'Progress' in psychiatry

I have practiced community mental health in Fayetteville, NC for 12 years and have observed every point Dr. Nasrallah made in "A skeptical view of 'progress' in psychiatry" (From the Editor, Current Psychiatry, June 2011, p. 18-19). As psychiatrists, we share a great deal of the blame. We handed over leadership of community mental health centers to social workers and allowed ourselves to be "carved out" of community hospitals. State hospitals are dysfunctional at best.

Dr. Nasrallah is correct in asking who is the "genius" behind these decisions. Many new psychiatric practices are based on family practice models of herding 60 to 80 patients per day. I'm not sure I will even recognize the practice of psychiatry in 10 to 20 years. Perhaps with obstinate rigor we can restore what we've lost.

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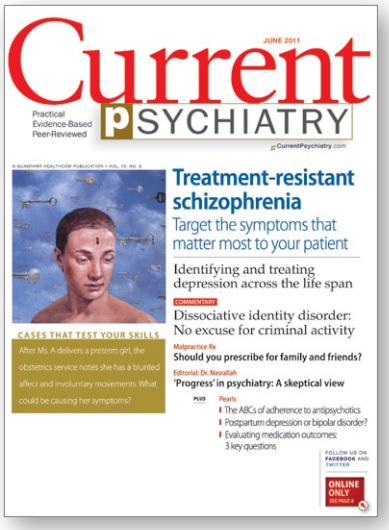
Missed progress

I, too, am concerned with the lack of recent progress in psychiatry. Nevertheless, Dr. Nasrallah is missing some of the progress he downplays ("A skeptical view of 'progress' in psychiatry," From the Editor, Current Psychiatry, June 2011, p. 18-19). For instance, the discovery of chlorpromazine brought about concomitant serious side effects and homelessness, but many patients gained a life in society, which allowed some to become peer specialists, helping others with mental illness. Sure, insurance hassles for state hospitalization did not exist and



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hospitalization stays today often are much too short, but 40 years ago, state mental hospitals were so-called "snake pits" of overcrowding with excrement on the floor, and precious little treatment. Yes, in psychiatry we have more legal constraints, but in part this is a reflection of past coercive and unneeded hospitalizations.

I agree funding reductions have broken public mental health systems, but psychiatrists generally have preferred private practice with mentally healthier patients and sat quietly while other disciplines took over psychotherapies. I also don't like the term "behavioral health," but behavior can be measured, and we have precious few ways to measure progress and outcomes in psychiatry. Maybe pharmaceutical companies are abandoning drug development because they have been unsuccessful in developing novel medications in the last few decades, instead benefitting from serendipitous discoveries such as chlorpromazine. We may need new approaches to biologic treatments to progress any further, but this should not be surprising, given how difficult it is to access and study the brain

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Focus on change

Dr. Nasrallah's editorial ("A skeptical view of 'progress' in psychiatry," From the Editor, Current Psychiatry, June 2011, p. 18-19) is intriguing because it summarized concerns I have seen frequently expressed in publications catering to psychiatrists. Since the advent of managed care, these kinds of "poor psychiatry" articles have appeared regularly.

Instead of bemoaning the lack of "progress" in psychiatry, perhaps Dr. Nasrallah would have been better served by focusing on change and its inevitability. I found it ridiculous he contrasted the "asylum era" with current practices in order to focus on length of stay. At that time, the mentally ill were—except for well-intentioned attempts at "cure" via "milieu therapy"—warehoused for years, if not lifetimes, under filthy conditions.

Dr. Nasrallah then segues into the expected attacks upon insurance companies, lack of parity, and drastically shortened lengths of stay. It is obvious 3 to 4 days of acute care generally is not sufficient for serious psychiatric conditions. As an experienced managed care and independent reviewer, I can assure Dr. Nasrallah such strict criteria sets are the minority. What about psychi-

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atrists who keep patients until their insurance runs out or let relatively benign patients languish because they did not call attention to themselves and kept a bed filled? Contrary to Dr. Nasrallah's assertion, judges and lawyers do not tell us how to practice medicine; they are part of a necessary system of checks and balances that, in a highly imperfect world, help prevent inappropriate or abusive practices by incompetent, uninvested, or morally deficient physicians, of which there are plenty.

Dr. Nasrallah should be aware terms such as "behavioral health" are largely the result of efforts to destigmatize mental illness, leading society to coin more politically correct and palatable terms for just about everything.

