Laura Roberts (00:14):

Hi. I'm Dr. Laura Roberts, Editor-in-Chief for the Books Portfolio of the American Psychiatric Association, and welcome to The APA Books Podcast. We're speaking today with Paul Summergrad, who's just an awesome leader in American psychiatry. He was the president of the American Psychiatric Association, serving as the president from 2014 to 2015, and for many years, has been the Dr. Frances S. Arkin professor, chair of the department of psychiatry, and professor of medicine at Tufts University School of Medicine. He's the psychiatrist-in-chief at Tufts Medical Center, and he likes multiplicity clearly. He is board-certified in internal medicine, psychiatry, psychosomatic medicine, and geriatric psychiatry, and has put together just an amazing textbook for us on medical psychiatry. He worked with other colleagues, David Silbersweig, Phil Muskin, and John Querques, in putting this together, but I wanted to thank Paul for visiting with us on the podcast today. I think you thought of this book, or you were working on this book while being president of the APA. Is that right? Am I remembering correctly?

Paul Summergrad (01:28):

No, it's actually I've been working on it for about 30 years.

Laura Roberts (01:32):

Oh, you've been working on it for 30 years? Okay.

Paul Summergrad (01:36):

So this is a book that really got gestated, if you will, when I was an internal medicine resident. I was in the Boston City Hospital, which is now known as Boston Medical Center. You know, so I did all the usual general medical things, but when I was an intern, we had an end-of-year intern party, which was kind of raucous, and they handed out t-shirts with the most common admitting diagnoses on a little kind of stick figure person, and it was all kind of really not great in the way people related in some ways to patients, but the most common admitting diagnosis to the hospital was what we called delta-MS, which stood for change in mental status. It was the most common... It was like 28.9% of people who were admitted to the hospital had an altered mental status, and at some point, I began to feel working there, that almost nobody had a normal mental status, so I became incredibly interested in what were the medical disorders that produced neuropsychiatric manifestations. But I was still kind of committed to being an internist, and that was my goal at that point.

Paul Summergrad (02:47):

Then in my second year of medical residency training, they asked me to be chief resident in medicine, which was a big honor, and I ended up setting up Year of Neurology with Marty Samuels at Brigham, and a whole bunch of other things to do in my third year, and then I'd come back in my fourth year and be the chief resident in medicine. And I recognized as I was going through that year, that I couldn't figure out really what specialty in medicine I wanted to be in. You know, was I going to be a neurologist? I didn't think so. Wasn't going to be an endocrinologist. The only thing I was interested in was reading all the articles that said 100% of people with Graves' disease are anxious, and I thought, "That's great. That's cool," you know?

Paul Summergrad (03:35):

And I would be on pulmonary rotations, and I'd find some obscure reference to neuropsychiatric manifestations of sarcoid, you know, tuberculous meningitis. Whatever the topic had to be, it came

clear to me that it was not only related back to psychiatry and neuropsychiatry, but at the same time, I realized that, and eventually I couldn't resist anymore, so I kind of gave in, and I gave in to the pull of psychiatry, but I never forgot that sense of being embedded within medicine, for the fact that there were tons of medical disorders that were somehow connected to the problems that the patients we have, that we see, have.

Paul Summergrad (04:19):

And that's separate from does depression cause increased risk of cardiovascular problems, or do people post-MI, who have a depression, die earlier than people who done, or the role of inflammation in psychiatric illnesses of an idiopathic nature, causing other medical difficulties. This was really just around the things that made people unwell neuropsychiatrically.

Paul Summergrad (04:45):

So eventually, I went to do psychiatry at Mass General, and part of the reason I went to Mass General, which was probably at that point, I would say probably the largest, or if not, close to the largest of the Harvard Medical School training programs in psychiatry, was that it was the most medically oriented, not biologically oriented. That medical component was really about the medical disorders that are connected to psychiatric practice in a variety of different ways. And when I was there, I just kept on seeing all of these patients who had medical manifestations... psychiatric manifestations of their medical disorders, or who were mislabeled as having an idiopathic psychiatric disorder, but actually had an undiagnosed medical disorder of some kind, so I became fascinated with it.

