



## *The Bureaucratic Destruction of Patients' Faith in Their Doctors: Public Psychiatry's Negative Lessons for General Medicine*

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**Abstract.** *The doctor-patient relationship, so important in all of medical practice, has been destroyed in much of American public psychiatry. That destruction should serve as an important negative lesson for a medical care system facing reorganization. The desirability of having the same psychiatrist caring for a patient both in the mental hospital and after discharge—continuity of care—should have been obvious, but its significance was not defined explicitly, to this author's knowledge, until about 1979. White's demonstration that the therapeutic relationship's positive impact seems to "account for about half of the benefits" associated with medical and similar ministrations underlines its importance. Continuity of competent public psychiatric care, and its therapeutic effectiveness, have been impeded by the harmful attitudes and actions of American psychiatry and the care-fragmenting acts of public officials. Soon after the continuity concept was informally presented in 1979, official American psychiatry, increasingly influenced by drug companies, began denying the importance of a physician's continuing care by redefining "continuity" as though public mental health care had to be fragmented. Specific policy decisions by officials are also largely responsible for the destruction of good public psychiatric care. This in turn has produced gross overuse of medications and the near disappearance of competent public psychiatric leadership and effective therapeutic relationships. An example from the federal Health Care Finance Administration shows how comparably harmful bureaucratic decisions concerning health care can also be made on the federal level. If similar decisions are made under the proposed reorganization of general medical care, that care, like American public psychiatry, may become harmful to its patients.*

A patient's relationship with her or his physician has always been profoundly important in medical care. Its significance is, however, often neglected or denied in this high-technology age.

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American psychiatry, its public sector especially, has particularly denied its importance—most markedly in New York State—thus severely impairing its own therapeutic efficacy. The medical profession and its policy planners should understand the negative lessons and dehumanizing impact of this denial, to prevent similar harm to therapeutic relationships if and when health care is reorganized nationally.

### ***The Importance of the Doctor-Patient Relationship and Continuity of Care***

Before the beginning of the 19th century, standard treatments were as likely to harm patients as to help them<sup>1</sup>: bleeding, purging, and use of emetics are examples. Although the net effect of specific medical therapies was often zero, physicians nevertheless helped patients greatly through their emotional impact on them.<sup>2</sup>

A generation ago, British psychiatrist Michael Balint<sup>3</sup> described the qualitative impact of primary physicians upon their patients. Recently, Kerr L. White,<sup>4</sup> former deputy director for medical affairs of the Rockefeller Foundation, quantified the doctor-patient relationship's importance, noting that "factor X"—the sum of the placebo and Hawthorne phenomena—*seems to account for about half of the benefits associated with medical and other health professions' ministrations*" (italics in original). (The Hawthorne effect is the increased productivity following *any* interest by management in what its workers were doing.) "Factor X" and trust underlie Ambroise Paré's classic statement,<sup>1(p.37)</sup> "I bound the wounds, God healed them." The psychophysiological mechanisms through which physicians evoke healing pleasure in their trusting patients were also recently described.<sup>2</sup>

Continuity of care is the administrative principle necessary for maintaining trusting doctor-patient relationships. Continuity means that the same physician treats patients wherever they are—in hospital, clinic, or office. The neglected concept of the primary physician is based on, and implies, that continuity.

Organizing medical care in ways that deny the importance of the

doctor-patient relationship—of continuity of care—will reduce its effectiveness and increase its costs. Medical funds will then be spent increasingly on defensive paperwork at the expense of patient care, as has already occurred throughout public psychiatry.

### **The Doctor-Patient Relationship in Psychiatry**

The doctor-patient relationship is even more important in psychiatry than in other branches of medicine because the specialty lacks the scientifically validated therapies, such as antibiotics or specific surgical procedures, the others have. Adolf Meyer,<sup>5</sup> Harry Stack Sullivan,<sup>6</sup> and Henri Baruk<sup>7</sup> in this century, the "moral treatment" of 19th-century American mental hospitals,<sup>8</sup> and Pinel<sup>9</sup> during the French Revolution have all shown that psychiatric care of even the most disturbed patients can be effective and successful when based on continuing, competent, voluntary counseling—focusing with patients on their present and past experiences to help solve the problems and conflicts producing their complaints. Fragmentation of care, on the other hand, dilutes and destroys doctor-patient relationships, and can make patients dubious about any trusting relationships in the future.

Patients with chronic mental illnesses particularly require long-term contact with a trusted, competent psychiatrist to help them face and resolve their difficulties and heal their relationships.<sup>10</sup> Oliver Sacks's treatment of patients with chronic neurological problems<sup>11</sup> provides a model: a partnership between two experts—a patient uniquely knowledgeable about his own past and present experiences and a physician who understands illness and respectfully attempts to comprehend and treat both the patient and his specific reactions. They do this by trying to work out together patterns of regularity in the patient's past difficulties and in his current responses to treatment. Their working closely together in this way is an act of love, far more therapeutic in itself than is usually recognized.

