AA P&P Association for the Advancement of Philosophy and Psychiatry

Newsletter

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From the Editor

The year has been a successful one for AAPP, with a growing membership and an ongoing, close association with the Philosophy Group in the U.K. Two changes are worthy of note for the upcoming year. The first is that we will extend our annual meeting from one to two days. The number of submitted papers of good quality has been large enough that we have not been able to accomodate many of them. The expanded format will allow for greater exposure of members' work. Our meeting will take place in Philadelphia on May 21 and 22, 1994, in conjunction with the American Psychiatric Association Annual Meeting.

The second change in sight is the appearance of PPP, *Philosophy, Psychiatry, and Psychology*. The journal will be jointly sponsored by the American and British groups and is expected to begin publication this coming spring. The journal will be incorporated into the dues structure of AAPP and will be included with membership. Members will be informed of details in a mailing concerning membership renewal.

The current issue of the newsletter continues much of the structure of the first issue. Our president, Michael Schwartz, offers a reflection on health reform and its implications for psychiatry. Manfred Spitzer continues our effort to track the progress of philosophy/psychiatry in other countries by offering a view from Germany. We continue to report on associated local groups with a description by Bradley Lewis of a newly formed group in Washington, D.C. We will also relate information about established groups that might be of interest to the membership and include in this issue a report by Richard Rojcewicz of the annual meetings held by the Simon Silverman Phenmenology Center at Duquesne University. There is also a note provided by Bill Fulford on one of the activities of the Philosophy Group, a lecture series to take place in London. In our effort to provide in-depth reviews of relevant books we have two reviews in this issue, Larry Davidson on Jerome Bruner's *Acts of Meaning* and Greg Mahr on Daniel Dennett's *Consciousness Explained*. John Sadler continues his regular column, "Philosophy and Psychiatry in the Literature." In addition, we have included in this issue a report by Mark Sullivan on the 1993 annual meeting. We will include a report on the annual meeting as a regular feature for the autumn issue of the newsletter. Finally, there is a report on the winners of the 1993 Karl Jaspers Award, with an attached note on the publication successes of all previous winners.

James Phillips, M.D.

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President's Column

Health Reform, Primary Care and the Future of Psychiatry

Circumstances culminating in the recent unveiling of the Clinton administration's health package have led me to put aside previous plans for this column and turn instead to the issue of health care reform. I will address this issue especially from my vantage as a psychiatric educator in a mid-sized residency training program.

Before the end of the decade, the system of health delivery in the United States will be substantially revised. Massive changes will occur — are already occurring — regardless of the success or failure of the present administration's current proposals. Clinton's proposals may pass or fail, but the issues motivating them will continue to press for remediation, and all of us will participate in change at many levels. Going into this process as psychiatrists, we are especially concerned about the future of our discipline. Which changes should we advocate for, and which should we resist?

The crisis that we are facing has multiple causes — demographic, cultural, historical, political, ethical and ideological. The relative importance of each one of these issues may be debated, but the economic factors which press for imminent change cannot. Health care now consumes over one sixth of our nation's Gross National Product, and continues to inflate annually at a double digit or nearly double digit rate. If no changes are made, total health care costs in the United States will exceed one trillion dollars a year while President Clinton is still in his term in office. Beyond this, by the year 2000, these costs will exceed two trillion dollars and consume over one quarter of the GNP! Such numbers tell it all — despite politics or rhetoric, such a scenario simply will not occur — by necessity, there will be change.

The economic determinants of the dilemma make it possible to predict much of what is coming. There will be less, not more. Health care will be rationed (no matter how this is presented politically), biomedical research will be slowed down, regulations will increase, not decrease, gate-keepers will be brought into the system at many levels (including primary care physicians as clinical gate-keepers), "luxuries" in the system will diminish (such as choice of physician or even access to a physician rather than a non-medical provider), and marginalized parts of the new system (such as non-primary care physicians including psychiatrists) will be devalued.

continued on page 2

President's Column

continued from page 1

The changes that are anticipated certainly challenge us, but the process of change also presents us with important opportunities to advance mental health agendas. In the anvil of change, we have an opportunity to correct long standing inequities in health policy for the mentally ill. It is conceivable, for example, that public health issues such as universal access to care and non-discriminatory coverage will play a larger role in the future health care system. Such principles can greatly benefit our patients. We should try to unify around issues of public policy, be vigilant, avoid pessimism, and be as pro-active as we can in the coming political process as citizens, voters, and advocates.

