Synapse

THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

Published Bimonthly

September-October 1999 EDITION

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

President's Message: Happy Birthday Synapse!

This year marks the 10th anniversary of our official newsletter, the Synapse. Congratulations to Robert Sobel, MD, our editor, and to Syed Abdullah, MD, our co-editor. The Synapse has excelled and has won several awards from the American Psychiatric Association. This is remarkable for a district branch of our size. Our 150 members should be proud!

A lot has happened in the past 10 years. The state hospital system has been squeezed down from 20,000 to 6,000 beds in New York State. Managed care has altered the fabric of private practice. Hospital stays are measured in fractions of a day. Residency positions have decreased. Licensing bills seek to expand the scope of practice of non-physicians. At times we feel we are fighting for our professional lives.

This has also been the "Decade of the Brain". Knowledge of brain structure and function has been growing by leaps and bounds. Brain imaging techniques have shed new light on psychiatric disorders. Psychiatric treatments have emerged that have given new hope for so many, and in so short a time. Clozapine became available in the United States in 1989, and despite the difficulties with blood monitoring, has resulted in countless improvements in the lives of those with "refractory" schizophrenia. The newer atypical antipsychotics, risperidone in 1994, olanzapine in 1996, and quetiapine in 1997, have given us new choices to offer. Antidepressants have also undergone a revolution, with fluoxetine leading the way. These SSRIs and others have opened up treatment opportunities for patients who otherwise would never have come forward, or for whom the side effects of the older medications would have been intolerable.

We have made significant efforts towards the destigmatization of mental illness. Since 1992, our district branch has conducted annual depression screenings at local shopping malls in Rockland and Orange counties. Literally hundreds of people have completed the screenings, with some seeking treatment for the first time. Thousands of others have passed by the booths and picked up literature to bring home to their family and friends. This year will be no exception, with National Depression Screening Day scheduled for Thursday, October 7, 1999.

By partnering with other mental health providers, the WHPS has led the field in the development of the Mental Health Coalition of Rockland County. Created in 1996, the work of the coalition has involved schools (from elementary to college), the police, the clergy, and the general public. These activities have involved presentations from psychiatrists, family members, and patients, as well as events such as the ever-popular "Picnic for Parity". The goal has been to dispel myths, to inform, and to educate. The coalition has received national recognition, culminating in the APA Public Affairs Network Award in 1998. Get ready for the Third Annual "Breaking the Silence" presentation at the Clarkstown Town Hall on Wednesday, October 27, 1999, where we will hear from noted psychiatrist Francine Cournos, MD, author of the autobiographical work "City of One", published this year to rave reviews.

These past ten years have seen a wide variety of district branch meetings featuring a diversity of lecturers. We've been host to Nancy Andreasen, MD, PhD (editor of The American Journal of Psychiatry), Harold Eist, MD (then President of the APA), Richard Surles, PhD (then Commissioner, New York State Office of Mental Health), Tom Gutheil, MD (noted Forensic Psychiatrist), Ian Shaffer, MD (then Vice-President, Medical Affairs, American PsychManagement Inc.), and Thomas Maeder (author of "Children of Psychiatrists"). Our next meeting is scheduled for Friday, October 15, 1999, at the IBM Palisades Conference Center, where we will hear from our own Alan Tuckman, MD, Forensic Psychiatrist for Rockland County.

In the past decade, our methods for communicating have changed. Home computers are commonplace, with the internet connecting all of us by e-mail and web-pages. If you misplace your printed copy of the Synapse, you can retrieve an electronic version at the WHPS website at <http:// www.rfmh.org/whps>, where you will find all back issues to January 1997. Need to look up a colleague or make a referral? You'll find our district branch referral guide "on-line" too. You can also look at <http://www.nyspsych.org/referral/index.html>, the New York State Psychiatric Association's on-line searchable database.

Where will the next 10 years lead us? I foresee new treatments, new understanding, and new hope. This newsletter will continue to reflect our organization, our profession, and our desires. We all look forward to another decade of faithful service from the Synapse. ▲

Leslie Citrome, MD, MPH.

In This Issue...