The psychiatric literature contains many reports of the great impact the doctor-patient relationship, and expectations within it, can have. Examples are the 19th-century "moral treatment,"<sup>8</sup> the



initially very successful "tent therapy" at Manhattan State Hospital for the insane in 1901,<sup>12</sup> Rashkis and Smarr's 1957 study<sup>13</sup> showing "measurable improvement" in 81% of 48 female patients with chronic schizophrenia spending 28 weeks in a special research ward where they received neither medication nor placebo, and the 1965 report from Johns Hopkins' Phipps Clinic<sup>14</sup> that 14 of 15 neurotic patients felt better a week after taking pills which, they were told frankly, contained only inert material.

### Doctor-Patient Relationships in Public Psychiatry

Public psychiatry deals primarily with the mentally disabled, as contrasted with the troubled-but-functioning individuals receiving most private treatment. While most private psychiatrists work primarily in their offices, those with admitting and treating privileges in hospitals can provide true, voluntary continuity of care for their disabled patients before, during, and after hospitalization.

I saw true, successful public continuity of care in Cambridge, England, in 1978, and have advocated it here since.<sup>15</sup> There, each psychiatrist worked in both ward and clinic, and treated his or her patients both in the hospital and after discharge. Improvement rates, and the satisfaction expressed by patients and doctors, were most impressive.

The number of psychiatrists sequentially treating a patient over his entire illness can be seen as a measure of the *discontinuity* of his care and of the *absence* of effective doctor-patient relationships. The treatment given 19-year-old Judith Singer in 1981 was a hideous example of that discontinuity and the distrust it evokes. Ms. Singer was in good physical health when involuntarily admitted to Staten Island's South Beach Psychiatric Center for a manic episode.<sup>16</sup> Thirteen physicians treated her, one after another, in four different wards. They could not persuade her to take oral medication, so they gave her 34 injections of seven different major psychopharmaceutical drugs. She was tied down in restraints for most of her 6 days in the hospital and lost 23 pounds. Then she died.

The best-known example of care-discontinuity is "Sylvia

Frumkin," the real-life subject of Susan Sheehan's 1982 book.<sup>17</sup> Over an 18-year period, she was treated in 45 different New York City settings. The cost of her treatment was conservatively estimated at \$636,000,<sup>18</sup> more than if she had been confined to a state hospital for that entire period. (In contrast, Cambridge, England, whose per capita costs I compared with New York State's in 1982,<sup>19</sup> needed only 40% as much staff to give far better care.)

### Transfers Aggravate Demoralization and Mental Illness

The demoralizing effect on patients of repeated transfers between psychiatric facilities or within them is easily understood. These transfers play a major but almost unrecognized role in undermining trust in doctors and impeding recovery. Newly admitted psychiatric patients, overwhelmed by their problems, begin to hope when they pour their hearts out to a psychiatrist. When administrative rules prevent them from ever seeing that doctor again, their hopes are dashed. Then it happens again—and again. Each transfer destroys a potential relationship with a doctor, undermines hope that treatment by physicians can help them, and leaves them humiliated, often feeling, accurately, that they have been "dumped." "Treatment" can thus become antitherapeutic and demoralizing, especially when all that each new doctor offers is still another medication. Yet I have never seen the harm produced by such transfers described in any scientific publication.

### The Organisation of Public Mental Health Care

In the past, most disabled public patients were admitted directly to state psychiatric hospitals, often geographically remote and of poor quality. Over the past 20 to 30 years, however, many patients have gone instead to psychiatric wards in general and community hospitals. These wards are, however, often set up only for relatively short stays.

New York State has long taken the lead in public mental health care—for both better and worse. This author is particularly familiar with its system, having first worked in it in 1947. New York spends



more money per capita than any other state—twice the national average.<sup>20</sup> But in recent years, it has helped lead the destruction of doctor-patient relationships throughout this country.

For decades, state hospitals all over the country were organized, as New York's were, around admission and long-stay, chronic services; patients not improving sufficiently within a given time on admission wards were transferred to chronic services. Those patients therefore had at least two different psychiatrists during their hospital stay. When doctors were rotated, or patients were transferred for "administrative" reasons, the number of physicians caring for each would increase. In community hospitals, however, patients usually remain on the same ward, with the same psychiatrist, until released.

