aapa

PSYCHIATRIST ADMINISTRATOR

NewsJournal of the
American Association of Psychiatric Administrators

Volume 2, Issue 3 Summer 2002

The Psychiatric Chief Resident as A Future Psychiatrist Administrator
Pedro Ruiz, M.D. and Mary E. Bret, M.D. 59

Commentary on Dr. Ruiz and Dr. Bret article
Alan Schmetzer, M.D. and Judith Bealke, M.D. 64

A Review of Insanity Defense
Judith J. Regan, M.D., Ann Alderson, B.A.,
and William M. Regan, M.D. 66

Science, Policy Decisions and Social Change:
Reflections in Honor of Richard J. Wyatt
Daniel Luchins, M.D. 71

Ethics Column
H. Steven Moffic, M.D. 74

Instructions for Authors 78

NEWSJOURNAL OF THE AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS

Editor Sy Atezaz Saeed, M.D., MS, FRSH

Published 4 times a year
Winter • Spring • Summer • Fall

Executive Director: Frances Roton
P.O. Box 570218
Dallas, Texas 75357-0218
Ph.: (800) 650-5888
Fax.: (972) 613-55329
Email: frda1@airmail.net

AAPA PAST PRESIDENTS

1961-1962	**Archie Crandell, M.D.**
1962-1963	**M. Duane Sommerness, M.D.**
1963-1965	**William S. Hall, M.D.**
1965-1966	**Herman B. Snow, M.D.**
1966-1967	**Donald F. Moore, M.D.**
1967-1968	**Francis Tyce, M.D.**
1968-1969	**Harry Brunt, M.D.**
1969-1970	**Walter Fox, M.D.**
1970-1971	**Dean Brooks, M.D.**
1971-1972	**George Zubowicz, M.D.**
1972-1973	**Emanuel Silk, M.D.**
1973-1974	**Hubert Carbone, M.D.**
1974-1975	**Hayden H. Donahue, M.D.**
1975-1976	**Ethal Bonn, M.D.**
1976-1977	**George Phillips, M.D.**
1977-1978	**John Hamilton, M.D.**
1978-1979	**Tom T. Tourlentes, M.D.**
1979-1980	**Mehadin Arefeh, M. D.**
1980-1981	**Roger Peele, M.D.**
1981-1982	**Stuart Keill, M.D.**
1982-1983	**Gloria Faretra, M.D.**
1983-1984	**Darold A. Treffert, M.D.**
1984-1985	**Thomas G. Conklin, M.D.**
1985-1986	**John Talbott, M.D.**
1986-1987	**Dave M. Davis, M.D.**
1987-1988	**Robert W. Gibson, M.D.**
1988-1989	**Robert J. Campbell, M.D.**
1989-1990	**Stephen Rachlin, M.D.**
1990-1991	**Haydee Kort, M.D.**
1991-1992	**Boris Astrachan, M.D.**
1992-1993	**Gerald H. Flamm, M.D.**
1993-1995	**A. Anthony Arce, M.D.**
1995-1997	**L. Mark Russakoff, M.D.**
1997-1999	**Paul Rodenhauser, M.D.**
1999-2001	**Gordon H. Clark, Jr., M.D.**

The Psychiatric Chief Resident as a Future Psychiatrist Administrator

Pedro Ruiz, M.D., and Mary E. Bret, M.D.*

INTRODUCTION

During the last three decades, major events in the psychiatric field have led to a profound change in the role and functions of psychiatrists administrators. First, came the demise, during the early 1970s, of the public sector "community mental health centers" system during the Nixon government (1). Next, the failed national deinstitutionalization model which fell short of the adequate provision of community-based mental health services, and led to the criminalization of the mentally ill as well as the homelessness and street-housing of the psychiatric patient population, which took place in the late 1970s and in the 1980s (2)(3). Finally, the advent of the managed care system during the last two decades has occurred, which has profoundly discriminated against psychiatric care and still negatively impacts on the quality and quantity of health and mental health care; manage care has, in particular, negatively impacted on the ethnic minority populations of this country, as well as the poor and disadvantaged populations (4)(5)(6).

