historically

marginalized population. Many common symptoms in end-of-life scenarios are depression, anxiety, and delirium. In the present case report, depressive illness was preventing the patient from progressing through the stages of dying and limited her desire to see her children.

Barriers to Treatment of Mental Illness at the End of Life

One estimate found that as many as 77% of terminally ill patients meet criteria for a major depressive episode (2). It is important to rule out other causes of depression, anxiety, or delirium, including uncontrolled pain, withdrawal, organic causes, and medications. However, multiple barriers that may prevent assessment and treatment of psychiatric symptoms still exist. For instance, many clinicians misinterpret depression as a natural response to the dying process (2). They may avoid a therapeutic intervention for fear of upsetting the natural course of illness either due to a lack of confidence or lack of clinical competence (2). Historically, there is minimal physician education regarding death and dying, since it is contradictory in a field intended to treat disease and prolong life. As a result, there exists a clinical boundary that is difficult for many physicians to traverse, thereby subverting interventions that may otherwise optimize the quality of a patient’s final days.

Standard Treatments of Depression

Traditional pharmacotherapy, such as selective serotonin reuptake inhibitors, serotonin norepinephrine reuptake inhibitors, dopamine and norepinephrine reuptake inhibitors, tricyclic antidepres-

sants, and monoamine oxidase inhibitors, has demonstrable benefit in the treatment of depression and anxiety. However, their temporal course (even when effective on the first medication trial) is on the order of weeks to months. Although improved, the median time that patients spend in a hospice service receiving palliative care is less than 4 weeks (4). Psychotherapy plays a significant role as well, although it is a process that takes weeks to months also. This is time that the patient simply may not have. When more rapid treatment of depression is necessary, such as in the aforementioned clinical case, other interventional modalities must be considered.

Rapid Treatment of Depression

Since their introduction in the 1930s, psychostimulants, such as amphetamine and methylphenidate, have been used in the treatment of depression. A recent analysis examining 19 randomized, controlled trials of methylphenidate found evidence of efficacy in the rapid treatment of depressive symptoms, particularly those of depressed mood, fatigue, and apathy (5). These medications are also known to produce antidepressant effects within 72 hours (5). The use of psychostimulants as short-term antidepressant treatment to combat fatigue allows the opportunity of more meaningful final days for patients and their families.

A recent and novel research study conducted by Irwin and Iglewicz (3) examined the use of ketamine as a rapidly acting treatment with minimal and transient side effects commonly seen with traditional antidepressants. Some of the desirable properties for its use include ease of administration, rapid onset of action, low cost, a safety profile at sub-

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anesthetic doses, and significant analgesic properties. In addition to the lack of adverse effects reported in the study, there were significant improvements on psychometric assessments related to both depression and anxiety lasting 1 to ≥ 2 weeks, with return of symptoms being less severe. Furthermore, antidepressant effects were noted to occur almost immediately, without evidence of delirium or change in cognition. It is thought that antidepressant action may occur more rapidly through glutamatergic pathways than via intracellular signaling cascades of classical antidepressants.

The proven efficacy of ECT and its rapid onset of action make it a viable option for the rapid treatment of depression (6). Encephalopathy is a common side effect of ECT and more pronounced in the elderly population frequently found in hospice care settings. Therefore, there must be careful consideration of the balance between quality and quantity of life. Though historically controversial in this vulnerable population, recent evidence supports the use of ECT in the palliative care setting as a compassionate and minimally invasive modality to enhance quality of life, particularly in patients receiving maintenance care prior to a terminal diagnosis (7).

Transcranial magnetic stimulation, which is the use of a transcranial electromagnetic coil to electrically stimulate the dorsolateral prefrontal cortex, was recently approved by the Food and Drug Administration for the treatment of major depression (6). Despite its promising efficacy, minimal side effects, less invasive nature, and lack of drug inter-

actions, other considerations may be prohibitive. These include arranging daily treatments, costs up to \$10,000, and physical restrictions, such as transport to the treatment facility and the need to tolerate an upright seated position for more than 30 minutes.

