

Reflections from the editor-in-chief on 20-year tenure

JOSEPH H. FRIEDMAN, MD
joseph_friedman@brown.edu

I HAVE BEEN THE EDITOR-in-chief of the *Rhode Island Medical Journal* (RIMJ) since January 1999 and will leave this position in December 2018, making an exact 20 years. The journal is small, reflecting, in a very positive way, the small size of the state. We have one medical school and a signif-



icant percentage of the graduates stay here after graduation. The smallness encourages a sense of belonging, since the degrees of separation between individuals, especially doctors, is always small. It is virtually impossible for one doctor not to know a second doctor who knows a third doctor.

The journal has been, I hope, a friendly presence. Unlike the national journals which generally hope to either compete with the *New England Journal of Medicine* (NEJM) or take its place within the niche of whatever specialty it represents, and measures success by its impact factor, the RIMJ has always sought to encourage local health professionals to communicate with each other. We encourage junior faculty, fellows, residents and students to submit their work. We view the RIMJ as a training ground for health professionals with an interest in research or publishing for various reasons. We often offer issues with a theme, in which the guest editor, sometimes a junior faculty member,

can organize an issue, write an article, and gain the experience of encouraging others to write, editing someone else's manuscript and adding a few lines to his/her CV. Learning how to critique someone else's work in a way that is helpful and not hurtful requires either a natural talent or a learned

expertise that usually comes from having been on the receiving end of the criticism. Being told that your work is trash is an experience that makes one gentler and more understanding when critiquing someone else's submission. It is not our approach. We try to improve submissions to make them sufficiently well written to merit publication.

I did not apply for the editorship. The late **STANLEY ARONSON, MD**, in addition to having been the founding dean of the medical school and a weekly contributor to the *Providence Journal*, had been editor-in-chief of the journal for several years. When he decided to give it up, notices went out, primarily, I think, in the journal itself. I believe that other announcements were also sent out to be posted in appropriate venues. After a period of time, and when no one applied, Stan, on bumping into me unexpectedly, asked me to take this on. On the one hand, it's always flattering to be asked to do something, especially something that can sound prestigious, even when it's

not, but, in this case, more importantly, it was a request from Dr. Aronson himself. He thought I could do a good job. I could not turn him down (I now have the Stanley Aronson, MD, Chair in Neurodegenerative Disorders at Butler Hospital, which was not a quid pro quo for accepting the editorship). I learned a little later that the editor's position might not last much longer as the journal had long been going over budget. I was told that I needed to cut down on expenses. I was given a strict page limit and a year to bring the journal around. We did that, which was one measure of success. Stan told me that I should consider myself as successful when I was able to reject a submission because of poor quality, without having to worry about not having enough manuscripts to fill each issue. In days gone by, the journal often reprinted articles from other journals.

Obviously, the journal, sponsored by the Rhode Island Medical Society, has survived, although sometimes only barely, due to financial challenges. In an effort to constrain printing costs, we gave up our print edition in 2013, and now send an email blast with a link to the journal to more than 10,000 people who are registered professionally with the Rhode Island Department of Health. In 2017, readers accessed about 40,000 pages of the Journal archived online (rimed.org/rimedicaljournal-archives.asp). Annually, the Journal attracts approximately 25,000 readers, not only in the state, but worldwide.

The bulk of my job is not in deciding what to publish, but in editing submissions to improve them. We don't aim to compete with national journals but we do aim to make the articles, which often are case reports, research involving small numbers, descriptions of new techniques or therapeutics newly available in Rhode Island, that the uninformed medical public may think are only available in Boston. We had the first minimally invasive spine surgery in New England, the first gamma knife and still the only psychiatrist-neurologist in New England who is a specialist on psychogenic seizures and movement disorders. (Since I'm a neurologist I know about these things, but not the special advances in other fields, but am sure there are many.)

I'm pleased with the journal, and hope we'll find someone to replace me, perhaps you, who will bring the journal to a higher level, although not by sacrificing the mission of serving the medical community of our state. ❖

[Thanks to Mary Korr and Patrick Sweeney, MD, MPH, PhD, for the data.]

Author

Joseph H. Friedman, MD, is Editor-in-chief of the *Rhode Island Medical Journal*, Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, chief of Butler Hospital's Movement Disorders Program and first recipient of the Stanley Aronson Chair in Neurodegenerative Disorders.

