RIPSNEWS

RHODE ISLAND PSYCHIATRIC SOCIETY • *A District Branch of the American Psychiatric Association*

President's Message

Barry W. Wall, MD

This is my last President's Message. It has been a pleasure and a privilege to lead the Society for this term. I am in-debted to all of you for giving me this opportunity, and I want to express my gratitude to several people in particular.

Lou Marino's easy-going style, his ability to reach out to members, and his capacity to manage a calendar infinitely better than me has helped keep the Society on track. Without Lou, I would still be planning the 2001 meetings. He will do an outstanding job in the coming term.

Jay Thornton has transitioned into his new position as newsletter editor. Software and staffing matters momentarily slowed newsletter production, but we are back on track. Jay is dutiful, takes his job seriously, and we are lucky to have him. If he ever asks you to write an article, do it – and make the deadline!

Several stalwarts of the Society, including Pat Recupero, Robert Johnston and Mickey Silver have given me their wisdom and advice over the past few years, for which I am thankful. Particularly without Pat's vision and initiative, our Society would not be a part of the Medical Society's current program to increase public and legislative awareness of the problems doctors and patients face in Rhode Island.

Last but not least, I want to thank Sarah Stevens, who took Edwina Rego's former administrative position after a time of personal tragedy for Edwina. Sarah has become an accomplished and indispensable part of the Society. It has been a joy to work with someone so professional, devoted, and cordial.

I believe that the Society is a more relevant and vital organization now than it was a decade ago. Over the past several years, the Society has continued to effectively advocate for persons with mental illness and has strengthened connections with advocacy groups and legislators. Our membership is growing. There has been more participation by junior members.

But there needs to be more participation by all members. Working in a volunteer organization is difficult because none of us have extra time, and we often feel like we are losing the healthcare battle. But when you sit with, say, the Governor and House and Senate leaders like I did a few weeks ago, and you clarify to them that the (highly-paid) insurance company lobbyists and leaders they met with the day before cleverly glossed over some important issues about patient access to care, and the leaders listen, you realize that you are having an impact. Without input from psychiatrists, industry and legislators will continue to make it more difficult for mentally ill persons to receive treatment. It will become even harder to practice our profession and to earn a good living. Quality of patient care will continue to suffer. The lobbyists and executives will remain out in full force because influencing powerful people is their full-time job, and the more businesses influence policy-makers the more that business profits. Yes, the *continued page 8*

June 2003

Station Nightclub Fire

Volume 34, Number 2

Editorial

Anthony Jay Thornton, MD
Editor

The Station Fire Disaster: "Ground Zero Rhode Island"

Everyone by now is certainly familiar with what has become known as the "The Station fire", Rhode Island's largest and most horrific fire disaster. Described by the *Providence Journal* as "our ground zero", 100 individuals lost their lives and hundreds more were injured. It seems everyone in our small state was affected to some degree, with the national and international news spreading the response globally.

Less well known is how the Rhode Island mental health community responded to this disaster. Rhode Island has an emergency response agency known as RIEMA (Rhode Island Emergency Management Agency), which is the state version of FEMA (Federal Emergency Management Agency). There are a number of required emergency service functions with Rhode Island the only state where the mental health function is separated out (Kathryn Powers, Director of the Department of Mental Health, Retardation and Hospitals is in charge). The Rhode Island Behavioral Management Task Force is the entity that manages the mental health emergency service function. Critical Incident Stress Management Teams are being developed statewide with each of the eight Community Mental Health Centers developing regional teams. Gerald Lewis, Ph.D, is conducting statewide training in Critical Incident Stress and Trauma Management. All of this has been formed after the 9/11 World Trade Center tragedy to help combat terrorism. Prior to this, individual centers, such as the Providence Center and Newport County Mental Health Center, had developed their own programs and had participated in previous disasters (such as the 9/11 world Trade Center and the Egypt Air disasters respectively). This latest effort was to ensure a *continued page 8*

The Rhode Island Psychiatric Society Newsletter, *RIPSNEWS*, received an Honorable Mention in the 12–16 Page category of the 2003 APA Newsletter of the Year Award.

The Station Nightclub Fire: The Mental Health Response

James Campbell, Ph.D.

Dr. Campbell is the Director of the University Counseling Center at the University of Rhode Island. He is an adjunct faculty member at the university and teaches courses in traumatic stress and workplace violence. He is the Rhode Island Coordinator for the American Psychological Association/American Red Cross Disaster Response Network and is author of the book *Hostage: Terror and Triumph.* He has provided services to survivors of hostage incidents, bank robberies, natural disasters, and other traumatic events including the Egypt Air crash, 9/11, and The Station nightclub fire.

The headline in *Rolling Stone* called it "Three Minutes in Hell." The phrase attested to the speed with which the fire at the Station engulfed the nightclub and its 300 patrons. The tragedy in West Warwick, Rhode Island claimed 100 lives and injured 180. Many of the injuries were horrific: flesh burned to the bone, faces so charred that victims were unrecognizable—even to loved ones. The community—the whole state—was stunned. Nevertheless, there was a massive mobilization of resources to investigate, to treat, to comfort, and to identify the bodies of those who lost their lives.

