Synapse

THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

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Robert N. Sobel, M.D., Editor & Syed Abdullah, M.D., Co-Editor

President's Message: Y2K

What will Y2K bring us? New stationary for our new telephone area code, new paper checks to eliminate the pesky 19__, and something else to blame the winter on (besides el nino or la nina).

Many things will remain the same. Our fight for destigmatization of mental illness, our battles with managed care organizations, and the protection of our professional identity in the face of legislative challenges with scope of practice laws. We need active participation of our members in ongoing recruitment and retention efforts.

A major push will come with the availability of names and addresses of psychiatrists who are not APA members - we'll need your help in efforts to enhance the membership rolls.

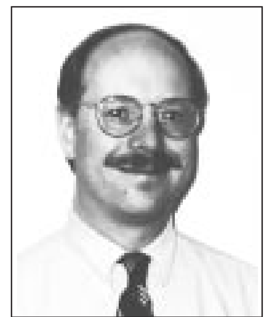
A very significant change will be up for the ballot box in the upcoming APA election. There will be a referendum on the change, of the APA's tax status, permitting the better use of APA funds to promote our profession. I urge you to vote, and to vote "yes" on this question.

Your "yes" vote won't matter if not enough people vote however. Let me remind you that because of voter apathy referendums have failed - for example last year the proposal to change the fellowship membership category failed because a quorum was not reached. Had it passed, it would have made it less cumbersome to become a fellow of the APA, and put the fellowship designation on par with that for other specialty organizations. Your vote does count!

The WHPS Executive Council would like to welcome two new members to leadership positions within our district branch. They are Meryl Rome, MD and Bharati Palkhiwala, MD. Both will work on membership issues. Dr. Rome will be focusing on Early Career Psychiatrists (ECP) and will be our ECP Representative. Dr. Palkhiwala will be focusing on Womens' Issues and will be our Womens' Committee Representative. These two dedicated volunteers will help round out our executive council and improve its diversity and representativeness. We still welcome more active participation from our membership and all are welcome to sample one of our regular monthly meetings - call me for details at 914-398-5595 or e-mail me at citrome@nki.rfmh.org.

Friday night April 14, 2000 will be our next gala dinner-meeting starring Eric Hollander, MD. The exact place will be announced very soon - watch your mailbox. We are grateful to our education coordinator, David Brody, MD, for bringing us these top-notch speakers. Based on feedback from those who attended our last meeting at the IBM Palisades Conference Center, the format will revert back to the traditional cocktail hour-dinner/speaker arrangement.

Start planning to attend the APA Annual Meeting in Chicago May 13 to May 18, 2000. The theme is the Doctor-Patient Relationship. As APA members your registration fee is a small fraction of the fee charged to non-members. You will soon be getting information about hotels and rates. I urge you to consider calling the hotels yourself as well, and ask for the AAA discount - often less expensive than the convention rate! I'm told that flying into Chicago's Midway airport rather than O'Hare will bring you closer to the Chicago convention center at McCormick Place.



This upcoming year promises to serve up some interesting challenges. Together we can work on some of them. Don't hesitate to call upon the district branch, our area council (the New York State Psychiatric Association), or the central APA (toll free for members 1-888-357-7924).

Let me conclude by wishing every one of you a hearty season's greetings, and all the best for the New Year. I look forward to hearing from you.▲

Leslie Citrome, MD, MPH.

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Expert Testimony continued

In my prior column, I spoke about the standard required of experts when testifying about "syndromes" in Psychiatry. I explained that we are required to follow the "Frye rule" which imposes upon us the requirement that what we testify to must have "general acceptance" in Psychiatry.

But there is a newer standard which, while limited previously to Federal Courts, has been drifting down to lower Courts as well and has even in a recent case (Kumho Tire v. Carmichael 119 Sct. 1167), expanded this new requirement from "scientific" testimony to even include "technical" testimony.