Nowadays, the psychiatrist administrator requires a different knowledge and skills to effectively administer, manage, and provide the appropriate leadership to succeed in the mental health care system that currently prevails in this country (7)(8). As one reflects on the need to train and promote future psychiatrist administrators, the position of psychiatric chief residents quickly comes to our minds. The roles and functions of psychiatric chief residents have over the years, received much focus and attention (9)(10)(11). In psychiatric administration, there is a beginning which requires an ideal foundation upon which to build a strong and successful administrative career. In many respects, the position of psychiatric chief resident can be conceptualized as the first step toward future and successful psychiatrists administrators. Therefore, in this article, we will address, dwell on and discuss the ingredients and issues required to effectively build psychiatric chief residents in today's health/mental health care environment, and thus future psychiatrists administrators as well.

THE PSYCHIATRIC CHIEF RESIDENT

The position of psychiatric chief resident is the initiation of a professional step leading to the challenges related to managerial administration and leadership issues within the current health and mental health care system. The future of managerial leaders and administrators, here particularly with psychiatry, depends a great deal on the experiences during the first managerial administrative exposure. This is what the chief resident is. Chief residents may not realize that their position is their first managerial experience. As Colenda has stated it (12), the chief resident is an information manager; that is, he/she is able to access information at all levels of a department, across faculty, and within the residents' boundaries. Mishaps can arise if the chief resident misunderstands the dynamics of the position, and sensitive information is either too freely passed from one level of the academic psychiatry department to another, or not passed freely enough. For most chief residents, this is their first encounter with this sort of pressure to communicate what should be just enough and no more, as well as a possible poor understanding of concepts of time management, information systems, and basic administrative skills of communication. If a chief resident does not have these skills, it becomes quickly apparent in their effectiveness in the position, and whether they want to or not, the chief resident needs to acquire the basic administrative skills required from an information manager. It is, therefore, important that chief residents pay a lot of attention to feedback, guidance and mentorship during their function and job experience. Additionally, it is important that didactic information and supervision be offered to chief residents to complement their field experience. For example, conferences for chief residents are offered annually at Tarrytown, New Jersey, and at Alton, Utah. It is imperative that we produce the most apt chief residents to generate top future administrators in the psychiatric field.

MENTORSHIP ISSUES

The role of a mentor for the chief resident is an essential ingredient during his/her administrative career advancement. It is possible for all residents to have a mentor, and indeed, it is desirable. The chief resident is able, however, to use the experience of mentorship in a different way; the mentor's input and feedback can increase the chief resident's ability to function in the various levels of a department, and also to promote at the same time the chief resident's personal growth. As the mentor is exposed to a heavy flux of information, the chief resident can learn first hand as an apprentice how this flux is processed and interpreted. Because the position of chief resident rarely comes with a job description, and because

predecessors may not remain available and able to help, the mentor is actually an indispensable part of the chief resident's experience. Without the appropriate knowledge, effective supervision, and didactic teaching, the position of chief resident would become largely honorary and without substance. To avoid this, a psychiatrist administrator in each psychiatric department needs to be willing and available to expend his/her time with chief residents. Being a leader requires a commitment of one's character; being an administrator requires a commitment to the communicating of that character. The presence of a personal model for the chief resident during this growth process is crucial. Interestingly, as women and men learn to share these positions in administration, it appears that mentors of both sexes are necessary. Male and female chief residents face similar issues as well as unique challenges in interacting with the junior residents, the staff and the faculty at large. Thus the chief residents have to look to more experienced role models, preferably of their own sex, to form a template on how to deal with gender related issues in the work environment.

ADMINISTRATIVE ISSUES

Hogan (14) describes the new administrative tasks of psychiatrists as being systematic, cost-effective, evidenced-based with documented quality improvement, and able to comply with the ever-more sophisticated requirements of public state mental health programs and the courts. Additionally, the doctor-patient relationship in the inpatient service has evolved from the luxury of a long experience-based phenomenon to an objective, goal-oriented system. Psychiatrists plan for the short stabilization of patients and their long aftercare services in community mental health systems which are totally unconnected with the inpatient psychiatrists. These are the priorities of the current mental health care system. So the task of the teacher/mentor, whether it is a faculty member or a chief resident, has dramatically changed. The junior residents need to develop the skills required for crisis stabilization, and short term care, and quick documentation. Rapid inpatient stays may become exercises in cataloguing psychiatric symptoms. The human element of a relationship with a patient, the element which has been a unique aspect of psychiatry as a subspecialty, is being short-changed during training as a direct result of the managed care realities. Justifying this reality to junior residents may fall to the chief resident. These recent changes in the mental health care system have no boundaries in training programs. As years have gone by, priorities have changed; moving away from academia, training and research, and quality clinical care. These new experiences have changed the role of the chief resident. Requirements for demonstrating competence in the various learning tasks of psychiatric residency become more objectified and demanding of quantification; this means that chief residents have become more involved in teaching junior residents as to how to achieve these clinical requirements. At the same time, the chief residents have to continue developing their own managerial skills.

