



# Synapse



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

## Managed Care

I recently came across a resource document on the APA website that, despite some mind-boggling bureaucratic neologisms, was quite fascinating and thought provoking. Entitled "Alternatives to Managed Care", the document is a well organized description of the profound changes, for good and ill, taking place in the "health care marketplace". The article is dense enough to defy quick summary - it is well worth reading in full at [www.psych.org](http://www.psych.org) - but I'll try to present some of the highlights, along with some editorial asides.

The good news is that managed care as we know it seems to be dying. At the very least, the main purchasers of health care, such as employers, who pay for nearly half of all health care expenses, and government agencies, are actively looking for alternatives to the current system. Reasons for this include a declining economy over the past 3 years and the realization that the administrative costs of managed care are exorbitant, in the 30% to 50% range according to recent studies. The American health care system as a whole spends twice as much on bureaucrats as does the Canadian system - \$752 more per year for every man, woman, and child in the USA.

Another factor cited by the report is the growing disillusionment of purchasers with antagonistic relationship between managed care organizations (MCO's) and providers (we used to be known as physicians). When MCO's first arrived on the scene about 15 years ago, they promised purchasers lower costs by implementing such business practices as limiting practitioner networks, imposing lower fees, instituting medical necessity authorizations and gatekeepers, and promising economies of scale.

These and other techniques resulted in a 10% reduction in the total value of general healthcare benefits paid out from 1993 to 1998. During this same period, the value of mental health benefits was reduced by a staggering 54%. The readers of this newsletter are all too familiar with how this withdrawal of funding has hurt our field. One sad result is that despite the recognized need for more psychiatrists, and despite the exciting scientific and clinical innovations at our command, too few medical school graduates are choosing to go into psychiatry. I'm not aware of any formal studies on the subject, but onerous, demeaning demands for justification of treatment, coupled with stagnant (at best) incomes, can't have helped psychiatric recruiting.

The good news is that healthcare purchasers are finally growing impatient with high administrative costs, unavailability of providers, and dissatisfied patient/employees that have come to characterize managed care. The bad news is that the alternatives proposed all come with their own worrisome drawbacks. A major current force in healthcare is "disease management", that is the application of "evidence based" medicine and practice guidelines to standardize optimal treatment and thus achieve good outcomes and (presumably) cost savings. Techniques such as patient registries, patient outreach and education, practitioner education, coordination of services, and practice profiling are included in the concept of disease management, as well as prospective payment schemes that pay hospitals and doctors lump sums for given diagnoses.

In theory, disease management approaches can encourage professional excellence

among practitioners and improve access to care and compliance for patients. The quantification of treatments and outcomes allows for continuous quality monitoring and data feedback, which should eventually lead to lower overall costs. It seems to me though that this approach rests on 2 highly questionable premises. First, can psychiatric diagnoses and treatment ever be sufficiently standardized so as to allow for valid "evidence based" criteria. The APA report clearly states that there are many factors beside DSM criteria that need to be considered in formulating a treatment plan - no news to any of us. Second, can those who fund the gathering of evidence, e.g. drug companies, and those who fund the payments for treatment e.g. large corporations, be trusted to be objective and committed to best practices? Unfortunately, the prevailing pattern seems to be that pecuniary interests most often outweigh the needs of patients or psychiatrists. "Evidence based psychiatry" can too easily become a clinical straightjacket that promotes the cheapest



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## Struggling With Suicide

### We all know the statistics:

- The number of completed suicides per year - between 25,000 and 30,000.
- The number of suicide attempts - at least 10 times the amount of completed suicides.
- The risk of suicide increases when there had been prior suicide attempts.
- At least 50% of successful suicides have had contact with a professional caregiver

in the weeks or months prior to the suicide.

- The questionable value of "contracts for safety," in which individuals sign a form agreeing to advise their therapist if their suicidal intentions occur or increase, prior to taking suicidal action.
- The development of hundreds of suicide prevention centers throughout the country, beginning with the Los Angeles Suicide Prevention Center in the early 1970's, apparently having no impact at all on the constant and consistent number of successful suicides through the years.