As a benefactor for the patient's health and well being, it is the physician's primary role to create the most comfortable dying environment for their patient. Alternative interventional modalities, compared with traditional pharmacotherapy, could rapidly provide symptom relief for mental illness, most notably depression. Untreated depression could create barriers to catharsis, hinder family dynamics, affect decision-making capacity, and have a negative effect on the patient, family, and society as a whole. These rapid interventions could provide a more meaningful parting with loved ones and make the burden of death less taxing on both the patient and family, thus allowing the patient to reach final goals, achieve a purposeful and peaceful end-of-life experience, and provide comfort and closure for family members.

Conclusions

Treating psychiatric illness in the rapidly growing population in hospice care settings poses a significant challenge for physicians given the conflict between limited life expectancy and the quality of remaining time with a terminal diagnosis. The lack of standardized guidelines for the treatment of psychiatric illness in hospice care makes it difficult for physicians to comfortably treat the illness. Traditional pharmacotherapy is the first line of treatment for depression in this population, but other techniques, such as

psychostimulants, ketamine, ECT, and transcranial magnetic stimulation, should be considered given their rapid onset of action and proven efficacy. These modalities are especially important to consider in the end-of-life population where time is of utmost importance.

Dr. Sylvester is a third-year resident in the Department of Psychiatry, University of Florida, Gainesville, Fla.

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Secrets and Lies

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I saw her again months later. It took me a moment to place her as she was walking toward me, head down and eyes fixed on the pavement. I was surprised how natural she looked among the “white collars” scurrying home after a long day, yet at the same time her steps seemed heavier, as if weighed down by something lurking just beneath the surface.

I had spoken to her briefly in clinic before going to present her case to my attending, who waited with the patience I am convinced my temperament precludes me from attaining. I asked my questions based on notes from a previous visit. Yes, she still kept a bottle of wine in her car for the mornings; yes, she would still spend an hour after work in the liquor store parking lot; no, her husband and children did not know; no, she would never tell them; no, she had no desire to stop.

Her husband had the next appointment. A recovering alcoholic, he was proud of

the battle he thought he and his wife won together, convinced their marriage was stronger because of it and that they were able to tell each other everything. She encouraged him whenever his cravings came; she never had any; he knew she would tell him; she had always been stronger.

As our paths crossed, her eyes remained on the sidewalk. She did not hesitate or look up. I doubt she would have recognized me. Outside of the clinic that tucked away our meeting months earlier, I doubt I existed to her anymore. This anonymity was comforting. She did not have this luxury; rather, she was draped in ambiguity. Was she the supportive wife and recovering alcoholic? The successful businesswoman? The closet drinker? Remembering the lies she had told her husband, I briefly wondered how many she told me. My supervisor would tell me that what she says is not nearly as impor-

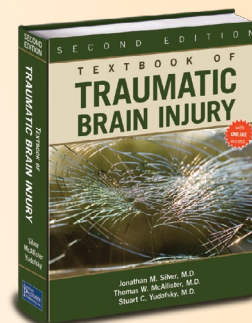
tant as why she says it—that her desire to speak tells me more than what she says, that I should try to access the secrets of which she herself is not aware. But I am ambivalent about this, caught between the allure of the abstract and the need for the concrete. Maybe sometimes we need to take things at face value. Maybe they are not secrets and lies but rather her reality in which the obvious dichotomy fades into something that just simply exists.

It was 5:00 when she turned the corner. She would be home by 6:00. Where she would spend the interim hour was not mine to know. The end of her story, like many others, will elude me. I take comfort in this. In the unknown, there is always hope.

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Textbook of Traumatic Brain Injury, Second Edition

Edited by Jonathan M. Silver, M.D.,
Thomas W. McAllister, M.D., and Stuart C. Yudofsky, M.D.



As soldiers and combat veterans have returned from the wars in Iraq and Afghanistan traumatic brain injury (TBI) has been identified as the “signature injury” of those wars. This new edition of *Textbook of Traumatic Brain Injury* has been thoroughly revised and updated from the 2005 first edition to reflect the exponential expansion of research and clinical data amassed in the intervening years. Each chapter was written and reviewed by the foremost authorities in neuropsychiatry, neurology, rehabilitation medicine, and the other specialties who assess, diagnose, and treat these patients.

