President’s Column: Managing APA Finances
by Jim Nininger, M.D.

A t the November 2001 Assembly meetings in Washington, D.C., psychi atrists from across the country received a sobering assessment of APA's finances from the Steven Mirin, M.D., the APA Medical Director. We learned that for many years the APA has been operating with an ongoing operating deficit funded by drawing from APA reserves. The APA currently spends approximately $50 million each year to support its wide-ranging activities. For the past several years, APA has been operating from year to year with a budgeted operating deficit of several million dollars that was balanced only by dipping into APA savings and investment portfolio. Because of this practice, APA reserves have dropped from $30 million to $15 million. Many years of strong growth in APA investments permitted this approach to continue without significant adverse results. However, with the decline in the stock market, increase in operating expenses and the continuing operating deficits, the APA was faced with the prospect of depleting all its current reserves within a few short years if aggressive action was not taken. For this reason, a detailed analysis of the financial problems confronting the APA, please read the detailed report of Herbert Pesyer, M.D., Area II Trustee on page 3.

Therefore, at its December 2001 meeting, the APA Board of Trustees approved a 2002 budget that calls for significant cuts or withdrawal of expenditures in line with anticipated revenues without drawing upon reserves. NYSAPA supports strong efforts to bring the APA operating budget into balance and urges the Board of Trustees to support that APA management is held accountable for.

[See President on page 8]

Remembrances of Things Past
By Herb Pyser, M.D.

I was so deeply appreciative of the Area Council having given me the Warren Williams Speaker's Award. I hadn't expected it, hadn't even thought of it. When Sy Gers, who chaired the Awards Committee, got up and announced it I was astonished, opened my mouth, couldn't say anything. Ed Gordon laughed and pointed to me and said, "He's speechless!" And Ed Gordon laughed. So there really is something to say, we really do find our existence, in the eyes of the other? True. After all, do we not find our significance, our meaning, maybe our very existence, in the eyes of the others? So there really is something to say, and I want to pay the Council back for the award by explaining what it means to me, by telling the story of how I got into this work and why.

When I went to medical school I had wanted not only to be a doctor but also to do something specific, something special. I wanted to do immunohistochemistry, and I did some bench work on that under Michael Heidelberger at P & S for about a half-year. One of the reasons I left it was that it seemed terribly monotonous, terribly monotonous to me. You can't really have a dialogue with a chemical, no matter how interesting the chemical is.

I decided I would have to do medicine then and be a doc, but I looked around for something specific, anything, as I said, to add to it. I went to intern in Michael Reese then in its halcyon days before managed care, when it was a fervent hotbed of biochemistry under Samuel Soskin and Rachriel Levine. But Chicago was more than that. It was a hotbed of psychiatry under Roy Grinker and psychoanalysis under French and Alexander, and I got infected. There was dialogue, not all the place. I returned to New York where I had committed myself to a fellowship in pathology before I would move on, but at once began to look for a residency in psychiatry. My chief there, Dr. Paul Klemperer, was one of the most wonderful mentors I ever had. Maybe the best, despite all the fine teachers, supervisors, psychoanalysts, whatever, that I have known. I believe, the wisest in many ways, a fine teacher, supervisor, psychoanalyst, whatever, that I have known. I believe, the wisest in many ways, a fine teacher, supervisor, psychoanalyst, whatever, that I have known. I believe, the wisest in many ways, a fine teacher, supervisor, psychoanalyst, whatever, that I have known. I believe, the wisest in many ways, a fine teacher, supervisor, psychoanalyst, whatever, that I have known. I believe, the wisest in many ways.

As you can see I was a bit in awe of him, still am, I guess. And I was nervous as I went in to see him. I thought how difficult it would be. A pathologist takes a liver up in his hands, looks at it, cuts it, he looks at that, he takes little pieces of it out and fixes them and stains them and then looks very closley at the liver. And psychiatry? Words. Evanescence, ephemeral. And it wasn't made any easier by the pictures of those German pathologists on the walls of his office. I can see...
As We Enter 2002
by Leslie Citrome, M.D.