The "receiving hospital"—Bellevue and Kings County at first, and now others also—has been a fundamental part of New York City's public system since early in this century. Patients are first admitted there, and then, if they have not improved sufficiently, transferred to state hospitals. Routing public patients through receiving hospitals significantly increases the number of psychiatrists treating each of them. Unfortunately, however, this care pattern has been spreading through the country.

Despite after-care's immense importance, its quality varies greatly. Some public patients are carefully discharged to good follow-up, albeit with a different psychiatrist, while others are sent to clinics or practitioners whom neither the hospital nor the patients know. Still others are blatantly dumped onto the streets with not even a paper follow-up.

Patients vary considerably in their success in reaching follow-up care; the looser a hospital's relationship to a clinic, the fewer patients who will reach it. Only rarely are the ward and clinic part of the same organization—the pattern established in the 1960s in New York, which discontinued it 15 years later—and I know of no public system in this country where, as in Cambridge, the same doctor now cares for a patient both in the hospital and after it.

In the late 1960s, New York State greatly improved its care

system. It built new state hospitals within New York City limits so patients would no longer have to be sent far from home and family, and it divided each state hospital's service region into "catchment areas"—neighborhoods of about 150,000 people—each with its own Chief of Service and its own wards and clinics. The previously centralized statewide after-care service was also divided, and each clinic was then connected with the appropriate hospital service.

Patients under this new set-up remained on one ward until release, rather than being transferred, and were then treated in one of that unit's clinics near their homes. These changes—designed to create closer connections between hospital and community—had the salutary but unplanned effect of reducing intrahospital transfers. They also allowed the development of close, cooperative relationships between the in- and outpatient services treating the patient sequentially, greatly reducing patient and staff problems at release and readmission.

The most difficult, and in many ways the most important, aspect of hospitalized mental patients' treatment occurs immediately after their release, when they again face the situations under which they broke down. Considerable therapeutic skill is needed at that time to help them, and those around them, not to provoke each other and reactivate psychotic processes. It is then, however, that most public patients face the additional stress of a new psychiatrist, whose ignorance of the case makes it impossible for him to give this necessary kind of help. This aspect of treatment has also received no attention that I have seen in the psychiatric literature.

When patients are readmitted and must go to a new ward, there to repeat their stories to still another doctor and treatment team, the process can be a nightmare—especially if the new doctor takes an entirely different treatment approach, including different medication. If patients know and trust the psychiatrist who will be treating them in the hospital, as they did in Cambridge, readmission's traumatic effect can be greatly reduced, and even eliminated.



### ***Psychiatric Impediments to Doctor-Patient Trust***

Many aspects of psychiatric practice throughout the country represent impediments to the creation and maintenance of trust between patient and psychiatrist.

#### ***Involuntary Psychiatric Hospitalization***

The existence of involuntary psychiatric hospital admission creates a problem between mental patients and their doctors that no other specialty has. For doctor-patient relationships to be truly trusting, they must be voluntary. How can the involuntary hospitalization dilemma be resolved so physicians can become, and be seen as, healers rather than jailers?

Psychiatrists are responsible, particularly with patients admitted against their wills, to act in their genuine interest by convincing them they want to help—and then starting to do so. When I ran a state hospital female admissions service more than 40 years ago, I introduced myself to each patient the afternoon she came in, told her we were there to help her calm down so she could return to normal living, and immediately began, with my staff, discussing the problems leading to her admission.

While psychiatry repeatedly insists that involuntarily hospitalized patients be changed to voluntary status as soon as possible, it does not always support that principle in practice. If it did, patients would remain in the hospital, or accept other treatment, only because they thought it could help them, rather than because they were forced to. Such efforts to win patients' trust occur with diminishing frequency nowadays. Psychiatrist-patient relationships therefore often become, and are seen as, adversarial.

#### ***Placing Drug Treatment Ahead of Counseling***

Over the past 35 years, psychiatry's therapeutic emphasis has shifted to pharmacotherapy from counseling and psychotherapy. In some psychiatric residencies, psychotherapy is no longer taught. The shift has affected doctor-patient relationships, therapeutic efficacy, and the nature and morality of psychiatric practice. The

resultant new association of psychiatric care with drug-abuse treatment has also created a serious threat to the voluntarism that should underlie psychiatric care.

Medicating patients routinely, immediately upon mental hospital admission, alters their thinking, feeling, or both, and impairs their capacity to work problems through with their doctors, as Sacks's patients do. Focusing on medication can imply that psychiatrists act *on* their patients rather than *with* them. Psychopharmacology is aimed at symptoms, and at responses to medications, rather than at patients' problems. The increased focus on the alleged biologic disorders the medications supposedly correct strengthens the mounting belief that mental patients are neurophysiologically, and perhaps permanently, different from the rest of us.

