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Advances in Psychiatry and Psychopharmacology

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Paul M. Steen, MD

Advances in Psychiatry and Psychopharmacology

A few months ago, I read an article by a psychiatrist from a teaching hospital who claimed that there was little evidence that psychopharmacology was effective. This flew in the face of what I read when I researched the subject. This contradiction led the Editorial Board to set the theme for this issue: what is the state of the art in therapy of psychiatric disorders?

The first article is by Anthony Rothschild and takes on the issue of efficacy for depression, anxiety, bipolar disorder and schizophrenia. This is a very good overview, convincing the reader that the evidence is good for the effectiveness of treatment while pointing out that more research needs to be done.

Next, the article about TMS (Transcranial Magnetic Stimulation) by Dr. Och is a must read.. This is very new technology that seems to be replacing electroshock therapy ~ and with lower side effects. The article by Kathryn Raymond is on medication adherence in psychiatric disorders. It discusses just how important this issue is to success in controlling patient symptoms. The critical factor appears to be the therapeutic alliance between patient and provider. There is an excellent discussion of what this means (for the non-psychiatrist) and how it is attained. The last article is an update on the latest drugs used in schizophrenia, major depressive disorder and insomnia. A table that summarizes indications, dosage, side effects and costs accompanies it.

Lastly, I'd like to point out the short article on the Spoken History Project. This project was done many years ago to interview senior physicians about their early years in practice. The material has been sitting in boxes and should have more exposure. This is my attempt to extract some interesting quotes from one physician's experience. I'd appreciate feedback on how valuable this is and whether should we continue.

Paul M. Steen, MD

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Taking Stock of Advances in the Use of Medications to Treat Psychiatric Illness

Anthony J. Rothschild, MD

Anthony J. Rothschild, MD

Introduction

In recent years, there have appeared articles in the lay press questioning whether medicines used to treat psychiatric disorders "really work." Unfortunately, these articles have been based on only a few publications in the medical literature that have been extensively criticized for using flawed methodology in their analyses. What these articles often fail to note is the extensive amount of highly replicated findings in the medical literature that psychiatric medications are effective for a large, but certainly not universal, group of patients and that they produce recovery and full remission of illness. Whether it is a person who has recovered from a serious depression by taking antidepressants, a person suffering from schizophrenia now attending college because he or she is taking a second generation antipsychotic medication, or a person suffering from bipolar disorder who is a successful physician or attorney because he is taking lithium carbonate, the advances in psychiatry over the past 40-50 years have profoundly improved people's lives.

Psychiatric illnesses are brain disorders which can be scientifically studied and for which treatments can be developed. Psychiatric diagnoses are standardized through rigorous scientific evaluation and field-test trials. Studies using neuroimaging and other biomarkers (e.g. evaluation of endocrine systems) have reported consistent and replicable abnormalities in many psychiatric disorders. While no one would question the use of insulin to treat diabetes or anti-hypertensives to lower blood pressure, unfortunately, perhaps because of stigma, people feel comfortable questioning whether psychiatric medications are efficacious.

While the focus of this article is on the use of medications to treat psychiatric illness, it is important to point out that psychotherapy ("talking therapy") is also an important tool in the psychiatrist's therapeutic armamentarium and that the relationship with the physician is important as well. While medications are very effective in treating the symptoms of psychiatric illness, most people who suffer from psychiatric illness also have problems in their life, whether at work or in relationships, that can benefit from psychotherapy. Psychotherapy can be very helpful in aiding people with the stresses in their lives as they are on the road to recovery. Indeed, psychotherapy has been reported to be effective for depression, anxiety disorders, bipolar disorder, and schizophrenia.

Medications that are approved by the United States Food and Drug Administration to treat psychiatric illness are studied in rigorous, randomized, double-blind, placebo-controlled trials, where in order to be approved the medication must demonstrate efficacy and safety. As is the case with other illnesses addressed in medicine, no medication used in psychiatry is effective in 100% of patients. However, the advances in psychopharmacology (the use of medication to treat psychiatric illness) in the past 40-50 years have resulted in the vast majority of patients with psychiatric illness being treated in the ambulatory setting, and with a high probability of becoming productive citizens leading normal lives.

Depression

Antidepressants revolutionized the practice of psychiatry after their discovery in 1954. Today, they are among the most widely prescribed medications in the world. Since the introduction of Prozac (fluoxetine) in the United States in 1987, the treatment of depression has changed dramatically. Prior to fluoxetine, only some psychiatrists, known as psychopharmacologists, prescribed antidepressants, mainly because of the complexity of prescribing tricyclic antidepressants and monoamine oxidase inhibitors. Today, in part due to the newer antidepressants which have fewer side effects, many non–mental health professionals feel comfortable prescribing antidepressants. Antidepressants are prescribed for many patients in addition to those who have major depressive disorder, including patients with Bipolar Disorder, Generalized Anxiety Disorder,

Panic Disorder, Posttraumatic Stress Disorder, Obsessive-Compulsive Disorder, Social Anxiety disorder, specific phobias, Psychotic Depression, schizophrenia, personality disorders, substance abuse disorders, and medical illnesses.

There have been occasional publications questioning the efficacy of antidepressants. One notable example was published by Kirsch and colleagues in 2008, when they reported on a meta-analysis of the data held by the FDA from 35 randomized placebo-controlled trials of four newer antidepressants in the acute treatment of major depression. The authors claimed that although antidepressants are statistically superior to placebo, the magnitude of the drug-placebo difference is small, and that these differences were only clinically relevant in patients with severe depression. Surprisingly, the paper received considerable attention in the popular press, including radio and front-page newspaper coverage. The focus on questions about whether antidepressants really worked needlessly upset patients and their families. What has not received equal coverage in the popular media is that many experts in the field have argued that the analysis by Kirsch and colleagues is seriously flawed because of the selective use of clinical data from short-term studies and unusual statistical techniques biased against antidepressants. Furthermore, the efficacy of antidepressants is documented by the experience of clinicians worldwide and the millions of patients who have benefited from taking them.

Anxiety Disorders

Antidepressants now constitute the mainstay of pharmacological treatment for a broad swath of anxiety disorders (e.g. Deneralized Anxiety Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Post Traumatic Stress Disorder, Social Anxiety Disorder) and, because of their efficacy for comorbid depression, are increasingly replacing benzodiazepines as the first line option for anxiety treatment. Research in recent decades also has clearly established the potent efficacy of cognitive-behavioral therapy (CBT) for all of the anxiety disorders. Thankfully, debate about which modality is superior is dying down. Many comparative studies show that antidepressants and CBT have roughly comparable efficacy, at least in the short term. Outstanding questions now focus on whether combination treatment offers an advantage over single-modality treatment, whether there is differential treatment modality efficacy over the longer term, and how best to accommodate patient preferences for specific modalities.

Bipolar Disorder

The introduction of lithium carbonate in the United States in 1970 changed the lives of millions of people who suffered from bipolar disorder, allowing them to lead normal lives without the ravages of mood swings into mania or severe depression or the need for frequent and long inpatient hospital stays. Since the introduction of lithium carbonate, additional medications (e.g. antiepileptic medications and second generation antipsychotic medications) have also been shown to be efficacious in treating Bipolar Disorder.