Disclosures on website

Figure 1. Published contributions to the RIMJ from faculty, fellows, residents, and students, January 2016 through November 2017.*

Medical Department/Division	Faculty	Fellows	Residents	Students
Medicine	67	3	7	29
Emergency Medicine	32	1	3	1
Orthopedic Surgery	27	0	2	2
Pediatrics	25	0	1	0
Neurosurgery	16	0	1	1
Ophthalmology	13	0	2	6
Neurology	11	1	1	0
Public Health	7	0	0	0
Psychiatry	6	0	3	0
Family Medicine	6	0	2	6
Medicine/Pediatrics	4	0	0	0
Plastic Surgery	4	0	0	0
Hematology-Oncology	3	1	1	3
Pediatric Orthopedics	3	0	0	0
Infectious Disease	3	0	0	0
Geriatrics	3	0	0	1
Pathology	3	1	2	1
Pediatric Endocrinology	3	0	0	0
Hospital Medicine	2	0	0	0
Medicine – Cardiology	2	0	0	0
Urology	3	0	0	0
Radiology	1	0	1	0
Rheumatology	1	0	0	0
Dermatology	1	0	0	1
Surgery	1	0	0	0
Community Health	1	0	0	0
Endocrinology	1	0	0	0
Adolescent Medicine	1	0	0	0
Totals	250	7	26	51

Insurance News that's Beneficial for Medical Professionals

Medical professionals now save on their business and personal insurance through the Rhode Island Medical Society's exclusive partnership with Butler & Messier.



Contact Robert A. Anderson, AAI at 401.272.1050 – randerson@rimsibc.com



EXCLUSIVE INSURANCE PARTNERS

Home & Autos | Boats | Umbrella Liability | Flood | Business Insurance
1401 Newport Avenue, Pawtucket | 1085 Park Avenue, Cranston
405 Promenade Street, Suite B, Providence
butlerandmessier.com

When the competent patient refuses personal care

HERBERT RAKATANSKY, MD

ARTHUR (NOT HIS REAL name) was a 45-year-old paraplegic admitted to the hospital for pneumonia. At home he required full-time care for routine personal care including body turning to prevent bedsores and cleaning and hygienic care of bowel function. After a prolonged hospital stay he refused to have the necessary personal care. Personal care refers to the activities of daily living such as but not limited to: basic hygiene, dressing, moving about, eating, etc. From another viewpoint personal care are those activities not covered by Medicare.



Consequently Arthur started to develop bedsores, and sanitary issues due to bowel function became major concerns. It might be argued, however, that the repositioning was medical care (rather than personal care) as it was due to a medical condition, paraplegia.

During this time he remained alert and lucid. His attending physician and a consulting psychiatrist agreed that he had the capacity to make decisions about his medical care. (Arthur had recently been a patient in a local hospital.)

Both medical ethics and legal standards agree unreservedly that persons with the capacity to make decisions may refuse any and all medical treatment, even if the lack of treatment will exacerbate illness and lead to death.

Capacitated, competent people may make the same decisions about non-medical, personal care. But are health-care facilities (HCFs) obligated to follow them in all circumstances?

It is clear that persons in our society may refuse personal care – even to the point of remaining

homeless. Persons may continue to smoke and drink alcohol even when such activities are life threatening. An exception occurs when such behaviors threaten the well being of others. We restrict smoking in areas where second-hand smoke may affect others. We may deny alcoholics the right to drive. The state has the power to isolate persons with certain contagious diseases. People may choose to live in what most would consider unacceptable social and sanitary conditions. Some people believe that those choices result from mental illness. In our society, however, we endorse a diversity of life styles. Should we assume that a patient in a HCF who refuses personal care is de facto mentally ill and therefore does not have the capacity to refuse personal care?

It may be argued that there is an assumption that when a patient is admitted to a hospital or other health care institution they have agreed to basic personal care (not medical care) as a condition of admission. One observer

has called this assumption the “web of understanding.” This agreement, however, is not spelled out. The general consent I signed upon being admitted to a local hospital in the past contained no mention of personal care and review of the current consent form reveals no change.

HCFs should have a policy that all patients will receive appropriate personal care, regardless of their decision to receive medical care and interventions. During the process of being admitted to the HCF (in non-emergency situations) this policy should be explained and acknowledged in writing by the patient or proxy.