The Daubert and Kumho guidelines or factors the trial court should consider in determining whether the testimony will be allowed include:

a) Whether the expert's theory or technique had been tested

b) Whether it had been subjected to peer review and publication

c) Whether there was high "known or potential rate of error" in the method

d) Whether the theory or technique enjoyed "general acceptance" within a "relevant scientific community"

e) And the gatekeeper (the Judge) must ensure that the expert employs in Court, the same intellectual rigor of an expert practicing in the relevant field.

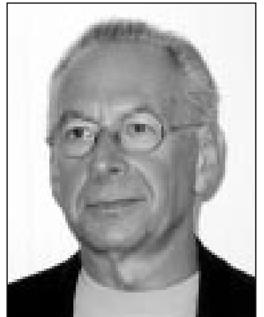
In applying these standards to Psychiatrists, the following should guide your testimony:

a) Opinions should be based on data gathered and observed in the case

b) You should clearly separate raw data from inferences drawn from the data

c) You should consider the methodology you apply in assessing the data and be able to support your methodology and its efficacy

d) You should be familiar with any empirical data supporting what you rely on



e) You should rely on good clinical observations, assessments and experience to support your interpretation of the data

Disregarding generally accepted Psychiatric literature, studies or treatises (like DSM IV) casts aspersions on the whole field of Psychiatry.

I am reminded of a quote by Dr. Seymour Pollack: "In no other branch of Medicine do practitioners attempt so to deny authenticity to clinical procedures and judgements made by their colleagues. In no other medical field do practitioners respond so individualistically and idiosyncratically and in no other field of medicine is reliability so low. Reliability is reflected in credibility".

Additional Information:

Our malpractice carrier - PRMS - has available many "Risk Management Tip Sheets" which they will send you copies of if you call them at 1-800-245-3333, ext. 347. They are very informative. ▲

Alan J. Tuckman, M.D.

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Coming Out of the Shadows: Breaking a Stigma

Once again, despite competition from Game 4 of the World Series, the Public Forum "Breaking the Silence III- Mental Illness Comes out of the Shadows" was a great success!! Over 200 people crowded Town Hall in New City on October 27, 1999 to hear three inspirational speakers! To our amazement, not only was the seating filled inside, but the parking lot was filled to capacity!

Many thanks to our three courageous speakers: Francine Cournos, MD, Ira Minot, CSW, and Trudy Kornfein. Dr. Francine Cournos, a Psychiatrist at Columbia University, who is the author of *City of One: A Memoir* spoke eloquently about how she struggled as a Psychiatrist to come to terms with her own need for treatment (including anti depressant medications). It took twelve years for her to accept the fact that she needed medication to help her depression. She summed it up when she said " You don't have to be mentally perfect to become a mental health provider."

Ira Minot, CSW, spoke about how he used his despair as a tool for personal growth. He is the publisher and founder of Mental Health News, which is a newspaper covering Rockland and Westchester Counties. He also spoke about what it is to be like on both sides - that of mental health provider one year and as patient the next. Depression, he noted, has no boundaries. It strikes all classes, races, and professions.

Trudy Kornfein, M.A., Vice President of NAMI FAMILYA, has a family member who has been hospitalized for years. Trudy touched the hearts of many by speaking about the pain and suffering of the family, as well as their lowered goals and expectations. She emphasized the importance of involvement in support groups such as NAMI FAMILYA.

Special thanks to those who participated in the Forum, including:

1) County Executive C. Scott Vanderhoef

2) Maryanne Walsh-Tozer, C.S.W., Commissioner of Mental Health of Rockland County

3) Dr. Les Citrome, President of West Hudson Psychiatric Society

4) Sherry Glickman, CSW, Co President-elect of the Mental Health Coalition

5) Carol Olori, CSW, Co President, Mental Health Coalition of Rockland County

6) Rena Finkelstein, Co President, NAMI FAMILYA

7) Pat Holbrook, CSW, Co President-elect of Mental Health Coalition of Rockland County

8) Members of the NAMI FAMILYA organization who helped welcome guests.