Schizophrenia

Antipsychotic medications revolutionized the practice of psychiatry after the discovery of chlorpromazine in 1952. Patients who would have otherwise been chronically psychotic and institutionalized began to receive treatment that alleviated many of their symptoms and permitted them treatment as outpatients. In the ensuing years, more than 20 antipsychotic compounds that had similar pharmacologic properties as chlorpromazine were identified ~ namely, dopamine antagonism. This first wave of antipsychotic medications are referred to as conventional antipsychotic medications, "typical" antipsychotics, or First Generation Antipsychotics (FGA). A second revolution occurred with the introduction of the first "atypical" or Second Generation Antipsychotic (SGA), clozapine, in the United States in 1990. This led to the second-wave of antipsychotic medication development. Antipsychotic medications have greatly reduced the number of people who suffer from schizophrenia who require long stays in psychiatric hospitals. The SGAs have also resulted in the ability of people with schizophrenia to function independently.

Conclusion

There have been major advances in psychiatric medications over the past 40-50 years that have allowed most people with psychiatric illness to be functional and productive members of society with reduced symptomatology and an improved quality of life. Clearly, more research needs to be done to find more efficacious medications with fewer side effects. Current research in neuroimaging, genetics, and other areas provides hope for better treatments and prevention of illness.

Anthony J. Rothschild, MD, is an Irving S. and Betty Brudnick Endowed Chair and Professor of Psychiatry and the Director of the Center for Psychopharmacologic Research and Treatment, Department of Psychiatry, University of Massachusetts Medical School.

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What is TMS?

Rachid Och, MD

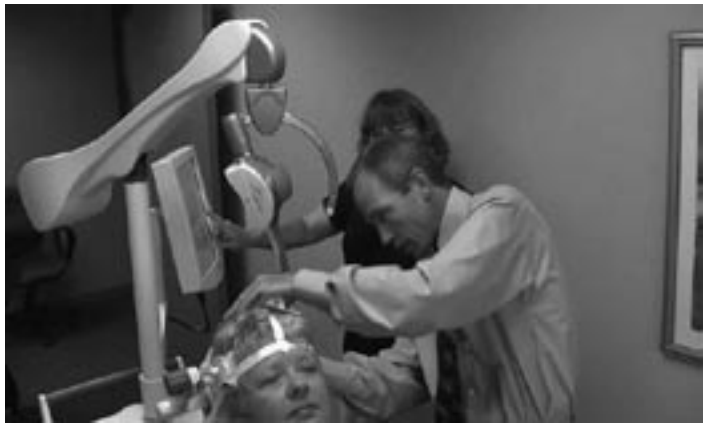

Photo by Cole Miller, NewsNetNebraska

Transcranial Magnetic Stimulation is a non-invasive procedure with clinical trials that treated mental illnesses including depression, mania, bi-polar, hallucinations, catatonia, post-traumatic stress disorder and drug cravings. Tests also looked at effectiveness for neurological disorders like Parkinson's, pain disorders, tics, stuttering, spasticity, epilepsy, and migraine headaches. TMS uses magnets to create a small electrical current to stimulate the prefrontal cortex. Other areas of the brain get indirect stimulation from the currents.[1]

The FDA cleared TMS devices from the company Neuronetics for the treatment of depression in 2008.[2] Neuronetics is the only company to have TMS approved for general outpatient treatment.

How Does TMS Differ from Electroshock Treatment?

Electroshock uses electrical currents directly, instead of using magnets, which cause seizures. These seizures make certain parts of the brain vulnerable, leading to memory loss as a common side effect.[3] With the lower electrical currents, memory loss is not a problem in TMS treatment, and clinical trials by Columbia University Medical Center are studying whether TMS therapy may enhance memory.[4]

The force of the electrical currents makes anesthesia and muscle relaxants necessary, but TMS is completely non-invasive.

Finally, TMS is approved for outpatient use while electroshock is not. Outpatient use allows for flexibility for patients who have home commitments and/or are not sick enough to be admitted into an in-patient facility.

What Are the Side Effects Associated with TMS?

Most side effects of TMS use are concurrent with the session of TMS, and go away immediately after the session is over. These include scalp discomfiture associated with how the head is placed in the equipment, headaches, twitchy facial muscles and light headedness.[5]

Seizures and hypomania are rare side effects. Rossi et. al. identified 9 such cases of seizures in meta-analysis.[6]

Patients using TMS equipment other than Neurostar have reported pain at the site of stimulation, but patients using Neurostar equipment did not report this side effect in clinical studies.

What is the course of treatment?

TMS treatment involves a major commitment from the patient, as the course of treatment is about five 40 minute long treatments a week for 4 to 6 weeks, depending on improvement of the depressive symptoms.

Who Should Use TMS?

TMS should be used by patients suffering from depression who have not responded well to frontline strategies such as medication, lifestyle changes and therapy. TMS can and is often used to supplement medication courses that have not been as effective as the patient and his or her doctor would have liked.

TMS is as effective as ECT in treating patients' depression (Grunha us et. Al, 2000) without the major side effects previously discussed.

Who Should Not Use TMS?

TMS cannot be used with patients that have metal plates or pacemakers[7], and might not effective when treating patients with depression with psychotic features. Though no study has tested the safety of TMS use with cochlear implants, it is likely unsafe.

TMS can be used even if the patient has braces and tooth fillings.

How Effective is the Treatment?

TMS treatment using Neurostar equipment showed a 22.1% average reduction in depressive symptoms compared to a 9% reduction in the inactive (control) group.[8] Patients being treated with Neurostar also showed improvement in anxiety and physical symptoms associated with depression.

A study using TMS equipment not produced by Neurostar found that 14% of patients resistant to anti-depressant medication saw remission of their symptoms, compared to 5% of the placebo group. 5% of patients decided to discontinue use because of the side effects, while 54% of patients reported significant improvement in their symptoms.[9]

Meta-analysis continues to confirm the value of TMS. Meta-analysis research undertaken by Machi et al., 2006, Loo et. al., 2008 and Janicek et al., 2008 observed the benefits of TMS with few side effects.

The rigorous testing undertaken by Neurostar and presented to the FDA in 2008 made Neurostar the first and still only TMS treatment cleared by the FDA for non-clinical trial and general use by trained professionals.

Payment and Insurance Companies

TMS is still awaiting general approval by insurance companies, but providers can work with insurance companies to get TMS treatment approved on an individual basis. If you or your patients are interested in TMS treatment, work with the local TMS center to see if you can get this treatment approved by your insurance company.

Neurostar is now available in over 300 centers across the U.S. There are treatment centers in New Hampshire and Boston; the closest center to Central and Western Massachusetts is located at 108 Grove Street and is known as TMS Worcester housed at Island Counseling Center. Other centers are located at McLean Hospital and Beth Israel Deaconess, among others.

For further information you may visit ICCWorcester.com or a Neuronetics website.