Looney (15) has pointed out that psychiatrists who become administrators are advanced in their positions because of their past performance as clinicians, teachers or researchers; ideally, he/she will have developed an understanding of their motivation and will have become patient, flexible, and a practiced listener. Objectivity, decisiveness, and the ability to plan and allocate resources are high priority skills for psychiatrists administrators. As such, the administrator's clinical and academic experiences served as backdrops for their skills as managers. Looney (15) further proposed six models to define the traditional psychiatric chief residency: the ward chief, the teacher chief, the research chief, the resident advocate chief, the faculty advocate chief, and the interface chief. The clinical duties and the advocacy duties place the chief residents in a position of conveying crucial information to their peers; the social environment of inpatient and outpatient psychiatric care has its own hierarchies and systems of information movement; the chief resident is in the ideal position of being an ombudsman to junior residents in this environment, both by virtue of their personal experiences and by virtue of direction from faculty/mentors.

GENDER ISSUES

The field of psychiatry has also changed a great deal with respect to gender in the professional administrative arena. Over twenty years ago most medical students, psychiatrists and administrators were men; slowly, however, this emphasis has changed (16). Currently, over 40% of medical students are women, and 43% of all the psychiatric residency positions are also filled by women (17). Many psychiatric positions which once were occupied by men are now occupied by women. The literature of the past 20 years reflects this perspective. For example, Kessler (18) noted that the chief residency position was open to women in 1982, but at that time there were disadvantages about being a woman chief resident. For instance, women chief residents were more likely to identify "inadequate managerial talents" as a problem (19). As a result of this, the majority of psychiatric administrators today are still men; however, there is a growing cohort of

women entering the administrative field. Clearly, the phenomenon of the glass ceiling for women in managerial positions is changing; if for no other reason than because of the promotion of a number of women by their male mentors. Who do administrative women look for as role models? Who will new administrative men look for as role models as more women become highly placed in the psychiatric administrative structures? It would appear that the new cohort of women administrators will learn to emulate what their male predecessors have established; that is, they will learn and pass it along to the younger women who follow. That provides a great opportunity for the female chief resident to learn the skills of being a "boss" and a "mentor" at the same time, and to overcome the old feelings of "inadequate managerial talents".

TRAINING ISSUES

Weissman (20) points out that between 1988 and 1996, medical students matching for psychiatry in the National Residency Matching Program dropped by 40% to the 1980 level. This means that one of the important functions of the academic departments of psychiatry in the last decade has become the recruitment of qualified U.S. graduate residents. The chief residents are the representatives of these residents, and as such there is now additional pressure for the chief residents to devote a large portion of their time to recruiting medical students to psychiatry, and to put a best face forward. In recent years, the number of US medical school graduates entering psychiatry has decreased and the number of international medical graduates (IMGs) has increased. This has created a different type of psychiatrist administrator. In some parts of the country, residents are unionized, and the continuing growth of this type of organizational change presents unique challenges. Placing limits on the service provision by residents or requiring more hands-on by the attending physician inevitably creates tension with the attending faculty who must take up those responsibilities.

CLINICAL ISSUES

Clinical services in the age of managed care are demanding more faculty participation and documentation of services. This may eliminate opportunities for clinical experiences that residents previously enjoyed. For example, the inability to charge for residents' psychotherapy services limits the amount of services that the residency programs can afford to offer their patients. To be able to provide this type of training, departments will have to make a commitment to allow residents to provide psychotherapy without being reimbursed for these services. Quotas of numbers of psychotherapy patients have to be set to offset direct losses in reimbursement to the psychiatry department; residents have to see "just enough and no more" patients to gain the competence they need without overburdening the system financially. Tasman (21) proposed different models for funding psychiatric education in an era of managed care: 1) requiring residents to pay tuition for training, 2) taxing all health care services, 3) developing payback arrangement between institutions and residents, 4) linking care for the indigent to training cost reimbursement, 5) working without compensation, and 6) permitting residents to work under supervision in community settings while being paid for their services. The chief residents have to find time, while spending 50-70% of their time in administrative tasks, to demonstrate their own personal competence in their clinical tasks. The pressure for residents to be service providers for psychiatry departments has never been more challenging in this age of managed care, and to be an administrator and a resident at the same time carries an additional balancing act for the chief resident. Clinical rotations nowadays require documentation of the hours spent on them for reimbursement purposes, as well as for demonstration of adequacy on the learning experience, and chief residents are less of a direct service provider than the other residents.