A
s we usher in the 2001-2002 holiday season and New Year, we are faced with new realities and changes to our everyday routine. In our professional lives, many NYSPA members have generously donated their time and services to those affected by the events of 9/11—essays about PTSD, neuropsychiatric News can be found on page 4. The events also impacted on those whom we were already treating, whether in the office or in the hospital. We will surely be reporting on in the near future and will be a subject in our upcoming professional meetings. The Bulletin can also serve as a sounding board. I encourage NYSPA members to e-mail their stories to me at citrome@nki.rfmh.org.

The Trustee report on page 3 summarizes the current issues regarding the APA budget and different ideas on how to reduce a projected deficit. The next issue of The Bulletin will continue to report on these late-breaking developments, including the controversy surrounding the contract and salary of the Medical Director. The NYSPA Executive Committee is hard at work to protect our interests and to maintain or increase the impact that we have on APA governance.

In the next issue of The Bulletin we will hear about the new plans for our website, www.nyspsych.org. This revamping explains the "This site is under construction. Please check back soon." message. In addition, although The Bulletin looks the same, we have switched to a different vendor for our layout, printing, and mailing. This should result in timelier publication at a reduced cost.

Thank all of you who have taken the time to write, call, or e-mail to keep the printed Bulletin alive. In closing, we are still searching for my successor as Editor-in-Chief. Applications will be accepted until February 1, 2002, and then the help on

From the Editor's Desk...

The New PSA Health Plan Complaint Form is Now Live!

In the summer of 2001, the House of Delegates directed the AMA to establish an electronic information clearinghouse so physicians could report information about administrative disputes that they encounter with third party payers. Consistent with this resolution, Private Sector Advocacy (PSA) developed the "Health Plan Complaint Form" (HPCF). This form serves as a tool for the collection of information related to the administration of health plans by health insurers and third party payers. It gathers very sophisticated data on the types and severity of the administrative "hassles" that physicians experience on a day to day basis in the managed care environment. Using this data, PSA will provide updates and present findings at the HPCF with the information collected through the Health Plan Complaint Form. This information will be used to identify trends, and to facilitate discussions with national health insurers to resolve the administrative hassles and complaints that physicians are encountering with health insurers or third party payers on a regular basis. In addition, this information will be used to promote legislative and regulatory changes to benefit patients and physicians. No physician names are used, gathered, or retained as part of this data collection.

The official HPCF can be seen at the Private Sector Advocacy Web site at: www.ama-assn.org/go/psa. This form is intended to be completed by physicians or physician staff only. Therefore, physicians using the form will be required to register and use an AMA Internet ID. The AMA Internet ID ensures that the information submitted is coming from a physician located in the AMA database. However, once the physician is verified, there is no way to OA who submitted the form. The survey itself is completely anonymous and confidential.

*NOTE: The AMA Internet ID is different than an AMA members only username and password. All physicians, whether they are an AMA member or not, are eligible to register for an AMA Internet ID and to fill out the Health Plan Complaint Form. Non-physicians do not have access to the form via the PSA Web site. Therefore, if you are not a physician and wish to view the HPCF go to: https://psl.ama-assn.org/physinfo/surveys/forms/public/hpcf.htm

This version is not password protected, and the "submit" button at the bottom of the official form has been removed. Therefore, non-physicians will not be able to submit any data while testing the form. The AMA press release is attached, as well as a one-page announcement about the form that is going to the AMA’s House of Delegates at the AMA’s Interim Meeting. If you have any questions, contact Marc Basravala at 312.446.2485 or email: mbasravala@ama-assn.org.
Budget, Medical Director’s Contract & Central APA Move
by Herb Peyser, M.D.

The December Board meeting was in great part occupied with APA’s difficult financial situation. In November the Medical Director had presented the Assembly with APA’s unbalanced budget and the erosion of its reserves. The Board, deeply concerned, strongly and critically questioned top management and top governance as to how it happened and what would be done. Crisis requires leadership, which means no excuses, admitting one’s responsibility, confronting one’s role in the matter, and laying out a program to turn it around. Here is the Board’s response. Top management is to do similarly.