Finally, thanks to the audience for challenging questions and for coming out to support the forum. Your presence gave a message to the community of the importance of promoting good mental health even if it was Game 4 of the World Series.

I would like to give special recognition to Dominick Ferro, MD, Rena Finkelstein, Gerry Trautz, and Diane Polhemus who did an excellent coalition College program at Dominican College on December 1, 1999. It was a well received program and both the students and teachers appreciated the first hand stories from consumers, family members, and professionals who courageously shared their personal experiences with mental illness. We will also plan along with other groups a Picnic for Parity and additional college programs.

The coalition is now looking ahead to planning for May 2000- Mental Illness Awareness Month. Some of our projects include a Program for Business in Rockland County on Understanding of Mental Illness. Every year, the coalition chooses one group to educate about mental illness. Past year's groups have included the clergy and police. Each project has been well received.

Our next meeting is January 13, 2000 at 12 noon in the Building F conference room at the Rockland County Department of Mental Health. We welcome new members and look forward to having more Psychiatrists participate in the coalition! ▲

Lois Kroplick, D.O.
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Medicare Billing

Many of you may have recently received a request from Medicare for copies of your office notes. I perceived this to be a violation of patient confidentiality and so promptly called Seth Stein, at NYSPA. I learned that Medicare has been doing this as part of an audit, as they have done in other parts of the country. They do have the right to these notes if your patients signed the Medicare form, as nearly all do. The good news is that the audit is a time limited effort and requests for your notes will not persist into the future for very long. The take home lesson: be circumspect about what you put into your notes. Meet documentation requirements and whatever additional information you need to keep track of your work. Don t put anything else in a note that could one day be read by many others.

Several years ago Mr. Stein spoke to our district branch on Medicare billing and advised that we could bill for both a psychiatric evaluation (90801) and medication management (90862) on the same day. I recently received a denial of this from Medicare. Mr. Stein confirmed that in 1999 Medicare changed their policy and you may not bill for both on the same day. Keep abreast of Medicare policies, which are constantly changing.

PRODUCTIVITY

I recently undertook a limited study of psychiatrists productivity in response to the issue arising in my work at Helen Hayes Hospital. This consisted of a limited literature search, contact with a few colleagues to see what the standards were in their institution and finally a sample of my own practice to see how efficient I was in the privacy of my own practice.

LITERATURE SEARCH

The world's literature is meager on the topic of psychiatric productivity. In a study of psychiatric staff in a general hospital in Denmark, 32% of total work time was used for direct treatment and a further 32% for indirect treatment (conferences etc.)

"Using 2/3 of the total work time available for treatment is acceptable." Sogaard & Lindhardt

"From our work...we have estimated that the typical psychiatrist has about 28 (70%) hours of time available per week to provide direct patient care" (Faulkner & Goldman).

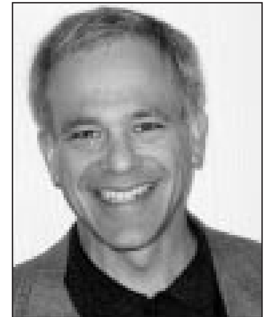
Atkins created a computer program to predict staffing requirements of psychiatric programs in mental health facilities. Using the graphs found in Atkins article we at Helen Hayes Hospital would require 11 to 17.25 FTE to properly staff only our inpatient units. We currently have 7.25 staff who also provide a considerable volume of outpatient service.

Personal contacts with other psychiatric programs revealed: In the OPD at St. Lukes Hospital, NYC, psychiatrists are expected to spend 50% of their time in face-to-face patient contact. This is a clinic for chronic psychiatric patients. There is on average 1 new patient monthly for each psychiatrist.

The Outpatient Clinic at the local Community Mental Health Center has a 65% productivity standard for the staff which is rarely met due to frequent No-Shows and other impediments to 100% productivity, similar to our inpatient and outpatient programs. This staff does no "intakes"; that service being provided by a separate Intake Unit.

