RIPSNEWS

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

President's Message

Louis J. Marino, MD

A lot has happened in the past several months. After years of no one listening to psychiatrists as we called attention to inequities and abuses, it seems that there is now a receptive audience. The plight of Rhode Island physicians has recently received attention from the Governor, the Lt. Governor, the state legislature, the community, and even Blue Cross. Problems of patients with inadequate access to psychiatric help, harassment at the hands of payers, inadequate reimbursement for psychiatric services, and the stigma of mental illness are all being studied by interested parties.

Blue Cross took a bold step in the right direction when they decided to fund the SHAPE II study. The Statewide Health Assessment Planning and Evaluation study was a year long project to examine the demographics of Rhode Island, its healthcare utilization, its healthcare resources, and healthcare trends (www.shaperi.org). The original SHAPE study created more questions than it answered, and upset many physicians with its findings. For instance, the first sentence of the summary of the RI healthcare workforce stated, "Regardless of what your neighbor may be telling you over the backyard fence, you should be able to find a doctor in Rhode Island." It did not go on to say whether the doctor that you found was taking patients or if that doctor was even seeing patients.

The SHAPE II study seeks to address many of the questions raised by the original study. It is composed of individual components, which will examine the physician work force, nursing, facilities, etc. Behavioral health is the only medical specialty which has its own committee. An advisory panel of stakeholders from across the behavioral health spectrum meet regularly to make sure that the findings of the consultants correspond to reality and that the most important strengths and weaknesses are identified. The goal of the behavioral health study is not only to identify problems, but also to allow solutions that draw on models of our most functional systems in the public and private sectors. Because Rhode Island is a small state, we are in a good position to improve the network of care available to our patients.

More recently Blue Cross took another step in the right direction when they agreed to raise reimbursement rates for physicians. I have been struck to the degree that Blue Cross previously refused to discuss the issue of their undervaluing our work. In the first meeting of the SHAPE II study leadership, I was informed that physician reimbursement was specifically excluded as a topic of the study. (Needless to say, that rule changed by the end of the hour). As a consultant to Blue Cross's behavioral health division, I was informed of the same thing. In this case, the issue of fairness was not off the table, and Peter Erickson of the RI Psychological Society did a great job of pushing for the adoption of Resource Based Relative Value Scale as a model of reimbursement (www.ama-assn.org/ama/pub/category/2292.html). Blue Cross has gone from paying less than Medicare rates to paying greater than Medicare rates, and is basing its rates on the Medicare reimbursement schedule. *continued page 7*

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Editorial

Anthony Jay Thornton, MD
Editor

The Times They Are A-Changin': The Death of qD

"If your time to you is worth savin',
then you better start swimmin' or you'll sink like a stone;
for the times they are a-changin'"
—Bob Dylan

If you work in a JCAHO accredited facility, you are aware by now of the **Do Not Use Dangerous Abbreviations** list. Beginning three years ago, JCAHO encouraged healthcare institutions to banish potentially dangerous abbreviations as designated by the Institute for Safe Medication Practices (ISMP). In 2004, there is a set of required abbreviations on the list, and each institution must pick three more from a longer list. These abbreviations are not allowed on any handwritten patient-specific communications. The required list includes "U" (mistaken as the number 0 or 4 causing a ten-fold overdose), "IU" (mistaken as IV or 10), qD and qOD (mistaken for qid), trailing zero/lack of leading zero (putting a 0 after a decimal can be mistaken for a ten-fold greater dose if decimal is not seen; if a zero is not placed before a decimal, a ten-fold mistake can occur if decimal is not seen), and MS/MSO_4/MgO_4 (mistakes between magnesium and morphine sulfate). Other commonly used abbreviations scheduled for banishment are "hs" and "D/C". The longer list at the ISMP (website www.ismp.org) has dozens more listed, including "SSRI" (sliding scale regular insulin mistaken for selective serotonin reuptake inhibitor). A phrase that is no longer allowed is "resume previous medications" (you must spell out each medication). Preliminary 2005 JCAHO National Patient Safety Goals signal the inevitable trend — none of the ISMP abbreviations will eventually be allowed in any form of medical communication. I am certain there is a tragic medical mistake behind each of the abbreviations on the list, but this does not make it any easier to change "hardwired" prescriber behavior.