APA has in effect been running a structural deficit despite the appearance of balanced budgets. The Assembly, Board, and management, each, had been developing multiple programs, for which, if not well intentioned and valuable, but revenues were not keeping up with those newly added expenses.

Budgets had not shown this clearly because, under the auditing system inherited from the past and continuing four years into the present, they appeared balanced as presented to the Financial/Budget Committee and the Board. However on the expense side there had actually occurred significant cost overruns, particularly where the IS (Information System) was concerned, but elsewhere as well. On the revenue side the estimates of publishing and Annual Meeting revenue, etc. often did not come in. Top management did not do due diligence as membership slowly decreased in APA (as in other professional organizations, the medical societies, etc.). Dependence on pharmaceutical advertising was of increasing concern.

To fund programs APA borrowed from its reserves (less expensive than borrowing from banks), planning on replenishing them when revenues came in. Unfortunately it had not been clear that revenues were not adequate for that, replenishing was falling short of expectations, and reserves were being eroded. Investment in costly activities (e.g., Medem, the IS, legal expenses) additionally decreased reserves and therefore investment income. Furthermore, returns from investments in the financial markets were decreased due to the national economic climate.

New auditors were brought in as a new CFO and finance team came in over term lease due this year will not continued, and one smaller, expensive lease (about half the space) will be put off. The long-term inexpensive river to a new building in Rosslyn, Va., was put off. The long-term inexpensive (space,salaries, benefits, etc.), must do its part too, reducing infrastructure and activities not contributing toward covering overhead. Programs must reflect sustainable revenue. Other organizations must be surveyed re relationship of staff to revenue, number of members, size of governance, and the budget and more.

A sort of comptroller function is being developed. A financial management group (President, Medical Director, Finance/Budget Committee Chair, probably President-Elect, Treasurer and Assembly representative) will confer monthly, reviewing current finances, making adjustments, and reporting to the Board Executive Committee that confers twice monthly. Minutes of those sessions are distributed to the Board.

Several of us on the Board had been arguing for legal and administrative consultant advice to help with the APA reorganization process, and I expect that this, as noted, will occur. I anticipate that the Business/Financial Expert Advisory Panel Workgroup may of help here. APA net non-dues revenue sharing is now decreased to $55 per state. The Spurlock Office has been put off. The question of increased dues was raised but not acted upon. All these matters will be closely reviewed before the next Board meeting.

I am very grateful to the Assembly and the Assembly Executive Committee for their strong questioning of top management and governance. It has contributed greatly to the above corrective actions. The Assembly must continue to increase its participation in the governance process as a kind of checks and balances with the Board.

Inside-the-beltway is not outside-the-beltway. Outside is vastly larger. The Bronx DB President-Elect asked that dues be decreased, said APA was not paying enough attention to the serious problems of members in community hospitals, should cut its infrastructure, and, along with the Indiana DB President-Elect, reported on lower general membership interest in APA. This problem too must be addressed.

So much for the most difficult Board meeting, in terms of the seriousness of the problems confronting APA, that I have encountered in the five and a half years I have been on the Board.
Throughout New York Area, Psychiatrists Respond

Members of district branches in and around New York respond to the World Trade Center attacks by generously volunteering their time and services. Rosalie Landy, executive director of APA’s New York County District Branch in Manhattan, started getting calls from psychiatrists offering to help within 24 hours of the World Trade Center attacks last month. “The number of calls has been overwhelming. Psychiatrists in New York, New Jersey, Connecticut, Massachusetts, Florida, Colorado, and even Argentina have offered to come here to assist us,” Landy told Psychiatric News.

She is not turning anyone away because the need for psychiatrists is expected to increase in the coming weeks and even months. Untold millions witnessed the terrorist attack in person or on television and were directly or indirectly affected by the deaths of approximately 5,400 people at the World Trade Center. In addition, many more people are experiencing a range of symptoms—from anxiety to insomnia—because of these tragic events and fear that more attacks could occur at any time.

Although psychiatrists are still needed to go to family-assistance and crisis-counseling centers in Manhattan, Landy said she is trying to get calls from people seeking individual counseling by psychiatrists.