The Red Cross, the Medical Examiner, state police, and others established a center for families and friends of victims at the Crowne Plaza Hotel in Warwick. I arrived there on the morning after the fire. Red Cross staff were trying to bring some order to the inevitable chaos that reigns in the first hours of a response to a major disaster. The hotel offered several ballrooms and meeting rooms for the hundreds of family members, staff and volunteers. Mental health professionals and clergy arrived by the dozen. Before the support center closed five days later, hundreds of volunteers had made themselves available—often serving overnight shifts. Mental health professionals and clergy provided a "compassionate presence" to the anxious and grieving families. Some individuals wished to talk; some just wanted to wait quietly with support. Some family members wanted information about how to talk to young children about the fire and the loss of a parent or sibling.

It has often been noted that what people most want after a disaster is information. The Station fire disaster affirmed this observation. Family members hung on every scrap of information. They went through the exhausting and excruciating process of providing identifying information to personnel from the medical examiner's office: descriptions, photographs, dental records, and DNA samples. Then they could only wait. The burden of not truly knowing the fate of their loved ones weighed heavily. Two hospitalized burn victims remained unidentified for days. This left families wondering—hoping—that perhaps their daughter or sister was still alive. Identifying the bodies of victims was given top priority, but it went so slowly for the waiting families. It seems to me that each disaster has a particular moment that becomes etched in your heart and mind forever. For me that moment occurred when the health department announced that most of the identifications would have to be accomplished by dental records. The cry of anguish that arose from the hundreds of family members is a sound I will never forget. In an instant, they realized that the fire had wrought unspeakable devastation upon their loved ones. The images created in the mind's eye by such an announcement remains the stuff of nightmares.

Remarkably, in this crucible of sadness and suffering, family members forged friendships with one another. They reached beyond their pain to support others. I found myself drawing strength from their determination and courage. I found myself in awe of the helpers as well. People young and old came to help, to pass out water, to distribute stuffed animals to children, and to provide counsel and consolation. The clergy and mental health professionals were individuals

who, generally, had experience with trauma and bereavement. Nevertheless, the scale and intensity of the disaster could leave the most experienced professionals shaken. The Red Cross had asked me to organize and staff the debriefing function. Before leaving the site all volunteers were asked to participate in a short debriefing to help them consider and articulate their experience, and to assist their transition back to the world beyond the disaster. We guided the discussion with questions: What did you do? What was one of the hardest things about your work? What is a positive thing you will take away from this experience? What will you do to take care of yourself when you go home? Then we would look at them directly and thank them for all that they had done. Volunteers reported that they found this debriefing useful. It helped them begin the process of transforming this highly affective experience into a meaningful narrative. The debriefers, all experienced clinicians, were deeply moved by the dedication and courage that we witnessed in these volunteers. They shared, frequently through tears, what was difficult and what was inspiring about the work they were doing. We became acutely aware of the privilege of helping the helpers—and the victims—of this terrible tragedy. The psychologists and counselors, many of them on my staff at the University of Rhode Island Counseling Center, worked long hours, sometimes overnight, with grace and generosity. When I think of them I still feel moved—and so very proud—to have had the honor of serving with such outstanding professionals.

A student in a class I teach told me that he had planned to go to the Great White concert that tragic night, but he could not find anyone who wanted to go with him. He skipped the concert and was feeling "like the airline passenger who misses his flight, and then learns the plane crashed." It occurred to me that this kind of catastrophic event can

(Above) Associate Judge Stephen Erikson, recepient of the Third Annual Eleanor Slater Award, and Barry Wall, MD.

(Right) L–R APA Assembly Representative Pat Recupero, MD; President-elect Paul Lieberman, MD; Incoming President Lou Marino, MD; Past-president Barry Wall, MD; and Secretary-treasurer Dawn Picotte, MD

2003 Eleanor Slater Award Presented at Annual Dinner Meeting

RIPS' Annual Dinner Meeting was held at Mediterraneo's in Providence on April 28, 2003. Members and guests were treated to excellent food and service in a beautiful meeting space overlooking Atwells Avenue and downtown Providence. Edward Brown, MD, Clinical Associate Professor of Psychiatry and Human Behavior at Brown Medical School was guest speaker. A synopsis of his presentation "*The Future of Psychiatry – What Does History Have to Teach US?*" can be found on page 10 of this newsletter.

A highlight of the evening was the presentation of the Third Annual Eleanor Slater Award to Associate Judge Stephen P. Erickson. Judge Erickson was appointed to Rhode Island District Court in July 1990. Notable activities include Chair of the State Housing Appeals Board and Administrative Judge, Third Division. He organized and implemented with Kent County Mental Health the first mental health diversion program in the Rhode Island judiciary. He was appointed by the Governor in 2002 to give the judicial perspective to the Governor's Advisory Council on Behavioral Health. He serves on the Newport Hospital ethics committee. He

touch us all in the same way. We are confronted with our mortality in graphic and disturbing ways. We are left with the challenge—and the opportunity—to face our own existential anxiety. If my life is finite, how will I make each moment count in some meaningful way? How will I treasure those I have the opportunity to love for these numbered days? I surely do not have the final answers to these questions, but the questions point me a useful direction as I seek to bring meaning to disasters such as the Station fire. ❖

L–R Incoming President Lou Marino, MD and guest speaker Edward Brown, MD

has received numerous other awards including the Eleanor Briggs Award (Kent County Mental Health) and the Thomas Perry, MD Distinguished Service Award (Rhode Island Council of Community Mental Health Centers). Dr. Wall paid the highest compliment in regards to the complex interface between the judiciary and mental health care, "he gets it". To those of us making the trip to Cranston and St. Joseph's Hospital for court ordered treatment for our patients, we find a caring and concerned judge with a great understanding of the complexities of our field. ❖

Station Fire Aftermath

Scott Haltzman, MD
Chair, Ethics Committee
Medical Director, NRI Community Services

Four years ago, NRI Community Services launched an initiative to prepare for critical incident response and crisis debriefing services. Traditionally, NRI has always been part of community response when there are traumatic life events in Northern Rhode Island. As a result of homicides, suicides, fires and then September 11th, more staff members have been trained to respond to critical incidents, and the reach of the services has extended beyond the northern part of the State. NRI has participated with the Rhode Island Division of Behavioral Health and the Mental Health Centers in their planning for statewide crises.