During the 2001 Tarrytown Annual Chief Residents' conference, sponsored by the Albert Einstein College of Medicine, chief residents were divided into small groups of about a dozen. Each group was asked to draw up a list of the five major problems faced by psychiatric residencies nowadays. It was remarkable how across the groups the five problems were similar: 1) too many patients, 2) not enough teaching, 3) more managed care training needed, 4) more political activism needed, and 5) more psychotherapy training needed.

FUTURE PERSPECTIVES

The chief resident can be sitting in the driver's seat as the changes take place. Not only can the chief resident be a passive recipient of the changes, but he or she can and should also play an active part in implementing these changes (22). The chief resident has a unique opportunity to help design and program the role of psychiatric administrators as well as to fully participate in the improvement of the countrywide system of psychiatric care. If the system makes demands on the psychiatric chief resident to become more objective and more goal-oriented in an era of managed care and psychiatric carve-outs, the chief residents will have to step up to the plate and articulate needs of their own (23). As the amount of documentation increases and the length of stay of our

patients decreases, the amount of time we have available to treat our patients decreases; we will have no options but to bring what our electronic age has to offer, that is, handling data more efficiently (24).

The opportunity to operate in a more multicultural and pluralistic system is a wonderful opportunity for us as well. Psychiatric administrators and chief residents bring together a variety of backgrounds and experiences. Sharing these ethnic and cultural backgrounds and experiences enriches everyone involved. With the increasing challenges in continuing to provide quality of care to our patients, all psychiatrists will be called upon to develop new skills and modes of interaction. The academic psychiatry departments need to provide the learning environments for acquiring these new skills and clinical experiences. Richness of cultural, gender and training backgrounds can bring new philosophies of administrative task making to psychiatrists administrators. These new venues will provide chief residents with the opportunity to network and mentor with psychiatrists administrators in new and exciting ways. The integration of the enthusiasm of chief residents for productive change and the instruction of seasoned psychiatrists administrators for ways to implement needed change will be an essential combination in coming up with solutions for the current challenges facing academic psychiatric departments. When one looks towards the future we no longer see a homogenous group of patients and staff but a more diverse human representation. Without question, the challenges in front of us are enormous but so are the opportunities for growth and success for future psychiatrists administrators.

**Both authors are affiliated with the Department of Psychiatry and Behavioral Sciences of the University of Texas Medical School at Houston, where Dr. Ruiz is Professor and Vice Chair, and Dr. Bret is Chief Resident.*

References

1. Ruiz P: The Fiscal Crisis in New York City: Effects on the Mental Health Care of Minority Populations. American Journal of Psychiatry 1979; 136(1): 93-96.
2. Geller JL: The Last Half-Century of Psychiatric Services as Reflected in Psychiatric Services. Psychiatric Services 2000; 51(1): 41-67.
3. Carlson RJ, Ruiz P: the Chronic Young Adult : Trends in Deinstitutionalization and Public Sector Hospital Care. In R.C. Chacko (ed.): The Chronic Mental Patient in a Community Context. Washington, D.C., American Psychiatric Press, Inc., the Monograph Series, 1985, pp.26-40.
4. Pardes H: The Future of Medical Schools and Teaching Hospitals in the Era of Managed Care. Academic Medicine 1997; 72(2): 97-102.
5. Leigh WA, Lillie-Blanton M, Martinez RM, Collins KS : Managed Care in Three States : Experiences of Low-income African Americans and Hispanics. Inquiry 1999; 36: 318-331.
6. Ruiz P, Venegas-Samuels K, Alarcon RA: The Economics of Pain: Mental Health Care Costs Among Minorities. The Psychiatric Clinics of North America 1995; 18(3): 659-670.
7. Lazarus A: Managing the Clinical-Administrative Interface: Recommendations for Psychiatrist-Executives. Psychiatric Services 1997; 48(4): 457-458.
8. Silver MA, Marcos LR: The Making of the Psychiatrist-Executive. American Journal of Psychiatry 1989, 146 (1): 29-34.
9. Ruiz P: Psychiatry: Why Nobody Wants To Be Chief Resident. Resident and Staff Physician 1977; 23(2): 57-61.
10. Griffith E, Ruiz P, Feiner J: New Concepts for the Administrative Training of Psychiatric Chief Residents. Journal of Medical Education 1978; 53: 212-214.
11. Borus JF: Teaching Residents the Administrative Aspects of Psychiatric Practice. American Journal of Psychiatry 1983; 140(4): 444-448.
12. Colenda CC : The Psychiatry Chief Resident as Information Manager. Journal of Medical Education 1986; 61 (8): 666-673.
13. Delgado AK, Griffith EEH, Ruiz P: The Black Woman Mental Health Executive: Problems and Perspectives. Administration in Mental Health 1985; 12 (4): 246–251.
14. Hogan EA, Sharp J, Miller MC: Inpatient Residency Training in a Time of Change. Harvard Review of Psychiatry 1998; 6 (1): 49-52.
15. Looney JG, Engleberg SJ, Gode RO, Knesper DJ: The Psychiatric Chief Residency: a Preliminary Training Experience in Administrative Process. American Journal of Psychiatry 1975; 132(7): 729-733.