Another focus in 2004 is effectiveness of communication among caregivers. This is the perennial verbal order problem. Now, the nurse must read back to the doctor what he/she has already written down for verification. This sounds simple,

but in implementation there can be many phone calls back and forth between care providers. The third National Patient Safety Goal for 2004 is improving accuracy of patient identification. There is a requirement for two patient identifiers when administering medication. This would seem obvious and prudent to prevent medication mix ups, especially in the hospital. It becomes somewhat more complicated to accomplish this in outpatient clinic settings.

Is everyone aware of the brouhaha that erupted some months back regarding the issuance of sample medications? Rhode Island only allows pharmacists and physicians to dispense medications. This law had been ignored for years, and sample medications were routinely handed out by nursing, and sometimes administrative staff, in many clinics. The Community Health Centers wanted the law to give them an exception so nursing staff could hand out samples (authorized by the physician of course). This did not occur, so currently only physicians can dispense. Because of all the regulations surrounding the use of samples, some institutions have abandoned them altogether. The use of medication coupons has partially filled the void, but the reduction in this valuable service is a shame.

Look alike-sound alike drug names is another area of focus to prevent medication errors. An example would be Celexa which can be confused with Celebrex, Celebra, and Zyprexa. There is a suggestion to write out the reason for the medication on prescriptions to help prevent confusion. There is a long list of all the potentially confusing medication names at the ISMP website.

It seems almost daily that a new warning is being issued by the FDA on one of our medications or medication classes. Is your monitoring program for the atypical antipsychotics all set up and running? It has seemed like for the longest time confusion has reigned with conflicting recommendations from all quarters. Consensus guidelines include following the fasting blood glucose, lipid panel, the patient's weight (and computing BMI), diabetes risk history and diabetes symptoms. Also, get out your tape measures, as abdominal girth is to be followed as well. Coordinating the lab work with the primary care doctor who may be ordering the same labs can be a nightmare (insurance will often not pay for the same labs drawn in a certain time frame). You can punt this ball entirely to the primary care physician, but many are unaware and some are resentful at monitoring for possible side effects of a medication you prescribe. I do not even want to discuss the recent suicide warnings for our newer antidepressants.

The Rhode Island Medical Society "Whitepaper" discussed in this issue presents the problems with the current health care system in Rhode Island (along with suggested repairs). Laughably low and flat reimbursement rates, skyrocketing malpractice insurance premiums, and relatively high overhead make Rhode Island a somewhat hostile practice environment, according to the "Whitepaper".

I did have a friend who abandoned his practice altogether to open up a bed and breakfast along the California coast. Given all I have discussed so far, that idea sounds attractive. So why do we all continue to practice psychiatry in this vortex of change and increasing complexity and liability? I can only answer for myself, and that would be I just love being a psychiatrist. It is challenging, fun, exciting, frustrating, and scary all at the same time. And I suspect that the bed and breakfast isn't all it is cracked up to be. ❖

New and Emerging Treatments for Memory Loss

Stephen Salloway, MD
Director of Neurology, Butler Hospital
Associate Professor of Neurology, Department of Clinical Sciences,
Brown University School of Medicine

Lou Marino, MD; Steve Salloway, MD

A Presentation at the February 2004 General Membership Meeting

The February 9, 2004 General Membership Meeting was held at the Napa Valley Grille in the Providence Place Mall. Dr. Salloway presented timely information regarding treatments for memory loss. For those of you who did not attend, you missed a very enjoyable evening, earning a CME credit as you eat a wonderful meal and socialize with friends. What follows is a summary of his presentation provided by Dr. Salloway.

Alzheimer's disease (AD) is a mental illness that affects psych, soma, and identity. There are over 4 million cases of AD today, and there will be 14 million within a generation. To keep our synapses healthy we need to stay mentally and physically active, socialize, control risk factors (weight, blood pressure, cholesterol, blood sugar, stop smoking), and eat a balanced diet with vitamin E.