Psychiatrists' primary reliance on prescribed psychotropic medication often conflicts with patients' dislike of it, and their wanting to stop. Making unwanted medication a condition for continuing treatment, especially over long periods, can transform what should be a mutual, collaborative relationship into one based largely on submission ("compliance").

Maintaining medications for long periods, or permanently, continues their impairment of patients' ability to think. But prolonged medication is in the interest of the drug companies, which play an ever-increasing role in funding the scientific and social activities of organized psychiatry.

Between 1943 and 1948, before the psychotropic drug revolution, fewer than half of the first-admitted schizophrenic patients in the New York state hospitals were readmitted after release. Over half of the admitted cohort was living in the community 5 years later, without any apparent need for treatment, during an era when public mental hospitals were over-retaining patients. Even larger fractions of patients hospitalized with less-ominous diagnoses remained unreadmitted then and were living in the community. Few apparently needed treatment after the first posthospital year.<sup>21</sup> Today, with drugs as the major treatment, readmissions are



far more frequent,<sup>10(p.121)</sup> and treatment continues far longer—sometimes for decades.

Psychiatry's concentration on drug treatment can be seen as providing the final coffin nail for the Prohibition era's central moral principle: that using chemicals to feel better is utterly wrong. Today that use is widely accepted—cocaine at the highest business and Hollywood levels, for example, and Prozac recommended everywhere. The social value of such long-term drug dependency must be questioned.

This change in moral attitude is especially important for mental patients, particularly those who have been hospitalized. If they are already medically authorized to take chemicals to feel better, they wonder why they should not take the street drugs they like rather than the prescribed medications they abhor. Many do; about half the patients in public psychiatric wards today are also drug-abusers. Psychiatry and drug-abuse treatment have consequently become increasingly associated officially. This association, however, creates a problem concerning voluntary treatment.

Most drug-abusers are defiant, and many are also law-violators. Treating them successfully, especially when ordered by the law, often requires an element of compulsion or punishment—potential or actual—should they refuse treatment or fail to cooperate with it. But care for the mentally disabled should be entirely voluntary. Voluntary hospital treatment of the mentally disabled who are also drug-abusers, or are treated alongside them, may therefore be difficult to maintain.

### Emphasizing Diagnosis Instead of Problems

Partly because of the demands of third-party payers for "diagnoses," psychiatry now places considerable emphasis on that process as defined by the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual*.<sup>22</sup> Psychiatrists are often obliged to label their patients' illnesses quickly—an increasingly complicated process—before trying to understand them. The manual's various categories are based primarily on patients' symptoms and their duration, and, although the APA denies it, it is also widely

claimed that particular medications are specific for particular diagnoses.

Liddell<sup>23</sup> showed that animals displayed similar characteristic reaction patterns under unremitting stress: first inhibition or depression, then behavioral and emotional disorganization. Menninger et al<sup>24</sup> described the same sequence in humans under stress. Balint<sup>3</sup> emphasized the symptom fluidity in medical patients first approaching their physicians, and the fluidity of early psychiatric symptomatology has also long been recognized.

Nevertheless, psychiatry has increasingly been selecting portions of fluid symptom patterns as the bases for fixed diagnoses. The diagnosis borne, perhaps for years, by someone who is depressed over his situation on Monday, anxious on Tuesday, and disorganized on Wednesday, may therefore depend on the day the psychiatrist sees him.

### The APA's Undercutting of Continuity of Care

In 1979, I suggested to the APA's annual Hospital and Community Psychiatry Institute that it choose "continuity of care" as the theme for its 1980 meeting, and include a report on the treatment pattern I saw in Cambridge. Although the program chairman said my suggestion had been accepted, the Institute's title was "The Patient, Where? Lost in the Mental Health System," which assumes and accepts a treatment system based on repeated transfer; it thus denied true continuity of care. The major concern in such a system is not whether doctors know their patients and work with them over time, but rather, that bodies and papers do not get lost. The Institute's only discussion of a real continuity-of-care system was offered by some young midwestern social workers whose efforts had begun only a few months earlier.

In May 1980, I organized a symposium on "Rehumanizing the Chronic Patient" for the American Psychiatric Association's Annual Meeting in San Francisco to discuss "Effective Psychotherapy of Chronic Schizophrenia"<sup>10</sup>—my own experiences with about 100 personally treated, unselected, state hospital aftercare clinic patients. My best-known panel member was John A. Talbott, MD,



who has been chosen since then to be president of the American Psychiatric Association, editor of *Hospital and Community Psychiatry*, the Association's second most important journal, and, in 1985, psychiatry chairman at the University of Maryland. The media have quoted him regularly, both then and now, on chronic mental illness. He suggested that I invite University of Maryland sociologist Dr. Leona Bachrach, wife of the editor of the *Index Medicus*, which I did.