(Endnotes)
References

1 Padberg, Frank and George, Mark S., "Repetitive Transcranial Magnetic Stimulation of the Prefrontal Cortex in Depression," Experimental Neurology, p.3

2 Ostrovsky, Gene, "Neuronetics TMS Depression Therapy Gets FDA OK," MED GADGET, Oct 9, 2008, http://medgadget.com/2008/10/neuronetics_tms_depression_therapy_gets_fda_ok.html

3 Dahl, Melissa, "Shock Therapy Makes a Quiet Comeback," MSNBC.com, http://www.msnbc.msn.com/id/26044935/ns/health-mental_health/t/shock-therapy-makes-quiet-comeback/

4 Perez, Sylvia, "Magnetic Minds," Healthbeat, Thursday, May 15, 2008

5 Baldouf, Sarah, "Brain Stimulation: Transcranial Magnetic Stimulation," U.S. News, July 15, 2009, http://health.usnews.com/health-news/family-health/brain-and-behavior/articles/2009/07/15/brain-stimulation-transcranial-magnetic-stimulation

6 Rossi et. al., "Safety, Ethical Considerations, and Application Guidelines for the Use of Transcranial Magnetic Stimulation in Clinical Practice and Research," Clinical Neuropsychology, 2008

7 Dr. Duckworth, Ken, ed., "Transcranial Magnetic Stimulation," NAMI, October 2009, http://www.nami.org/Content/ContentGroups/Helpline1/Transcranial_Magnetic_Stimulation_(rTMS).htm

8 Demitrack, MA, Thase, ME. Clinical significance of transcranial magnetic stimulation (TMS) in the treatment of pharmacoresistant depression: synthesis of recent data. Psychopharm Bull. 2009

9 Dr. Duckworth, Ken

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The Therapeutic Alliance and Psychiatric Medication Adherence

Kathryn Raymond, MS, APRN, BC

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Adherence to psychiatric medication in patients with severe and persistent mental illness, such as schizophrenia, is a major health concern. While adherence reduces symptoms of the illness, poor treatment adherence increases patients' risks for relapse, re-hospitalization, and poor daily functioning. Additionally, adherence to psychiatric medications may be considerably lower than adherence to other types of medication. For example, a meta-analysis of 24 studies comparing medication adherence with psychiatric medications versus medical medications reported the mean adherence rate for antipsychotic medication was 58%, compared to 76% with non-psychiatric medications (Cramer & Rosenheck, 1998). The therapeutic relationship or therapeutic alliance between the patient and health care provider can have an important impact on medication adherence. As an inpatient psychiatric nurse clinician who prescribes medication under the supervision of a psychiatrist, I have found that the development of a trusting alliance with patients many times increases their willingness to adhere to medication regimens. The development of a therapeutic alliance with patients can become the vehicle for enhancing medication adherence.

The Importance of Psychiatric Medication Adherence

Adherence to prescribed medication regimens promotes positive treatment outcomes for psychiatric and medical conditions (Lacro, Dunn, Dolder, Leckband, & Jeste, 2002). Patients who are non-adherent to psychiatric medication are at increased risk for exacerbation of psychotic and/or mood symptoms, frequent crisis visits to clinics and emergency rooms, and re-hospitalizations (Lacro, et al., 2002). Psychiatric patients' quality of life can be enhanced by medication adherence. Psychiatric medication adherence promotes symptom management and decreases the risk for disruptions in patients' daily functioning, family life, social relationships, and employment opportunities.

Multiple Factors in Treatment Adherence

Important factors that influence treatment adherence are patients' attitudes toward treatment and the strength of the therapeutic alliance with their health care providers (Goff, Hill, & Freudenreich, 2010; Day, Bentall, Roberts, Randall, Rogers, Cattell, Healy, Rae, & Power, 2005). Patients' beliefs and attitudes about medication and mental illness affect their decisions to take medications. Patients' cultural and religious/spiritual beliefs may also influence how they view illness and treatment options (Zygmunt, Offson, Boyer, & Mechanic, 2002). There is some evidence that patients' attitudes and beliefs about their quality of life are related to medication adherence, i.e. actual and perceived side effects, and effects of medication on their daily functioning (Puschner, Angermeyer, Leese, Thornicroft, Schene, Kikkert, Burti, Tansella, & Becker, 2009). Perceived coercion of patients by treatment providers regarding medication recommendations can adversely affect rates of adherence (Day, et al., 2005). Patients who lack insight into and knowledge about their illness, medications, and risks and benefits of treatment are at greater risk for medication nonadherence (Hardeman, Harding, and Narasimhan, 2010).

The therapeutic alliance between patients and psychiatric treatment providers has been identified as a predictor of medication adherence (Lacro, et al., 2002). Trust is an essential element in the clinical relationship and is especially so with psychiatric patients whose perceptions of reality are most often distorted. Characteristics of the clinician can influence the development of a working relationship with the patient (Gray, White, Schulz, & Aberhalden, 2010). The tone of voice of the clinician, the clinician's willingness to understand the patient's beliefs, attitudes, and knowledge about their

mental illness and treatment, and the clinician's ability to promote patient choice are factors that can foster a therapeutic relationship and influence patient medication adherence (Gray, et al., 2010).

New Policy, New Model of Care

A paradigm shift in the delivery of mental health services was proposed with the passage of the October 2008 mental health parity legislation as a way of integrating mental health and medical health care. This new paradigm moved away from the traditional medical model focusing on illness and illness stabilization (Power, 2009). People-centered, recovery-oriented mental health services is the treatment model being promoted to transform the current public mental health system by the Center for Mental Health Services (CMHA) part of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services (Power, 2009). In this model, the clinician works collaboratively with patients to assess their needs and to promote self-efficacy, recovery, and shared decision making. Practicing from a person-centered, recovery-oriented care model can enhance the development of the therapeutic alliance. Clinicians are asking their patients to enter into a reciprocal relationship, centered around patients sharing their expertise of living with mental illness and clinicians sharing their expertise in psychiatric evidence-based practice.

A Collaboration Process: Trust, Listening

Trust is an important building block in the therapeutic alliance. Trust can sometimes take years to establish. Trust may be a difficult issue for some patients who have had difficult experiences with past treatment providers. Trust in the relationship can be fostered by the clinician's ability and willingness to illicit from patients their beliefs and attitudes about mental illness, prior treatment, and the factors that influence their beliefs and attitudes.

Listening to patients' stories can give the clinician an understanding of how patients have dealt with mental illness, past treatment responses, factors that influence their quality of life, and recovery goals. This valuable information aids the clinician is assessing patients' educational needs and assists the clinician in negotiating with patients around appropriate and acceptable treatment plans. This collaborative process, therefore, encourages medication adherence (Puschner, et al., 2009).

The clinician whose practice model is person-centered and recovery-oriented has a greater probability of building a therapeutic alliance and promoting shared decision making in the treatment planning process. The use of this model is not a cure for dealing with difficult treatment issues such as patients' denial of their mental illness and persistent treatment resistance. The therapeutic alliance between prescribing clinician and patients is a basic and vital factor in medication adherence because it cultivates the art of negotiating around treatment interventions, and it promotes patient self-determination, self-efficacy, improved quality of life, and hopefulness for a life worth living.

References

Cramer, J. A. &Rosenheck, R. (1998).Compliance with medication regimens. Psychiatric Services, 49, 196-201.

Day, J. C., Bentall, R. P., Roberts, C., Randall, F., Rogers, A., Cattell, D., Healy, D., Rae, P., & Power, C. (2005).Attitudes toward antipsychotic medication.Archives of General Psychiatry, 62, 717-724.

Goff, D. C., Hill, M., &Freudenreich, O. (2010). Strategies for improving treatment adherence In schizophrenia and schizoaffective disorder. Journal of Clinical Psychiatry, 72, 20-26.

Gray, R., White, J., Schulz, M., &Abderhalden, C. (2010). Enhancing medication adherence in people with schizophrenia: An international programme of research. International Journal of Mental Health Nursing, 19, 36-44.

Hardeman, S. M., Harding, R. K., &Narasimhan, M. (2010). Simplifying adherence in schizophrenia. Psychiatric Services, 61, 405-408.

Lacro, J. P., Dunn, L. P., Dolder, C. R., Leckband, S. G., &Jeste, D. V. (2002). Prevalence of and risk factors for medication nonadherence in patients with schizophrenia: A comprehensive review of the literature. Journal of Clinical Psychiatry, 63, 892-909.

Power, A. K. (2009).A public health model of mental health for the 21st century.Psychiatric Services, 60, 580-584.