Most cases of refusal of personal care are resolved directly by the nursing staff. Communication with patients to reassure them of the compassion felt for them and reassurance about protecting their privacy is essential.

Sometimes cultural and/or religious beliefs may be the reason for refusal and attention to these issues is appropriate (same gender care-giver, etc.). Racial bias of the patient should not be tolerated but harm to the patient must not result (see [Addressing patient biases toward physicians](#), RIMJ December 2017).

What happens if a patient continues to deny consent for personal care? An English study reported that “there is evidence that nurses will administer the care in the absence of consent.” Presumably this is compassionate care administered for the benefit of the patient and

to decrease risk to other patients (from unsanitary conditions, etc.).

Another report documents a rise in legal actions against nursing homes. Bedsores and falling are major reasons for the lawsuits. It is not clear how many patients in this review received substandard personal care because they refused it. It is likely that almost all, if not all, patients either desired care or lacked the capacity to decide to reject care. After all, patients enter nursing homes to get good care. There is the additional possibility that poor care of our senior citizens might be interpreted as elder abuse. In this case regulatory agencies may become involved, with adverse effects on the HCF. In any case, HCFs are under significant legal pressure to provide high quality personal care even if the patient refuses it.

In today's paradigm of shared decision-making in medical care decisions, there is little place for strong persuasion by doctors for patients to accept specific medical treatments. But that model may not apply to the decision to accept basic nursing and personal care. Provision of high-quality personal care is fundamental to the proper running of a HCF. In my opinion, it is quite acceptable for the nursing staff to be persuasive in their efforts to convince the reluctant

patient of the benefits of compassionate personal care.

The staff of HCFs usually can solve such situations but a process to resolve difficult cases should be in place. As mentioned above, institutions should have a written policy about this issue.

The policy should specify that a health care proxy may not refuse the provision of personal care. First, the proxy has decision-making power over only medical care. Second, in an analogous situation it is established policy in at least one RI hospital that a proxy may not withhold pain relief (though the patient, him/herself may do so). Thus only the refusal of personal care by a capacitated patient would be problematic.

If a capacitated patient continues to refuse personal care after diligent nursing intervention and attempts at persuasion, etc., family meetings, consultation with the ethics committee, appropriate clergy, friends and others would be the next steps.

If all these steps fail to reverse the decision of the patient, a plan for essential personal care should be developed, taking into consideration both the patient's safety and the safety and functioning of the HCF. Since touching a person against their wish is legally

"battery" it is important that the HCF legal counsel be involved at this point. This individualized plan ("The Plan"), respectful as much as possible of the patient's requests and of the cultural background, as well as the needs of the HCF should be instituted.

When such a case (admittedly very rare) arises, the HCF policy should designate a process to approve "The Plan" for the specific patient. Approval by the chief of service and/or the ethics committee, for example, could accomplish this end.

This approach balances our ethical goals both of respect for individual patient autonomy, and the principle of Justice, which considers the health and welfare of the greater community, in this case the HCF.

Arthur's plan might include sanitary care only after defecation, turning only as much as necessary to prevent bedsores, etc.

The medical care team must remain true to its mission, the care of the patient, even when the road is a bit rocky. ❖

Author

Herbert Rakatansky, MD, FACP, FACG, is Clinical Professor of Medicine Emeritus, The Warren Alpert Medical School of Brown University.

Increase your **REVENUE**

Do you have a financial policy in place?

Having a strict policy will not only protect your office but also help the patient.

Sending monthly statements may not be enough:

Most times an office may think that sending a monthly statement can be enough, but is important that you try to make verbal contact with your patient so you have the chance to explain the amount owed and why.

When is it the right time to get a 3rd party involved:

If your office is not having success with communicating with the patient. Collection agencies have the man power to be on the phone throughout the day while you are focusing on your day to day office needs. Keep in mind the longer you hold onto the debts, the harder it is to collect.

In collections, *time really is money*. The value of your accounts receivable decreases rapidly over time. Studies show that once receivables are older than 90 to 120 days, their value drops 25 - 50%. In medical practices, accounts receivable over 120 days average 16%.

Take control over this issue today!!