This book includes a Foreword written by Bob Woodruff (the ABC World News correspondent who sustained a TBI while covering the war in Iraq) and his wife, Lee Woodruff, who underscore that although this volume is intended to be read primarily by professionals, patients and families may also find the information in the textbook to be of keen interest and practical application.

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Reducing and Preventing Cannabis Use in High-Risk Patients

Justine Wittenauer, M.D.
Arshya Vahabzadeh, M.D.

Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta

Case

An 18-year-old young man is brought by his mother to a psychiatry outpatient clinic for an initial visit. The mother has concerns about her son's grades dropping and that he no longer goes out with his friends. In the past 6 months, he has experienced an increase in social anxiety and lack of motivation. He initiated cannabis use 3 months prior, and while showing improvement in certain social situations, he has been having problems maintaining attention. The patient recently began isolating himself from both friends and family. Although denying depressed mood, he admits to feelings of anhedonia. His once occasional use of cannabis has now become a daily occurrence. Of note, there is a family history of schizophrenia (paternal uncle). You have some concern that this young patient may be in the prodromal phase of schizophrenia.

Cannabis herb, commonly called marijuana, gathers its psychoactive effects from the molecule tetrahydrocannabinol. Tetrahydrocannabinol interacts with endogenous cannabinoid receptors and has been shown to increase dopamine release in both the prefrontal cortex and nucleus accumbens. Some of the effects produced include relaxation, euphoria, pain relief, and, to a lesser extent, anxiety and paranoia. Effects can be experienced within seconds after cannabis smoke is inhaled and have been noted to last approximately 3 hours. Cannabis can be detected in urine for up to 1 month in heavy users (1).

Cannabis Use and Psychiatric Disorders

Over the last few years, the link between cannabis use and psychiatric conditions has been increasingly investigated. A key focus in this research surrounds the use of cannabis among adolescents. Cannabis is

a commonly used drug among many individuals during the adolescent years. One study conducted in 2008 found that 34% of 12th-graders had used cannabis in the last month and 5% smoked it daily (2). Cannabis use in adolescence may have subtle, long-term effects on both cognitive and emotional processing. In some individuals, the use of cannabis may be linked to both psychosis and schizophrenia (2).

Adolescence is accompanied by significant neurodevelopmental changes. It is believed that youths between the ages of 10 and 20 years are susceptible to alterations in typical neurodevelopment by exogenous substances such as cannabis (3). Not only has cannabis been linked to the onset of psychotic disorders, it has also been shown to have continued effects during the course of illness, and patients often continue to use the substance over the course of the disease. Thus, it is important to recognize cannabis use early. Green et al. (4) conducted a review of 58 studies and showed that cannabis use in patients with schizophrenia or psychotic disorders was significantly higher than in the general population. Among the studies analyzed, cannabis use reached a lifetime prevalence of 42.2% and an abuse prevalence of 22.5%.

Reducing Cannabis Use in High-Risk Populations

To effectively treat high-risk patients, they must first be identified. Symptoms must be recognized as high risk for conversion to a psychotic disorder. One study aimed to define ultra high-risk patients in a sample with a mean age of 19.1 years (SD=3.8) (5). Patients were separated into groups based on attenuated psychotic symptoms, brief-limited intermittent psychotic symptoms, and nonspecific symptoms of anxiety and

depressed mood. High-risk traits were identified as poor functioning, low-grade psychotic symptoms, depression, and disorganization. The study found an overall rate of conversion to a full psychotic disorder of 40.8% within 12 months (5).

To date, there are few published randomized, controlled trials on the treatment of cannabis dependence in patients at high risk for psychotic disorders. Moreover, treatment outcomes vary with each individual. Some of the options for treatment of substance use disorders include pharmacotherapy, brief interventions, and cognitive-behavioral therapy (CBT).

There is evidence that treatment of primary psychiatric disorders may result in beneficial decreases in cannabis use. In a systematic review (6), two randomized, controlled trials demonstrated a reduction in the rates of cannabis use once existing psychiatric disorders were treated. One trial found that treating existing psychosis with either olanzapine or risperidone significantly reduced the number of positive cannabis urine samples during the study period (6). Another study using fluoxetine to treat symptoms of depression reported a statistically significant decrease in cannabis use in the fluoxetine-treated group relative to the placebo group (7).