Paul Summergrad (05:33):

And then, I realized that there was a book in the UK literature called Organic Psychiatry, by William Alwyn Lishman, a very famous-

Laura Roberts (05:42):

Yeah, I know that book.

Paul Summergrad (05:42):

... neuropsychiatrist, who just... Yeah, who just passed away. And that book was somewhat more focused on purely on neurology, and I felt that there maybe would be a place for something like this in the US literature, so it's been in my mind for a long time, and finally got to the point where I thought, with the support of you and APA, to be able to produce it.

Laura Roberts (06:05):

It was really neat to see that book develop, Paul, with your leadership, because it was always a big idea, but as it began to evolve, it went from being what we call a professional title, so a nice, solid book on a topic, to being really a much larger endeavor, what we then had it evolve to become a textbook, because we wanted to signal its positioning in our portfolio. It really is a definitive source, and I think really, really came together beautifully. Can you say what you think distinguishes the book, either by its structure, or its content, or your approach, from other books that are out there?

Paul Summergrad (06:58):

Yeah, so here's the way I think of this book, as opposed to, let's say, other great titles, like Jim Levenson's book on psychosomatic medicine, or some of the other texts around psychosomatic medicine, or the Mass General Hospital guidebook of kind of general hospital psychiatry. This is less focused on types of care, meaning therapies. It's less focused on systems of care. It's less focused on important structural issues that relate to care, such as for example, financing, or ethics, or law. Those are all really, really important topics, and it's less focused, although doesn't ignore, the impact of psychiatric illness on medical disorders or the management of comorbidities, which is a different topic a little bit. You can have somebody who has major depressive disorder and they've got diabetes. We've got to figure out what meds to give them. Or they have a psychotic depression, and you want to put them on a medicine that's going to make their blood sugar worse. Those are real problems that need to be attended to, and while some of those come up in different chapters in the book, they weren't kind of the heart and soul of it.

Paul Summergrad (08:12):

What really distinguishes it is how do you approach the patient clinically? That's the first section, so how does an internist approach a patient, how does a neurologist approach a patient, kind of from a bedside examination standpoint? What about cognitive bedside testing? What's the role of neuroimaging? What's the role of toxicology and laboratories? And how do you kind of just begin to approach the patient? Now, I'm conservative this way, so I think the most important way to approach the patient is with humility and paying attention, and spending a moment before you actually enter their room, the old Arthur Conan Doyle approach in the Sherlock Holmes, and Doyle was a physician, and Sherlock Holmes sees, and just looks at them, and of course, he divines all of this stuff about them just by the way their heel looks, and you know, the way their something is worn on their clothing, but it's not quite that, but I think it's really important to just start with how do you approach the patient? How do you keep this kind of stuff in mind? That's number one. And also, when do you kind of, and again, throughout the book, when do you think about a medical disorder, and our literature is not 100%... a neurological disorder? Our literature's not 100% clear.

Paul Summergrad (09:37):

And then I think of the book as, in some ways, a guide for clinicians when they're perplexed a little bit. You know, if they see somebody, and they're thinking about this, where do they go to get some summary information that would then allow them to investigate something more fully? And as I thought about it, I realized that people approach patients, in some sense, based on where they're seeing them and what they know about them, so if you're an internist, caring for somebody, and you've got somebody with Hashimoto's thyroiditis, or you've got somebody who has lupus, and they're beginning to have some psychiatric illness or neuropsychiatric manifestation. If you know that about the person, what else do you need to know about the ways in which lupus, or various neurologic conditions, or Cushing syndrome, or hyperparathyroidism, or any number of other conditions, infectious disorders, et cetera, may present if you look at it through the lens of general medicine and neurology. That's one lens, if you will. That's one portal into this problem.

Paul Summergrad (10:50):

The other problem that comes up, or the other portal, is really, if you're in a general psychiatric setting of some kind, and you see somebody, and they're depressed, and they're not getting better. For example, and I'm going to change factoids around this so I'm not violating any kind of privacy or confidentiality, but I remember seeing someone many years ago, who was a man in his late 40s, early

50s, who had been worked up by one of the very best internists at Mass General and had had seemingly a full panoply of work, and was depressed, or thought to be depressed, and was admitted to an inpatient service.