Exclusive Collection Agency for



**RHODE ISLAND
MEDICAL SOCIETY**

For a free consultation
call Carmella Beroth at
508-553-1916 or visit
www.debtmanagementinc.com



“COLLECTING THE UNCOLLECTIBLE”

Clinical Challenges in the Growing Medical Marijuana Field

JONATHAN BARKER, MD

ABSTRACT

Unique clinical challenges arise with the growing number of patients who possess medical marijuana cards. Medical marijuana patients with mental disorders can have worsening symptoms with marijuana use. Often there is sparse continuity of care between the patient and the medical marijuana practitioner. Lack of communication between the patient's treating practitioners and the practitioner who has authorized the medical marijuana can be problematic. This article is a discussion of the new clinical challenges practitioners are likely to encounter with the growing number of medical marijuana patients.

KEYWORDS: cannabis, cannabinoid, cannabidiol, medical marijuana

BACKGROUND

According to an article published in the Providence Journal in 2015, the number of Rhode Island medical marijuana patients increased from 4,849 in 2013 to 11,620 in 2015.¹ The Rhode Island Department of Health issued a statement entitled, "Minimum Standards for Authorizing Medical Marijuana," on September 30, 2011.² This statement expressed that "The Rhode Island Department of Health (HEALTH)'s Board of Medical Licensure and Discipline has concerns over its ability to safely regulate the management of patients seeking authorization for medical marijuana." Physicians who choose to authorize medical marijuana cards should be aware that the Massachusetts Board of Medicine recently suspended the license of two physicians due to their practice of authorizing medical marijuana.³

The endocannabinoid system is extremely complex, and we know relatively little about it. THC is one of more than 60 cannabinoids present in the cannabis plant.⁴ While there certainly may be medicinal properties of cannabinoid receptors, the current practice of dispensing a highly variable drug to the population at large and observing what happens is not only unscientific, it is dangerous. The Institute of Medicine gave the following statement upon review of the clinical uses of cannabis:

"If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their

synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug but rather to serve as a first step toward the development of nonsmoked rapid-onset cannabinoid delivery systems."

Presently, potential clinical conditions with symptoms that may be relieved by cannabis include nausea, wasting syndromes (such as AIDS and cancer), chronic pain, inflammation, multiple sclerosis, some forms of muscle spasticity, and glaucoma.⁵ There is research suggesting that cannabidiol (CBD) has anti-epileptic and antipsychotic properties.^{6,7,8,9,10}

There are special cases of severe conditions, such as treatment-resistant intractable epilepsy or end-stage diseases, for which cannabis extracts may be more beneficial than traditional FDA-approved anti-epileptic medications. However, working with patients who are using medical marijuana, even for appropriate indications, presents special challenges.

For example, I saw two patients in an outpatient, partial hospitalization day program who each reported to me during the initial intake session that they had an outpatient physician prescribing them medical marijuana. Both were daily smokers. One had become paranoid and delusional. The other was manic and had physically assaulted hospital staff. I advised both patients about the dangers of cannabis, and the potential for cannabis to worsen mania and psychosis. I was put in a difficult position when one of the patients responded by saying his outpatient psychiatrist gives him a medical marijuana card. Having two different doctors with seemingly opposing messages about cannabis confused the patient; one doctor saying it was good for the patient, and one doctor saying it was bad.

The following are issues commonly encountered in treating patients who use medical marijuana, and some suggestions for dealing with these challenges:

1. Gaining trust of the patient and forming a therapeutic alliance.

The patient may not know whom to trust. Another doctor with whom the patient has already formed a therapeutic alliance gives the patient the authority to purchase medical marijuana. This means the patient's other doctor thinks marijuana is good for them. The patient likes using

marijuana, and may even be addicted to its use. Now a new doctor tells the patient that marijuana is not good for his/her mental health.

For the patient who is manic with no insight into the mania and enjoys being manic, it is easier to continue with the marijuana-prescribing doctor and fire the doctor opposing the use of marijuana. For the patient who has paranoid delusions that are real in the patient's mind, and now hears that the delusions are being exacerbated or caused by the marijuana, it is easier to trust the marijuana-prescribing doctor.