▲ *Pg 2-3 Looking Back at Newsletters*

▲ *Pg 3 Public Affairs*

▲ *Pg 4 Testifying About Syndromes*

▲ *Pg 5-8 The Terminally Ill Patient*

Looking back at Newsletters

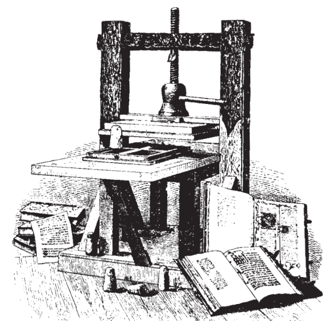
The first newsletter published in North America was in the beginning of the 18th Century. Mr. John Campbell noticed that the news of arrival of ships and the related commercial and travel information were disseminated by word of mouth - a most unreliable, inefficient and slow method of communication. Being a man of ingenuity and enterprise, John Campbell launched his newsletter titled The Boston News Letter in 1704. He was a versatile and resourceful man of remarkable dedication. He wrote the articles, selected the illustrations, set the type, did most of the printing job and maintained a list of mailing addresses - all by himself. To this day the success of a Newsletter is dependent on this quality of versatility in the editor, who must work with limited budget, little or no advertisements and a paucity of staff support.

The history of publication of newsletters is linked with man's innate urge to communicate his thoughts, ideas and the perception of beauty to others. The cave paintings go as far back as thirty thousand years depicting in simple pictographs, powerful images of animals and people, the story of man's struggle to survive and to pursue truth and beauty. Over thousands of years the pictographs evolved into letters and alphabets leading to the emergence of a class of professionals called scribes, who meticulously recorded significant events and thoughts of their times. Some of them embellished their work with beautiful illuminated manuscripts.

The printing of books and artwork was invented in Asia in the 9th century. Words and images were carved in woodblocks which were then covered with ink and pressed into paper. This form of printing evolved into a sophisticated artwork which has survived to this day in many parts of the old world.

In the 15th century Johannes Gutenberg, skillfully using movable type, forged by him, started experimenting with refined methods of printing books and pamphlets. He modified the wooden press, used for pressing wines, to devise the printing press. A genius by all counts, he worked under difficult circumstances hounded by money lenders and the guardians of the guilds of Mainz. One of his notable inventions was the use of two colors in the printing process. He also pioneered in the use of oil based ink. The first printing of the Bible in 1450, by his techniques, ushered in the era of the mass production of books that remained the norm until the 20th century! Unfortunately Gutenberg, in the pursuit of ex-cellence, died in financial hardship due to the seizure of his printing equipment by court order obtained by his detractors.

There has been an explosive increase of newsletters in recent decades. It is estimated that there are upward of 1,000,000 newsletters in existence in the country. While many large and expensive magazines and journals are having difficulty in surviving the fluc-tuations in reader interest and the fierce competition for advertisements, newsletters are becoming an increasing presence all over the corporate and professional world. The informal newsletters offer inside information advice and forecasts to a targeted clientele. Simple in format, crisp in style, they are rarely dependent on advertisements. In recent years they have received a boost from the develop-ment of desk top publishing technology and have become increasingly sophis-ticated and highly readable. They have been credited with breaking the barriers of censorship and state control in se-veral dictatorial countries, shaking up the oppressive regimes. In 1977 The Newsletter Association was founded in New York City which now has a chapter in London.



Sketch of a printing press found in Mainz in 1856, which may have belonged to Gutenberg. (Library of Congress)

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Articles published in Synapse represent the views of their respective authors and do not necessarily represent the views of the West Hudson Psychiatric Society or its members.

SYNAPSE designed by Lydia Dmitrieff

Newsletters...continued

Ten years ago here at the West Hudson Psychiatric Society we started publishing the Synapse, in its present format, as the newsletter of the District Branch. Under the able leadership of our editor, Robert Sobel, M.D., and the use of personal computers, we launched this spunky publication on a shoe string budget using the desk top printing methods. This bi-monthly publication has not missed a single issue in ten years. And in this time we have won national awards from the APA almost every year of our existence, including the Newsletter of The Year Award twice! Bob has constantly striven to improve the quality and content of Synapse which is presently being printed in two colors.

The first few issues were printed on xeroxed legal sized paper. In September, 1989 the first issue of Synapse appeared in its present format. There was not much to boast about in terms of its technical qualities but a laudable beginning was made and the endeavor for excellence started.