Paul Summergrad (11:38):

During the course of that hospitalization, he never really got better, and also didn't really get worse, and it wasn't clear that he was actually depressed as we might think about it. You know, he was not feeling well. He had some pain and discomfort. And this was an era when you could actually spend time with people, so it wasn't like a four-day hospitalization. You know, now he would have been probably not even admitted in the first place, but during the second week or so of the hospitalization, I remember going back and talking with him, and going through his symptoms very, very, very carefully.

Paul Summergrad (12:19):

It turned out that he really, he was concerned, he was worried, but he didn't have any of the kind of stigmata that I think of as being more typical for a serious or severe depression. He wasn't preoccupied. He wasn't agitated. He hadn't really lost his sense of pleasure. He could still eat, but he just wasn't that hungry, but he hadn't lost any interest in food, and he began to say that what was really bothering him was pain. And as we investigated his pain, he described boring pain that went through to his back, and I started getting really uncomfortable, and we sent him off for some further imaging. And he had a pancreatic tumor, which he died from.

Paul Summergrad (13:04):

Now, we couldn't save his life. What was valuable was that his family knew what was going on with him, and they had time to spend with him to be able to grieve and to deal with the last days that he had. But it was also important to just... So it was that kind of... And that's from a psychiatric setting. That's where the third part of the book is organized around. Mood disorders, psychosis, catatonia. There aren't quite as many chapters, we probably could have thrown in a couple of others, but those seem to be the major ones, substance use, where if you're looking at somebody through the lens of general psychiatry, when do you begin to question whether your diagnosis is right? And also, if you begin to worry about it from that lens, what are the kinds of medical disorders that are more likely than not to present?

Paul Summergrad (13:54):

So there's a lot of overlap between the two different parts, but there are two different doors, and that's really... And then there's a small section at the end, on things that are really just in the border zone, but those three large sections are really the approach to how to approach the patient, how to approach them within a known medical setting or known medical diagnosis, how to approach them from the standpoint of psychiatry, from-

Laura Roberts (14:19):

[inaudible 00:14:19] Another piece that is very special about this book is that it is so well edited, and has such symmetry across the different chapters, and is so well written, that really someone could sit and read it, just read it straight through, and really learn and benefit from the entire book. A lot of textbooks, I think people grab it as a resource when they've got a question, and then they check in in different sections of the textbook, but I think this is a book that I think trainees, I think a lot of CL physicians, frankly a lot of primary care physicians, could just sit and read straight through, and really, really learn a lot, or put together information that they know into a little bit more of a framework.

Paul Summergrad (15:11):

Yeah. I would hope so. I mean, and again, I think having a reference... And again, so many [inaudible 00:15:21] People have references online, and again, it's a different kind of world. I mean, I'm old enough to remember when we had books chained to the walls in the emergency room, because they were so valuable, and that was actually one of my favorite cases that also helped me think about this field a lot.

Paul Summergrad (15:42):

I was called one night, and again, I'm going to disguise this, to see somebody in the emergency room when I was a psychiatry resident. It was a woman in her 40s, and I was called because they said she had hysterical blindness. I thought, "Oh, that's interesting. I've never seen anybody with hysterical blindness. What do I know about this? You know, I'll go see her," but I'd seen a lot of people who had neurologic, because we took care of all, at Boston City Hospital, the medical center, internal medicine took care of all of acute neurology, so I had taken care of tons and tons of people with bleeds, and strokes, and herniation, and [inaudible 00:16:20] was horrible.

Paul Summergrad (16:21):

So I went to see her. She was lying in bed, and I looked at her, and she had bilateral, widely dilated pupils. And I thought, "That's interesting. That takes some talent if you're going to be able to produce this kind of through some unconscious conflict." I got out my flashlight, and her eyes didn't respond to light. They didn't respond to confrontation or threat. There was no blinking, and I wasn't able to do accommodation, but it was... And these were widely dilated. It didn't look like this was just a little bit of dilation.