2. Treating the patient's mental illness knowing that the patient will continue to use marijuana.

If the patient wants to continue to use marijuana but is also accepting treatment, should the doctor agree to start treatment knowing that the patient will continue to use marijuana? A similar question could be asked of a patient who has a stimulant-induced mania and is unwilling to stop the stimulants. Should the doctor treat with antipsychotic or mood-stabilizing medicine to counteract the stimulant-induced mania knowing that the patient has no intention of stopping the offending agent?

3. Contacting the outpatient provider who is providing the patient with the medical marijuana card when the patient does not want providers communicating with the medical marijuana-authorizing provider.

Patients may not give you permission to contact the marijuana-authorizing doctor because they are afraid if you talk to the marijuana-authorizing doctor, they will no longer be able to renew the medical marijuana card from that doctor.

I suggest the following for outpatient providers who are faced with the above challenges:

1. As the new provider, you should be well educated about the research accounting for the dangers and benefits of cannabis in different areas of medicine. I suggest starting the conversation with the patient by acknowledging the confusion he or she might be experiencing. By explaining the science, the patient is more likely to view you as an expert on the subject, which will make it easier for the patient to trust you.

2. I suggest continuing treatment if the patient trusts you enough to start engaging in treatment, but does not want to stop the cannabis use. With treatment, either medication or psychotherapy, the patient may gain a better understanding of the ways in which cannabis is affecting his/her mental health and agree to discontinue its use. The alternative is that the patient may continue the cannabis use without the treatment you could provide.

3. If the patient does give permission to contact the marijuana-authorizing doctor, I would suggest doing so to provide the doctor with information about the patient's mental state

while using cannabis. If the patient does not give you permission, I would suggest not breaching confidentiality unless there is an emergency, because you are likely to drive the patient out of treatment if you do so. Furthermore, marijuana is easy enough to obtain. The patient is likely to continue its use even if you breach confidentiality and the marijuana-authorizing doctor agrees not to continue providing the patient with a medical marijuana card.

Acknowledgment

I wish to thank Edward Silberman, MD, and Devra Barter, MS, for helping with the review process of this manuscript.

References

1. Bogdan J (July 22, 2015). "Number of medical marijuana patients in RI skyrockets." *The Providence Journal*. Retrieved from <http://www.providencejournal.com>
2. "Minimum Standards for Authorizing Medical Marijuana," Board of Medical Licensure and Discipline, September 30, 2011
3. Freyer F, Lazar K (June 3, 2016). "Medical marijuana doctor loses license to practice." *The Boston Globe*. Retrieved from <https://www.bostonglobe.com/metro/2016/06/03/medical-marijuana-doctors-loses-license-practice/L5jRBrby55bFWb8p8AwB6I/story.html>
4. Pacher P, B atkai S, Kunos G. The endocannabinoid system as an emerging target of pharmacotherapy. *Pharmacol Rev*. 2006;58:389-462.
5. Volkow N, Baler R, Compton W, Weiss S. Adverse Health Effects of Marijuana Use. *N Engl J Med*. 2014; 5;370:2219-2227.
6. Consroe P, Wolkin A. Cannabidiol--antiepileptic drug comparisons and interactions in experimentally induced seizures in rats. *J Pharmacol Exp Ther*. 1977;201(1):26-32.
7. Cunha J, Carlini E, Pereira A, et al. Chronic administration of cannabidiol to healthy volunteers and epileptic patients. *Pharmacology*. 1980;21(3):175-85.
8. Porter B, Jacobson C. Report of a parent survey of cannabidiol-enriched cannabis use in pediatric treatment-resistant epilepsy. *Epilepsy Behav*. 2013;29(3):574-7.
9. Jones N, Hill A, Smith I, et al. Cannabidiol displays antiepileptiform and antiseizure properties in vitro and in vivo". *J Pharmacol Exp Ther*. 2010;332(2):569-77.
10. Jones N, Glyn S, Akiyama S, et al. Cannabidiol exerts anti-convulsant effects in animal models of temporal lobe and partial seizures. *Seizure*. 2012;21(5):344-52.

Author

Jonathan Barker, MD, Clinical Assistant Professor of Psychiatry and Human Behavior, Alpert Medical School of Brown University; Assistant Clinical Professor of Psychiatry, Tufts University School of Medicine.

Correspondence

Jonathan Barker, MD
170 Governors Avenue
Medford, MA 02155
216-393-7540
Jonathan.Barker@tufts.edu