Her paper<sup>25</sup> opened the symposium by describing a Maryland patient who had been admitted 17 times in 6 months to three different hospitals. To correct such situations, she called for "continuity of care," which she defined as "the orderly, uninterrupted, and unlimited movement of patients among the diverse elements of the service delivery system." This definition, like the Hospital and Community Psychiatry Institute's theme, accepts fragmented treatment systems and thus also denies the importance of continuity of doctor-patient relationships. Her paper was published as the lead article in the APA's official *American Journal of Psychiatry*. (Mine was rejected and appeared 2 years later in a less widely read publication.)

During the following years, the APA legitimized the fragmentation of treatment everywhere<sup>26</sup> by sponsoring lectures throughout the country by Bachrach on her concept of "continuity of care," and by repeatedly honoring her. One important consequence of this widely accepted discontinuous definition of continuity has been to shift the primary responsibility for patients from psychiatrists to case managers.

### ***The Destruction of Competent, Continuity-Based Care in New York***

#### **The Leadership Hemorrhage**

The destruction of competent care in New York State started much earlier, in 1974, after the election of Democratic Governor Hugh Carey. He inherited a cadre of fine Office of Mental Health psychiatric leaders, 69 of whom held director-level positions, 11 of them in the central office. By 1979, only 16 psychiatrists held

director-level positions, with only 2 left in the central office; a major leadership hemorrhage had occurred, with 77% of the system's top psychiatrists having left during that 5-year period.<sup>27</sup> In 1984, after the election of Democratic Governor Mario Cuomo, neither of the two central office psychiatrists—the new commissioner and his deputy—had had any previous state hospital experience, and the deputy complained informally to me about the agency's lack of organizational memory.

The departure of these leaders was neither accidental nor coincidental. In 1977, one psychiatrist-director was faced by a typical "no-win situation." "The Civil Service Commission reversed the director's attempt to discipline an employee for patient abuse and restored the employee to full status. The union then charged the director with employee harassment even as the media attacked him for encouraging child abusers to work in that hospital." A state legislator, learning of this attack, demanded the director's removal. "The department's response was a deafening silence." This account comes from an article in the *Bulletin* of the New York State Psychiatric Association, titled "And Then There Were None,"<sup>28</sup> describing the state system's loss of psychiatric leaders and published 7 years later, when no action could be taken.

Other cruel and arbitrary treatment by OMH of its top leaders discouraged responsible psychiatrists from remaining in it. In the spring of 1979, Dr. Hugh Butts, African-American psychiatrist-director of Bronx Psychiatric Center and Deputy Commissioner of the Department, who had criticized state policies' effects on his patients, returned from Albany to find that, by order of the Commissioner, the locks to his office had been changed and he had been dismissed. That fall, Dr. E. Richard Feinberg, psychiatrist-director of Bronx Children's Psychiatric Hospital, and another critic of state policy, was abruptly suspended for 4 months (publicly and with newspaper headlines) when a disgruntled employee falsely accused him of sexually abusing adolescent male patients. The commissioner justified the suspension as having been "for alleged personal practices involving patients."<sup>28</sup>

In 1979, after most of the leadership hemorrhage had occurred,



the importance of competent psychiatric leadership was emphasized by Lawrence C. Kolb, MD, the immediate past commissioner, and former OMH Regional Director Hagop Mashikian, MD.<sup>27(p.6)</sup> Dr. Kolb, past-president of the APA, former director of the New York State Psychiatric Institute and former chairman of psychiatry at Columbia's College of Physicians and Surgeons, said presciently that "only the physician psychiatrist has the independence and security in the face of political onslaught when circumstances demand he support or defend a course of action relating to patient care which happens to come into conflict with the political aspirations of others. As the health field becomes more and more politicized, the increasing tendency is to appoint administrators whose decision-making is seriously impeded through the need to make political obeisance or to preserve their own sinecures." His statement is equally applicable to proposed organizational changes in general medicine today.

Dr. Mashikian noted that "psychiatrists as state facility directors were often a thorn in the side of central office officials since they often resisted new directives in the interests of quality programming, and on many occasions they were right. The ability to do this came from a sense of security as a physician with demonstrated ability." Noting that administrators without such a background might lack that security, he added that "insecurity in program executives does not make for effective or efficient programs."

#### Intimidating the Psychiatric Leaders Who Remained

Other intrahospital problems were also used to destroy leaders and intimidate psychiatrists. When a patient on an authorized pass from Pilgrim Psychiatric Center murdered his ex-wife in December 1979, the OMH publicly blamed two of the hospital's most respected psychiatrists.<sup>29</sup> After the deputy director, a psychiatrist, defended them, he stepped down and soon retired. The hospital's director, another psychiatrist, was promoted to a deputy commissionership, and a nurse was appointed director of the system's largest facility.