Puschner, B., Angermeyer, M. C., Leese, M., Thornicroft, G., Schene, A., Kikkert, M., Burti, L., Tansella, M., & Becker, T. (2009). Course of adherence to medication and quality of life in people with schizophrenia. Psychiatry Research, 165, 224-233.

Zygmunt A., Olfson, M., Boyer, C. A., & Mechanic, D. (2002). Interventions to improve medication adherence in schizophrenia. American Journal of Psychiatry, 159, 1653-1664.

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Update in Psychopharmacology

Anna K. Morin, PharmD

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Schizophrenia

The side effect profiles of recently marketed antipsychotics are not as well-characterized as the older agents. Side effects, cost, and dosing frequency are all considerations when choosing an atypical antipsychotic. Risperidone is available as a generic; generic olanzapine is expected in late 2011, and generic quetiapine and ziprasidone in 2012.

Iloperidone has been promoted as being better tolerated than other atypical antipsychotics. However, the use of iloperidone has been limited due to cardiac concerns, as it can prolong the QT interval, possibly increasing the risk of arrhythmias.

Promoted as a new atypical antipsychotic for schizophrenia, the active ingredient in paliperidone is not really that new...it's the active metabolite of risperidone. Efficacy of paliperidone is similar to that of risperidone, with similar side effects such as extrapyramidal symptoms and hyperprolactinemia. Due to paliperidone's extended-release formulation, patients might see a ghost tablet in their stool.

Asenapine comes as a sublingual tablet that must be dissolved and absorbed under the tongue. It is not effective if swallowed, due to an extensive first pass through the liver. Due to its side effect profile, asenapine should be reserved as an option for patients not tolerating other atypicals or patients with trouble swallowing.

Marketed in 2011, lurasidone is the tenth oral atypical antipsychotic marketed in the US. Dosage should not exceed 40 mg/day in patients with renal and hepatic dysfunction and it should be taken with food to increase bioavailability.

Major Depressive Disorder

Trazodone extended-release has been shown to be more effective than placebo for the treatment of major depression; there are no studies comparing it to other antidepressants, including immediate-release trazodone, which has been available in the US since 1981 and is available as a generic formulation. It has been postulated that a once-daily extended-release formulation of trazodone may improve adherence. If discontinued, tapering is recommended to minimize withdrawal symptoms (e.g., anxiety, agitation, sleep disturbances). Of note, trazodone is not considered a first-line agent for treatment of depression but can be considered an option for patients who experience anxiety, insomnia, weight gain, or sexual dysfunction with first-line agents (e.g., SSRIs, venlafaxine).

Vilazodone is a dual-acting serotonergic antidepressant (serotonin reuptake inhibitor and partial agonist at the 5-HT1A receptor). Efficacy studies found vilazodone to be more effective for depression than placebo but not more effective than fluoxetine or citalopram. In studies, onset of symptom improvement with vilazodone was statistically superior to placebo by the end of week one, but SSRIs can also provide symptom improvement by the end of the first week of use. Overall, vilazodone's incidence of sexual side effects and weight gain is comparable to placebo but the incidence of gastrointestinal side effects is high compared to most SSRIs, even with slow titration. Post-marketing experiences and long-term studies are needed to clarify vilazodone's role in the treatment of major depression.

Insomnia

Doxepin has a new indication for insomnia in patients with difficulty falling asleep. It should be taken within 30 minutes of bedtime, but not within 3 hours of a meal, as food can delay onset and prolong next day sedative effects. In studies comparing doxepin to placebo, sleep onset was faster by 3-6 minutes and total sleep time was increased by almost 30 minutes with no reported anticholin-

Update: Recently Marketed Psychopharmacologic Agents

Brand name	Generic Name	FDA Approved Indication	Recommended Dosing	Adverse Effects	Additional Information
Fanapt® AWP: $11.54 (1 mg, 2 mg, 6 mg, 8 mg, 10 mg, 12 mg)	Iloperidone	Schizophrenia	***Schizophrenia:*** Titrate to 6-12 mg twice daily (12-24 mg/day); titration pack available.	***Common:*** dizziness, dry mouth, fatigue, nasal congestion, orthostatic hypotension, somnolence, tachycardia; Risk of weight gain is moderate, diabetes and dyslipidemia is low; ***Higher risk of*** QT prolongation than other atypical agents	***To minimize orthostatic hypotension***, starting at a dose of 1 mg twice daily, then moving to 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, and 12 mg twice daily on days 2, 3, 4, 5, 6, and 7 respectively, to reach the 12 mg/day to 24 mg/day dose range; ***Avoid with*** other medications that prolong QT interval and inpatients with risk factors for QT prolongation
Invega® AWP: $18.14 (1.5 mg, 3 mg, 6 mg); $27.22 (9mg)	Paliperidone	Schizophrenia; Schizoaffective Disorder	***Schizophrenia and Schizoaffective Disorder:*** 6-12 mg/day	***Common:*** EPS, somnolence, dyspepsia, constipation, weight gain, and nasopharyngitis; Risk of weight gain, diabetes and dyslipidemia is low; ***Higher risk of*** EPS, hyperprolactinemia, and QT prolongation than other atypical agents	***Tablet should be swallowed whole***, do not chew, crush or divide; Dosing must be individualized according to renal function status; ***Avoid with*** other medications that prolong QT interval and inpatients with risk factors for QT prolongation; ***Also available*** as a long-acting intramuscular injection: Invega Sustenna®
Latuda® AWP: $16.80 (40 mg, 80 mg)	Lurasidone	Schizophrenia	***Schizophrenia:*** 40-80 mg/day	***Common:*** somnolence, akathisia, nausea, EPS agitation; Risk of weight gain, diabetes and dyslipidemia is low; ***Lower risk of*** QT prolongation than other atypical agents	***Avoid with*** with strong CYP 3A4 inhibitors (e.g., ketoconazole) or inducers (e.g., rifampin); ***Take with*** food (at least 350 calories).
Oleptro® AWP: $3.84 (150 mg); $4.68 (300 mg)	Trazodone extended-release	Major Depressive Disorder	***Starting dose:*** 150 mg once daily at bedtime ***Increase*** by 75 mg/day every 3 days to a ***maximum*** of 375 mg/day.	***Common:*** Sedation, dizziness, constipation, blurred vision, orthostatic hypotension ***Rare:*** Priapism, QT prolongation	***Avoid with*** other medications that prolong QT interval and in patients with risk factors for QT prolongation; ***Use cautiously in*** patients with arrhythmia risk; ***Monitor for*** suicide risk, serotonin syndrome, NMS; mania, abnormal bleeding, hyponatremia ; ***Do not use*** within 14 days of an MAOI ; ***Do not take*** within 3 hours of a meal as food may delay onset and cause next day effects
Saphris® AWP: $11.53 (5 mg, 10 mg)	Asenapine	Schizophrenia; Bipolar Disorder (acute manic or mixed episodes)	***Schizophrenia:*** 5 mg SL twice daily(acute); 10 mg SL twice daily (maintenance) ***Bipolar Disorder:*** 5-10 mg SL twice daily	***Common:*** akathisia, oral hypoesthesia, and somnolence; Risk of weight gain is moderate, diabetes and dyslipidemia is low; ***Higher risk of*** QT prolongation than other atypical agents	***Caution patients*** regarding possible allergic reactions...difficulty breathing; swelling of the face, tongue, or throat; hives; etc; ***Avoid with*** other medications that prolong QT interval and inpatients with risk factors for QT prolongation
Silenor® AWP: $6.28 (3 mg, 6 mg)	Doxepin	Insomnia (sleep maintenance)	***Starting dose:*** 3 mg (≥ 65 years) 30 minutes before bedtime; 6 mg (<65 years) 30 minutes before bedtime ***Maximum:*** 6 mg	***Common:*** Sedation, nausea, upper respiratory infection	***Contraindicated*** in patients with severe urinary retention, untreated narrow angle glaucoma; ***Do not use*** within 14 days of an MAOI; ***Avoid with*** other CNS depressants; Monitor for abnormal behavior and suicide risk
Viibryd® AWP: $4.74 (10 mg, 20 mg, 40 mg)	Vilazodone	Major Depressive Disorder	***Starting dose:*** 10 mg once daily with food for 7 days; increase to 20 mg once daily with food for 7 days; the increase to the ***maintenance dose*** of 40 mg once daily with food ; starter kit available	***Common:*** diarrhea, nausea, dizziness, dry mouth, insomnia, vomiting, and decreased libido, dry mouth ***Rare:*** May cause new or worsening cataracts with long-term use	***Must be taken*** with food to maintain bioavailability; ***If discontinued***, tapering is recommended to reduce risk of withdrawal symptoms; ***Do not use*** within 14 days of an MAOI; Monitor for suicide risk, serotonin syndrome, NMS, seizures, mania, abnormal bleeding, hyponatremia