Unfortunately, all too frequently, therapists feel reassured if their patient has not voiced ideas or intent to commit suicide, when asked, not recognizing that many completed suicide are impulsive acts coming into consciousness only hours or days before the completion of the suicide. Thus, patients who were asked days or weeks or months prior to a suicide about any suicide intent, may make the therapist feel more comfortable and secure but may have little impact on increasing the therapist's awareness of their patient's intentions. Of course, speaking about suicidal thoughts, even in a non-suicidal patient, at least allows therapist and patient to discuss this openly and to have the patient recognize that if they do ever think about suicide, the therapist is quite available to discuss it. This is in contrast to other individuals in these patient's lives who, frequently, avoid those discussions, or, if individuals allude to suicidal thoughts, change the subject or avoid exploring it further. Suicide is such a frightening thought to everyone, much as cancer has, or had been in the past, that it is extraordinarily difficult for most people to confront it (even therapists and other caregivers).

In psychiatric malpractice cases, while psychiatrists may believe that their patient, having made no suicidal statements, or having denied suicidal ideas when questioned, "lets them off the hook," this is not accurate and may still leave the psychiatrist vulnerable to charges of having

missed indicia of suicidal intent or behavior. The denial of suicidal ideas, at a particular time, does not guarantee that the patient will not become suicidal



at some other time. Of course, in many cases, it will be impossible to predict or know that a patient will commit suicide. The law does not require physicians to be perfect or omniscient, but simply to make assessments commensurate with those comparable and appropriately trained and educated physicians.

Yet, in some cases, denial of suicidal ideas at one point, without a further, in-depth assessment of "suicide risk factors," may leave a practitioner open to a charge and a finding of malpractice.

Thus, it is imperative that, in assessing suicidal risk, throughout a course of therapy, we all have some formal or informal scale by which we gauge the potential for a patient decompensating to thoughts of suicide. One of these suicide risk scales is described below. It, by no means, is the only scale that can be used, but it describes quite well many of the factors which must be considered in a formal manner in assessing suicide risk. The law simply requires that a psychiatrist act appropriately, having taken the steps that other psychiatrists would have taken in assessing a patient's suicide. If, while utilizing appropriate methods, the psychiatrist comes to the conclusion that the patient is not suicidal and the patient commits suicide anyway, the psychiatrist, at least, has a solid basis for claiming that all appropriate steps were taken and despite all of these steps, the patient committed suicide. The law does not require us to be infallible, but simply to maintain the appropriate "standard of care."

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Telephone (845) 638-6992

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SYNAPSE designed by Lydia Dmitrieff

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**Suicide, cont'd**

**SUICIDE RISK SCALE**

**A. NATURE OF SUICIDE PLAN**

1. Vague idea and no weapon.
2. A weak plan.
3. Some specific, realistic plans.
4. Complete plan with some details available.
5. Complete plan with lethal details and weapon included.

**B. PRIOR ATTEMPTS**

1. None - is only talking about present time.
2. Some past threats.
3. Numerous past ineffectual attempts.
4. None, but threatens lethal attempt now.
5. Has made lethal attempts in the past.

**C. MOOD**

1. Not healthy, but improves while talking.
2. Controlled, but depressed.
3. Partially controlled - but bursts of extreme mood.
4. Little control of mood, but only moderate ups and downs.
5. Extreme depression, possibly with bursts of screaming or resigned and calm.

**D. SUICIDE METHOD**

1. Mentions suicide, but cannot explain.
2. Specifies a suicide method, but does not have the means available.
3. Has a barely adequate idea with the means available (i.e., freeze to death).
4. Wants to overdose, cut wrists or inhale gas and has means to do it.
5. Wants to shoot self, hang self or jump and has the means at hand.