Although a forum was held at the May 1980 APA meeting on the case (and on the persecution of Dr. Feinberg), its title was "Psychiatric Caring versus Political Pork-Barreling in the New York State Mental Health System" the organization publicized neither the case nor the forum and followed up neither. Although the case had received national attention, front page headlines in the *New York Times* and two reports on *Sixty Minutes*, the convention's greatest attention, and that of its *Daily Bulletins*, was given instead to the Equal Rights Amendment.

It took a year to exonerate the falsely accused psychiatrists and another before the killer was finally convicted of murder and given a maximum sentence.<sup>30</sup> But in the meantime, state hospital psychiatrists had been shown that they were expected to serve as public sacrifices when the system made administrative errors. When Judith Singer died in 1981 after 6 days of mistreatment at South Beach Psychiatric Center, the last physician to treat her was blamed rather than administrators who were really responsible for her fragmented and incompetent care.

Scapegoating occurred again after a strait-jacketed patient was found strangled at Creedmoor Psychiatric Center in 1984. Screaming newspaper headlines forced out the director (another psychiatrist who had been publicly critical of one of the Governor's decisions), two of his three deputy directors, one a psychiatrist, and several other respected psychiatrists. It was noted that this director learned only in the commissioner's office "that his office had been sealed and that he and two other senior members of his staff had been removed from their positions."<sup>28</sup>

In spring 1985, I submitted a piece, "Why There Are None," to the *Bulletin* of the New York State Psychiatric Association. Amplifying "And then there were none,"<sup>28</sup> it detailed OMH persecutions of psychiatrists which that article had not mentioned, pinpointed wrong-doing by power-holding psychiatrists within the system (whom it named), and criticized and analyzed APA inaction. As published in the March-April issue,<sup>31</sup> my article included the issues agreeing with the earlier article, but all of its more specific points, three-quarters of the entire piece, were cut out.



### Administrative Changes That Fragmented Care

*Separating Inpatient from Outpatient Services.* Before being appointed clinical director at Brooklyn's Kingsboro Psychiatric Center in 1973, I had served for 5 years as a chief of service at the Bronx Center. I spent a significant fraction of my time there, perhaps 10%, negotiating (arguing might be more accurate) with the receiving hospital about the admission or release of particular individuals. Because there was nobody to resolve those disputes, the negotiations could go on endlessly—and sometimes did. At Kingsboro, on the other hand, disputes between in-patient and clinic staff were solved easily by the Chief of Service responsible for both.

In 1979, Albany separated in- and aftercare services administratively by ordering that different deputy directors be responsible for each of them at each center. This created new conflicts between these staffs and increased the burdens at admission and discharge upon both patients and staff. I estimated that at Kingsboro before that change, about 0.25% of admission ward patients needed to be transferred to chronic services; at Creedmoor after it, I found that 12% had been transferred.<sup>32</sup>

*Reinstituting "Levels of Care."* In 1981, the state reinstituted "levels of care": admission, subacute, and chronic wards, among which newly admitted patients were transferred, thus greatly increasing the number of doctors each patient saw sequentially. After this change, about half of the patients at Bronx needed transfer,<sup>33</sup> in comparison with 12% earlier at Creedmoor and 0.25% at Kingsboro.

*Shattering Aftercare.* The most important and destructive change occurred in 1984. After strong public protests about harmful mental health care—for example, during the previous 5 years, 17 psychiatric hospital patients had died as Judith Singer had in connection with being tied down<sup>34</sup>—Governor Cuomo appointed a Select Commission on the Future of the State-Local Mental Health System, whose chairman, a social worker, was executive vice-president of the Jewish Board of Family and Children's

Services, and whose vice-chairman was the bishop heading Catholic Charities.

Immediately after the Commission's appointment was announced, I sent its chairman material demonstrating the value and importance of continuity of care and asking to testify before it as soon as possible. He did not invite me until it was already preparing its final report, when I had been asked to discuss mental health problems on local television. Despite the material I had sent, none of the Commission members had ever heard of continuity of care.

They therefore continued with the recommendation upon which they had already agreed: State funding of private agencies to provide aspects of aftercare for hospital discharges, rather than continuing to have all aftercare provided by state-hospital clinics. The Jewish and Catholic agencies whose heads ran the Commission benefited in great measure financially from the new changes. The number of different organizations facing each discharged patient was greatly increased, making it much more complicated and difficult for him or her to obtain care. To help patients negotiate this newly (and perhaps deliberately) created administrative labyrinth, case managers were then appointed.