PRIVATE PRACTICE

I calculated productivity during two fairly representative and separate weeks in my private practice. I added up all the hours I spent in practice related work. This included patient contact, telephone calls I could recall, paper work, supervision, reading, accounting etc. It did not include listening to professional tapes in the car or informal consultation with colleagues, etc. I found I spent 54% of my time one week and 57% another week in direct patient contact. I used to consider myself very efficient. I may have to reconsider that.



What does this mean for reimbursement standards? How do we fare compared to our medical colleagues? Are my productivity findings the same as yours in the privacy of your offices? I d love to hear from others about the "efficiency" of their work. ▲

Faulkner LR & Goldman CR, Estimating psychiatric manpower requirements based on patients' needs. Psychiatric Services. 48(5):666-70, May, 1997.

Atkins RM, A computer based model for analyzing staffing needs of psychiatric treatment programs. Psychiatric Services. 46(12):1272-8, Dec, 1995.

Goldman CR, Faulkner LR & Breding KA, A method for estimating psychiatrist staffing needs in community mental health programs. Hospital & Community Psychiatry. 45(4):333-7, April, 1994

Sogaard U & Lindhardt A. Physician time and the direct contact with patients at Roskilde County Hospital Fjorden. Ugeskrift for Laeger. 159(17):2546-50. April 1997.

James Flax, M.D.

Psychological Services for Patients with HIV & AIDS

Psychiatric and psychological manifestations of the Human Immunodeficiency Virus are complicated, multifaceted and multifactorial and can represent nearly the entire DSM IV. Evaluation and treatment of this population requires teamwork of professionals familiar with the disease.

There are several important ingredients involved with the provision of effective clinical services to individuals diagnosed HIV+/AIDS.

Chief among these is recognizing that the HIV+/AIDS client population is not really one population at all, but in actuality several population groups, each with its own unique characteristics and needs. These characteristics and needs must be taken into account as they effect the individual s response to an HIV+/AIDS diagnosis. However, disenfranchisement, stigma, and poverty are common denominators among all the different sub-groups. A diagnosis of HIV+/AIDS further exacerbates these conditions.

Thus, successful therapeutic intervention is built on the foundation of the fulfillment of an individual s basic needs for food, clothing, shelter, human connection and adequate medical care. Therefore, the first step in clinical treatment is to conduct a thorough assessment of the individual s needs and if necessary refer the client to an HIV/AIDS specific community agency for case management assistance in establishing access to concrete resources. The clinician must also gather and interpret HIV-related medical information such as date of diagnosis, stage of disease, t-cell and viral load data, and HIV medication regimen. This assessment process can provide a clearer picture regarding psychosocial functioning and needs. Thus, a clinician is better equipped to determine the degree to which emotional symptoms, such as depression, are attributable to advanced disease progression, medication side effects, psychosocial and environmental factors.

Clinical treatment issues stemming from the HIV+/AIDS diagnosis itself include coping with: self-blame, guilt and shame; self-image or persona disintegration (especially as related to sexuality and gender identity); emotional and behavioral responses to anticipated and actual stigmatization; struggles related to dependency and autonomy; problems related to trust, disclosure and hiding; life-style changes resulting from an often reduced and debilitating energy level; dissonance related to one's peer group; loss of, or altered dynamics in, significant relationships; grief related to the loss of one's future dreams and plans pre-HIV+/AIDS; the meaning and purpose of one's existence; spiritual crisis.

Unfortunately, as life does not exist in a vacuum, treatment is further complicated by the presence of concurrent psychological problems, marital/family problems, trauma (physical, mental, sexual abuse), chemical dependency, unresolved developmental tasks, other chronic medical illness, etc.