Abbreviations:
AWP = Average Whole Sale Price (From Redbook Online; as of September 29, 2011)
EPS = Extrapyramidal side effects
MAOI = Monoamine oxidase inhibitor
NMS = Neuroleptic Malignant Syndrome
SL = Sublingual

ergic or amnesia effects. There are no studies comparing doxepin to other agents used in patients with sleep maintenance insomnia. Unlike other sedative agents, doxepin is not a controlled substance and may be preferred in patients with a history of substance abuse. Doxepin has been available in the US since 1969 for the treatment of major depression.

References:

Fanapt (iloperidone) prescribing information. Vanda Pharmaceuticals Inc., Rockville, MD; September 2011.

Invega (paliperidone extended-release tablets) prescribing information. Ortho-McNeil Janssen Pharmaceuticals, Inc., Titusville, NJ; April 2011.

Latuda (lurasidone HCl) prescribing information. Sunovion Pharmaceuticals, Inc., Marlborough, MA; October 2010.

Oleptro (trazodone HCl extended-release tablets) prescribing information. Angelini Labopharm Europe Ltd., Dublin, Ireland; December 2010.

Saphris (asenapine) prescribing information. Schering-Plough Corporation. Kenilworth, NJ; August 2011.

Silenor (doxepin) prescribing information. Somaxon Pharmaceuticals, Inc., San Diego, CA; March 2010.

Viibryd (vilazodone HCl) prescribing information. Forest Pharmaceuticals, Inc., St. Louis, MO; March 2011.

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Patient Safety at Fallon Clinic

Michael Kelleher, MD

Michael Kelleher, MD

Correction: In the September/October issue of *Worcester Medicine*, the heading for the malpractice table graph was placed above the wrong image. We offer this reprint of the article in its correct entirety.

Please note: Fallon Clinic has recently changed its name to Reliant Medical Group.

Background Information

Fallon Clinic has a long history of dedication to the quality and safety of care delivered to our patients, with particular focus and energy subsequent to the in-house migration of our malpractice insurance coverage in 2003. In concert with the creation of our captive insurance company, we implemented a major upgrade of our state-mandated Patient Care Assessment (PCA) Program, staffing our new risk management department with four FTEs. At that time, we also formally merged our peer review, quality improvement, and risk management functions, moving to a combined database for all related clinical events.

All of these performance improvement functions were also restructured to report up to our Medical Director for Quality and Patient Safety, helping to ensure tighter integration for these closely-related activities.

This model has proved to be very successful for our organization, which was recognized in 2007 by the American Medical Group Association with its prestigious "Acclaim Award" for patient safety.

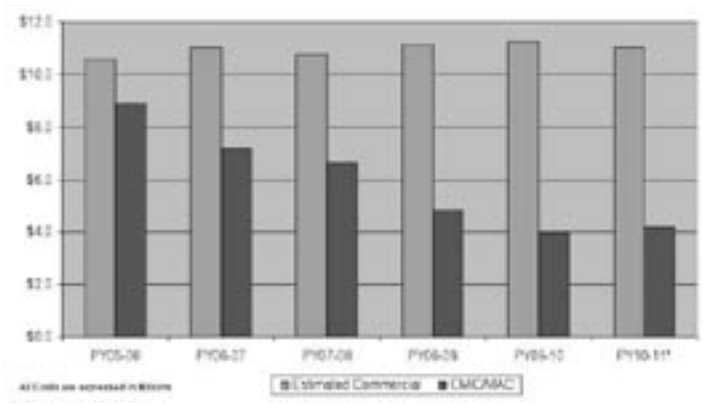
The following sections summarize the major tracking/reporting tools and interventions that have substantially improved patient safety at Fallon Clinic over the last seven years, while at the same time promoting a culture of safety and trust, essential for the engagement of our medical staff.

Global Risk Score Tracking

By 2004 we recognized the need for a tracking tool to assess the impact of our interventions across multiple categories of events including patient complaints, minor adverse clinical events, major events, claims, and lawsuits. We performed detailed analysis to determine the average dollar cost for each of these event categories as determined by our actual experience. For complaints this was challenging, but we were able to determine the likelihood of losing a capitated patient because of a complaint, enabling a reliable estimate of that cost.

Subsequently, we have been able to demonstrate a significant improvement trend for our global risk score, as depicted below. We have also seen a comparable decline in our malpractice premium costs, saving the organization more than $20 million over the past six years.

Fallon Clinic Malpractice Premium Trend
$2M/$6M Coverage, $25M Aggregate Limit



*not including premium rebate for 2011

By 2008 we had sufficient data in our registry to enable reporting of this innovative risk score for our clinical departments and for individual physicians, using 95% confidence intervals to identify outlier performance. This has been a valuable tool for our department chairs to use in monitoring performance in the patient safety category, and we have also incorporated this data into our recredentialing process to ensure that those important decisions are driven by objective data.

System Interventions to Promote Patient Safety

The list which follows summarizes the top 10 interventions that we have launched over the past six years in support of our patient safety goals. The impetus for most of these interventions came from our peer review program, where we invariably identify system drivers as well as individual performance issues when we investigate significant adverse events.

(1) Clinical Guidelines. Our clinical guidelines committee has posted more than 30 guidelines on our Intranet, and we have embedded these guidelines as appropriate into our chronic disease management programs and our electronic record decision support systems.

(2) Anticoagulation Clinic. Our peer review process identified performance gaps when the management of these patients was delegated to site staff members who had many other duties. Accordingly, we have established a dedicated anticoagulation clinic with nine nurses who have substantially reduced the frequency of adverse events related to this high-risk treatment.

(3) EMR Decision Support. Our informatics team has embedded into our EMR Best Practice Alerts for drug monitoring with real-time feedback to clinicians, as well as drug interaction alerts and

health maintenance alerts. The system identifies patients who are past their due date for important preventive services, pegged to their age, sex, and chronic medical problems.

(4) Medication Error Tracking. Our dedicated Pharm-D works with our P&T Committee to identify medication errors, relaying them to our peer review program for investigation and for planning of system interventions. The Pharm-D also sends out monthly prescriber alerts regarding new interaction warnings and "black box" PDR alerts.