She is keeping a list of New York County DB members who have offered to provide free initial counseling sessions and can refer people commuting to Manhattan from Connecticut and New Jersey to district branches in their home area.

Landy said that APA’s Erich Lindemann disaster support grant her DB received last month will be used to educate state and federal legislators about the psychological trauma resulting from the attacks, update the DB’s disaster Web page, conduct workshops to educate members about treating disaster victims, and cover related administrative costs.

The Web page, under the heading “Disaster Outreach,” features a bulletin board, which includes a peer-support group. Messages cover a gamut of topics from requests for volunteers to information on mental health services for victims and their families and rescue workers. There are also links to trauma-related Web sites and downloadable documents that include information for clinicians and patients.

The workshops will be organized by the co-chairs of the DB’s disaster committee, Craig Katz, M.D., and Francine Cournoyer, M.D. Cournoyer directs the Mental Health Training Project at Columbia University, which presented a free mental health disaster training session last month with the Center for Trauma Studies at Columbia.

Katz is president of Disaster Psychiatry Outreach (DPO), which has been recruiting, training, and sending psychiatrists to sites run by the Salvation Army and American Red Cross.

Lois Kroplick, D.O., president of the West Hudson Psychiatric Society (WHPS), took the DPO training before she volunteered at the Pier 94 Family Assistance Center, which was set up to help the families of the victims of the World Trade Center attacks. Kroplick lives in Rockland County, about a 40-minute drive north of Manhattan.

Kroplick said she learned about the disorders that victims are likely to develop, medications appropriate to dispense on site, and crisis interventions.

“Katz emphasized that our purpose was to meet people’s basic needs while helping them regain some equilibrium,” said Kroplick.

She described the Pier 94 Family Assistance Center as consisting of miles of booths with representatives from numerous organizations, including the New York State Office of Mental Health, American Red Cross, Salvation Army, police and firefighter unions, and companies with missing employees. There were also insurance company representatives on hand to help people file for benefits, said Kroplick.

During the third week of September, when she worked her first shift, Kroplick talked to tour guides employed by the World Trade Center who just missed the plane crash and lost colleagues. “They were jobless and having trouble eating and sleeping. I encouraged them to maintain as much of a normal routine as possible and showed them where to apply for financial help,” said Kroplick.

She also helped families of security guards who perished at the World Trade Center obtain free counseling near their homes and apply for financial aid.

Kroplick helped a woman who was unable to live in her building because of its proximity to the World Trade Center. “She had symptoms of acute stress disorder from watching the planes crash into the building, people jumping to their death, and the buildings collapse. Because she said she hadn’t slept in days, I gave her some sleeping pills. The Red Cross gave her unlimited funds to live in a hotel until she can move back,” said Kroplick.

She observed that the mood of family members had changed when she returned for her second shift at the Pier 94 center at the end of September. “Last week they still hoped their relatives might still be alive; this week the reality set in, and there were anger and depression.”

She continued, “I was able to help a family obtain funds for a memorial service for their uncle. That was a success story.”

She and another WHPS member, Bhairavi Palkhiwala, volunteered to go to Manhattan and help people affected by the attacks. She went to the New York University Law School near the World Trade Center, where students had witnessed the unfolding tragedy and were concerned about their safety.

In addition, several members of the WHPS and the Psychiatric Society of Westchester County offered to provide three or four free counseling sessions to people affected by the disaster.

Other New York DBs Respond

The following are among the actions taken by other New York district branches in the wake of the terrorist attacks:

The New York State Psychiatric Association signed up more than 100 volunteers at the request of the state Office of Mental Health to assist victims and family members across the metropolitan area and state.

The Queens District Branch secured half-hour public television spots for panel discussions consisting of trauma experts.

The Greater Long Island Psychiatric Society sponsored a talk at a community day care center on depression, post-traumatic stress disorder, and grief. The DB also worked with the American Red Cross to provide counseling to the families of airline victims and a local agency to provide counseling services to widows and children of deceased firefighters.

DB Secretary/Treasurer Frank Dowling, M.D., has been counseling police officers and emergency workers at a stress-management center near the World Trade Center.