SYNAPSE

THE WEST HUDSON DISTRICT BRANCH NEWSLETTER

September 1989 EDITION

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

It is no exaggeration to say that Synapse brought the DB to life. Though one of the smallest district branches of the APA, we became one of the most active. The attendance at our meetings and dinners increased significantly as members started connecting and communicating with each other. Members came forward to assume leadership roles in the organization: presently Les Citrome, M.D. is our President; Lois Kroplick, D.O. Pre-sident-Elect and Chair of Public Affairs; Paul Ducker, M.D. Secretary; Andrew Hornstein, M.D. Treasurer; James Flax M.D., Chair, Private Practice Committee; Alan Tuckman, M.D. Chair, Forensic/Ethics Committee; Mark Tarle, M.D. Chair, Government Relations Committee; Jayna Gerber, M.D., Chair Membership Committee; David Brody, M.D. chair, Managed Care and Educational Committee.

These and other members have written for Synapse on a regular basis, sharing their expertise with others. The last ten years have been a decade of challenges and opportunities for our profession and in this our Newsletter has played the role of rallying the members to action and awareness. It has also carried our input into the Area II Council and the National Assembly. Our second decade of publication will triumphantly extend into the 21st century and the New Millennium. ▲

Syed Abdullah, M.D.

Public Affairs by Lois Kroplick, DO

As Mental Illness Awareness Week approaches, the Mental Health Coalition is preparing for the "Third annual Public Forum". This year's forum will take place on Wednesday October 27, 1999 from 7:30 p.m. to 9:30 p.m. at Town Hall in New City, New York. Three excellent speakers are scheduled to share their inspirational and heart warming stories with the audience.

This year's forum is entitled "Breaking the Silence III- Mental Illness Comes Out of the Closet". The three speakers include Francine Cournos, MD, Ira Minot, CSW, and Trudy Kornfein.

Francine Cournos, MD is a psychiatrist, professor, and author of a new book, City of One, a memoir which speaks openly about her experience with childhood bereavement and adult depression.

Ira Minot, CSW, is a social worker and a successful fundraiser, who was struck down by a serious form of depression. He now uses his talents to help others and is the creator and publisher of Mental Health News.

Trudy Kornfein is a retired teacher and Vice President of NAMI FAMILYA as well as a passionate advocate for people with psychiatric disorders. She will eloquently reveal her struggles with mental illness in her family.

This year's forum promises once again to be a great event. County Executive Vanderoff, and Commissioner of Mental Health Walsh-Tozer will give introductory presentations.

A special thank you to the co-chairs for this event- Rena Finkelstein, Co President of NAMI FAMILYA, Carol Olori, CSW, Pat Holbrook, CSW, and Sherry Glickman, CSW.

One of this year's goals is to recruit as many psychiatrists as possible to attend this exciting event !!! Your presence at the Public Forum is important. Please attend!!

The coalition is also planning the Fourth Annual Elementary School Project. This year's project will be at Nyack Elementary School.

The schools at which the coalition performed included: Stony Point Elementary School- 1996; Link Elementary School- 1997; Nanuet Elementary School- 1998.

Each year this project has been a great success. This project will probably take place in the fall.

The West Hudson Psychiatric Society will run depression screenings at Palisades Mall on October 9, 1999.

Anyone interested in participating in Public Affairs or the Mental Health Coalition should contact me (Dr. Lois Kroplick) at 914-364-2428. We look forward to seeing you at our first meeting of the year- Thursday September 16, 1999 at 12 noon in the Conference Room of Building F at the Rockland County Department of Mental Health. ▲

Testifying About "Syndromes"

When psychiatrists testify in Courts, at least at the local and state level (there is a different standard in federal Courts), what they testify to must meet the "Frye-Standard" - a requirement that the procedures they follow, as well as the content of their testimony, must be "generally accepted in the psychiatric community".

A recent example is the "Rape Trauma Syndrome", in which women who have been forcibly raped, present symptoms of a post-traumatic stress disorder. This is then used by the prosecution to rebut a defense contention that the sexual activity was consensual. The prosecution expert testifies that the victim would not have these symptoms it the sex were consensual, and ipso facto, the sex had to have been forcible - thus a rape.