Never did NRI Community Services expect to be so directly effected by traumatic events within their own staff family. First, Alicia Curran, a senior licensed social worker, lost her sister, a stewardess, on one of the planes on September 11, 2001.

Now NRI is mourning with their Director of Information Technology, John O' Donnell, the death of his daughter, Katherine, in the Station fire and Brenda Poette, Coordinator of Wilson House (a substance abuse residential facility) on the death of her sister, Dina Ann DeMaio. Another employee who attended the Great White concert escaped the blaze without injury.

However, in the midst of this loss, the Rhode Island Department of Behavioral Health recognized the NRI team for its excellent work during the crisis. NRI is being credited for the time, compassion, and expertise they are bringing to Rhode Island Emergency Management Agency and Red Cross efforts at the Crowne Plaza, the disaster site, and now at the new Family Resource Center.

Christine Mattera, a mental health clinician and administrative coordinator, helped in handling the round-the-clock scheduling. Kristine Carey, NRI's Emergency Services Coordinator, had to notify a family on the death of their son. Richard Crino, RN, a former Emergency Coordinator at NRI, now responsible for multiple programs, debriefed police and fire officials involved in the tragedy. Lee Dalphonse, a Senior NRI staff and Coventry resident, also debriefed police officers in his home community.

In working with the families in the days following the fire, Alicia Curran integrated her social work skills with her own personal experiences from September 11th. Ms. Curran pointed out that families of the two disasters absorbed the loss similarly: "When people approached the information desk the day after the fire, they were not reporting their family members as dead, but rather as missing persons. Parents, siblings or spouses could see no body, so they held on to the hope that their loved one was still alive." These families continue in their transition from hope to acceptance.

The efforts to support those affected by the Station fire will continue in the coming months, and NRI will continue to play an active role in providing resources and care to the victims of this disaster. ❖

General Membership Meeting
February 2003

Larry Price, MD; Lou Marino, MD

RIPS' General Membership meeting was held on February 24, 2003 at Spain Restaurant in Cranston. As the meeting occurred only four days after The Station nightclub disaster, the issue of RIPS participation in post-event mental health care was discussed. Dr. Wall indicated that the APA and RIPS work via the Red Cross to provide any requested services in such incidents. Several members indicated they had already been involved.

Dr. Wall addressed the membership regarding the formation of a panel by Governor Carcieri to mediate differences on a number of issues between BlueCross/BlueShield of RI and area physicians. Dr. Brandon Krupp, Dr. Barry Wall, Dr. Mickey Silver, Dr. Patricia Recupero, and Dr. Lou Marino were to meet with RIMS (Rhode Island Medical Society) representatives to ensure psychiatry would be represented. It was noted that RIPS is in danger of losing its seat on the RIMS Council as less than 50% of our membership do not belong to RIMS. Everyone is urged to join RIMS as this organization is very active in Rhode Island advocating for all physicians.

Brandon Krupp, MD; Gabor Keitner, MD

Lawrence Price, MD, Professor of Psychiatry and Human Behavior at Brown Medical School and Clinical Director and Director of Research at Butler Hospital, spoke on recent developments in diagnosing and treating Bipolar Disorder. Dr. Price discussed the epidemiology of Bipolar Disorder, how patients actually present to clinicians, and standard and novel treatment approaches.

The interesting concept of "soft" Bipolar Disorder as a possible transition form of affective illness was presented. This comprises the spectrum ranging between recurrent unipolar depression and borderline personality on one end, and bipolar disorder on the other. Bipolar II disorder would be considered a "soft" bipolar disorder. Patients often present as diagnostic dilemmas with mild to moderate symptoms, but often with severe functional impairment.

RIPS members enjoy dinner at the Spain restaurant.

They are usually difficult to manage, engendering complex pharmacologic and psychosocial treatment approaches.

Standard antimanic agents (lithium, divalproex, carbamazepine, neuroleptics) are often added to newer agents (lamotrigine, gabapentin, topiramate, atypical neuroleptics, and omega-3 fatty acids). Combination treatment in bipolar disorder is the rule rather than the exception. Dr. Price discussed numerous additional agents reported to have antimanic or mood stabilizing effects (benzodiazepines, thyroid hormone, clonidine, inositol, donepezil, oxcarbazepine, tiagabine, zonisamide, transcranial magnetic stimulation, and subcaudate tractotomy). Psychosocial interventions are indispensable as an additional treatment tool. ❖

Bill Braden, MD; Robert Florin, MD

Join the Rhode Island Medical Society!

RIPS needs members to join the Rhode Island Medical Society to maintain its seat on the RIMS Council, which requires 50% of active members in RIPS to be members of RIMS.