At no point does Dr. Nasrallah even hint at offering solutions. For example, psychiatrists have done next to nothing to educate the public about their profession. Meanwhile, a substantial number of prominent psychiatrists are more than happy to accept steak dinners and honoraria from drug companies, along with going out and speaking at free CME events, in order to oh-so-subtly hawk a medication that just happens to be manufactured by the company paying for the "free lunch."

Forget about judges and lawyers "telling us how to practice." What about "Big Pharma" manipulating us and advertising on television, urging viewers to "talk to their doctor" about medication X? Dr. Nasrallah is preaching to the choir here. What we need is less breast-beating and more constructive action.

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Managed care woes

Regarding Dr. Nasrallah's insightful editorial ("A skeptical view of 'progress' in psychiatry," From the Editor, Current Psychiatry, June 2011, p. 18-19): Since the late 1980s and early 1990s, the Employment Retirement Income Security Act, has enabled managed "care" to exist, with failed attempts to repeal or limit the act. Managed "care" has worked hard to change our language, such as "primary care physician" instead of physician or doctor and "behavioral health" instead of psychiatric or mental health care. These changes minimize our importance, influence, and reimbursements as well as the medications and treatments we use. When it was obvious what was happening, we abdicated our responsibility and control to the kind of people Dr. Nasrallah described.

There will be more cuts on reimbursements and limits on us unless we say "no." We are not allowed to organize, physicians in Congress have not helped, and our elected professional organization leaders have little influence. We can give in and accept the "inevitable," but the Hippocratic Oath seems to preclude such irresponsibility. We can refuse to treat anyone, except in emergencies, unless we choose to do so in good conscience. We need to change and the law has to change. The people who control our health care are evil, immoral, and venal; why should they be dictating care?

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Dr. Nasrallah responds

Thanks to all my colleagues who took the time to read and express their views, to agree or to challenge the tenets in my editorial that lamented the lack of progress in certain practice aspects of psychiatry. Current Psychiatry *is a marketplace of updates, ideas, suggestions, critiques, and rebuttals. It is interesting psychiatrists who have worked for a long time with seriously mentally ill patients in hospitals or the community seem to feel the pain of the lack of steady progress and/or the slippage in some areas, while those who identify with the managed care model of care see things differently—ie, managed care is, in fact, progress.*

We psychiatrists evaluate and treat patients in very diverse settings and perceive things through different prisms, which is why we have disparate views. No one has a monopoly on the truth, but we all have important common ground: we all share an intense loyalty to our suffering patients, and we all share pride in our noble profession regardless of its ups or downs. We know in our hearts psychiatry remains indispensable for the well-being of all citizens. Pass it on…

Henry A. Nasrallah, MD
Editor-in-Chief

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Visit this article at CurrentPsychiatry.com for more letters about Dr. Nasrallah's June 2011 editorial

Insidious progress

I love Dr. Nasrallah's editorials, but none more so than his commentary in the June issue, "A skeptical view of 'progress' in psychiatry" (From the Editor, Current Psychiatry, June 2011, p. 18-19), in which he deftly highlights factors hindering the advancement of our profession. Clearly, his arguments come from the heart and speak directly to many psychiatrists' concerns about what is happening in clinical settings.

I believe managed care has contributed to the proliferation of irrational polypharmacy. This is a consequence of clinicians who find themselves under unrealistic time pressures and cost constraints to come up with an expedient, "magical" treatment for acute hospitalized patients.

In reference to the comments about the phrase "behavioral health," I have always objected to the pejorative term "providers" to refer to physicians. The designation "behavioral health providers" lumps psychiatrists and all other workers in the mental health field under the same umbrella, blurring the roles and identities of the different professions. Insurance companies further dismiss our psychiatric follow-ups as "medication management," which ignores the broader, more specialized nature of our work with patients for the purpose of slashing fees. We often take these terms for granted, accepting them as nothing more than semantics or corporate jargon, but they are not so innocuous. We all should be aware of how these labels limit psychiatric practice and allow us to be subjugated by parties with financial motives.

On behalf of all of us who see the insidious side of the so-called progress being made in psychiatry, thank you for this insightful, well organized, and well written editorial.

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To tell the truth

I loved Dr. Nasrallah's editorial in the June 2011 issue ("A skeptical view of 'progress' in psychiatry," Current Psychiatry, June 2011, p. 18-19). It's calling a spade a spade. This should be published as an op-ed piece in the *New York Times* or another national newspaper so the public can see the reality of the situation.

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