

WESTCHESTER PSYCHIATRIST

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Message From Our President

When I became president of the District Branch, little did I imagine that I would feel the way Barack Obama must have felt when he moved into the White House: "Why me?"

You may be thinking now, my God! Is this Hajal having a fit of grandiosity?

Let me explain.

I had no idea I was walking into a DB facing a serious financial crisis, where each of the council's meetings would be dominated by concerns over the financial status and health of the DB (actually, its financial ill-health). That's when I started thinking of "fiscal cliff," "sequestration," "balancing the budget" This was like a bad dream, without a China poised to lend a few of the thousands we needed to avoid falling off the cliff.

Seriously, though, what got us into this predicament?

Two things, and a few more. Falling membership is a major one, not just of the DB, but of the APA, as our dues income is tied to APA members belonging to the Westchester DB. No other sources of revenues, as we do not have a system or way to seek donations from members or other potential donors. Ending our ties with pharmaceutical companies has put an end to a source of revenues generated when companies financially supported CME meetings and other similar activities. Small attendance at our CME meetings leaves us in the red when paying for food and such.

The other thing is of course expenses. Cutting back on expenses becomes crucial when revenue sources are scarce to nonexistent. Terminating activities that cost becomes a priority. Among the ones

discussed over and over again is the cost of the newsletter. Do we need to lose money on it? Do we need a print newsletter? Couldn't we do with an electronic one instead? Or none? Do we need a yearly dinner-dance-auction event (or similar activity) if we can't generate revenue from it? Let's not ignore the administrative cost of supporting the DB. Is it too high? What are we buying with the money we spend on our contract? Can it be, should it be streamlined? How far, how low? The expense of the CME meetings since so few attend them in spite of their excellent quality? Should we scratch them?

Now you can see the emerging sad picture if all this were to pass: a bare bones DB. Is this what we want? If not, what do we do to repair this financial state? Raise dues? Encourage potential members to join it, invite donations (directly or through the APA)? Seek business groups interested in supporting our activities? These are some of the ways being discussed. At this point, I would like to encourage members to send us ideas, suggestions by mail, email, or on the website, to help us put financial health back into our District Branch. ■

Fady Hajal, MD, President



Primum non nocere should not be replaced by caveat emptor

by Richard McCarthy, MD

Psychiatry's real conflict of interest is not with Pharma, it is much closer to home.

"Psychiatrists that go to drug company dinners are whores." Over the years, I had listened to the discussions about conflicts of interest and drug company dinners. Having been a speaker for a number of companies over the years (Jansen once, Bristol Meyers a few, Eli Lilly several times, Astra Zeneca, frequently and Novartis quite a lot) I had always been troubled by these discussions. At the speaker's trainings that I had attended, I learned a good deal about the medication in question and from real experts and walked away from these sessions with a good understanding of medications pharmacokinetic, pharmacodynamics, potential benefits and limitations. I can assure you that for those medications where I have not been on a speaker's bureau, this level of sophisticated information has been hard to come by through other means. I do not regret going to these trainings, nor do I regret giving these talks, at dinner meetings and otherwise. I strove to

be as objective and as clear as possible, and thought of my talks as educated discussions with colleagues about treatment options. They were usually a lot of fun, but only for those companies that did not demand, sometimes insist and occasionally threaten me if I did not stay on their sales message. As the years progressed, the FDA got involved, the talks became more rigid, decidedly less educational and exclusively sales oriented as FDA requirements insisted and threatened speakers and companies stay on the FDA approved message. Starting in some academic centers, criticism of Big Pharma along with allegations of corruption and influence peddling began to be made. This has since escalated to the notion that psychiatrists are unduly influenced by such drug company dinners and that this was a huge problem. While "Evidence Based Medicine" is all the rage nowadays, there is surprisingly little evidence to support these allegations. What little evidence there is largely impressionistic, is based on small studies, and is of a quality that would not seem to be convincing if it were

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caveat emptor *continued from page 1*

about anything else. I have never found physicians to be easily lead or convinced. Nor have I found it to be easy to change their behavior. Nevertheless, like Caesar's wife, we must be above suspicion and not have even an appearance of a conflict of interest. What may have started with this, has slowly evolved into "Psychiatrists that go to drug company dinners are whores," largely because no one, me included, has stood up to speak out against all of this.

There are most certainly conflicts of interests in psychiatry, and such conflicts can and do on occasion occur with Big Pharma. I believe that notifying people about our potential conflicts is the best way to deal with this. In my office I have taken to posting what dinners, trainings or honoraria I have received and from whom I have received it for the past 5 years. I am happy to answer questions from my patients about this and, if they are fearful that I may have chosen poorly for them, I again present the alternatives and encourage them to choose for themselves. As I tell them, I do not care what they choose since I do not have stock in any of these companies. I can do this, in part because all of these agents work, and with only a few exceptions they are not terribly different from each other in efficacy but do differ somewhat in adverse effects.