In addition to Council representation, RIMS members receive many other benefits, including:

- **Free Publications**
- **Insurance services**
- **Benevolence Fund**
- **Brown University Library privileges**
- **Free websites for medical practices**
- **Continuing Medical Education**
- **Referrals**
- **Distinctive listing in Folio's Medical Directory**
- **Representation, advocacy and opportunities**

To join the Rhode Island Medical Society, visit the website, www.rimed.org, or call the Society's office at 331-3207.

President's Message continued

system is often unfair. And it is unfortunate that we can't lobby full time since we are spending our days treating patients. But if we don't participate, the balance will be even more lopsided.

After two years, the most important statement that I can make in this column is the most important insight that I have gained as president: Getting involved is rewarding. Really. ❖

Our Website Is Up and Running!

The RIPS website has been launched. The address is psychri.org. You will find information on upcoming meetings and Grand Rounds, the most recent newsletter, and more. Visit the site!

Editorial continued from page 2

coordinated and comprehensive statewide response to any future disasters.

Sound impressive? It is, except that the system is still in its early developmental stage. The first statewide training in Critical Incident Stress Management (CISM) was scheduled over two days – Wednesday, February 19 and Friday, February 21. Of course, The Station Fire disaster occurred on February 20. You can imagine the initial chaos that ensued.

By all accounts, initial efforts at a coordinated response were difficult and spotty. Mayor Cicilline seemed to take the lead initially followed by MHRH. This is not to say that there weren't sufficient mental health professionals from all over volunteering their time and efforts. There were in fact many who were turned away. However, after a day or two, the statewide embryonic mental health emergency response system seemed to mature rapidly, working closely with the American Red Cross. As you may know, it is the Red Cross that calls the shots during such disasters. The Red Cross and MHRH had come to an agreement previously that the Red Cross would remain in charge if the Red Cross recognized the expertise of MHRH mental health professionals. Prior to this, only Red Cross trained individuals were allowed to participate.

Initially at the Crowne Plaza, and then later at the former Daewoo Motors building where a Family Service Center was temporarily set up, mental health professionals from numerous disciplines spent countless hours with the many victims, friends, and families touched by this incident. Area businesses donated everything from Kleenex to food to cell phones. The Family Service Center has been described as a great success where every possible service needed by victims and their families could be accessed under one roof. It seemed many of the individuals presenting for help had scarce personal resources and many had no health insurance.

RADM Brian W. Flynn, Ed.D, Assistant Surgeon General (USPHS, Ret.) and Associate Director for the Center for Studies of Traumatic Stress at the Uniformed Services University of the Health Sciences, gave a presentation entitled "Moving from Response to Recovery – Mental Health Implications Following the West Warwick Fire". He discussed the phases of disaster (Zunin/Myers) as a heroic period, honeymoon period of community cohesion, disillusionment, working through the grief/coming to terms, and reconstruction. This process takes one to three years, and all of us have seen in our practices many who take much longer. In the initial phases where there is an outpouring from the community there is much less of a problem than over the long haul as resources dwindle. Also, mental health workers who are available when the tragedy initially occurs are likely to be incorporated as part of the event and thus may more easily be accepted later on by the victims, families and friends when further help is needed.

Many weeks now after The Station Fire tragedy, we are hearing more and more regarding the legal wrangling and less about the victims and those affected (evidence we are passing into the disillusionment phase). Since then, we have lived through a war with Iraq, broadcast real-time into our living rooms on a 24 hour per day basis. A new series of terrorist attacks is underway around the world with warnings that further attacks in the US are almost assured. Everyone's anxiety level is elevated along with the terror alert level. It is all too easy to let the plight of the many people affected by The Station tragedy fade into the distance.

Let's work as a Society to help support the efforts in this state to develop a model statewide mental health emergency response system – a system that not only responds heroically in the days and hours after a tragedy, but also is available to arrange longer term assistance for those who need it. The development is in its beginning stages, and I believe we can all contribute and support. ❖

Committee on Women

Alison Heru, MD

Why do medical schools need an Office of Women in Medicine?

Despite equality of opportunity, women continue to be under-represented at higher levels in the medical school and women perceive the medical environment to be unsupportive and in some cases, outright hostile.

- 8 Deans of the 125 US medical schools are female.
- Women sit in 8% of medical school department chairs, which is 1.7% per medical school.
- There are 21 women full professors (usually one per Department) compared to 161 male full professors.
- In emergency medicine, otolaryngology and orthopedic surgery, the proportion of women professors has declined in the past 6 years to 6%, 7%, and 1% respectively.
- Promotion to higher levels for women occurs at a lower rate than for men. Looking at the cohort of 1980, 83% of men compared to 59% of women had achieved associate or full professor rank, 23% of men and 5% of women at full professor rank. Women were less likely to have office or laboratory space, protected time for research, or to have begun their faculty careers with grant money.
- Women comprise 14% of tenured faculty, a decline from 15%, 6 years ago.
- Women are less likely to be promoted.

On tenure tracks, 36% of eligible men were promoted to associate professor, compared with 24% of eligible women. On non-tenure tracks, 18% of eligible men and 10% of eligible women were promoted to associate professor.

- Women in surgery are less likely to be married and have children than men in surgery.
- Pay discrepancies at some medical schools are described as, "Unexplainable gender-related differences."
- Harassment and gender-based discrimination is reported at 77% of female faculty.
- There are 13 medical schools that have formal women faculty organization.

This data on women was collected over four years from Dean offices from 95% of medical schools, by the Association of American Medical Colleges and is published in *Academic Medicine*, October 2002.

