Folks,

To prevent patient complaints about having to wait too long in your waiting room, to the waiting room, add mirrors.

Below is a resource for your patients considering using emergency contraception medications. Resource warns which other meds the patient may be on that might prevent the results desired.

http://www.medscape.com/viewarticle/869116?nlid=109344_2863&src=wnl_dne_160923_mscpedit&uac=23073EY&impID=1202284&faf=1

Several of you have pointed out that three of our Roman Numeral Pages were incorrect in Sentinel #129. So, get out your DSM-5 and make the following three corrections:

Page xxi, Avoidance restrictive food intake disorder should be F50.89, not F50.8

Page xvii, Disruptive mood dysregulation disorder should be F34.81, not F34.8

Page xxiv, Gender dysphoric in adolescence and adults should be F64.0, not F64.1

As we know, ICD-10-CM has many more psychiatric conditions than DSM-5. A number of you do fine work using only ten or less diagnoses year after year. Others like to use many different diagnoses, attracted to the specificity of not only the syndrome and signs but also identifying the etiology that is captured with Z-codes. For the latter clinicians, we have developed the attached eleven-page listing of the psychiatric disorders NOT selected for DSM-5, that is, the “F” codes not in DSM-5. Since these non-DSM-5 codes are available to the other specialties, I assume they are available to us.

A couple of ICD-10-CM notes:

1] ICD-10-CM often lists more than one acceptable name for a condition. For example, you have a patient that fits borderline personality disorder, F60.3, a condition regarded in some circles as meaning that the person is very unpleasant. For F60.3, ICD-10-CM also lists:

a] aggressive personality disorder,
b] aggressive personality,
c] emotionally unstable personality,
d] explosive personality, or
e] explosive personality disorder.

So, you can use one of these five instead of “borderline personality disorder.” Actually, you may find that you are in a code-only setting, that you can select a name not even in DSM-5, a name you regard as most actuate, most therapeutic. This reminds me of a Washington School of Psychiatry faculty member, who said he wanted to stress the uniqueness of his patients, and named the condition after the patient. For example, in providing psychotherapy to George Sampson Jones, he would tell the patient that he had, "George Sampson Jones Disorder."

2] You also may want to select a name in DSM-5 that does not involve a long, hard-to-follow, explanation. For example, F48.2 Pseudobulbar affect can be hard to explain. “Involuntary emotional expressive disorder,” is also available for F48.2 in ICD-10-CM. You may find it easier to explain "involuntary emotional expressive disorder" than "pseudobulbar affect."

“One in three patients with mental disorders die by suicide within 3 months of discharge from an inpatient psychiatric unit” [Medpage, 23 Sep 2016]. While we want to be careful and not claim we know how to prevent suicides, we can note that suicides were very rare among “discharged” Anacostia patients at Saint Es in the 1960s and 70s.” I put “discharged” in quotes because the patients were still being treated by the same clinical team, whether they were inpatient or outpatient, as Saint Es stressed continuity of care in those years, especially its program for Anacostia folks. Controlled studies may find that continuity saves lives. Maybe even a retrospective study might find that clinicians who followed their patients when their patients during their hospitalizations, had a decreased suicide rate than those who did not.

The results of the Match of medical students into their specialty interest finds that of the twenty-one specialties, medical students going into psychiatry and family medicine came in last as to test scores, but we know that they would come in first in two categories not tested: altruism and wisdom.

Roger