Although a range of psychosocial techniques has been shown to be beneficial, two of the more researched techniques are motivational interviewing and CBT. However, the literature suggests that a more comprehensive approach may be needed in treating patients with pre-existing psychiatric disorders. Every patient is an individual, and multiple techniques may be necessary to notice a significant response. Several treatment modalities may be offered concurrently, and in such cases, it is the combination of these mo-

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dalities, not any one alone, that results in a positive outcome of reduction in cannabis use (8).

The use of brief interventions has been a common treatment for substance use disorders. Motivational interviewing is a model of treatment based on the associated stages of change, which include pre-contemplation, contemplation, preparation, action, maintenance, and relapse. In disorders such as schizophrenia and its preceding prodromal phase, lack of insight and negative symptoms already causing ambivalence may make motivational interviewing alone not as efficacious as other combinations of treatment and therapy. It has been shown that heavy users of cannabis, as well as those with more chronic mental health issues, may respond better to more intensive interventions, involving 10 sessions of motivational interviewing/CBT, than to brief interventions (9).

CBT may be used individually as a treatment but is commonly paired with motivational interviewing. CBT may also be used in a time-limited setting to help patients develop goals and strategies to prevent relapse. In one study, an overall

behavioral therapy that also included motivational interviewing in a population of patients with severe and persistent mental illnesses was created (10). The investigators observed excellent improvement in the number of positive drug screens among patients receiving the dual therapy relative to those receiving supportive treatment alone (10).

Drs. Wittenauer and Vahabzadeh are first-year residents in the Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta.

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THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL WORKSHOP

Date: Sunday, May 15

Time: 9:00 a.m. - 10:30 a.m.

Location: Plumeria Room, Ala Moana Hotel



TEST YOUR KNOWLEDGE



In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions.
(answers will appear in the next issue)

This month's questions are courtesy of Justine Wittenauer, M.D., and Arshya Vahabzadeh, M.D., from the Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta. (Please see the accompanying Treatment in Psychiatry article in this issue.)

Questions #1.

Which of the following medications has been shown to have efficacy in reducing cannabis use in high-risk populations?

- A. Ziprasidone
- B. Haldol
- C. Wellbutrin
- D. Fluoxetine

Questions #2.

What is the lifetime prevalence of cannabis use in patients with schizophrenia or other psychotic disorders?

- A. 42.2 %
- B. 58.9%
- C. 25.6%
- D. 14.7%

ANSWERS

Answers to February Questions. To view the February Test Your Knowledge questions, go to <http://ajp.psychiatryonline.org/cgi/data/168/2/A38/DC2/1>.

Question #1.

Answer: C. Dorsolateral prefrontal cortex.

Question #2

Answer: A. Transcranial magnetic stimulation

▶ We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment in the issue in which their questions are featured.

Submissions should include the following:

1. Two to three Board review-style questions with four to five answer choices.
 2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.
- *Please direct all inquiries and submissions to Dr. Fayad; fayad@ufl.edu.

Author Information for *Residents' Journal* Submissions

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
- 3. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
- 4. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
- 5. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
- 6. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in the Residents' Journal will be considered for publication if received within 1 month of publication of the original article.
- 7. Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Issue Themes

Please note that we will consider articles outside of the theme.

April 2011

Section Theme: Psychosomatic Medicine
Guest Section Editor: Amit Pradhan, M.D.;
dramitpradhan@hotmail.com

May 2011

Section Theme: Child Psychiatry
Guest Section Editor: Michael Ascher, M.D.;
michaelaschermd@gmail.com

June 2011

Section Theme: No specific theme
Guest Section Editor: Deepak Prabhakar, M.D.;
dprabhakar@med.wayne.edu

We invite residents who are interested in participating as Guest Section Editors to e-mail Dr. Cerimele at joseph.cerimele@mssm.edu. If you are interested in contributing a manuscript on any of the themes outlined, please contact the Section Editor for the specified month.