In one case (People v. Taylor), the Court held "That the relevant scientific community has generally accepted that rape is a highly traumatic event that will in many women, trigger the onset of certain identifiable symptoms. We thus held expert testimony of rape trauma syndrome admissible when "offered to explain behavior that might appear unusual to a lay juror, not ordinarily familiar with the patterns of response exhibited by rape victims", (such as delays in reporting the rape or confusion about identifying the rapist).

But the expert cannot testify that the rape occurred or a particular person is the rapist. They can only testify that the victim's symptoms conform with those of known rape victims.

Now, another attempt has been made to utilize a novel "syndrome" to prove that a woman who kills her newborn immediately after its birth, (as in some well publicized cases recently) is not responsible (insanity) because she suffers from "neonaticide syndrome".

At trial, the defense presented expert testimony which tried to establish that;

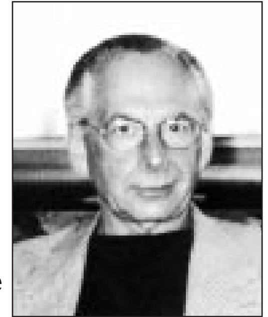
"1. She completely denied the existence of her pregnancy

2. Such denial occurs in almost all cases in which women kill their newborn infants immediately after birth, and

3. In a large number of these cases the women believed that they were not pregnant and suffered from a brief reactive psychosis".

While the Court allowed this testimony, it would not allow the experts to offer evidence that a specific "profile" exists of these women who kill their newborns, since the defense did not first request a "Frye hearing", even not wanting one, which would have determined whether the disease or syndrome or profile was generally accepted in the psychiatric community and that it would assist the jury in rendering a verdict.

Thus, as you can see, while Courts broadly allow any expert testimony which is relevant and would help the jury, it will not allow testimony which does not meet the Frye rule that a novel scientific principle or procedure must be "sufficiently established to have gained general acceptance in the particular field in which it belongs".



This is in contrast to the rule in the Federal Courts, which hold to the "Daubert" standard, imposing responsibility on the trial Judge to determine the appropriateness and relevance of novel scientific testimony (based upon a review of the scientific literature and expert testimony about it) rather than "general acceptance". ▲

Alan J. Tuckman, M.D.
Chairman, Ethics Committee

Doug Ward
Sheila Redmond
John Moynihan

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The Terminally Ill Patient

Sharon L. Sageman, MD is Clinical Assistant Professor of Psychiatry at NYU Medical School and attending psychiatrist at Bellevue Hospital on the Acute Inprtient Psychiatry Teaching Ward. She is also in part-time private practice in general psychiatry. She has published several articles on dealing with patients who have A.I.D.S. She teaches third year medical students psychosomatic illness, death and dying, and psychiatric disability.

Death is not an easy subject to talk about. Woody Allen had a joke about this. He said he's not afraid of death, he just doesn't want to be around when it happens.

Our society is evolving in such a way that death is becoming less of a personal and shared experience and more of an isolated and institutionally based event. The shift from dying at home (80 percent in 1900) to dying in an institution (80 percent in 1980) is a pattern that has reduced direct experiences with death. No longer do most families assist in the terminal care of a member, and rarely are they now involved in preparing the body for burial. Indeed the health care and funeral industries have tended to take over more and more of what formerly was the family's role before and at the time of death of one of its members.

In the 1960's there was a rekindling of interest in the clinical care of the terminally ill. Elisabeth Kubler Ross investigated the coping responses that were involved in patients' adjustment to terminal illness. Based on a study of the emotional reaction of 200 dying patients, she formulated the paradigm of the Five Stages of Dying.

These five stages tend to characterize patients' emotional responses to any major trauma, not just death and dying.

Stage I - Shock and Denial

On being told that one is dying, there is an initial reaction of shock. The patient may appear dazed at first and may then refuse to believe the diagnosis or deny that anything is wrong. Some patients never pass beyond this stage and may go from doctor to doctor until they find one who supports their position.

Stage 2 - Anger

Patients become frustrated, irritable, and angry that they are ill. A common response is, "Why me?" They may become angry at God, their fate, a friend, or a family member. The anger may be displaced onto the hospital staff or doctor, who are blamed for the illness. Patients in this stage are difficult to manage. The doctor who has difficulty dealing with dying patients may withdraw from the patient or transfer the patient to another doctor's care.