### *The Destruction of Competent Care Elsewhere* Undercutting Continuity of Care on the Federal Level

The bureaucratic undercutting of the continuity of care principle has occurred at the federal level as well. In 1986, I took a 2-day training course given by the Health Care Finance Administration for prospective inspectors of psychiatric facilities. Most of the students were high-level psychiatrists, including two former state commissioners and one deputy commissioner, whereas the faculty was almost entirely nonmedical. They told us that our inspections were limited to issues of staffing and records. Recalling what had happened in New York, I asked what we should do as inspectors if, on reexamining a facility, we found that administrative changes—increased fragmentation, for example—had impaired treatment. I was told the question was outside our purview as



inspectors, and a few weeks later was notified that my services as an inspector would not be needed.

### A Returnee's View of the Recent Changes

Pinheiro<sup>35</sup> has described the magnitude and speed of recent changes in treating the psychiatrically disabled in Baltimore. He went there from his native Brazil for psychiatric training in 1958, practiced there until returning home in 1974, and resumed practice there in 1987. He said that although "American psychiatry [now] considers itself more scientific" than it had been 13 years earlier, it has actually "changed for the worse in terms of patient care" by returning "to the unfortunate attitudes of pre-Freudian days" (pre-Meyerian would be more accurate).

He said "a whole new generation of psychiatrists, coming from the best medical schools, . . . are unable to pay attention to their patients' subjective worlds. They have been trained to look at people's outsides: behavior is what counts, in the best American, mechanistic, pragmatic tradition. . . . Psychosocial factors, once so popular, now seem almost forgotten." Instead, the current "emphasis on the brain . . . is being used defensively by patients, families and professionals alike. One patient recently said to me, 'I am upset today because of my brain chemistry. Would you please adjust my medication?' A mother recently said to me about her schizophrenic son, 'we just hope that someday you doctors will find a way to fix his brain chemistry.'"

Pinheiro questioned the new use of multiple diagnoses—schizophrenia plus antisocial personality and alcohol abuse, for example. "This fragmentation of diagnosis is leading to fragmentation of treatment, and patients are frequently being placed in competing therapeutic programs." (Such fragmented treatment can legitimately be called "schizotherapy.") One borderline patient who "also shows some masochistic, self-mutilating tendencies, [is] because of her multiple symptoms, now in outpatient treatment *both* in a sexual disorders program and a community mental health clinic, requiring an enormous amount of communication among the professionals involved."

He viewed rather negatively some of the major changes imposed on psychiatric practice from above or outside. Third parties, including "government advisory groups and insurance companies, are now determining what constitutes good clinical practice although their major interest, dictated by economic concerns, is not always related to the patient's well-being. . . . Available funds are now the main determinants of treatments . . ., with patients being shipped from program to program in order to comply with funding." The relative importance of patients and paper was indicated by the colleague who told him, "in this hospital, if you lose a patient, that is bad. But if you lose a patient's records, you must be prepared to leave town."

He concluded that the basic thrust of the new psychiatry could perhaps be represented by his own mental response to a "miserable, disheveled man on the street, . . . shouting disconnected statements in a desperate, agitated way." "For a moment I was embarrassed," he wrote, "until these thoughts came to my mind:

Problem: shouting continuously in front of a shopping center.

Goals: decrease shouting to three times a week.

Intervention: prolixin decanoate, 1 cc (25 mg) IM."

Then he asked, "how far can this country continue to move in [this] direction before people realize that they are missing something?"

### Effects of These Changes on Treatment

The great harm today's psychiatry often causes its patients can be shown in many ways. No other medical specialty has organizations of treatment "survivors" the way psychiatry does. In August 1993, some 1,200 American ex-patients gathered to celebrate the ninth annual reunion of the group they had created.<sup>36</sup> The bitterness of many of those present toward physicians, psychiatrists particularly, could probably not be matched outside an assemblage



of malpractice plaintiffs. This group represents the end-product of psychiatrist-patient relationships gone totally awry.

Two very different recent books described the poor public mental health care,<sup>37</sup> especially in New York City, which evoked these deep antipathies: social worker Dr. Ann Braden Johnson's *Out of Bedlam*<sup>38</sup> and journalists Rael Jean Isaac and Virginia C. Armat's *Madness in the Streets*.<sup>39</sup> After carefully studying New York's public mental health system from within, Johnson characterized it as "overly responsive to the whims, fantasies and fads of remote, detached and faceless bureaucrats who may or may not know that they are talking about. . . . People and agencies uncertain of their ability to perform their assigned task . . . wield incalculable power over the system of patient care simply because they hold the purse strings." Since the system is "run by its need to maintain a certain level of reimbursement, its directors plan services to do just that"; the short range "bottom-line" of funding is therefore primary everywhere—as Pinheiro also pointed out. Patients' needs are consequently one of the lowest priorities of this "anxious and insecure system," within which increasingly incompetent bureaucracies make often-harmful treatment decisions regarding patients about whom they know progressively little and care progressively less. The Isaac-Armat book also describes psychiatric care's harmful effects, and especially how it criminalizes patients by teaching law-abiding people to become social menaces, but it incorrectly blames the problems on "liberals" and civil libertarians rather than on bureaucrats and biologically oriented psychiatrists.