The cognitive continuum goes from normal cognitive functioning, to mild cognitive impairment, to dementia in varying levels of severity. Mild cognitive impairment is a disorder of short term memory. Symptoms consist of misplacing things a lot, and difficulty recalling messages, details and appointments. The symptoms are more than a nuisance, but there is normal functioning overall. The risk factor for AD is 12–15% per year.

Cholinesterase inhibitors stabilize functioning in the first year of AD and make subsequent decline more gradual. Other benefits include a delay in time to nursing home placement and a decrease in behavioral symptoms. Colinesterase inhibitors include tacrine (Cognex), donepezil (Aricept), physostigmine SR (Synapton), rivastigmine (Exelon), metrifonate, and galantamine. There is no clear evidence of superiority in efficacy between them, but there may be advantages in dosing and tolerability.

Glutamate plays a role in memory consolidation, mood, anxiety, psychoses, seizures, and excitotoxic injury. Memantine (Namenda) is a weak NDMA competitive antagonist and has recently been released with an indication to treat moderate to severe AD. Initial dosing is 5 mg each morning for 2 weeks, 10 mg each morning for 2 weeks, and then 10 mg twice each day. Monotherapy drug trials reveal a significantly slower decline and less caregiver time. Combining medications with different mechanisms of action, such as memantine and donepezil (Aricept), are a safe and effective treatment in AD.

Associated neuropsychiatric symptoms in AD include apathy, delusions, hallucinations, agitation, dysphoria, and disinhibition. Mood stabilizers, such as valproate and lithium have been beneficial to treat agitation. The effects may be dependent on potentially neuroprotective actions, such as inhibition of apoptosis and slowing of neurofibrillary tangle formation.

Vitamins E and C when taken together, but not alone, are associated with a decreased risk of AD. Low dose NSAIDs used early prior to dementia onset may decrease risk of AD (but do not help people with AD). Estrogen has no benefit for women with AD, but may have a protective effect for women at risk. The combination estrogen/progesterone is associated with a small, but signifigant increase in AD. Long term treatment with statins may decrease risk of MI, stroke, and AD even in the absence of hypercholesterolemia (cholesterol is involved in amyloid deposition).

There are many promising symptomatic and disease modifying treatments in the pipeline. The focus now is on mechanism based treatments through decreased deposition and increased clearance of amyloid. An example is the use of heavy metal chelators to enhance amyloid clearance.

A very important treatment aspect with AD is helping caregivers cope. The situation needs to be faced directly with common sense problem solving. Education and a supportive network are needed. The home environment needs to be structured to promote familiarity and calm. A predictable routine that is simple and limits choices is helpful. ❖

RIMS: The Whitepaper

(L–R) Paul Lieberman, MD; Tilak Verma, MD, President, RI Medical Society; Newell Warde, PhD, Executive Director, RI Medical Society; and Michael Ingall, MD

Many RIPS members belong to the Rhode Island Medical Society (RIMS), but a majority do not. Tilak Verma, MD, MBA, President of RIMS spoke at a RIPS general membership meeting December 8, 2003 at the Florentine Grille in North Providence.

RIMS is very active politically in the state and has embarked on an aggressive campaign to:

- **Raise public awareness** of the crisis facing Rhode Island's physicians: rising costs and falling reimbursement rates, and their effects on patient care.
- **Empower physicians** and other medical professionals to advocate for a health care system that promotes quality of care.
- **Advance legislation** to bring more balance to the relationship between third-party payers and medical professionals, and to relieve the pressures that make Rhode Island uniquely inhospitable to practitioners.

2003 was a very busy year with a rally at the State House attended by more than 700 doctors, *Time With Your Doctor* print and radio campaign, ad campaign criticizing Blue Cross' *87-10-3* campaign, and articles in local publications such as the Providence Journal focusing on Blue Cross' practices.