**E. AGE AND SEX**

1. Young woman.
2. Middle-aged person.
3. Young man
4. Older woman (65+).
5. Older man (65+)

**F. INTERPERSONAL CONTACTS**

1. Has a family, friends and school/job presently.
2. Has a family and school/job, but no friends.
3. Has friends and school/job, but no family.
4. Has only family member(s) or friend(s) for social contact.
5. Has no social contacts (i.e., no family, friends or job).

**G. LOSS: PERSONAL OR SITUATIONAL**

1. No loss incurred or upcoming.
2. Possibility of such a loss (retirement, job, loved one, financial).
3. A loved one has been lost, but does not seem to be chief concern.
4. Loss has occurred or will, and person is upset about it.
5. Loss has taken place or will, and the person is alcoholic and upset.

**H. MEDICAL PROBLEMS**

1. None - in good health.
2. General or vague physical complaints.
3. Has serious physical symptoms but has hope for cure.
4. Have serious medical symptoms.

5. Older person who has serious medical problems.

**I. CHEMICAL/MEDICATION USE**

1. None.
2. Occasional or social use, or meds taken as prescribed.
3. Tends to self-medicate, uses chemicals to cope.
4. Uses impulsively or has history of abuse.
5. Currently abusing or tends to mix substances.

**J. PSYCHIATRIC HISTORY**

1. No psychiatric or suicidal history in the family.
2. History of psychiatric problems in family.
3. History of client hospitalization.
4. Successful suicide in family.
5. More than one successful suicide in family.

**TOTAL SCORE (Sum, of A-J)**

\*Scoring: Low (10-20) Moderate (21-31)  
High (32-50) ▲

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# Elisabeth Kubler-Ross, M.D.: Her Dedication to Death and Dying

**"Dying is nothing to fear. It can be the most wonderful experience of your life. It all depends on how you have lived."  
Elisabeth Kubler-Ross.**

**E**lisabeth Kubler-Ross, 78, a Swiss-born psychiatrist who taught the world how to speak openly about death and dying and whose best-selling book "On Death and Dying" provided a framework for doing so, died on Tuesday August 24th 2004 at her group home in Scottsdale, Ariz.

She graduated from the University of Zurich medical school in 1957. She married a fellow medical student Emanuel Ross, an American neuro-pathologist with whom she migrated to the USA in 1958.

They moved to New York City, where she

became a research fellow at Manhattan State Hospital on Ward's Island.

She was appalled by the treatment of dying patients; they seemed like untouchables, ignored, isolated and avoided. She wrote that dying patients were kept as far away as possible from the nurses' station, and doctors refused them pain medication, fearing they might become addicts!

"Not really knowing any psychiatry," she wrote in her book "Death Is of Vital Importance," "and being very lonely and miserable and unhappy, and not wanting to make my new husband unhappy,

I opened up to the patients. I identified with their misery and their loneliness."

In 1962, she and her husband accepted teaching positions at the University of Colorado medical center in Denver, where she began lecturing on the care for dying patients.

In 1965, the couple moved to Chicago, where she became an assistant professor of psychiatry at the University of Chicago's medical school. She and a hospital chaplain began holding Friday seminars at Chicago's Billings Hospital, with K u b l e r - R o s s interviewing dying patients while hospital staff members, medical students and divinity students watched.

At first, doctors on the staff objected, some of them accused her of exploiting the terminally ill. But she stayed the

course, fired with a determination to make the study of the process of death an integral part of the medical teachings. By 1968 her seminars had become an accredited course. She spoke to a culture that had grown reluctant to discuss death and the experience of dying, and to a medical establishment that considered death an affront to medical science.



She insisted that doctors and nurses treat the dying with respect and dignity. Her work gave rise to hospice care, which allows a person to die at home, surrounded by family and friends, instead of in an impersonal, institutional setting. She also insisted that patients should have a choice about where to die and an opportunity to participate in the decisions doctors were making about their lives.

The interviews with dying patients led her to believe that dying patients go through five psychological phases, beginning with denial. After denial comes anger, at God and the world. Next, the patient bargains with God to postpone fate and then falls into depression. Given time and support, she believed that the patient would arrive at acceptance, the fifth and final phase.