Dowling, who is a medical advisor to the Police Organization Providing Peer Assistance (POPPA), estimated that 1,500 to 2,000 police officers rushed to the scene to assist or rescue people after the planes crashed into the north and south towers and were inside or near the buildings when they collapsed. A number of them are now presumed dead, Dowling told Psychiatric News.

The vast majority of the 40,000 officers in the New York Police Department (NYPD) have been working at ground zero since the attacks. They have been securing the area, digging for survivors, searching for remains, and working at the morgue and the landfill where removed material is sent, said Dowling.

“While we are especially concerned about the initial responders, we are aware that nearly all of the NYPD has been exposed to the trauma in real, vivid, graphic, and painful ways and can benefit from assistance coping with the effects,” said Dowling.

Many police officers have come to group debriefings led by peer-support officers trained in crisis intervention, with clinicians present in case police officers develop serious emotional problems, said Dowling.

“Our goal is to help them cope with the common stress symptoms that result from such exposure and pre-existing PTSD, depression, alcohol abuse, relationship and marital problems, and, of course, suicide,” said Dowling.

Frank Dowling, M.D., secretary/treasurer of the Greater Long Island Psychiatric Society (front row, far right), is pictured with police officers and clinicians trained in crisis intervention at the Stress Management Center in Manhattan.
studies have focused on healing aspects of spirituality and its integration into standard therapeutic practices for recovery, especially with the chronically mentally ill. Results of one such study (Tepper L et al. The prevalence of religious coping among persons with persistent mental illness. Psychiatric Services, 52:3, 660-665, 2001) suggest that involvement with religious activity may be associated with a reduction in symptoms when religious beliefs and activities, such as prayer or reading spiritual materials, are used by individuals to cope with daily difficulties and frustrations.

In light of these issues, a group that focuses on spiritual themes has been offered to patients on the Clinical Research Evaluation Facility (CREF) at the Nathan Kline Institute since February 2001. I initiated this group at N.K.I. as an outgrowth of my previous involvement with such a group at the Second Chance program at New York Presbyterian Hospital during 1999-2000, co-led with Chaplain Amy Manierre. We learned that despite stereotypes, individuals who chose to attend the group did not profess religious delusions, but rather, focused on the source of strength and emotional stamina that religious affiliation related to diverse backgrounds and ongoing use of spiritual values afforded them. The group protocol was presented at CREF and the program initiative quickly gained support from the director and unit chiefs at CREF, Leslie Citrome, MD, MPH and Henry Epstein, MSW. The CREF Spirituality Matters group began with co-leaders Chaplain Ariel Verdesi of Rockland Psychiatric Center, Vera Hill, COTA, and various unit staff, including students and volunteers who are interested in group process training.

The “Spirituality Matters Group” meets weekly and is comprised of individuals who are self-referred. This allows inpatients to experience personal causation and the opportunity for making choices. It also establishes a point of identification with peers that go beyond diagnostic cate-

The “Spirituality Matters Group” meets weekly and is comprised of individuals who are self-referred. This allows inpatients to experience personal causation and the opportunity for making choices. It also establishes a point of identification with peers that go beyond diagnostic cate-

gorization by fostering a commonality that is grounded in a sense of self that has positive valence and meaning apart from one’s hospitalized status. In addition, many patients on CREF exhibit difficulty with impulse control and aggressiveness. This group attempts to facilitate the prerequisite mechanisms that inspire self-control, instill comfort and hope and provide resources for positive esteem via the affirmation of a ‘higher self’ and ‘higher power’ and by using an emotion-focused coping style. Individuals are coached to envision ways to gain control by changing the meaning of a situation that may in fact be beyond personal control. Cognitive reappraisal and reinforcement of positive emotions heighten awareness that even in situations that appear to be hopeless, a sense of faith can help an individual to prevail when used in the context of social support and open communication about life’s dif-
ficulties. This validates the reality of coping with chronic mental illness without negating the frustration of one’s daily realities of taking medica-
tion one doesn’t want to admit need-
ing, dealing with family abandon-

ment and limited personal resources, or living on the edges and boundaries of society due to stigma.