On February 23, RIMS presented *Rhode Island Health Care: Symptoms, Causes, and Solutions* ("the Whitepaper") to the General Assembly. You may download this 12 page document from the RIMS website at www.rimed.org. This paper does a good job laying out the problems that plague the system and frustrate providers, and provides viable suggested fixes. Some of the major highlights will be summarized below.

Salient problems of the Rhode Island health care system in 2004 are:

- **High and rising cost of health insurance:** In 2002, RI employers paid 22% more than the national average for HMO coverage and average group medical costs have risen by 46% in the last three years.
- **Rising numbers of uninsured Rhode Islanders:** The proportion of the uninsured has grown from 6.4% in 1999 to 9.8% in 2002.
- **Demoralization of healthcare professionals:** While the overhead costs of maintaining a medical practice are higher than the national average, Rhode Island physicians are paid at rates among the lowest in the nation [less than 50% of the rates in Hartford (CT), Boston (MA), Manchester (NH), and Portland (ME)].
- **Growing fragility of patient access to quality health care:** The majority of physicians have experienced difficulty recruiting and retaining a colleague into their practice. Mental health was specifically cited as bearing watching. Of the 85 adult psychiatrists trained at Brown University Medical School, only one chose to remain in Rhode Island in full-time private practice accepting insurance. Pediatric psychiatric services are listed as almost unavailable.

Legislation can ameliorate some of these problems by:

- **Reform the liability system:** Recommendations include adjusting prejudgment interest (currently 12% per year no matter what), requiring plaintiff to obtain a certificate of merit from a qualified expert, cap non-economic damages, timely disclosure of expert testimony, reducing the statue of limitations.
- **Revisit existing statutes and regulations governing Rhode Island health plans**
- **Enhance insurer transparency and accountability:** Establish an

independent cabinet-level position for an Insurance Commissioner who has the authority to assert the public interest in adequate rates, fair premiums, reasonable but not excessive reserves, competitive reimbursement levels, and fair contracting and business practices of insurance companies.

• **Reorganize and redirect Blue Cross & Blue Shield of Rhode Island:** The General Assembly should restructure and reconstitute the board of directors of BCBSRI to better reflect the community it serves and establish accountability to the community.

• **Restore balance in the relationship between insurers and professionals:** Enact the Health Care Fairness Act, which would enable professionals, under the Office of the Rhode Island Attorney General and the courts, to bring payers to the table and to address systemic abuses that tend to increase costs and bureaucracy at the expense of patient care, and contribute to making Rhode Island unattractive to new doctors. ❖

2004 Eleanor Slater Award Presented at Annual Dinner Meeting

2004 Slater Award winner, Charles Maynard (center) with President-elect Paul Lieberman, MD (left) and President Lou Marino, MD.

RIPS Annual Dinner Meeting was held at Mediterraneo on April 26, 2004. Members and guests were treated to excellent food and service in a beautiful meeting space overlooking Atwells Avenue and downtown Providence. A highlight of the evening was the presentation of the Fourth Annual Eleanor Slater Award to Charles E. Maynard, Chariman and CEO of The Providence Center. After nearly 36 years at the helm, he will retire from The Providence Center this month. Maynard played an instrumental role in creating Rhode Island's nationally recognized and highly effective community mental health system.

In 1968, Maynard was hired by the City of Providence to implement a $50,000 grant to open a clinic in the city that would treat adults and children with mental and emotional illnesses. His first office space was a room at The Biltmore Hotel, where he began developing services that would 35 years later serve more than 9,000 Rhode Islanders across the state each year. The Providence Center started with a staff of three professionals and an assistant. It currently has a staff of 500, including psychiatrists, psychiatric nurses, and clinical therapists.