Stage 3 - Bargaining

The patient may attempt to negotiate with physicians, friends, or even God, that in return for a cure, the person will fulfill one or many promises, such as giving to charity or attending church regularly.

Stage 4 - Depression

The patient shows clinical signs of depression–withdrawal, psychomotor retardation, sleep disturbances, hopelessness, and possibly suicidal ideation. The depression may be a reaction to the effects of the illness on his or her life (e.g., loss of job, economic hardship, isolation from friends and family) or it may be in anticipation of the actual loss of life that will occur shortly.

Stage 5 - Acceptance

The fifth and final stage is acceptance. The patient realizes that death is inevitable and accepts the universality of the experience. Under ideal circumstances, the patient is courageous and is able to talk about his or her death as he or she faces the unknown. Those persons, who have strong religious beliefs and are convinced of a life after death, can find comfort in these beliefs.

This is a stage that is reached after patients have worked through their emotional issues connected with dying, such that losses are mourned and the end is anticipated with a degree of quiet expectation. It is seen as a restful, albeit weary, time, almost devoid of feeling. One terminally ill patient described these feelings eloquently when he said it felt like he had been the host of a noisy party long enough, and that now he just wanted everybody to go home so he could get some sleep.

Physicians today generally prefer to tell cancer patients their diagnoses. Oken's study of 1961 documented that 90% of responding physicians preferred not to tell patients the diagnosis. When Novack et al. repeated this questionnaire in 1979, 97% of responding physicians indicated a preference for telling the cancer patients the diagnosis. One hundred percent of the physicians said that patients had a right to know. It is usually the physician who is responsible for the difficult task of letting the patients know that they have a life threatening illness. In these cases it 'is often helpful to ask patients certain questions before conveying information to them about their diagnosis, such as:

(1) What have you been told about your illness?

(2) What do you think will happen to you?

(3) How do you feel about it?

Patients often have difficulty in expressing the fears they have about dying, but is very important for these fears to be discussed in order to reduce their anxieties and provide practical solutions. It is important for us to know specifically what the patients are afraid of

Common fears are: (1) fear of pain, (2) fear of abandonment or fear of dying alone, (3) fear of being short of breath, (4) fear of being helpless, (5) fear of guilt and punishment.

It is also important to keep in mind that patients' reactions to receiving a

Continued on next page

terminal diagnosis are usually related to how sick they are at the time that you are giving them the bad news. Patients who are feeling well and living their normal lifestyle are likely to feel very upset and have a very intense reaction to learning that they have cancer or a terminal illness.

On the other hand, patients who have been feeling quite ill and weak, or have lost a lot of weight, or suffered pain for a long time may not be very surprised and upset to learn that they are seriously ill. The perspective of a dying person is something that we can't fully understand. Death is viewed by the health as a horror, but for those who are very sick and suffering it may be a great relief.

Why do we fear death? Rollo May, the famous existential psychologist wrote "death is of course the most obvious form of the threat of non-being." Freud grasped this truth on one level in his symbol of the death instinct. Life forces (or being) are arrayed at every moment, he held, against the forces of death (non-being) and in every individual life the latter will ultimately triumph.

The existential analysts hold that the confronting of death gives the most positive reality to life itself. It makes the individual existence real, absolute and concrete. One student put it, "I know only 2 things - one, that I will be dead someday, two, that I am not dead now. The only question is what shall I do between those two points."

People in a healthy state cannot conceive of death as a positive experience. The perspective is very different however for the very ill and the very old. The very ill may look to death as an end to their suffering. For the very old, who remain alive long after most of most their friends and family have predeceased them, life may feel like a lonely and alien-ating experience.

For the rest of us it is very hard to fathom one's own death and to imagine a world of non-being. Religion helps to ameliorate the threat of non-being. Most religions promise some sort of continuity of existence - whether it's thru the belief in an after life, or becoming part of the cosmos, or rein-carnation into another life form after death. The phrase "rest in peace" assumes that one still exists and is therefore able to experience peace. "May the good Lord bless you and keep you" sounds like an adoption phrase, and conveys that you are both still existing in some form and connected to God.