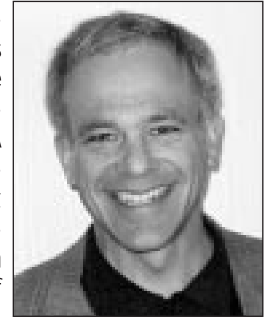
HIV enters the CNS soon after infection. In early infection 22% of asymptomatic individuals may demonstrate significant impairment on neuropsychological testing, especially slowed information processing and reduced verbal memory. In late infection, impairment is found in 60 to 90% of individuals with 20-30% found to have dementia and 43-65% to have delirium.

Depression is extremely common and must be differentiated from effects of treatment, fatigue, associated medical disorders and the psychological reaction to diagnosis and living with the disease. Psychotropics have complicated interactions with antivirals. The facts of this are evolving as quickly as new psychotropics and antivirals hit the marketplace. Bipolar disorders, mania and anxiety disorders are also very common and have the same complications of differential diagnosis and treatment interactions.

Various pain syndromes are found in 30-80% of individuals with HIV and AIDS and increases with disease progression. The incidence is comparable to those with cancer. It is often undertreated due to lack of recognition, histories of substance abuse, etc.

Psychosis can be seen due to the medical complications of the disease process, illicit or prescribed drugs and psychological reactions to living with the disease. Treatment consists of selective removal of offending agents and the medical & psychological treatment of psychosis.

Generally, the duration and intensity of treatment episodes waxes and wanes in accordance with medical and psychological crises resulting from the disease and concurrent factors. A clinician must understand that client no-shows and cancellations often reflect a period of remission of symptoms from the disease, or conversely a period of intense illness or cognitive impairment, rather than resistance to treatment . It is also essential that the individual become part of an HIV-related support group as soon as possible to provide the support and tools necessary to increase coping ability.



AIDS-Related Community Services (ARCS) offers a comprehensive HIV/AIDS focused Mental Health Program to individuals infected and affected by HIV/AIDS in our community. Its services include assessment, individual and conjoint therapy, psychotherapeutic group services, and psychiatric evaluation and treatment through a linkage with Helen Hayes Hospitals Psychiatric and Behavioral Medicine Service and their Attending Psychiatrist, James W. Flax, MD, a specialist in HIV/AIDS-related psychiatry. For more information about this program please contact Nancy Bushinsky, CSW at (914) 356 - 0570.

ARCS is a community-based agency that provides HIV/AIDS case management and support services to the seven counties in the Lower Hudson and Mid-Hudson Valley region of New York State. ARCS mission is to allay fear, reduce transmission of HIV/AIDS, and ensure access, equity, and justice for people affected by HIV/AIDS-related illness in order to maximize their quality of life. To this end, ARCS offers the following confidential programs:

HIV/AIDS Confidential HIV Testing and Pre-Test Counseling
Mental Health Case Management
Intensive Case Management to Medicaid eligibles and their families
Transportation
Food Pantry
Community Education

James Flax, M.D.

Dr. Small of WHPS in Nepal as Fulbright Lecturer

Dr. Arthur Small, a psychiatrist in Rockland County and a faculty member at the NYU School of Medicine spent from January to June 1999 in the Nepal as a Fulbright Visiting Lecturer.

Nepal, a country of 20 million people has approximately 20 practicing psychiatrists- none of whom has any formal training on Child or Adolescent Psychiatry. And this, in a country of approximately 9 million children and adolescents. Most research studies of various countries have shown that approximately 10% of the child and adolescent population are in need of some kind of psychiatric care. This means that Nepal's at-risk population is about 900,000.

As part of his assignment in Nepal, he taught "Principles of Child/Adolescent Psychiatry" to the psychiatric staff at Tribhuvan University, Institute of Medicine. He also established a Child and Adolescent Psychiatry Division within the Department of Psychiatry and started a child guidance clinic.

He taught Psychiatric Residents, Psychology Interns, and Pediatric Residents. Dr. Small also participated actively in the Adult Psychiatric training program by attending the weekly Grand Rounds, Case Seminars, and Case Conferences. He was a consultant to the Child Guidance Clinic which he founded in Nepal.