Established in 2001, the Eleanor Slater Patient Advocacy Award recognizes a public figure that has made a significant and sustained contribution toward the provision of services for persons with mental illness, and who has fought stigma by speaking out and supporting psychiatric care and treatment. The award also seeks to encourage advocacy for persons with mental illness. It was established in honor of Eleanor Slater, a long-time friend to persons with psychiatric disorders. Past recipients have been the Honorable J. Clement Cicilline, the Honorable Steven M. Costantino; Representative Patrick Kennedy, and Associate Judge of the District Court Stephen P. Erickson. ❖

President's Message continued

The Governor recently sponsored a breakfast in which he invited physicians to contribute to his fund and to share with him their concerns.T he Governor did most of the talking, and not everything he had to say sounded good. I pointed out to him that in focusing on the problems associated with having only one major private insurer, he missed the fact that simply introducing competition will not necessarily benefit the physicians. There once was competition in the healthcare insurance market. The competition was to see how low physician reimbursement could be pushed. Physicians need to be able to have meaningful discussions with the insurance companies (or even with each other) about what is fair. A number of good points were raised, and fortunately the Governor was much closer to getting it right after that meeting when he spoke before the press, than when he initially addressed the physicians. This experience reinforced for me the importance of political involvement, and especially the importance of spending money to have your voice heard by the people who make the decisions about our lives.

Even more recently the Lt. Governor held a public forum on mental health. The proceedings included testimony from facilities, providers, and patients and their families. The presentations were taped, and are to be presented to legislators to educate them about the relevant issues. The Lt. Governor has been a great friend to mental health patients and providers, and has done a lot to assist long-term care patients as well as to move toward parity for mental health services.

I would like to remind you to fill out the survey sent out by Patricia Nolan. The results of this survey will help to determine the current composition of the physician workforce in Rhode Island. The more psychiatrists we can get to complete the survey, the better the diversity of providers will be understood. This information will be used in the SHAPE II study, in part to determine what the psychiatric resources are and how they can be used. Don't be left out, be sure to be counted! ❖

Member Notes

We are pleased to announce the recognition of our colleagues who have received membership advancements.

ANTONIO CAPONE, MD – *Distinguished Life Fellow*
Dr. Capone graduated from the University of Naples, Italy. He first joined the American Psychiatric Association in 1959.

GEORGE H. CARTER, MD – *Fifty-Year Distinguished Life Fellow*
A graduate of Harvard Medical School, Dr. Carter has been a member of the American Psychiatric Association since 1954.

RONALD MARK STEWART, MD – *Life Member*
Dr. Stewart graduated from the New Jersey College of Medicine and is also an alumnus of Providence College. Dr. Stewart has been a member of the APA since 1970.

LAWRENCE H. PRICE, MD – *Distinguished Fellow*
Dr. Price is currently Clinical Director at Butler Hospital. A graduate of the University of Michigan, Dr. Price completed his Psychiatric Residency at Yale University. A respected teacher, academician, and researcher, Dr. Price is the author of over 200 publications.

MARK S. BAUER, MD – *Distinguished Fellow*
Dr. Bauer received his medical degree from the University of Pennsylvania, where he also completed his residency. A staff physician at the VA Medical Center in Providence, Dr. Bauer has been actively involved in a number of research initiatives from the NIMH and the VA. He is a long-time friend of NAMI Rhode Island and has twice received the NAMI Exemplary Psychiatric Award.

We wish them congratulations and best wishes! ❖

Committee on Women

Alison Heru, MD

Joining Other Women

For those of you who want to join an organization of women physicians and are unsure which to join, here is a run down of your options:

RI Medical Women's Association
RIMWA is your friendly welcoming local branch of AMWA. Their meetings are good venues to network with other physicians in different specialties. You can find good referrals for your patients, for example physicians who have a special interest in women and cardiac disease or gynecological evaluations of teenagers. Women physicians in the community may have particularly interesting practice models or may be interested in working closely with psychiatrists. It is at the very least, informative to see what is going on locally.

American Medical Women's Assocation
AMWA is the national organization of over 10,000 women physicians and medical students dedicated to serving as the unique voice for women's health and the advancement of women in medicine. AMWA was founded in 1915, at a time when women physicians were an under-represented minority. As women in medicine increase in numbers, new problems and issues arise that were not anticipated. Other medical organizations are starting to recognize these problems and are looking at ways to address them.