The group offers highly structured exercises that are designed to facilitate verbal expression and appropriate social interaction while focusing on the use of spiritual beliefs for coping. Use of cards and handouts with large print are used to compensate for prevalent cognitive and auditory processing deficits. During the course of a group session, individuals receive support and encouragement that may restore self-worth and repair self-

The Bernard L. Pacella, M.D., Parent Child Center

The Bernard L. Pacella, M.D., Parent Child Center of The New York Psychoanalytic Society is pleased to announce that it has received a major donation from an anonymous donor as a tribute to Bernard L. Pacella, M.D. The Center will be renamed, The Bernard L. Pacella, M.D., Parent Child Center of The New York Psychoanalytic Society, honoring Dr. Pacella for his work with children dating back to co-editing a book with Nolan D. C. Lewis, M.D. in 1945, “Modern Trends in Child Psychiatry.” Dr. Pacella, first certified in neurophysiology and neurology, trained in psychoanalysis with Ernst Kris, Edith Jacobson, and Otto Isakovitz, and collaborated with Phyllis Greenacre and particularly with Margaret S. Mahler. He is a past President of the Margaret S. Mahler Psychiatric Research Foundation and a past President and Treasurer of The American Psychoanalytic Association.

The Parent Child Center, established in 1990, has developed a model program of parent-child groups, with parents and children (ages 2-18) over 3 years. Examples of its work can be seen at www.theparentchildcenter.org.

Over the last few years, the Center has begun to receive funding that has allowed it to begin the development of a research program and since 9.11, begun a Trauma/Support Center.

With the inauguration of the Pacella Parent Child Center, we will be able to expand our programs to include services for children up to adolescence, families and children from disadvantaged situations, and most importantly establish a solid research program.

The Center, The New York Psychoanalytic Society and Institute, and The New York Psychoanalytic Foundation are most grateful to the generous donor and to Arnold D. Richards, M.D., without whose energy and devotion to psychoanalysis and Christian and Muslim backgrounds, who demonstrate appreciation and commitment to the group. Eighty percent of those who initially join the group continue their participation while enrolled in various research protocols on the unit.

In addition to the clinical aspects of the group, I am now planning to col-

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NEWS RELEASE: November 13, 2001
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Remembrances of Things Past
continued from page 1

Herb Peyser wins Area II Warren Williams Award
Herb's interest in impaired physicians springs from his long-time professional interest in the area of substance abuse and addiction treatment. Soon after completing his psychiatry residency and starting a private practice, Herb was a consultant at the Smithers Alcohol Center in New York City. Anyone who talks to Herb for any period of time about public policy knows his fervor and unfailing insistence that parity for mental illness must also include substance abuse. Every NYPSA position statement on parity includes at least in a footnote if not in the test a statement that mental illness includes substance abuse disorders. Herb applied the same focus and attention to his activities on behalf of the APA. As Area II Trustee, and even earlier as NY County DB representative, Herb led efforts to impose a national dues increase moratorium and provide revenue sharing for DBs and state associations. When he became Area II Trustee, Herb focused his attention on APA finances. Herb spearheaded efforts to insure fiscal accountability, reform budget process, hold down dues increases, improve APA central office communication with DB and State Associations, focused on APA information systems, led efforts to secure support for the establishment of a business advisory council for the APA, and finally insisted on full disclosure of the financial terms of the APA Medical Director's contract. However, any of you who know Herb know that this list of achievements cannot begin to provide a full picture of Herb First, anyone who had the pleasure of dining with Herb might describe Herb as a raconteur, wry connoisseur and gourmand, probably on at least one of his many trips to France.

MediComment: Coding Q & A
continued from page 1

Send questions regarding coding, Medicare, managed care practices and denials, documentation, other problems with managed care, or other practice problems that you have experienced, together with documenta-

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A Patient’s Destiny
Hagit Bat-Avi, M.D., PGY-IV, Beth Israel Medical Center

Many patients spend years of their lives cared for by psychiatrists working in hospitals outpatient clinics and in inpatient units. Some patients become well known to the staff and an integral part of the working team. Residents rotating through the different psychiatric services become familiar with these “conventional” patients. Residents happen to be so absorbed in the practice of psychiatry treating depression, schizophrenia, bipolar, and personality disorders we sometimes overlook the co-morbid medical illnesses that many patients have.