(5) Chronic Disease Management Programs. We have internally implemented disease management programs for diabetes, COPD, CHF, and HIV. All these programs incorporate our updated clinical guidelines and serve to prevent errors of omission, while at the same time engaging patients to be more compliant with their treatment program. We have been able to demonstrate substantially improved quality performance through these programs.

(6) High-Risk Patient Registries. We created tracking registries for patients with prior colon polyps and lung nodules to ensure that they are tested at the appropriate follow-up interval. In addition, we have created formal registries for our primary care staff to manage patients with diabetes, hypertension, and hyperlipidemia, as part of our Patient-Centered Medical Home.

(7) Staff Safety Alert Reporting. In June of 2010, we implemented an electronic staff safety alert reporting system. This rollout included focus on reporting near misses and patient adverse events, and we did see an increase in reporting of such events following implementation of the tool.

(8) Patient Safety Related Policies. We continue to create and update related policies, including our time-out policy for outpatient procedures and, more recently, a policy regarding tracking of "no shows."

(9) Specialty Quality Measures. We have created customized quality measures for each of our 25 specialty divisions. Most of these do focus on patient safety issues such as high-risk drug monitoring for the cardiology, GI, and neurology divisions, and procedure complications for our surgical and GI divisions.

(10) Narcotic Profiling. Recognizing the growing risk of overdose and death with high-dose narcotics, we have implemented tracking of narcotic prescribing profiles for our primary care physicians, identifying outliers using 95% confidence intervals for prescriptions per 1000 visits. This program has been effective, initiating appropriate coaching to ensure safer approaches to pain therapy.

We are encouraged by the results to date for our patient safety programs, but realize that much remains to be done to achieve our ambitious goal of defect-free care.

Dr. Michael Kelleher is the Medical Director for Quality and Patient Safety at Fallon Clinic, a multispecialty group practice serving 200,000 patients in Central MA. Prior to his arrival at Fallon Clinic in 1995, he served as Associate Medical Director for the Scott and White Clinic in Texas.

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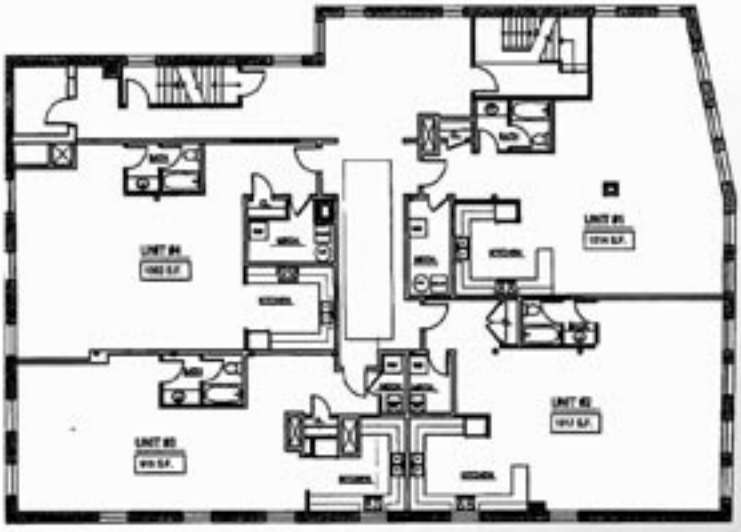

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Is It Me or My Meds? Living with Antidepressants

by David A. Karp (2006), Cambridge, MA/Harvard University Press

Anne Kane, RN, PhD

The evocative question in the title is one Karp answers through in-depth interviews with 50 people whose mental health treatment included psychotropic medications. Based on a study and intended for a general audience, the book informally and expertly presents the "central, repeating, and common dimensions" (p. 10) of the complex experience of psychotropic drug use.

This readable and provocative book could help providers, patients, and families understand and talk about a paradox of psychopharmacy: mind-altering treatment inherently challenges personal authenticity. "Taking psychotropic drugs is one part of a powerful illness drama that inevitably transforms people" (p. 244). Once psychopharmacological treatment begins, crucial issues and soulful questions arise that may be more important to patients than the biological side effects commonly discussed in treatment. Interviewees describe these deeply perplexing issues and questions as being active in their adherence, yet often undisclosed in encounters with providers.

Karp, a professor of sociology at Boston College who has depression, undertook the research project on which the book is based after struggling toward his own answer to the title question: "At age fifty-seven, I wondered just who I might be if I were free of medications. After all, I was surely not the same person who embarked on a drug career at age thirty-one" (p. 1). Setting even the most poignant memoirs aside as isolated perspectives, Karp systematically develops a rich description of the experience of psychopharmalogical treatment. The book describes experiences of those for whom prescription drug(s), singly or in combination, over time and often multiple attempts, worked well, somewhat, or not at all. The "black box" analogy applicable to both psychopharmacy and to mental illness is vivid here. Prescription pharmacological treatments might be shots in the dark, but readers of this book will be better positioned to work toward the relief of suffering within the ambiguities patients and providers face.

There's powerful suffering conveyed here, balanced by hopeful accounts and practical advice from adult and teen sufferers of mental illness. The epilogue, "Lessons from the Inside," presents seven data-based suggestions interviewees wanted to pass along to readers. The hopeful ending somewhat balances ~ but does not sugarcoat ~ the discouraging dimensions of chronic mental illness and treatment.

There are a few drawbacks to the book, but none of them negates its value. Surprisingly, the financial burden of prescription psychotropics does not arise here as a major dimension of patient experience. (Readers will note that the book predates federal and Massachusetts state mental health parity laws.) There may be various reasons cost does not emerge as an issue, including that it's outside Karp's sociological focus. An unabashedly critical chapter on some pharmaceutical industry practices will discourage some readers and possibly energize others. Finally, Karp's transparency about his own mental illness history may be another drawback for some who view science as necessarily objective, but the book is based on a qualitative study, and the methodology requires this kind of researcher disclosure. A detailed Appendix presents sufficient description of the study's methods to allow adequate appraisal of its merit as qualitative research.

Why read it? There are lots of reasons. One might be to prompt deeper dialogue with people living with depression. Learn to ask hard questions about their experience in the trial-and-error process of treating mental illness. Become a better listener, a better parent, spouse, neighbor and friend. Read something among the extensive references in the book's Notes. Better understand patients and providers whose best attempts to identify effective psychotropic medi-

cations often require more than marathon endurance. Deepen compassion.

There's an epic struggle for self in the mix. That's important to everyone who cares about anyone with mental illness.

References

1 One of Karp's earlier works focuses on the meaning of depression: Speaking of Sadness: Depression, Disconnection, and the Meanings of Illness, David A. Karp (1997) , New York: Oxford University Press.

2 For more information on the federal Mental Health Parity and Addiction Equity Act (2008), visit SAMSHA at www.samhsa.gov/healthreform/parity/; or the Center for Medicare and Medicaid Services at www.cms.gov/healthinsreformforconsume/04_thementalhealthparityact.asp .

3 For more information on Massachusetts' mental health parity laws, visit the state's Office of Consumer Affairs and Business Regulation at www.mass.gov or MassLegalHelp at http://www.masslegalhelp.org.

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The Emperor of All Maladies: A Biography of Cancer

by Siddhartha Mukherjee, MD

Tom Peteet

The Emperor of All Maladies: A Biography of Cancer, by Siddhartha Mukherjee, MD, was reviewed by Dr. Sidney Kadish in the July/August issue of *Worcester Medicine*.

The Emperor of All Maladies also was the University of Massachusetts Medical School all-campus summer reading assignment in anticipation of the September Convocation ceremony, the formal start of the academic year.

The Editorial Board welcomes a complementary review by medical student Tom Peteet, Class of 2012, University of Massachusetts Medical School.