There are two main points.

- Women are perceived to have equal access but there are invisible barriers such as lack of mentors or a work environment that prevent women from achieving true equality.
- Women may want to nurture their children more than they want to build a career. The medical hierarchy should allow them to do this and to return full time to a medical career at a later point in their lives. Men should also be afforded the same privilege.

Women tend to choose specialties that are compatible with raising a family, specialties that offer flexible hours and sympathetic colleagues. Women should be able to make a choice about their specialty based on their skills and interests, not on the inflexibility of the structure of that Department and whether or not the environment is welcoming to women.

Female physicians have to make difficult choices between home and family. Taking maternity leave, for example, may be problematic if the tenure clock is ticking. Colleagues may be unwilling to do "extra" call during maternity leave. The usual solution that female physicians work out, is to do more on call before going on leave in order to have someone cover her during leave. The usual solution to most problems that female physicians have, is to work around the problem, rather than confront the medical hierarchy head on.

The Office of Women in Medicine can identify the invisible barriers for women in the medical institution and develop a plan of correction.

Women tend not to speak up about small inequities or mistreatment because they do not want to be labeled or cause trouble. They realize that, for the most part, nothing personal is intended and "That is just the way things are". Women are also more likely to be on the periphery of the department and do not want to seen as "over-reacting" or doing anything that would push them more to the periphery.

If women do not speak up,
nothing will change.
Do you have a story to tell?
Would you be willing to put it in print?
Be anonymous if you wish,
or be bold and sign your name.
Email aheru@butler.org ❖

The Future of Psychiatry: A Lesson From History

Edward Brown, MD

A synopsis of the presentation given at the 2003 Annual Dinner Meeting.

It is one of the ironies of the present moment in psychiatry that even as we celebrate the discovery of new treatments for mental illness, the plight of the mentally ill may be worse than ever. The availability of good psychiatric treatments does not guarantee good treatment for the mentally ill, as Clifford Levy's recent Pulitzer Prize winning series in the New York Times suggests. This, however, is not a new phenomenon, but a theme running through the history of psychiatry.

The rise and fall of modern psychiatry's first treatment, known as moral therapy, provides an interesting object lesson. Before the advent of modern psychiatry the mentally ill were cared for by their families, if they were able. Doctors had virtually no role in this care and the state became involved only in cases where poverty or violence were an issue.

Modern psychiatry was born in 1793 when a physician, Philippe Pinel, was appointed to BicÍtre, a so-called hospice with nearly 4000 male inmates, including orphans, criminals and poor sick homeless people, only 200 of whom were regarded as insane. Pinel, armed with the ideals of the French Revolution, tried to reform a corner of this vast structure of despair. Having very little experience treating the mentally ill, he wisely chose to carefully observe the treatment conducted by the two lay caretakers Jean-Baptiste and Marguerite Pussin. In his 1800 *Treatise on Mania*, Pinel gave a formal description of their treatment, as well as a physiological rationale for their success. Moral treatment was born. His treatise was translated into English in 1806, and, along with the example of a very similar treatment developed by the Quakers of York England, it stimulated a wave of asylum building in the United States.

"The availability of good psychiatric treatments does not guarantee good treatment for the mentally ill."

American asylums were purposely built to provide moral treatment. They were small, with no more than about 100 beds. They were built in rural settings, often incorporating active farmland. Removing the insane to a quiet, rural spot, some distance from the urban center was thought to protect patients from the stresses that had led to their breakdown, not protect society from the mad. Superintendents lived on the grounds and conducted the asylum rather like a large family. Moral treatment was, however, thought of medically. Therapeutic interventions were often justified by the best neurophysiological theories of the time—those of phrenology. A number of factors combined to make the United States into fertile ground for planting the idea of moral therapy. Urbanization made family care more difficult. After the Second Great Awakening religious ideas contributed to the impulse to improve people. The creation of asylums for the insane was seen as part of a more general strategy for segregating disturbed and disturbing populations in asylums, penitentiaries and orphanages. Wealth allowed philanthropists to display their generosity by building hospitals.

When Butler Hospital was completed in 1847 it was one of the last of the small moral treatment asylums to be built. Since hospital treatment did not have a good reputation at the time, asylum superintendents, like Butler's Isaac Ray, spent considerable energy publicizing the healing properties of these new asylums. Early asylums attempted to treat the rich and the poor alike. Each town paid to have its indigent patients cared for. There were, however, different accommodations between rich and poor. For a time moral treatment seemed like a panacea, with cure rates of up to 100% sometimes reported.

There were, however, contradictions in the philosophy of moral treatment. First hospitals had to be small for the authority of the superintendent to prevail. Even before Butler was built, it was recognized that there were too many poor mentally ill people to be cared for in small private asylums. State asylums like Wooster State were the answer. No notice was made at first that these large institutions were not going to be able to provide the care that was the hallmark of the small private asylum. Dorthea Dix crusaded across the country urging state legislatures to build such hospitals,

Richard Gephardt Visits Rhode Island

[L–R] Representative Richard Gephardt; Brandon Krupp, MD; and representative Patrick Kennedy at a recent fundraiser for Presidential candidate Gephardt.

in the belief that they would provide care for the insane poor.