Paul Summergrad (17:01):

So, her boyfriend was down the hall. He was also a frequent flyer in the emergency room. He was also in restraints, and I said, "What's with your girlfriend?" And he said, "Oh, her." He said, "She took my pills," and I said, "What were your pills?" He said "Quinine." I go, "Hmm." Now, I knew nothing about quinine, other than it's part of gin and tonics, and they used it in India to deal with malaria, and it's sometimes used for other neurologic conditions. It's used for certain kinds of [inaudible 00:17:37] and some neurologic conditions, peripheral neuropathy, et cetera, I think.

Paul Summergrad (17:43):

Anyway, I go to... We didn't have Google, because we didn't have computers, because we didn't have the internet, so we had these books that were chained to walls, because they were so valuable that if you didn't chain them to walls, people would walk off with them. So there was some book of like poisons and toxicology or whatever, and I go and look it up, and there indeed is retinal blindness. It's a side effect of quinine toxicity. It depolarizes the retina, and you get about 12 hours. It's reversible. You get about 12 hours of blindness. So this woman was indeed blind, and she suddenly went from being a psychiatric whatever to a fascinoma that got sent over to the ophthalmology circles.

Paul Summergrad (18:24):

But the point was it required a careful examination, and it seems to me that that remains the hallmark of this. You can't assume that because somebody else says to you, no matter what their medical background, that they know what's going on, they may not know what's going on. They may be wrong, and we have an obligation, particularly a psychiatrist, because we're trained as physicians, to have that

ability to backstop the system, because so many patients of ours have medical comorbidities. So many patients die early, and we have a... and are often treated terrible in the healthcare system, that we have a particular obligation towards their justice for them, and equity, to make sure that they're being cared for well, in a holistic way.

Laura Roberts (19:14):

You know, I agree with you so much, and worry so much about this, and let me tell you my current worry list. With COVID, I think everyone appreciates the psychological impact of isolation, and stress, and distress, and of course, we're living in a society that's divided and exclusionary, and people are feeling the pain of that, no question. And some people are losing loved ones associated with COVID, so grief is a profound part of life now for so many people, so there's all of these different dimensions, but I... And I'm worried about them. But I'm really also worried about direct impact of infection of COVID on the brain, and the neuropsychiatric consequences that really, we're just beginning to appreciate now. I wondered if you had thoughts on that, and are my co-worrier about that.

Paul Summergrad (20:16):

Yeah, so I worry about this in multiple different ways. One way is that I think our patients, the patients that we have some unique responsibilities toward, is really folks who are homeless, who are [inaudible 00:20:30] who are in and out of forensic psychiatric facilities, state facilities, often which don't have... or even our regular inpatient facilities, which don't have necessarily great ventilation. They don't have negative pressure rooms. They're congregate settings. People are used to walking around, that certainly early on in the pandemic, we were very worried, and with good reason, that the settings... that our patients were at higher risk for getting infected, and I think that that's one piece.

Paul Summergrad (21:05):

There's also been some data. There was an article in JAMA about a month or two ago, suggesting that for folks with schizophrenia spectrum type illnesses, that their relative risk of dying from COVID was about 2.7 times higher than a control population, or even those with other psychiatric illnesses. And then I think there's... That's the second piece. There's a third piece about whether people will have access to testing and all of the other pieces that are needed, and obviously vaccinations, but then there's this other piece, which is really related to the neuropsychiatric and the psychological manifestations, so let me divide those for a second and take the psychological one second. I'll talk about kids in particular.

Paul Summergrad (21:54):

Recently, I've been talking to colleagues in Boston. I don't know what it's like in California or elsewhere in the country. Half the kids on our general pediatric floors at Tufts were kids who were awaiting beds in child psychiatric facility. Half the kids at Mass General Hospital for Children were awaiting beds in child psychiatric facilities, and 50 to 60 kids, between the emergency room and the general pediatric floors at Boston Children's Hospital, were awaiting beds in child psychiatric facilities, and while the Commonwealth of Massachusetts has planned to build new psychiatric facilities for kids, and to support that in the private sector, you know how long that takes to build up.