The Emperor of All Maladies elegantly captures the history of cancer, from Egyptian writing of 2500 BC to modern molecular genetics. Mukherjee writes this history using the widest perspective possible, ranging from biology to sociology to politics to poetry. He began the book as a medical oncology fellow at Massachusetts General Hospital in Boston, eager to locate his patients' struggles within the larger scientific war on cancer. His story centers on Sidney Farber, an oncologist and "father of chemotherapy" and on Mary Lasker, a Manhattan socialite and force behind the National Cancer Act. Mukherjee weaves the biological story of cancer around these two characters, citing Farber and Lasker's efforts in the 1960s to garner and consolidate political support to destroy a monolithic disease. His choice of characters is not incidental, as their stories reinforce his thesis that confronting cancer necessitates social, scientific, and political action.

Mukherjee describes the intellectual puzzles of cancer within the personal histories of its researchers. We learn how William Halsted's obsessive tendencies drew him to surgery and personal experimentation with cocaine and fueled a zeal to combat breast cancer with the most aggressive means possible. For readers who never quite grasped Knudson's two-hit hypothesis or lead-time bias, he introduces them with clarity and precision. He repeatedly returns to the question, "Are we making progress in the war on cancer?" and naturally turns to the epidemiology for answers. In the 1970s, while scientists waged war on biological targets, the medical community struggled to define what progress in cancer meant ~ a decrease in cancer mortality, prevention of new cases, or complete remission for certain diseases? The tools of epidemiology, statistics and early detection strategies (mammograms for breast cancer , Pap smears for cervical cancer) provided a framework to debate these questions scientifically. Mukherjee narrates the discord among physicians, researchers, and government agencies in their interpretation of new evidence. Should more funding go toward preventive strategies, basic science research, or chemotherapeutic trials? The stakes of debate were enormous, as governmental funding for cancer research reached 600 million dollars by 1973.

Mukherjee masterfully bridges the world of laboratory science with the political, from discussing funding to the National Cancer Institute to the machinations behind the Conquest of Cancer Act of 1971. As a clinician, he beautifully paints cancer from the "inside," and intersperses the stories of his patients throughout. The force of his prose, however, lies not in his patients' voices, but in his poetic articulation of the strange beast they are fighting, a beast that "lives desperately, inventively, fiercely, territorially, cannily, and defensively ~ at times, as if teaching us how to survive." In the end, we are left with both knowledge and humility: cancer is indeed the emperor, and we its unwilling ~ albeit inventive ~ subjects.

Thomas Peteet is a 4th year medical student at the University of Massachusetts Medical School. He can be reached at Thomas.Peteet@umassmed.edu.

A Network's Duty to Its Members

Peter J. Martin, Esq.

Peter Martin, Esq.

A fiduciary duty arises from a relationship in which one party reposes in another trust and confidence that the fiduciary will act on the other's behalf, such as, for instance, in a lawyer-client, doctor-patient, or trustee-beneficiary relationship. It has been called the highest standard of care recognized under the law. Chief Justice Benjamin Cardozo described it as follows: "Many forms of conduct permissible in a workaday world for those acting at arms' length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior."

A Massachusetts court recently found that the parent corporation of a hospital network owed fiduciary duties to its hospital subsidiary. As Massachusetts health care providers affiliate into ever-larger organizations in order to position themselves for global payment systems, this decision imposing the highest legal duties on such networks will have a profound impact on how such networks are formed and operated.

The case involved the ill-fated alliance of Lifespan Corporation, a Rhode Island hospital network, and New England Medical Center between 1997 and 2002. Under their affiliation agreement, Lifespan formed a Massachusetts entity which was the sole voting member of NEMC, with power to appoint NEMC's directors and control NEMC's operations, including third party payor negotiations. NEMC received $8.7 million per year from Lifespan, but held no more than twenty percent of the seats on Lifespan's board and paid its share of Lifespan's corporate overhead expenses, totaling $172 million over the course of the affiliation.

NEMC complained to Lifespan about the health insurance contracts negotiated on its behalf by Lifespan and about an interest rate swap recommended to NEMC by Lifespan's CFO. The parties then agreed to disaffiliate and entered into a restructuring agreement whereby NEMC would make a series of payments to Lifespan, but later NEMC refused to make some of those payments due to its losses incurred during the affiliation. Lifespan sued NEMC for breach of contract, NEMC counter-claimed for breach of fiduciary duty, unjust enrichment and unfair business practices, and the Massachusetts Attorney General later intervened under her supervisory authority over NEMC as a public charity. The trial court ruled that while Lifespan owed a fiduciary duty to NEMC due to its control over NEMC and the "faith, confidence, and trust" that NEMC placed in Lifespan, NEMC had released its breach of fiduciary duty claim against Lifespan under the restructuring agreement. The court permitted the Attorney General to pursue the breach of fiduciary duty claim.

The court defined fiduciary duty as comprising a duty of loyalty requiring the fiduciary to place the interests of the other party over its own, and a duty of care requiring the fiduciary to act with "complete good faith plus the exercise of reasonable intelligence." The Attorney General had argued that the "business judgment rule," which protects corporate officers and directors from liability stemming from good-faith business judgments reasonably believed to be in the corporation's best interests, did not apply in the context of charitable entities. The court disagreed, stating that under Massachusetts law, the business judgment rule expressly applies to officers and directors of charitable corporations. The result is that to find a breach of the fiduciary's duty of care, the fiduciary must act in bad faith or with clear and gross negligence.

NEMC claimed that Lifespan breached its fiduciary duty to NEMC by failing to re-negotiate some of NEMC's commercial health insurance contracts to include inflationary increases in reimbursement rates, failing to jointly negotiate other contracts along with Lifes-

pan's Rhode Island hospitals and failing to share Lifespan's Rhode Island hospital reimbursement rate information with NEMC. For example, Lifespan allowed two national payor contracts held by NEMC to be "evergreen"and thus to be renewed automatically each year without any inflationary increases in rates. The court ruled that these were "clear and gross" departures from the standard of conduct a reasonable party in NEMC's position could expect from its fiduciary, and thus violated Lifespan's fiduciary duty of care to NEMC.

NEMC also claimed that Lifespan breached its fiduciary duty through the actions of its CFO in urging NEMC to engage in an interest rate swap transaction involving Morgan Stanley. The transaction was initially proposed by a Morgan Stanley broker who had a longstanding business and personal relationship with Lifespan's CFO, a relationship which was never disclosed to NEMC. When NEMC's CFO objected to the proposed transaction and requested a second opinion as to its fairness, the Lifespan CFO both denied NEMC's request for competitive bidding against Morgan Stanley and insisted NEMC engage a financial advisor chosen by Lifespan to render the fairness opinion. This fairness opinion was not provided to NEMC until after it had entered into the interest rate swap. The court found that these acts by Lifespan's CFO breached Lifespan's duty of loyalty to NEMC and rejected Lifespan's argument that disclosure of a conflict of interest is only required if that non-disclosure unjustly enriched the fiduciary.

While this sad tale of a bad corporate marriage might be limited to its facts, particularly the fact that it was the Attorney General who was pursuing the fiduciary duty claims on behalf of a non-profit hospital, there is reason to believe that its lessons could apply more widely. Fiduciary duties are not limited to relationships among tax-exempt entities. They can apply wherever one party cedes significant control to another in an affiliation or other corporate structure. Health care providers who enter into such arrangements must now pay much closer attention to how the network operates to support the purposes and interests of all participants, not just of the system itself. As provider networks expand, balancing these varying interests will become more problematic and, given the Lifespan decision, more legally hazardous.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, whose practice concentrates on health care and non-profit law.