After the Civil War the movement to centralize and rationalize the administration of public welfare emerged in a self-conscious and mature form. Experience during the war convinced many that centralized administration was efficient. In Rhode Island, for example, concern about the growing number of poor and incurable patients at Butler led to a request that a legislative committee study the possibility of creating a separate less expensive institution for the incurably insane.The failure of moral treatment to live up to its promises was understood not so much as a failure of the treatment but as the result of hereditary weaknesses of certain populations. In the process, the distinctions between the categories of poor, incurable and Irish became blurred. A new scientific concept, hereditary degeneration, was developed to explain what people were observing.

"...when partial treatments fail to return chronic patients to full participation in society, there is a tendency to blame the patients..."

In line with this thinking Rhode Island built a state farm on the Howard farm in Cranston. When it was completed in 1870 it contained not only an Asylum for the Incurably Insane but also a state almshouse, and a work house and house of correction. There were also plans, which were acted on a few years later to build a state prison on the site. The cost consciousness of the legislators was evident in the construction of the asylum. It was a wooden structure, that was proudly proclaimed to be modeled after the Blackwells Island Asylum in New York, which was, even at the time widely regarded as the worst asylum in the country. Reflecting the disrepute of psychiatrists at the time, the asylum was managed by two lay people and had no doctor of its own. All the institutions at the farm were managed by a State Department of Charities and Corrections, which had broad discretionary powers. It was as if Rhode Island had rediscovered the French hospice that Pinel had sought to reform.

The first hundred years of psychiatry in America and Rhode Island involved the rise of moral treatment and its decline. It involves optimistic theories about the treatment of the mentally ill followed by pessimistic hereditarian ideas. The history of moral treatment demonstrates that when partial treatments fail to return chronic patients to full participation in society, there is a tendency to blame the patients as hopeless and to look for the cheapest means of hospitalizing them, often marginalizing doctors.

As Clifford Levy's articles suggest, we may be witnessing a repetition of this process today. ❖

State House

Michael Silver, MD
Chair, Legislative Committee

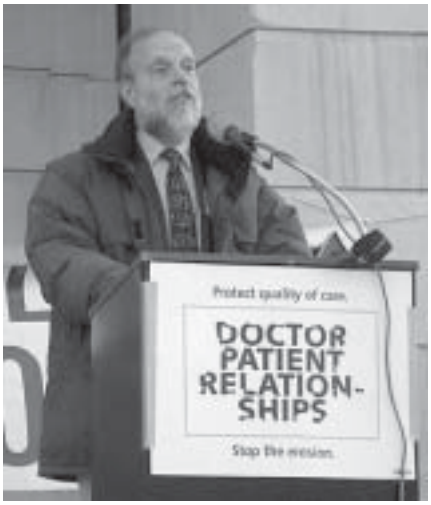
State House Rally

The rally of March 12, 2003 had a good turnout of medical professionals. Thanks to some good lobbying of the Medical Society by Barry Wall (with help by Pat Recupero, Lou Marino, and Brandon Krupp), we were well represented. I was one of eight speakers, which included the governor, Sheldon Whitehouse, and representatives from nursing, hospital administration, senior citizens advocacy.

Text of the speech:

People with mental illness often suffer in silence. Many individuals disabled by the disease have trouble advocating for themselves. Society also has difficulty coping with the realities of mental illness, and there continues to be stigma attached to those who suffer from this disorder. These illnesses aren't really considered quite as worthy as say heart disease or cancer, despite the fact that mental illness is the number one cause of disability in the world. Therefore these folks are easy targets when cost cutting is prescribed, and that is exactly what has happened in Rhode Island. The mental health community has been walking around with a big bull's eye on its back.

There has been a concerted effort over the past decade by the insurance industry to limit the expenditures for treatment of mental illness. Increasing efficiency is a laudable goal, but this was not the purpose of the effort. It actually seemed that the reverse was true. Initially insurance companies singled out mental health clinicians and required them to provide



Dr. Michael Silver at the State House Rally.

massive amounts of extra paperwork in order to get the needed authorization to deliver services.

Repeated multi-page treatment plans asking for personal information about patients had to be submitted every few months. This resulted in increased overhead costs to clinicians and decreased the amount of time that they could spend with their patients. However this strategy apparently did not achieve the desired cost savings, so Blue Cross got to the heart of the matter and cut reimbursements for outpatient services by 20%. This action proved to be effective, as a much smaller percentage of the Rhode Island health care dollar now goes to mental health treatment, despite the fact that the state has a law that ensures parity in coverage. Did the insurance companies pass the savings onto the subscribers? I don't think so. Where I work the rates went up 24% this year.

Of course there have been other costs, resulting from these strategic moves. A low percentage of residents graduating from the Brown University training program in Psychiatry go into private practice because of the current rate structure and reimbursement difficulties. Two major psychiatric institutions in Rhode Island, Butler and Bradley hospitals, closed their large multi-site outpatient programs because the services were losing too much money. As a result it is now difficult for adults to get a timely outpatient appointment, and it is almost impossible to see a child psychiatrist in a timely manner. Because of the large caseloads, outpatients cannot be seen very frequently, and therefore when patients get sicker, they are often hospitalized because alternative services are either unavailable or hard to access. As a result of these cuts and the limited funding in the public sector, psychiatric hospitals, which had a hard time filling their beds a few years ago, are now overflowing (not exactly an efficient use of health care resources). At times acutely ill psychiatric patients have to sit for hours or even days in a noisy emergency room waiting for a bed to become available.