AMWA has been doing this for over 85 years. The general membership is represented at the local level by its membership branches. These are governed by locally elected officers, but remain affiliated with the National Office and abide by the National Bylaws. There are a variety of Committees and Task Forces that allow members to participate directly in the functioning of the organization. The organization links up with international groups such as **Medical Women's International Association** which is holding its 26th meeting in Japan in July from 28–August 1.

Mrs. Sadako Ogata is the key note speaker on the theme of the conference: *Medicine in a New Life Styl*e. She is

the President of the Japan International Cooperation Agency, a member of the United Nations High Level Panel on Threat, Challenges and Change and Prime Minister Koizumi's special representative for Afghanistan Assistance.

The **Brown University Office of Women in Medicine** puts on breakfast meetings at least once a year and also hosts after-work presentations or social gatherings on occasion. These meetings tend to be University based and focused on career development. They are smaller than RIMWA but just as welcoming.

For psychiatry, locally, there is the **RIPS Committee on Women** which currently consists of this column in the newsletter. If anyone wants to be more active, meet and have goals, agendas or political action, speak up and I will arrange it.

Nationally, you have several options.

The **APA Women's Caucus** is one of seven caucuses that represent minorities and sends a representative and a deputy representative to the Assembly. They can propose activities and positions to the APA. The Caucus was established to address the under representation of women in local district branches. APA women members can enroll in the caucus by filling in a form from the Office of Minority and National Affairs or by signing up at the OMNA booth at the APA.

The **APA Committee on Women** (COW) was established 1975, replacing a former task force, and amongst other things, advocates for the advancement of women in the profession and explores ways to better serve women patients. The COW reports to the APA Council on National Affairs. Members are appointed by the APA President elect as openings arise, can propose APA activities through the Council on National Affairs but cannot act independently. It meets twice a year and has five members, each with three year terms.

I belong to the **Association of Women Psychiatrists**, urged by Leah Dickstein, who said that I would enjoy the newsletters and I would be glad I joined. "It will give you a feeling of belonging", she said. It is true indeed but most importantly, I get email daily that keeps me up to date on issues of importance to women, both from the press and "behind the scenes" from women in the know. Founded in 1983, one of its aims is to work with and influence APA policy. It is an independent organization; members elect their own officers and adopt their own positions. You can access this organization at www.womenpsych.org. Annual dues are $75 (residents $20). ❖

Mental Health Center News

THE PROVIDENCE CENTER

CHARLES E. MAYNARD, PRESIDENT, CEO, AND FOUNDER

of The Providence Center, recently received *The Ralph F. Gabellieri Award* from Goodwill Industries of Rhode Island. Maynard was recognized for his unique integration of competency and compassion both in life as a successful business leader and in his dedication to the community.

"Charlie is an exemplary Gabellieri Award winner," notes Lori Norris, executive director at Goodwill Industries. "He has not only given of himself tirelessly in working to improve the quality of life for people with mental illness, but he has also shared his experience and vast knowledge with others, like Goodwill, so that many individuals could be served – not just those who came through the doors of The Providence Center."

ADOLESCENT PARTIAL HOSPITAL PROGRAM

The Providence Center announced the opening of its Adolescent Partial Hospital Program (PHP). The intensive outpatient program is designed for youth between 13 and 21 years-old experiencing acute behavioral, emotional and/or psychiatric symptoms. The PHP will provide adolescents with helpful ways to identify and manage their symptoms in a supportive, structured environment. Five days a week, six hours a day, PHP clients attend group therapy sessions to help them reduce their symptoms, learn relaxation and impulse-control techniques, and build their self-esteem.

Each client receives individualized treatment from a team comprised of a doctor, therapist, and case manager, which works closely with the client's primary therapist, psychiatrist, school, and family. ❖

Lost in the Woods:
The failure of psychiatric hospitals to communicate with community caregivers

Michael A. Ingall, MD

I share the apprehension of Anthony Jay Thornton, MD expressed in his editorial in the December 2003 issue of RIPS News regarding the lack of availability of acute psychiatric beds in our state. The situation becomes graver each day. Word on the street was that Governor Carcieri was ordering the Department of Human Services to close 20 long-term beds at the Eleanor Slater Hospital. Such an action would lead to a further backup of patients with long-term needs in acute hospitals and emergency rooms, and, perhaps worse, to a rise in homelessness and incarceration of the mentally ill at the ACI (our newest psychiatric facility).