Such a common case was that of Mr. R. A 50 years old white male diagnosed with schizoaffective disorder in his early twenties. Mr. R. a tall gentleman was often treated in the inpatient psychiatric unit when his psychotic episodes would creep upon him making his sharp mind confused and in a total disarray.

Indeed he was very intelligent. I first met him during one of my inpatient rotations. He was sitting alone in the common area where a piano occupied the left side of the room, and bookshelves lined the other side along the wall. Mr. R. did not look up when I peeked through the open door. He was absorbed in reading a political review on the history of the USA government.

I was quite amazed at the sight knowing that only two hours earlier he was running in the corridor saliva drooling down his curled lips, and his speech made no sense. Now he was sitting quietly doing what he often liked to do: read.

I did not disturb him, but I was curious to know more about him. The nurses on the floor have known him for several years. He was hospitalized on the average of four to five times each year, and in the interim between hospitalizations was seen in the outpatient clinic. He lived alone, had no known relatives and was supported by public assistance.

His symptoms were treated for years with halodol but when he developed signs and symptoms of tardive dyskinesia he was switched to one of the atypical neuroleptics, and did well for longer periods of time without a need for hospitalization.

I also found out that he was quite an avid reader. He read philosophy, politics, history, and when the nurses found the daily newspaper, he read it from front to end. He was not my patient but I watched him while I was working on the floor. He mostly stayed by himself. He hardly talked to anyone. His sole communication was apparent when he was irritated, and threw a tantrum. It usually happened when he was asked to take a shower, to change his gown, or when he was expected to join the other patients for daily meals. Once or twice I saw a woman come to visit him. She said that she was his girlfriend, and together they sat in the common room conversing. She later on simply disappeared, and it was not clear from Mr. R. explanation why she stopped visiting him.

After that, I have not seen Mr. for almost a year, in fact I forgot about him. I was rotating in the outpatient clinic in my third year and one afternoon I saw him shuffling his feet slowly toward the registration desk. He carried a book under his arm and was very unsteady on his feet. He was receiving ECT treatment because he was depressed and catatonic, and the trial of ECT has helped him. He came to the outpatient clinic diligently to be seen both for individual sessions and for group.

As the year passed, I saw Mr. R. several times and he looked more confused, unsteady, and unsure of where he was. Mr. R. threw one of his well-known tantrums, as he wanted to get out of the chair; he was persuaded to lie on a stretcher while he was singing the wedding hymn saying that it was his favorite song.

Mr. R. explanation why she stopped visiting him.

"I have cancer, and I am dead" he said, ignoring my question. "You have become very thin since I last saw you" I continued, surveying him with a thought that he may be quite sick.

"I have cancer, and I am dead" he said, still looking at the wall.

"You are not dead" I said, "You are here with all of us". One of the nurses came over to join the conversation; she has known him for a long time. Mr. R. threw of his well-known tantrums, as he wanted to get out of the chair, he was persuaded to lie on a stretcher while he was singing the wedding hymn saying that it was his favorite song.

[See Destiny on page 8]

THE BENEFITS OF BELONGING TO...

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I left Mr. R. while the nurses were battling to take him to his room, he was resisting in every possible way. He made up his mind to stay where he was despite the discomfort. As the nurses were trying to convince him to lie still while they guided the stretcher to his room, I walked away free thinking that he indeed knew of his illness. He was completely aware of the fact that he lost half of his body weight. Even with mental confusion, frequent bouts of tantrum, and memory impairment, Mr. R. was aware of his medical condition and the outcome of the terminal diagnosis of cancer. Still, he was alone; no one seemed to bother with his present hospitalization. He, like many other patients was confronting both cancer and mental illness in the end of life, all alone. Like many of the severely mentally ill, Mr. R. lived alone all his life, and now alone he was vanishing slowly, and it made me feel sad and helpless.