Getting into the hospital only provides temporary respite from the system problems created by the funding cuts. Hospitals are often unable to get timely outpatient appointments for patients being discharged. It is well known that the period after hospitalization is a dangerous time for psychiatric patients, and close follow up is required to prevent bad outcomes. Lack of timely aftercare has resulted in clinical deterioration and even patient death.

If Rhode Island insurance companies are not willing to pay the market value for services, qualified professionals will choose to work elsewhere. Deterioration in the quality of all medical care will certainly be a result of these fiscal decisions. What's happening to mental health care today will happen to all health care tomorrow. Will the citizens of Rhode Island choose to suffer in silence? I hope not. ❖

Welcome to the Residents!

Below are short biographies on the incoming PGY-1 and PGY-2 Residents, who are entering the Brown University Psychiatric Residency Program. We look forward to their joining RIPS.

MICHELLE CONROY

Once again, we are very fortunate to keep a Dartmouth/Brown medical student in our fold. Michelle began her training in the combined program in 1998, spreading her third and fourth years over three years so that she and her husband, Jason McBean, would start their residency training together. So, this was actually a double coup in that Jason also will be starting his training in dermatology at RI Hospital in June. Michelle received her BA in history from Dartmouth where she was an All Ivy Goalkeeper. Michelle's very successful soccer career came to an abrupt end in the first game of her senior year, and the resulting injury, its treatment and the recovery process are what prompted her to investigate a medical career. She continued her involvement in soccer as a coach during her pre-med and clinical years of medical school. Michelle has a long-standing commitment to community service and also served on Brown's Student Health Council. The mentorship process she experienced through her work on the Council was instrumental in developing her career goal of becoming a child psychiatrist. Working as a T-32 Research Assistant to Dr. Sandi Kazura cemented that decision. Although it is unnecessary to welcome Michelle and Jason to Providence, we can say that it is wonderful they are staying here.

SHANNON DREW

Shannon has gone from a BA in Art History at Columbia to psychology pre-med studies to volunteer work at the NY State Psychiatric Institute (NYPSI) to an MD from Columbia to psychiatry to child psychiatry. While studying art as an undergraduate in Italy, Shannon realized that it wasn't the actual painting that fascinated her, but the person who painted the painting, making the progression of her education perfectly logical. It was her volunteer work as a research assistant in areas including substance abuse, PMS, anxiety disorders and ADHD at NYPSI that set her on the road to psychiatry. During medical school, despite enjoying all of her clinical rotations, she remembered why she had started on this path. It was during her psychiatry rotation that she was able to reach beyond the canvas of the patient, to the person within. After having married following her first year of med school, Shannon took a year off before starting her last year in order to relish the birth of their daughter and enjoy the first year of her life. Shannon's ultimate goal is to work as a child psychiatrist in a clinical and academic setting. We should be able to come up with playmates for the whole family.

ANGELA GOSS

It's possible that Angela never had a chance, considering her pedigree. She comes from a long line of physicians, psychologists, social workers and educators and the fact that her father is a psychiatrist may have had some influence on her career goals. But, even before medical school, dealing with medical problems in her family gave Angie an insight into the importance of emotional support and into people's behavior. Turning these life altering events into learning experiences has been a hallmark of Angie's developing medical career. She has had numerous volunteer experiences, working with both young and old people in a variety of settings. It was her work with severely developmentally disabled children that set the course to her planned career in child psychiatry. Angie graduated from Chicago College of Osteopathic Medicine in June after receiving her BA in Psychology from the University of Wisconsin and will be a great addition to this stellar cohort.

LAURA HENRICHS

Laura is another of our 2003 cohorts who can credit her family for her interest in psychiatry. Her father is a psychologist and her mother is a social worker, and together they are her role models showing by example the importance of community service and helping others. Growing up with seven siblings certainly must have taught her the importance of cooperation, in addition. Laura received her BA in Psychology from Boston College after spending her first two years of college at the University of Rhode Island. Throughout her schooling, Laura has enjoyed working with children and families, another byproduct of her upbringing, and initially thought of becoming a pediatrician. However, her experiences working in a psychiatric emergency room after college fascinated her and focused her goals on psychiatry. In order to combine her interests in children and psychiatry, Laura believes a child and adolescent fellowship is in her future. Laura is proud of following in her parents' footsteps and hopes that she, too, will make a difference in her patients' lives. She received her MD from the University of Rochester in May, is a member of AOA and a Rock Sleyster nominee. We're truly glad to welcome Laura back to Rhode Island.

GAIL KOPELMAN

Gail is another Providence returnee (sort of), and another from a Chicago area school. Gail received her BA in Biology from Brown University and received her MD from Rush Medical College this spring. Her husband (Mijail Serruya) is in the MD/PhD program at Brown, and Gail was able to complete some of her fourth year electives in Rhode Island. She recently returned from an elective in Costa Rica where she was able to use her fluency in Spanish. She is also fluent in Hebrew. When she began medical school, Gail was certain she would focus on internal medicine as a career. She soon realized, however, that her "thrill" in medicine derived from listening to her patients and developing an understanding of them. She then began her internal debate between medicine and psychiatry. It was during her elective in consultation/liaison psychiatry with Dr. Colin Harrington at RI Hospital

that she was able to balance the interface between medicine and psychiatry. Fortunately for us, the balance swung in favor of psychiatry (thanks, Colin!). Her clinical outpatient rotation at Chicago's public city hospital and her volunteer work at a homeless shelter are the basis for her career goal combining private practice and working with the underserved in an academic city hospital.