Dr. Small found the Physicians in the Department of Psychiatry to be bright, well-read and eager to learn. Problems in Nepal included a lack of adequate space for a clinic and no provisions for a children's in-patient psychiatric service.

Dr. Small commented that "the diagnostic problems we have seen in Nepal are similar to the ones we see in Western society, but in differing proportions. Unfortunately, as Nepal becomes more developed, the social and psychological problems of developed countries will inevitably follow- such as divorce, drug abuse, teenage pregnancies. Only with proper educational and financial planning can Nepal be in a position to satisfactorily cope with these predictable difficulties.

Dr. Small is a true role model for all psychiatrists. He was able to give generously of his time and talents to develop a Child Psychiatry program in an area of the world so greatly in need.

Dr. Small is to be commended for his extraordinary work in Nepal. ▲

Lois Kroplick, D.O.

Don't Forget to Vote... in the upcoming Apa Elections!

The Legacy of Franz Anton Mesmer

When Francine Shapiro, a California psychologist, came up with her Eye Movement Desensitization Reprocessing' or EMDR, the memory of Franz Anton Mesmer was revived in many critical observers. Shapiro took her healing show on the road to popularize it even though her professional peers were looking at her claims with skepticism, some denouncing it as pseudoscience. She offers an ingenious explanation of why her technique works: the rhythmic stimulus, she claims, whether it is hand-waving or a moving light or a tone sounded from one ear to the next, works like an external pacemaker to shuttle memories from one part of the brain to another. James Herbert, associate professor of psychology at Alleghany University in Philadelphia, finds her claims just preposterous based on anecdotal evidence without any scientific proof. Shapiro, undaunted, presented her paper on EMDR at the Annual meeting of the American Psychological Association in 1994. Recently the Association has added the technique to a list of "probable" treatments for some disorders.

In the late 18th century Mesmer, on being ridiculed and dubbed a charlatan in Vienna, moved to Paris with his road show, attracting a large following among the general public, and angry denunciations from the medical establishment. Philippe Pinel had arrived in Paris at about the same time and had started his project for unchaining the inmates of the Insane Asylums. Pinel attended the public demonstrations of Mesmer, was impressed by the power of psychological persuasion, but could not accept the theoretical claims that a magnetic fluid flowed from the therapist to the patients.

Faced with such denouncements, Mesmer gathered together a band of disciples whom he taught his techniques and indoctrinated them to practice and spread the doctrine of animal magnetism' and its immense therapeutic powers in a variety of illnesses. Francine Shapiro has a dedicated band of followers who claim that inducing eye movements, from side to side, by making the patients follow the finger of the therapist, resolves longstanding neuroses, specially those associated with trauma. And this, she claims, is achieved in a remarkably short time. Like Mesmer, she has gathered a large following of former patients, and of practitioners trained by her. She claims to have trained more than 23,000 therapists from 53 countries. She has published two books on the subject, one of which "EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma" (Basic Books), is geared to the general public.

In 1778 Voltaire had died leaving behind his doctrines of rationalism and reasoning. These were turbulent times in France in the midst of political upheavals and a chain of revolutions. The American war of Independence was concluded and the representative of the new Republic, Benjamin Franklin was in Paris to negotiate treaties with the friendly French authorities. On March 12th 1784, the Academy of Sciences appointed a committee led by Jean Bailly and consisting of such prominent persons as Lavoisier, Guillotin (the surgeon who invented the beheading contraption named after him!), and Benjamin Franklin. Mesmer refused to be examined by such a committee, instead, a disciple of his Dr. Delson appeared before the joint committee of the Academy and the Faculty of Medicine. Bailly, the revolutionary Mayor of Paris and a scientist in his own right, presided over the deliberations of the committees.