Let me make this point even clearer, all of these medications actually work, so, even if we are unduly influenced and choose poorly, our patients are still going to receive effective treatment. This is not the case with the major and entirely unaddressed conflict of interest we face, viz., insurance companies and hospital administrators. When insurance companies say discharge a patient, administrators and psychiatrists jump. Actually, the companies say that they will "no longer pay for unnecessary treatment at this level of care". They do not deny treatment, only deny paying for it. We deny treatment for them. After all, they pay our salary. Actually, they do not, the hospital does, the insurance company just pays the hospital, and will only do so if the hospital meets the company's expectations of appropriate care. This denial of care on behalf of our salary or our hospital employers is a real conflict of interest, and one we do not acknowledge. I do not belong to any managed care organization nor am I a participating provider for any organization, other than Medicare. I work for the state, so I have no concern about a hospital's bottom line. This does not make me a virgin in a land of whores, rather it reflects my discomfort with the insurance companies and their intrusion into my practice.

Demeaning other physicians will not help us find ways to address our conflicts of interest,. Such conflicts will only increase as business and its ethics invade medical practice. Even state hospitals will soon be beholden to "not for profit", and for profit Managed Medicaid providers. I am concerned that our patients, with whom we have a sacred trust, will become our "customers", to whom we owe nothing. First do no harm may become let the buyer beware. It is already happening, perhaps we need to wake up and attend to something significant not just to pens, post its, and note pads. ■

Book Review

The Age of Insight: Dr. Kandel Expands Our Perspective

by Eric Kandel, Random House, 656 pp, 2012.

In his remarkable new book, Nobel Prize winner Eric Kandel synthesizes research in art, psychology, and biology to convey a sophisticated view of the nature of insight using Vienna at the turn of the twentieth century as his starting point. Kandel moved to the United States from Austria as a child, and his personal connection with Viennese culture as well as with psychiatry makes this book compelling. Paintings by Klimt, Kokoschka, and Schiele, the literature of Arthur Schnitzler, and the scientific contributions of Freud and his predecessors at the Vienna School of Medicine are all presented here, and illustrate and exemplify an orientation to look beyond the surface in search of deeper understanding and meaning. The quest to understand the unconscious is the essential topic. Kandel effectively makes the point that this time and place are central to much scientific understanding today. This very well written book includes discoveries made only since the beginning of the twenty-first century. Columbia's Mind Brain Behavior Institute, of which Kandel is part, exemplifies a current research trend to connect disciplines and approaches. In this respect, the book reflects the maturity of the field. I highly recommend it to those interested in psychology, neuroscience, and art. ■

James P. Kelleher, M.D., M.B.A.

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Please note that Ballots must be received by June 4, 2013 in order to be valid.

Book Review

Crazy: A Father's Search Through America's Mental Health Madness

by Pete Earley, Berkley Books, 370 pp, 2007.

The author is a journalist who decided to investigate the mental health system in the US after his son had a psychotic episode and was arrested for breaking into a home while he was delusional. The book alternates between the story of his son's mental illness (his son has a diagnosis of Bipolar Disorder) and what Early found out about the current treatment of the severely mentally ill in the US.

Early gives a familiar history lesson: After state mental hospitals were gradually emptied beginning in the 1960s, many of the patients found themselves with little or no mental health care. Many became homeless. The "patient's rights" movement made it very difficult to get them treated against their will. Because of these changes, a significant portion of the mentally ill has entered the criminal justice system due to crimes perpetrated because of their illnesses. Many of the crimes are trivial but some are deadly. Being arrested is sometimes the only way that they will receive any mental health evaluation and treatment. He states that "Our jails and prisons have become the new asylums because there is nowhere else for the mentally ill to go." As a representative example, he investigates the experiences of the mentally ill in the Miami-Dade County Jail in Florida. He gives the stories of several individuals who repeatedly go through a process of jail, treatment, release and return to jail. They are functioning adequately upon release, but cannot tolerate their freedom and have inadequate treatment and inadequate support and supervision to function outside of jail. The segments that occur outside of jail will be very familiar to psychiatrists, but what will be unfamiliar to many are Earley's descriptions of the often horrific experiences of the mentally ill while in jail.

Early briefly gives his recommendations at the end of the book, which include training of law enforcement officers to properly deal with the mentally ill, adequate

funding of community mental health centers, more long term treatment including a return to state mental hospitals and changing commitment laws so that the chronically ill can be forced to obtain care.

Early is a good writer and the book is engrossing as well as easy to read. It certainly makes an urgent case for improving the mental health system rather than building more jails. ■

Karl Kessler, MD

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