KIMBERLY LEONARD

As Kimberly watched her friends struggle with their applications to medical school, she was glad that she had been accepted at age 19 to SUNY-Buffalo's School of Medicine through its Early Assurance program. As a high school student, she had already made the decision to become a physician. She graduated from the University of Rochester with a BA in Psychology. As she began her first year of medical school she quickly realized that her early and confident decision was not the last one she needed to make-what was she going to specialize in? Looking back on her volunteer experiences, it was apparent that she enjoyed working with children. After her surgery rotation she was able to rule out pediatric craniofacial surgery, but was still left with too many options. Fortunately, at the end of her third year, she completed a psychiatry clerkship that afforded her the opportunity to spend four weeks on a child/adolescent unit. Kimberly was once again decisive and confident with her newfound niche in child psychiatry. This was further bolstered during her elective at Bradley Hospital early in her fourth year. Her medical school years have been distinguished, having received several Letters of Distinction and induction into Alpha Omega Alpha. Kimberly is a delightful addition to our residency.

ANNA MALORATSKY

Anna received her BA in Biology and Neuroscience from Brandeis University in 1995, where neuropsychology courses started her on the path to medicine and psychiatry. She continued her interest in research after graduation, working for several years as a research assistant, first in Boston and then in California. She has also served as a Russian language tutor, having spent her early life in Russia. Her interest in psychiatry received a further boost from her volunteer work at Children's Hospital in Boston, when she provided support to families with children who were preparing for or had undergone neurosurgical procedures. The counseling she was able to provide, plus her interest in all things neurologic, prompted her entrance into medical school at Tufts in 1998. Her sights set on a psychiatry residency. Those interests continued throughout her clinical rotations, but received a final adjustment when Anna took a leave of absence to care for grandfather who was recovering from a stroke. Her involvement in his care, combined with her research work with the elderly under Marshall Folstein's guidance, made her acutely aware of the need for psychiatric care in the geriatric population. She is well aware of the difficulties sometimes encountered in her chosen patient population, but is up to the challenge. She hopes to also be able to continue her interest in research and contribute academically to the field. Although she doesn't have far to move, welcome to Rhode Island, Anna!

BRIAN MIKA

Brian is the last (alphabetically, that is) of our Chicago-area recruits. During his years at Notre Dame, as he was working on a BA in Psychology, Brian worked as a teacher assistant to multiply challenged children, as a residential counselor for adolescents with behavior disorders, and developed and implemented an educational program for homeless youth. It doesn't take too much perception to realize a trend here. After working for several more years as a research assistant and computer programmer, he realized that he missed the one-on-one interactions of his former careers and decided to pursue medial training. While he was applying to medical school, Brian worked full time as a research specialist at the University of Illinois, a position he still continues in today and that has resulted in numerous publications. He began his medical education at the University of Illinois-Chicago and graduated with his MD in May. When he first began working with children and adolescents way back when, Brian thought is would be "fun and easy." He has since discovered that while the "fun" part is definitely true for him, the "easy" doesn't always come easy. The challenges inherent in working with this population are part of what Brian is looking forward to. The other part focuses on continued involvement in research. We're delighted that the Windy City has blown Brian and his wife East to our own fair Ocean State.

THOMAS O'REILLY

Sometimes it's the little stuff that makes a big impression. An item that Tom included in his application materials speaks volumes to his makeup. Tom mentions his summer work experience during high

school and college as a house painter, stating, "…I cherish these experiences… working along side some of the nicest, most genuine people I have known. These men taught me the value of an honest, basic way of living." Comments in his Dean's Letter paint Tom in terms of his humanistic qualities, his interpersonal skills, and his deep commitment to his patients. Tom received his BA in Biology from Johns Hopkins in 1997, and then worked as a senior consultant conducting primary research interviews by phone, analyzing the data and preparing summaries for clients. He has continued this work on a part-time basis throughout medical school and has also done some freelance work writing for a healthcare communications firm. Tom received his MD from UMDNJ/RW Johnson Medical School this spring. During medical school, Tom quickly realized that what he enjoyed about medicine was connecting to patients. This all came together during his core clerkship in psychiatry, blending all that he loves about medicine into his career goal. At this time, Tom is contemplating a fellowship in child and adolescent psychiatry. Southern New Jersey will miss you, Tom, but we are certainly happy you'll be with us here at Brown.

MARCUS TJIA

Marcus graduated from MIT with a BS in Biology and received his MD from Mount Sinai School of Medicine in 2002. During medical school, Marcus had the opportunity to participate in several research projects and it was the last project, working with geriatric psychiatry patients to determine competency that stirred his interest in a possible career in psychiatry. This research project also resulted in a poster presentation at the 2001 APA meeting. As happens frequently, however, the pull of medicine was stronger than that of psychiatry and Marcus began his internal medicine residency at RI Hospital in 2002. As he proceeded through medicine, Marcus was surprised at the number of patients he encountered who were being treated concurrently with psychotropic medications. Although his treatment of patients addressed their physical needs, he felt inadequate in addressing their mental health needs. After discussing his dilemma with his training director, Marcus decided to take time off from medicine in order to apply for training in psychiatry knowing this would allow him to achieve his goal of helping people lead not only healthier lives, but also happier lives. Once again, internal medicine's loss is our gain. Welcome to psychiatry, Marcus. ❖

RHODE ISLAND
PSYCHIATRIC SOCIETY
235 Promenade Street, Suite 500
Providence RI 02908