The presence of cemeteries and gravestones are due to the refusal to acknowledge non-existence. We erect these markers to provide clear evidence of a life which has existed. The uprightness of a monument is an obvious contrast to the decaying body buried flat beneath it.

Aging and dying are anathema in this culture with its focus on youth, vitality and immortality.

When you are well and healthy yourself how do you counsel patients who are dying? Of course this brings up the question of how can you counsel anybody about problems which you haven't experienced yourself. Counselors have to have some sort of analogous intuitive grasp of the experience of a dying person. Death of anything or loss of anything has something in common with non-being and the therapist may be able to draw on their experience of their own personal losses to better understand and empathize with the patients experience of dying.

Once the patient have given up some of their denial of dying, they are in a much stronger position for making choices and for ensuring their autonomy in the process of dying.

Patients can then address questions about their preferences in regards to such issues as how much treatment they are willing to put up with, what's more important to them - staying awake or being pain free, quantity or quality of life, and what they hope to accomplish in the limited time that remains.

As a psychiatrist who has worked with many dying patients, I have experienced this as a very rewarding task in that patients are often very motivated to resolve issues that have troubled them for years, once they know that they are dying and that it is their last chance.

Angry, defensive borderlines or substance abusing patients may finally feel free to let their guard down and

Living Will Declaration

If you want, you can name someone to see that your wishes are carried out, but you do not have to do this.

Name
Address
If the person I have named above is unable to act in my behalf, I authorize the Following person to do so:

Right to Die
250 West 57th Street/New York, NY 10107

INSTRUCTIONS
Consult this column for help and guidance.

Name
Address
To My Family, Doctors, and All Those Concerned with My Care

Sign and date here in the presence of two adult witnesses, who should also sign.

Signed: Date:
Witness: Witness:

Keep the signed original with your personal papers at home. Give signed copies to doctors, family and proxy. Review your Declaration from time to time; initial and date it to show it still expresses your intent.

This declaration sets forth your directions regarding medical treatment.

If I should be in as incurable or irreversible mental or physical condition with no reasonable expectation of recovery, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.

You have the right to refuse treatment you do not want, and you may request the care you you want.

These directions express my legal right to refuse treatment. Therefore I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes, and in doing so to be free of any legal liability for having followed my directions.

You may list specific treatment you do not want. For example:

Cardiac resuscitation
Mechanical respiration
Artificial feeding/fluids by tubes

Otherwise, your general statement, top right, will stand for your wishes.

I especially do not want::

You may want to add instructions for care you do want-for example, pain medication; or that you prefer to die at home if possible.

Other instructions/comments:

Proxy Designation Clause: Should I become unable to communicate my instructions as stated above, I designate the following person to act in my behalf:

participate in an honest and caring relationship with their doctor or therapist. Patients who have been estranged from their families for many years may seek to mend fences with them.

Whatever the contemporary attitudes toward death there are other ways of looking at death, dying and bereavement from the one prominent in the west. There are numerous factors involved in the differences seen in attitudes toward death among different cultures but four major factors are: exposure to death, life expectancy, perceived control over the forces of nature, and the understanding of what it is to be a human being.

Exposure to Death.

Exposure to death and bereavement is the first element in an understanding of death. If one has little experience of the loss of significant others, death attitudes will be limited by that inexperience. Earthquakes in Mexico, volcanic eruptions in the Philippines and Central America, and chemical and nuclear disasters in India and Russia indicate that even the twentieth century is subject to uncontrolled mortality. However, these events create headlines precisely because they are unusual.

In most Western settings, children grow up protected from death. In other parts of the world, the young are exposed to death quite early through war and starvation. Even in the West, exposure varies. Persons living in inner cities, especially those of African descent, may have an awareness of death vastly different from that of most suburbanites. The child whose parents die early, or the child of a funeral director; or an emergency room physician, grows up with a greater exposure to death than does the average North American.

Life Expectancy.

Exposure to death is related to life expectancy. Most babies born in North America can be expected to live to their late seventies. The latter part of the twentieth century is a period of increased longevity and predictable age specific death rates due to fewer neonatal and maternal deaths, better sanitation and food supplies, and improved medical care. The discovery that contagious diseases could be prevented through inoculation neutralized diseases that sometimes killed whole populations in earlier times. Consequently, in developed countries, it is today reasonable to assume that most mothers will not die from infections contracted as a result of childbirth and that most children will live to maturity.