I've spent most of my career trying to find outpatient alternatives to hospitalization. Today, I work in a mobile treatment team that provides as intensive community-based treatment as you can find anywhere. Our team of social workers, case managers, nurses, vocational specialist, substance abuse specialist, and psychiatrists sees our patients on a daily basis, visiting them in their homes, taking them shopping, offering dietary guidance, dispensing their meds, assisting them with cleaning and personal hygiene, taking them to medical appointments, and engaging in recreational activity, such as bowling, pool, and exercise. We are available 24/7 to all 50 of our patients.

Sometimes, all of this is not enough, and our patients require hospitalization, which we help to arrange. While they are in the hospital, we visit them several times a week, helping them to prepare for discharge.

But sometimes, our patients want some extra attention. They may have got drunk or stoned, they may have run afoul of the law, or they just want a change of locale. They call the Rescue or take a cab to the local ER or psychiatric hospital and seek admission on their own. They've been in the system for a long time, and they know the buzz words: "I'm hearing voices! I'm suicidal! I took all my pills!"

A few years ago, I made an attempt to cut down on these unnecessary admissions. I met with the chiefs of every emergency room in the state and with the departments of admissions at all the psychiatric hospitals. I explained what our team was about and about our availability around the clock. I told them we wanted to be called day or night if one of our patients was presenting for admission. I gave them a list of our "frequent flyers," (the confidentiality laws allow sharing of information in emergency situations for the coordination of health care).

When one of our patients would be admitted without consulting us, I would call in indignation and outrage.

But after a while, I got worn down. The hospitals and ERs seemed interested in admitting anyone at their doors. There are a number of factors that can account for this. A hospital often makes more money on the first day of admission than on any other. Calling and discussing a case with a community provider takes time and effort, and the admissions area is a busy place. It is more expedient to admit and ask questions later. And then there is the "CYA" factor—a clinician in admissions does not want to risk turning away a patient who claims s/he is suicidal for fear of medico-legal repercussions. Often it would be two or three days after admission before a hospital would

contact us, and usually it was not to seek input from those in the community who knew the patient best, but rather to ask for an appointment upon discharge the following day ("so I can write it in the record").

There was a time, a century ago, when psychiatric hospitals were located in the woods or on a farm, to separate patients from the world in which they could not function. They bore such names as Hartford Retreat or Brattleboro Retreat. Even today, the admissions practices described above make me think that many hospital clinicians think the world begins and ends at the hospital gates.

Today, we cannot afford to remove all but the sickest patients from the world. It is our responsibility to coordinate the care between hospital and community. Shamefully, this rarely happens.

And so, we must take these factors into account in a discussion about lack of bed availability. A balance of long-term and short-term beds can only be achieved when there is a genuine working interface between hospital and community caregivers. ❖

Opportunities

PSYCHIATRIST

Provide psychiatric evaluations to correctional inmates at the DOC; responsible for providing 24/7 coverage to the RI DOC for any psychiatric emergencies; responsible for preparing reports and court documents for commitment of inmates to the Institute of Mental Health(IMH) when necessary; to keep accurate and detailed medical records as required.

Email resumes to HR@DLGI.COM or fax to 800-549-3067.
Phone 888-530-8228 ext.106

POSITIONS AVAILABLE
SE Massachusetts

Arbour-Fuller Hospital, a free-standing 82 bed psychiatric and substance abuse hospital, is currently recruiting for licensed psychiatrists to perform physician "on-call" duties (admissions, evaluations, unit response, etc.) on site weeknights and weekends.

This opportunity provides excellent clinical and networking experience for residents as well as staff psychiatrists.

For more information, please contact:
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