Today, most experts in the field accept the notion of psychological phases, although they point out that the phases are not as discrete, linear and predictable as Kubler-Ross suggests.

Her seminal work "On Death and Dying," based on interviews with about 500 terminally ill patients was an instant global hit. But the University of Chicago, questioning whether her work was valid medical research, denied her tenure. Thereafter she went into private practice

Continued on next page

and continued to write and lecture extensively. She also kept up the pace of her seminars, giving "Life, Death and Transition" workshops around the country. She inspired the establishment of hospices in America and overseas. Today, there are more than 3,300 hospices in the United States, serving more than 1 million people.

Starting in the 1970s, Kubler-Ross's work with dying patients led her to explore the idea that life after death may be a reality. She began emphasizing her belief in reincarnation and a spirit world.

She interviewed patients who had returned from near-death experiences. They told of being in contact with long-dead relatives who also spoke of seeing a light at the end of a tunnel.

As with her famous stages of dying, she theorized that humans experience four stages of actual death: floating out of the body; being converted to a form of spirit and energy; being guided by a guardian angel through a transitional phase; and finally a meeting with the Highest Source, or God.

She claimed "We have enough absolute verifiable knowledge, and once you know this, then you could share this with people."

Her descriptions of out-of-body experiences and her involvement with a Southern California hospice and retreat called Shanti-Nilaya ("home of peace" in Sanskrit) dismayed many who valued her pioneering work on death and dying. She became the focus of ridicules and rejections by the medical establishment. Her focus on the afterlife was so disturbing to her husband that in 1976 he divorced her and raised their two children on his own.

Shanti-Nilaya was nearly destroyed in a fire in 1983, and police suspected arson.

That same year, she established the Kubler-Ross Center, on a 300-acre farm in the Shenandoah Valley, near Head Waters, Va. She also began working with AIDS patients, particularly infected babies. In 1985, when she attempted to establish a home for children with AIDS on the wooded estate, Highland County residents protested. Two thousand people, almost every adult in the county,

signed a petition to keep the center away.

In 1994, that center also burned; again, police suspected arson. Along with the estate went notes, journals and photos Kubler-Ross had compiled over the decades.

She moved to Scottsdale to be near her son, Kenneth Ross. Her former husband also moved to a condominium near Scottsdale, and she and her son cared for him before he died in 1992.

Despite a series of strokes that left her partially paralyzed and near death she continued work on books. Her publications included the following books: *On Death and Dying*; *Real Taste of Life*; *Death: The Final Stage of Growth*; *Living With Death and Dying*; *On Children and Death*; *AIDS: The Ultimate Challenge*; *On Life After Death*; *Life Lessons*; *The Wheel of Life*; *To Live Until We Say Good Bye*; *Questions And Answers On Death and Dying*; *Remember The Secret*; *Working It Through*; *The Tunnel And The Light*.

She moved into a hospice after a fall in 2002. Her son says that when his mother didn't die as expected after the strokes, she told family members she was like a plane that had left the gate but hadn't taken off. He felt she was in the fifth and final stage of the dying experience: acceptance.

Stephen Connor, vice president of the National Hospice and Palliative Care Organization, has paid the following

tribute to her: "By raising awareness and taking it out of the closet, if you will, she brought the taboo notion of death and dying into the public consciousness. We've learned a lot about grief since then; what she taught us is that we have to listen to patients at the end of life. There is no right way to die, but in reality, everybody dies differently."

The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen.

Kubler-Ross

The above words describe Elisabeth Kubler-Ross and her dogged pursuit of the mission she defined for herself. ▲

Syed Abdullah, M.D.

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## Ruminations XX: On Being a Stepchild of Medicine

**"This article is reprinted from the New Jersey Psychiatric Association Newsletter, Summer 2004. Permission granted for its use in Synapse."**

After practicing Psychiatry for almost four decades you would think that I have come to my senses and resigned myself to the fact that Psychiatry is the stepchild of Medicine and we are second-class doctors. But nooooo....I still get irked once in a while when treated like that.