Around the turn of the twentieth century, the death rate was approximately 17 per thousand live population in the United States, whereas in the 1990s the figure is less than 8 per thousand live population. The very old constitute the fastest-growing segment of the population; 10 percent of those over sixty-five years of age have a child who is also over sixty-five. As the population ages, the rate of death will increase, especially because the birth rate is too low to replace those taken by these additional death. Women out live men, as they have always. The age-adjusted mortality rate in the United States, which was reduced by 26 percent for elderly males between 1940 and 1980, was reduced by 48 percent for elderly females in the same period.

Control over the Forces of Nature.

Attitudes toward death are particularly shaped by one's view of the world and one's place in, and perceived control of it.

One who believes that persons are entirely subject to the "laws" of nature will have a death attitude different from one whose view is that he or she has significant control over the forces of nature. In the West the dominant attitude is that nature exists to be used and controlled. Other cultures do not share that view. Those who live on the flood plain of Bangladesh or in the shadow of Mount Pinatubo in the Philippines have a different perception of their relation to nature than do those who move about in climate controlled cars and reside in air-conditioned and insulated offices and homes. Persons who believe they can be "pro-

Continued on next page

Health Care Proxy

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 ______

(1) I, ______

Address ______

hereby appoint ______

Witness 2 ______ (name, home address and telephone number)

Address ______

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decision in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

______

______

______

(Unless your agent knows your wishes about artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration. See page 28 for samples of language you could use.

(3) Name of substitute of fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

______
(name, home address and telephone number)

______

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions-stated below. This proxy shall expire (specific date or conditions, if desired):

______

(5) Signature ______

Address ______

Date ______

Statement by Witnesses (must be 18 or older)

tected" from nature have less respect for the power of nature over life.

Sense of the Individual Person.

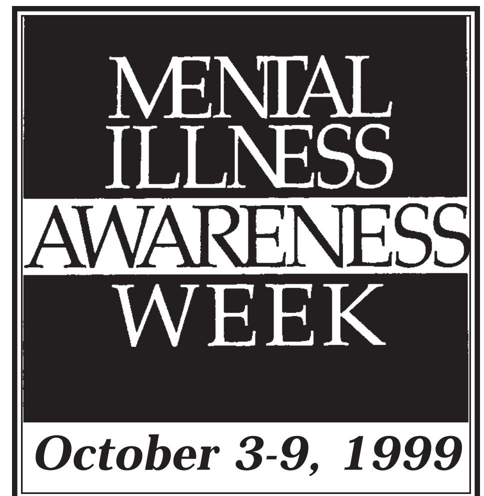
The most important element in the development of attitudes toward death is the perception of what it is to be a person. Most people in the West today believe that the person is unique. In a culture that emphasizes the individual and individual rights, persons will have a different orientation toward death than will members of a culture that perceives each individual as having meaning primarily as a part of the whole, whether religious or political, or perhaps as not having any meaning at all. Those who believe that each life is unique will perceive the end of that life as a different order of loss than those who perceive that a life has meaning only within a whole].

In many non-Western cultures, death is seen as a natural and well-integrated part of life. In Tibet it is commonly held that death is not something that awaits us in some distant future, but something we bring into the world with us at the very moment we are conceived. Our lives run up against death at every step. However, even the seeming finality of death need not be strictly negative; rather, in the religious traditions of Tibet, death is said to provide a unique opportunity for spiritual growth. In fact, the ultimate aim of Tibetan religious practice is the transformation of death into an immortal state of benefit to others. Among Tibet's many and varied religious traditions are found certain esoteric teachings that address the art and science of compassionate death. To these traditions belong the wisdom of the Tibetan Books of the dead.

In many respects, these popular texts are manuals of practical instruction for the dying, who are immediately facing death; for those who have died, who are wandering in the intermediate state between lives; and for the living, who are left behind to continue without their loved ones.

The living will and the health care proxy are important documents designed to ensure that terminally ill persons can receive the type of care they wish to have, or not have, after they have become too incapacitated to communicate their own choices. As of this time the Living Will Declaration is not accepted as law in New York State but the Health Care Proxy is. ▲

Sharon L. Sageman, MD



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