We psychiatrists will especially have to learn how to better work together as colleagues in a single profession. Psychiatrists are notoriously fractious as a group, often to our detriment in public forums. A recent example of this is our failure to address the escalating consequences of psychiatry's not being considered a primary care specialty. Public concensus and policy now demands that at least 50% of all physicians practice primary care (as internists, pediatricians and family practitioners). Unfortunately, we are presently quite distant from this target. As an example, 18% of last year's graduates from my medical center (Case Western Reserve) went on to careers in primary care. The mathematics of the situation are frightening: If a 50% goal is to be achieved within ten years, 85% of future American medical school graduates will have to choose primary care careers. Clearly, such a goal can only be met by draconian measures which are now being planned in Congress. One Congressional bill proposes severe penalties for medical schools when less that 50% of graduates enter non-primary care residencies. Another would limit the total number of PGY-1 residency positions to the number of U.S. medical graduates each year plus 10%. Currently, International Medical Graduates occupy slightly less than 30% of residency positions, including 26% of psychiatry positions and 36% of PGY-1 psychiatry slots (1992-93 data). Still another proposal threatens to penalize hospitals when more than 50% of a house staff do non-primary care training. Finally, recent medicare regulations increase hospital stipends for primary care residents significantly more than for non-primary care residents. The net effect of legislation and regulation of this sort will be a drastic downsizing of psychiatry — a downsizing currently estimated to be as much as 40%.

The irony of this situation is that at least two recent national studies conclude that psychiatry is a shortage specialty. Furthermore, many psychiatrists work is settings such as public mental hospitals and clinics and function as primary practitioners. Psychiatrists did have an opportunity to appeal being left out of national primary care initiatives. As will be described below, we failed to act because of internal divisiveness. In contrast, colleagues in obstetrics and gynecology were also excluded from primary care legislation but appealed this exclusion and successfully achieved at least partial recognition of their primary care role. As a result of this lobbying, obstetrics and gynecology residents will now receive the same medicare salary increases as primary care housestaff, and the same differential over secondary care (i.e., psychiatry) house staff. In contrast, the lower reimbursement for psychiatry residents in the face of uniform stipends for all will provide additional incentives for hospital administrators to diminish psychiatry positions, deepening an already downward spiral.

Significantly, efforts by psychiatrists to make the same case as our successful colleagues in obstetrics and gynecology were undermined from within. Factions within psychiatry lobbied to keep us out of the primary care arena, arguing that psychiatrists shouldn't physically examine patients and therefore cannot play any part in primary care.

This assertion brings us back to basic concerns. The position that psychiatrists should not perform or even oversee physical examination occurs, I maintain, because of unclear thinking about what a psychiatrist is. We are somehow "mind" doctors, or our method has a psuedo-psychoanalytic basis no matter how we conceive of it (so any touching will always be taboo, no matter how medicalized), or there is the romantic and somewhat mysterious notion that psychiatrists have more intimate relationships with patients than other physicians, and therefore can never touch them. All such ideas are rooted in confusion about the nature and goals of psychiatry. After all, cardiologists have heart disease as their area of special expertise and neurologists have illnesses of the nerves and the brain, but there is no consensus about the core expertise of the psychiatrist. Clearly, one "core" for us are those patients that no one else wants to treat anyway — the seriously and persistantly mentally ill. These patients are our natural constituency. Furthermore, they value our services, probably more than we value them. Beyond this core, I would assert that we are experts in abnormal human experience and behavior — in psychopathology. Such expertise cuts through mind/body dualism and through linkages to particular treatments and theories and makes us broadly relevant to societal health agendas. Psychopathology is a fundamental science for psychiatry, related to the mental disorders on the one hand and to human biology and human society and culture on the other.

When the dust settles on health care reform, mentally ill patients will remain whom no one else wants to or knows how to treat. Patients with perplexing behavioral and experiential problems will continue to seek out our services as physicians. There will still be a pressing need for well-trained psychiatrists. What is not clear is how many of us will be there to meet this need. We should strive to work together to assure that our field will continue to flourish and that we will be able to continue to serve these patients. This aspiration involves participating as citizens and as psychiatrists in the present debates about health care reform, and committing ourselves to work more diligently to clarify who we are and what we can accomplish.

Michael Alan Schwartz, M.D.
President
AAPP

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The View From Germany

In Germany, there has always been a strong interest in the philosophical underpinnings of psychiatric reasoning and practice. Philosophy used to be a required subject for medical students, and ever since, psychiatrists have taken a reflective stance on their experience and their professional concepts. This is exemplified in the works of Karl Jaspers and Ludwig Binswanger, to give just two examples. German psychiatry used to lead the field with such prominent figures as Kraepelin, Nissl, Alzheimer, Jaspers, and Kurt Schneider, who shaped psychiatry as it is practiced all over the world today. However, this is all a thing of the past. For the last three decades, few contributions have come from this country, compared to the growing influence of Great Britain and, in particular, the USA. This is reflected by the fact that German psychiatric journals once led the field, but today fare badly if