Who should know more about discrimination and second class treatment than me? Haven't you heard of songs written about short people? Poems about Baldies? Movies about Fat people? Jay Leno on Indians? Soon I will join the ranks of old folks too. This is a land of opportunity. A lot of opportunity to make fun of me! Even I make fun of me. The more opportunity you have, the more you lose sight of focusing your attention on the obvious.

As if psychologists, social workers, therapists, counselors and bill collectors were not enough to laugh at us psychiatrists, even urologists and proctologists make fun of us. Just because they make more money than us ("A lot more money, ha, ha, ha"). Every doctor makes more money than every psychiatrist. But is that enough reason to humiliate us? Yet when the same MDs can't diagnose a patient after a million-dollar workup, they call a psychiatrist to turf their challenging patient to us. We are superior, we don't do any procedures, and we are happy sitting and smoking our cigars. We don't believe in getting our hands dirty.

We think we are MDs; does anyone else agree with that? I have stopped telling people I am NOT a psychologist. That reminds me: we write prescriptions but we don't like to admit it. We still embrace psychoanalysis and the unconscious even though more than two thirds of us work in public treatment facilities, a third of our patients have a GAF score of less than 50, and 81% of our patients have a severe mental illness, according to the American Psychiatric Association. The other day a prominent psychiatrist spent a half hour explaining to a mixed audience what the Oedipal Complex is. And I know personally

that this prominent psychiatrist writes an average of 67.3 prescriptions a day.

I am aware of several hospitals in my area whose very survival depends on their psychiatric departments, but fifty percent of their employees, including their senior management, refuse to acknowledge that they have a department of psychiatry (GAF of less than 50). If these hospitals could, they would have the Psychiatrists' Lounge at the back of the hospital, a long distance away from the Doctors' Lounge. A few of them have closed their psychiatric units, others think of doing so when they can't get to sleep at night. The next day they reduce psychiatrists' on-call remuneration by 5% and increase that of the OB/GYNs by 12.4%. They need our patients for their lab and radiology, and medical and surgical procedures, or they would reduce our reimbursements by 107%. They are ashamed to call our department anything that suggests the word "Psychiatry"; instead they call us the Department of Behavior Medicine. We are not treating illnesses; we are changing behaviors (What! With corporal punishment?) Next the APA will soon change its name to the ABMA, American Behavior Medicine Association.

Despite my 34 years of dues to the APA, Medicare still pays us 50% of reasonable charges. So what if they pay 80% to the real doctors? I can't even resign from the APA; they made me a Distinguished Life Fellow and reduced my dues! Although now I think they are having second thoughts.

Lawyers don't leave us alone either. They used to go after deep pockets only; I guess they are getting desperate. In Colorado television ads are urging viewers to call a lawyer if they are taking or have taken Zyprexa ("Because of Zyprexa you must have had diabetic coma, you probably don't remember"), Risperdal ("The only cause of stroke ever"), Paxil ("You have killed yourself, probably you don't know that"), and so on. I have yet to see advertisements to sue for discomfort, pain and expense caused by unnecessary endoscopies, cardiac catheterizations and mammographies.

Religion is not far behind in mistreating us. It used to be that only the Church of Scientology went after us, now it is part of every sermon in every kind of place of

worship; priests of all denominations need more victims for their kind of counseling. I used to advocate that the definition of health should include spiritual well-being too. No more.

If you work in an emergency setting you get a kid-a-day sent from his school because he threatened another kid with a paper airplane, or said to his teacher that he is not afraid of dying, and the whole school went into a tizzy, and are now asking for a written certification from a board-certified psychiatrist that this child is safe to return to school. The same school has a seminar-a-week telling parents all the ills of psychotropics for their children. The same teachers argue with you to give the child Ritalin or he is not acceptable back in school. A schizophrenic system. Do these teachers tell the internist which nebulizer to use on the child, or the surgeon whether to take the appendix out or to look at it, pat it and leave it where it is?