Paul Summergrad (22:37):

So, why aren't we doing what we did with the care of folks with COVID for our kids, who are our most precious resource? Why are we not surging capacity? Why are we not thinking about using unused

college campuses? Why aren't we coming up with a mechanism where we could use some other unused school, something else? Test kids. Test them, which has been done very successfully in colleges, in Boston and elsewhere, so it's kept the rate of infection incredibly low. Why haven't we surged teachers, or others, or other people, to think about... Why haven't we brought people together to think about how do we provide care for these kids while this is going on? That's one.

Paul Summergrad (23:25):

A second is why are we not more curious about why this is going on? The assumption has been, and I've seen really, really smart and wonderful people that I follow and listen to a lot on the infectious disease stuff related to COVID, and I've spent more time probably reading infectious disease the last year than I have reading psychiatry, and why are we not... The assumption is kids are not going to school. Therefore, they're having difficulty. Well, maybe that's true. That's a hypothesis. It's probably a pretty reasonable hypothesis. It's also a hypothesis that their parents are incredibly stressed, and destabilized from what they're doing, and people have lost jobs, that they know people, their parents and grandparents, are worried, that they're not being able to see people that they care about, that they can't go out and play with their friends in the street and get out, all of the things that kids normally do when they're eight years old or 10 years old, but we ought to be investigating those hypotheses with the same rigor that we're investigating the hypotheses around anything related to COVID.

Paul Summergrad (24:28):

And then I think the third one is what about these neuropsychiatric manifestations? Some of them fall into the kind of postviral [inaudible 00:24:42] kind of picture that you see. Some of them seem to be associated with very, very severe post-traumatic stress disorder, people in such severe deliria in the hospital. Some of them may be atypical catatonic states, that then people are coming back from. But we don't know, and I'm glad that the NIH is now funding a large post-COVID, kind of long COVID... I think it's called post-acute COVID syndrome, a study to look and see what we can understand about what is the brain fog, what are all of those things connected to... There are a bunch of studies.

Paul Summergrad (25:23):

Somebody just asked me this morning, a very thoughtful psychiatrist just asked me this morning. I realized I didn't know the answer to this great question, "What's the risk of having neuropsychiatric consequences if you get a mild infection after being vaccinated?" I realized I have no idea, and I suspect we don't know the answer to it. So I think this is, all of these pieces are going to be very, very important going forward, both the more neuropsychiatric piece, and then these other pieces.

Paul Summergrad (25:51):

And then the other piece is pandemics, historically, reshape the world. They're like wars. They do that. So, people are coming back to a different world than the world that they were in, if we indeed are able to come back, and if the variants are held at bay, if all of our T-cells are happy enough to keep them under control. And we're feeling our way back into all of this, so this is a very... That's yet another piece that's obviously very disruptive. But what concerns me is I don't think I see the kind of level of focus, and surge, and attention on any one of those topics to quite the degree that I think is needed. Maybe the post-COVID piece is getting some attention, but the kids? I think it's scandalous. I really do.

Laura Roberts (26:43):

Yeah. Well, you've really illustrated a lot of the value of being able to think in this medical psychiatry sort of way, just with that analysis, plus all of the experiences you've had, and as I say, in leading the field. I want to thank you for putting this wonderful book together for us. I think it is unique, and it's really valuable. It's beautifully written, beautifully conceptualized. Apparently 30 years in its incubation, but having heard-

Paul Summergrad (27:14):

Well, I had great co-editors, and one of the things that we all did is we had a multiplicity of readers of the chapters, and then we did a fine kind of polish at the end, to make sure that the language was consistent, and some of the exemplars were consistent across the chapters, so that took a lot of work with my co-editors, and I really am incredibly grateful to them, and obviously grateful to all of you at APA for taking this on as a project and being willing to publish it as a textbook.

Laura Roberts (27:47):

Well, that's great. We did a beautiful job, and my thanks to you and your three co-editors. Thank you.

Douglas Noordsy (28:03):

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