On August 11, 1784 the joint committees submitted their report written by Bailly which concludes, "The committees, aware that the magnetic fluid could not be noticed by any of our senses, that it had no effect on the members of the committees, nor on the patients who were submitted to it; having assured themselves that the touchings and the pressures, (applied by the magnetizers), caused changes rarely favorable to the animal economy and disturbances always harmful to the imagination; having finally demonstrated by decisive experience that imagination without magnetism produces convulsions and that magnetism without imagination produces nothing, (the members of the committees) have unanimously concluded in regard to the question of the existence and usefulness of animal magnetic fluid that such fluid does not exist and therefore cannot be useful, that the violent effects seen in public treatments result from the touching (of the patients), from the imagination which is set into action, and from the machine of incitement, which we must admit against our own desire is the only thing that impressed us. At the same time (your committees) feel obliged to add the following observation which they deem important: the touching of patients and the repeated excitement of the imagination to produce crises may prove harmful; the spectacle of the crises is equally dangerous because of that imitation of which nature, it seems to us, made a law; consequently, any public magnetic treatment cannot but have at length very harmful results." (Incidently, Bailly was later guillotined for unrelated political reasons).

Pinel, though not a member of the committee, commented humorously "I am a little inclined to prescribe to the ladies the charming maneuver of magnetism. As to men I repulse them harshly and send them to a drugstore." In reality however, Pinel incorporated the psychological manipulations of suggestion and persuasion in bringing about recovery in patients under his care as he banned the use of such procedures as chaining, bleeding, purging, cold baths, and other harsh methods.

Despite these denunciations, Mesmer continued his work with a passion and zeal which made mesmerism a clinical and popular movement in all of Europe. Mesmer

Continued on last page

Mesmer..continued

wrote very little and had a limited interest in objective investigations. Jean Martin Charcot started his studies in hypnotism many years after the Joint Committee's denunciation of Mesmer's methods. Charcot, a neurologist, used methods remarkably reminiscent of the techniques of Mesmer, without the latter's theories of animal magnetic fluid originating from the stars. Freud learned from Charcot the use of hypnotism as a therapeutic and investigational tool. Thus the elements of mesmerism survived into the modern theories and practices of psychiatry.

Under various guises and purposes mesmerism retained its hold on many clinicians of repute. John Elliotson, professor of medicine, in 1837, in the University of London, was so impressed by the performance of mesmerism that he resigned the Chair of Medicine at St. Thomas' Hospital and devoted himself to magnetizing. He organized the Mesmeric Infirmary and with friends started a journal, The Zoist, in which reports of surgery performed under anesthesia induced by mesmerism were published. James Esdaile, in 1846 published "Mesmerism in India, and Its Practical application in surgery and medication."

Mesmerism was brought to the USA, in the middle of the 19th century by a French magnetizer, Charles Poyen, who gave public seances of magnetism. P. P. Quimby attended the seances and obtained his ideas of faith healing which he successfully applied on Mary Baker Eddy in 1861, curing her of hysterical paralysis. The direct historical and psychological continuity from Mesmer to Christian Science is striking. The influence of this trend pervades the charismatic Churches of America, where seances and trance states are practiced for religious and healing purposes. The modern day alternative methods of healing include the laying on of hands, which are embellished by the theory of a field of energy surrounding, pervading, and flowing in and out of all living things.

The work with hypnosis brought into focus the existence of a class of mental disorders that did not qualify to be labeled as psychosis. A group of disorders were thus recognized, that we now call the neuroses. It was realized that people suffering from these were not insane and did not belong in the Asylums. The effectiveness of mesmerism, and later hypnosis, in the understanding and treatment of the neuroses, accounts for its enduring popularity. The present fascination with the use of magnets for relief of arthritic pain has gained acceptance among athletes and others. This has triggered a resurgence of interest among the advocates of alternative medicine into the mysteries of the healing process and the invisible' energies that bring these about. In brief, the influence of Franz Anton Mesmer lives on and is reincarnated in every era defying the rational explanations of the miracle of healing. The mesmeric impulse has continued unimpeded in the direction of new knowledge and clinical discoveries. ▲

Syed Abdullah, M.D.

From the Editors:
Best Wishes for a Joyous, Healthy and Prosperous New Millenium!

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