Homeless mental hospital discharges have been decorating our cities' streets for years, but the situation has worsened markedly over the past decade. During the 1970s and early 1980s, New York's discharges were sent to clinics organizationally connected with the hospital, where they were followed relatively easily and effectively. The 1984 Select Commission's recommendations changed that completely.

In 1988, the "watch-dog" New York State Commission on Quality of Care for the Mentally Disabled reported that although

85% of discharges were theoretically referred to aftercare services, only 40% had specific appointments and only a still smaller fraction actually got there. (Such follow-ups on aftercare should be conducted routinely by the hospitals, with those responsible for failures being held personally accountable, rather than by seemingly scientific, long-after-the-fact "studies" like this one.) Some paper changes were made in these services, and a quarter of a billion dollars was poured into them, but in 1993, 22% of all patients, and 90% of those who also abused drugs or alcohol, got no aftercare services at all.<sup>40</sup>

The *New York Times* described 40% of the discharges as "unable to negotiate the complicated government and health-care bureaucracies that they rely on for help." Failure to provide aftercare was blamed for the 50% rehospitalization rates in New York City and on Long Island.<sup>41</sup> This situation will undoubtedly worsen, since with state hospitals closing down beds, there will be fewer and fewer places for these patients to go. The bureaucrats now running the New York State mental health system, once one of the country's best and still its most expensive, are therefore now dumping drugged, iatrogenically disabled psychiatric patients increasingly onto the streets.

### *The Meaning for General Medicine*

In the late 1970s and early 1980s, public mental health care in New York State was organized effectively and efficiently. The system's transfer of organizational responsibility from experienced psychiatric administrators to nonmedical bureaucrats, and the changes then instituted and implemented, are primarily responsible for the destruction within that system of doctor-patient relationships, and, consequently, of effective care.

Psychiatry's overconcern with drugs and symptoms is also responsible for the specialty's abandoning its traditional attitude of treating patients as people rather than as symptom packages. In general medicine, comparable overconcern with quantifiable,



"scientific" biology at the expense of appreciating patients' humanity could produce similar harm.

The impending reorganization of medical care throughout the country might also produce comparable difficulties. The more that distant, bureaucratic third parties structure doctor-patient relationships, the greater the danger will be that they do so in harmful ways. We have already had regulations from Washington, now fortunately removed, on what physicians could or could not tell patients about abortion. It is therefore not hard to envisage attempts, for example, allegedly to use physicians' time efficiently by creating bureaucratic rules from afar on how long they can see each patient or even what they must or must not discuss.

### Summary

The importance of the doctor-patient relationship for effective psychiatric treatment and of the continuity of care administratively necessary for its existence—having the same doctor caring for a patient in the hospital and after discharge—should have been obvious for years, but the significance of this continuity was not defined explicitly to this author's knowledge until about 1979. The therapeutic relationship's importance is underlined by White's demonstration<sup>4</sup> that its positive impact seems to "account for about half of the benefits" associated with medical and similar ministrations.

Two mounting impediments to continuity of competent public psychiatric care and to its therapeutic effectiveness have been the harmful attitudes and actions of American psychiatry and the care-fragmenting acts of public officials in New York State and elsewhere. Beginning soon after the continuity concept was formulated and increasingly influenced by drug companies, official American psychiatry has denied the importance of a physician's continuing care by redefining "continuity" as though public mental health care had to be fragmented. The bureaucratic decisions of public officials are primarily responsible for the shattering and destruction of good public psychiatric care, for its consequent gross

overuse of medications, and for the disappearance from it of competent psychiatric leadership and effective therapeutic relationships.

The federal Health Care Finance Administration example demonstrates how comparably harmful bureaucratic decisions concerning general health care can be made on the federal level. If they are, medical care in America, like public psychiatric care, may sometimes become harmful to its patients.

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*Excerpt from Editorial: This Issue of the Journal of Urban Health*

Lehrman's impassioned condemnation of the system of community psychiatry that resulted in what he calls "destruction of competent continuity-based care in New York" may appear to some to be too personal but, as he points out, this experience provides lessons that may be useful to the rest of the health care system as it undergoes reform. I encourage those with other views on this topic to write a letter to the editor.