Worcester District Medical Society's Spoken History Project

An Interview with Ralph Monroe, MD

Paul M. Steen, MD

This is an excerpt of an interview with Dr. Monroe in 1995 conducted as part of a series of interviews with practicing physicians called the Spoken History Project. Dr. Monroe was an internist practicing in Southbridge, Massachusetts and passed away after a long practice at Harrington Memorial Hospital. I've chosen quotes from his early days in practice in the 1960s.

"When a new physician came to town, he would make an appointment to visit all the physicians in town separately and go in and introduce himself, describe his training, and general situation, and kind of get acquainted. It's unheard of today."

"I made hospital rounds about 7:30 in the morning, came back to town to make house calls until lunchtime. I usually went back to the hospital and then had office hours from about 1:30 or 2:00 until 6:30, had supper, and went back to the office until 10:00 or 11:00."

"I carried a bag that weighed about fifty pounds and had it in the car. I had an EKG that I carried around, and so you had to have your medications and basic emergency equipment with you. So you learned a great deal. I didn't see much of my family, though, and I didn't make much money."

"So we decided in the early 1960s to establish a coronary care unit. We discovered that it was not considered profitable for a small hospital to have a coronary care unit. So we got acquainted with the man who invented the first cardioverter in Boston. His chief resident took us under his wing and educated us [about] what was known at that time about cardiovascular intensive care. We came back and established a coronary care unit and it was very exciting."

Ralph, who was my mentor and associate for many years, had a lot more to say and his words can be read in their entirety in the full transcript of the Spoken History Project.

Message Scarier Than the Crime

Dianne Williamson

Harvey Fenigsohn, 70, is a former English teacher at The Bancroft School who now works at the UMass Medical School's Lamar Soutter Library. Today, I'll let him tell his story, in his own words.

Just in case I forgot my religion, someone recently reminded me. Not long ago, I discovered a three-letter word scratched on the passenger door of my car. The three letters spelled the word JEW, which is what I am. I was shocked at the vandalism, but even more alarmed, and, yes, maybe even frightened, at what had been written. I quickly sensed that I was not merely a victim of vandalism. I was also most likely the victim of an especially vicious kind of crime ~ a hate crime. Who had done such a thing, and why? As far as I knew, or at least as far as I thought, I had no known enemies, much less anti-Semitic ones.

The police officer who inspected the damage concluded that the damage was indeed a hate crime. He would file a report and advised me to be on the lookout for any more such incidents in my neighborhood, though he had not known of any recently in the Worcester area.

Friends and family shared my concern and offered their opinion. Like me, they reached either one of two different conclusions as to what motivated the vandalism. In one scenario, an anonymous vandal, unaware of my religion, chose my car at random to mar with an insult. The perpetrator, maybe not even aware of the implications of his action, committed an aimless act of vandalism not specifically directed toward me and not knowing he had vandalized a Jewish man's automobile. A few held this opinion, perhaps because they wanted to help me feel better in thinking the act was arbitrary and not personal.

A majority, however, concluded that it was no accident that my car had been vandalized. They believed that not only did the vandal know it was my car, he or she also knew my religion. Thus, the vandalism was an act of harassment ~ hatred aimed squarely at me. I wanted to believe the former but dreaded the latter opinion was true. But I soon understood that the fact that the vandal may not have known me or my religion was not the point.

The point was that the vandalism was an attack on every person of the Jewish faith. In the city of Worcester, in the year 2011, an act was committed that might have well been committed in the city of Berlin, Germany, in the year 1939. At that time, German Jews were forced to wear a yellow Star of David along with the word JUDE, the German word for Jew, the same that had been scratched on my car door.

But this was America in the 21st century. How could I think that the mere scratching of a three-letter word on my automobile was the beginning of a pogrom, a term describing mob attacks against Russian Jews? Yes, times are different now, but then I remembered that this was the same country where not that long ago Native Americans were slaughtered and their land stolen. It was the same country where human beings were bought and sold like animals. It was the same country where these same people were lynched for having the wrong skin color. And it was the same country where loyal (Japanese) American citizens were herded into concentration camps.

Nevertheless, I reminded myself of how much progress this nation has made in eliminating prejudice and discrimination, and of how far we have come in guaranteeing justice for all. After all, we have become a nation where a black man could become president, and no longer are people of his race forced to ride in the back of the bus.

But there it was, clearly etched into my car door, a simple three-letter word, clearly reminding me of how little we have accomplished, and of how far we have to go.

Reprinted with permission from the Telegram and Gazette.

www.telegram.com/article/20110726/COLUMN01/107269864
Local & Regional News
Tuesday, July 26, 2011
Dianne Williamson can be reached at dwilliamson@telegram.com.

Note: Harvey Fenigsohn regularly writes book reviews for Worcester Medicine and for the Humanities in Medicine website at the University of Massachusetts Medical School Library.

WDMS Remembers Its Colleagues

Elliott M. Marcus, TUSM MD
1933-2011

"Dr. Elliott M. Marcus, TUSM MD '58, was an emeritus Professor of Neurology at the University of Massachusetts Medical School and a former Professor at Tufts Medical School. Born in Bridgeport, CT to Bessie and Kalman Marcus, he was valedictorian of the Danbury High School class of 1950. He was a scholarship student at Yale and graduated magna cum laude with distinction in psychology in 1954.

He graduated in 1958 from Tufts Medical School, where he was a junior member of Alpha Omega Alpha. He received postgraduate training in medicine at Yale (Grace) New Haven Hospital and in neurology, neuropathology, and neurophysiology at Tufts New England Medical Center and Columbia Presbyterian Hospital. While at Columbia, he met his future wife, Dr. R. Nuran Turksoy, and became a supporter of women in medicine.

He was passionate about the teaching of neuroscience and neurology. He established the neuroscience teaching program at Tufts. In 1976 he moved to UMass Medical School and to St. Vincent's Hospital in Worcester, where he organized an academic neurology service.

After his retirement in 1998, he continued to teach neurology to students and residents. He received numerous teaching awards at Tufts and UMass and published many research papers in the field of epilepsy. He co-authored four neuroscience textbooks with his dear friend, Dr. Stanley Jacobson.

He was the founding president of the Mass. Neurological Association in 1978 and served as MNA president again in 1995-1997. He was an active member of the American Neurological Association, the American Epilepsy Society, and the American Academy of Neurology and organized the AAN's annual "Neurology at the Movies" session.

He loved sailing, reading about history, exploring archeological sites in Turkey and Greece, attending baseball games with his grandson Zachary, and sharing amusing anecdotes with family and friends, preferably over a good meal. We will all miss his great wit and generous spirit. (www.legacy.com/obituaries/telegram/obituary.aspx?n=elliott-m-marcus&pid=152792399)

Dr. Elliott Marcus' obituary highlights his many great achievements and attributes. He was a real presence for years after his retirement here at St. Vincent's Hospital ~ both to students and residents during teaching conferences. He had the traditional Socratic Method, from which everyone benefited. He also remained a vital member of the Board of Directors for the MA Neurologic Association. The annual educational meeting will be named in his honor. Mostly, his viability, intelligence, humor and enthusiasm for what he did in his career and retirement will be missed.

On a personal note, Elliott was my first attending neurologist when I started on the wards in July, 1975 as a neurology resident. He continued these many years as a colleague and friend. I cannot overstate his influence on my professional practice. Not many physicians can say that they have so benefitted from their physician peers.

Thomas F. Mullins, MD

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