What we need is some meeting of the minds, and have a new organization, let's call it the STEP, Seeking To End Protectionism. We are not fighting FOR us; we are fighting AGAINST the organized medicine that treats us like the stepchildren. We are psychiatrists; we do things in a roundabout manner.

The STEP will meet every week, plan our strategy against everybody; the hospitals, doctors, psychiatrists, lawyers, clergy, psychologists, bartenders, garbage haulers ....the list is endless. I am confident we will be victorious in our mission. The mission is not defined yet; it will be ready within first twenty-six meetings. Some day we will be treated like a normal child. And my friend who suggested that we are treated like orphans, not like stepchildren, is not welcome to join the Executive Committee of STEP. After all, we also have some self-respect. Moreover, I wouldn't know how to break down the name of my association if I called it the ORPHAN. ▲



Jack Dang, M.D.

**Managed Care, cont'd**

and most expedient treatments.

Finally, a number of "consumer driven" systems are described in the report. What these disparate plans have in common is a retreat from employer imposed management of health care, and clearly defined limits on employer contributions for health care. The simplest form is the "defined contribution" health plan, where an employer allots a fixed sum for each employee's health insurance, usually enough to cover a basic HMO, and the employee then can purchase, at his own expense, whatever additional insurance he wants, e.g. an indemnity "see whatever doctor you want" policy. Such plans are already in wide use. A number of disadvantages to these plans are cited, including the likelihood that most employees will choose cheaper plans with poor psychiatric coverage

An increasingly popular and politically prominent (viz. The Republican party and the AMA) funding plan is the "health reimbursement arrangement", which

include medical savings accounts. A typical plan would have an employer offer a very modest health insurance policy with a high deductible, along with some form of catastrophic stop-gap coverage for extraordinary expenses. This combination of policies has been shown to be the most economical. In addition to these relatively cheap policies, employees can put aside, at their own expense, pre-tax dollars that can be used to pay the high deductible of their basic policy. This money, a medical savings account, can also be used to pay for medical services not covered by the basic policy. Employers can also contribute to (lucky) employees' medical savings accounts, and recent IRS rulings allow at least some of these contributions to roll over and accumulate from year to year, and to be carried over from job to job. Employee contributions, at least for now, have to be used within the year or else be taxed as income, with an additional 15% penalty added.

This is a complicated and controversial system that critics maintain will benefit only those rich enough to be able to set aside a portion of their income. It can, however, provide a modest tax break for those who pay for their own psychiatric care, and may allow for the purchase of insurance policies "rich" in psychiatric coverage with medical savings account dollars. Depending on the outcome of the upcoming elections, we may be seeing many variations on this theme.

The APA resource document lists a number of other proposed or conceptual systems for funding healthcare, including some, such as "physician education research certification organizations", that, to this writer, sound positively Orwellian in their control and regimentation of physicians' performance, as if this were a major factor effecting health care costs. The bottom line, at least as I see it, is not addressed in the APA report. The combination of an aging population, research driven

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*Do you know how to respond?*



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## Managed Care, cont'd

advances in available treatments, and possibly a decline in the national standard of living have all combined to drastically increase health care cost as a percent of total expenses. Rationing is imperative and is already well implemented, though it's not called rationing. End of life care is better funded than prenatal care. Procedures, however questionable, are better funded than psychotherapy. These are political, rather than clinical or at all rational decisions. We need to continue our efforts to educate both the public and employers about the importance and cost benefits of psychiatric treatments. We also need to vigilantly guard against those who would intrude in the therapeutic relationship between psychiatrist and patient. I personally feel that the individual practitioner is the one best suited to assess and treat patients, all of whom are unique. I also feel that the individual patient, aided by educational material increasingly available via the internet, for example, is the one best suited to assess the "performance" of psychiatrists, rather than statistically driven or managed care organizations. Perhaps "consumer driven" health care plans will once again recognize this. ▲

*Andrew Hornstein, M.D.  
President*

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