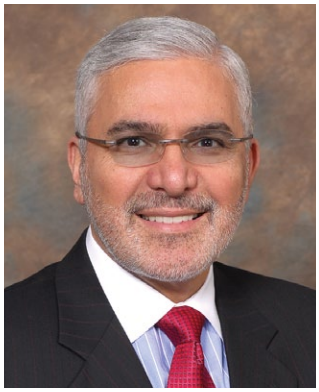

Henry A. Nasrallah, MD
Editor-in-Chief

Do you practice sophisticated psychiatry? 10 Proposed foundations of advanced care

Progress in scientific and clinical knowledge of psychiatry is proceeding at a furious ppace. Psychiatrists have to be diligent to remain on the cutting edge of rapid advances in brain–behavior linkages—keeping up not only with the "what" but the "how" of optimal psychiatric practice.

Some psychiatrists continue to practice as they did 30 or 40 years ago when they completed residency

Some psychiatrists are rapid adopters of the latest discoveries. Others wait before they adopt new modalities and change their practice accordingly. Then, there are some—admittedly, a minority—who stubbornly persist in practicing exactly as they did 30 or 40 years ago when they completed residency.

What are the foundations of exemplary, advanced, brain-based psychiatric care?

Here are my 10 proposed tenets of excellence in psychiatric practice. They reflect superior assessment and management of patients as well as personal growth and contributions to the specialty.

Provide a complete medical assessment for every patient at the first lifetime psychiatric contact, whether inpatient or outpatient. This includes routine physical and neurologic examinations and a panel of basic laboratory tests (complete blood count, liver and kidney functions, urine screen, thyroid-stimulating hormone, electrolytes, fasting glucose, and fasting lipids). All vital signs are measured and recorded. Referrals to other medical specialists are made as needed.

This medical assessment must, of course, include a comprehensive psychiatric evaluation: personal history, social history, medical history, family history, and a complete neuropsychiatric mental status examination.

Create a thorough 3-generation pedigree of all relatives, indicating not only psychopathology, addiction, and legal problems but also medical (especially neurologic) disorders and cause of death.

Perform basic assessment of brain structure and function (a MRI scan, a neurocognitive battery, and tests of neurologic soft signs).

Measure biomarkers that reflect potential harm to the brain according to emerging research—eg, pro-inflammatory markers (such as C-reactive protein [CRP], interleukin-6, and tumor necrosis factor alpha [TNF-α]) and oxidative stress biomarkers of increased free radical activity (superoxide dismutase [SOD], glutathione, thiobarbituric acid [GSH] reactive substances [TBARS], and catalase).

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Maintain measurement-based practice, in which:

- *severity of illness* is measured by a specific, appropriate rating scale (eg, Positive and Negative Syndrome Scale for schizophrenia [PANSS], Young Mania Rating Scale [YMRS], Montgomery-Åsberg Depression Rating Scale [MADRS] for depression, Hamilton Anxiety Rating Scale [HAM-A] for anxiety, Yale-Brown Obsessive Compulsive Scale [Y-BOCS] for obsessions and compulsions)
- *degree of response to treatment* is measured as a reflection of the extent of drop in the total score of those rating scales, which are administered at every visit
- *severity of common side effects* is measured by the Simpson-Angus Scale (SAS) for parkinsonism, the Barnes Akathisia Rating Scale (BARS), the Abnormal Involuntary Movement Scale (AIMS) for tardive dyskinesia, the Glasgow Antipsychotic Side-effect Scale (GASS), etc.

Use tier-1 evidence-based psychiatry (that is, findings from large, placebo-controlled, double-blind studies) to select best treatments. This includes being familiar with:

- principles of meta-analysis
- the meaning of low, medium, and large effect sizes
- for every medication used, the calculation and clinical implications of *number needed to treat* (NNT) and *number needed to harm* (NNH).

Always combine the dual management approaches of pharmacotherapy plus psychotherapy/psychosocial therapy.

Share knowledge and experience gleaned from practice with the community of psychiatrists, including:

- writing letters to the editor about a clinical matter
- submitting case reports or case series for publication
- teaching students or residents at the local medical school (after obtaining adjunct faculty status).

In addition, psychiatrists should educate the public to eliminate misperceptions and erase stigma about mental illness.

Participate in creating new psychiatric knowledge by developing skills to become a clinical trialist, so that you can participate as an investigator in multicenter clinical trials of new medications, or, at least, refer patients for possible participation in ongoing clinical trials conducted at local academic centers.

Engage in effective and continuous life-learning, by:

- attending weekly Grand Rounds at the nearest academic department of psychiatry
- attending national continuing medical education conferences annually
- scanning PubMed regularly (at least 3 times a week, if not daily) for the latest research related to one's patients or to read about advances in one's clinical subspecialty; read the abstracts and download several PDFs a week for subsequent reading.

Some readers will agree with part, but not all, of these proposed components of advanced psychiatric practice. That's to be expected; I welcome your letters rebutting some tenets, or proposing additional ones, of a sophisticated psychiatric practice. After all, sophistication is a journey, not a destination.

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