16. Matorin AA, Collins DM, Abdulla A, Ruiz P: Women's Advancement in Medicine and Academia: Barriers and Future Perspectives. Texas Medicine 1997; 93 (11): 60-64.
17. Kopriva P (ed): Women in Medicine in America. Chicago, American Medical Association, 1991.
18. Kessler MD, Hellekson-Emery C, Wilder JF: The Psychiatric Chief Resident: Does Gender Make a Difference? American Journal of Psychiatry 1982; 139 (12): 1610-1613.
19. Silver, MA: Women in Administrative Psychiatry. Psychiatric Annals 1995; 25 (8): 509-511.
20. Weissman S: Recruitment and Workforce Issues in Late Twentieth Century American Psychiatry. Psychiatric Quarterly 1996; 67(2): 125-137.
21. Tasman A: The Future of Residency Training in Psychiatry. Bulletin of the Menninger Clinic 1994; 58 (4): 474-485.
22. Lipton AA, Loutsch E: A Reconsideration of Power in Psychiatric Administration. Hospital and Community Psychiatry 1985; 36(5): 497-503.
23. Marcos LR, Silver MA: Psychiatrist-Executive Management Styles: Nature or Nurture. American Journal of Psychiatry 1988; 145 (1): 103-106.
24. Marcos LR: Dysfunctions in Public Psychiatric Bureaucracies. American Journal of Psychiatry 1988; 145 (3): 331-334.

CALL FOR NOMINATIONS

As Chair of the Nominating Committee, it is time to solicit nominations for candidates for Council. If you would like to nominate yourself or another member of the AAPA, please notify me by October 1, 2002. My contact information is as follows: 1 Forest Ave., Portland, ME 04101; fax (207) 780-1727; ghclark@maine.rr.com. Thank you.

Gordon H. Clark, Jr., M.D.
Immediate Past President

The AAPA on line . . .

Visit our new website: **www.psychiatricadministrators.org**

and let us know what you think.

If you have suggestions, we would like to hear from you!

Send your comments to: **frda1@airmail.net**

Commentary on Drs. Ruiz and Bret's Paper

"The Psychiatric Chief Resident as a Future Psychiatrist Administrator"

by Alan D. Schmetzer, M.D. and Judith Bealke, M.D.*

The role of the chief resident varies from one psychiatric department to the next. In some, all or most of the various possible roles described by Looney (1) come together as a package. In others, only one or two of these roles are expected of the chief resident. Faculty members select the chief resident in some academic departments, whereas the residents themselves choose their chief in others. Therefore, the cultural groundwork and preparation for future administrative roles is equally variable. This is a role, as noted in this article, that typically comes without a job description. While communication is a realm not unfamiliar to psychiatry residents, the way a chief resident must learn to communicate is completely new. The article well summarizes the dilemma of knowing how freely information should be shared across levels of a department. There is likely no amount of "didactics" that can prepare chief residents for dealing with the outcome of sharing too much or too little information, although experiential conferences like the Tarrytown meeting can help. The main hope here is that the person in the position of chief resident is indeed open to the feedback in such situations, which is usually immediate and unambiguous and, as such, represents a remarkable learning opportunity for the resident aspiring to an administrative career.

The importance of mentorship during the tenure of a chief resident cannot be overstated. The chief resident is placed in a position of having to explain the "rules" handed down from above while advocating for the needs and wants of the residents from below, often having no clear idea about how decisions are really made. In an academic setting, there are administrative layers within layers (e.g., Department of Psychiatry within the School of Medicine), placed in the complicated setting of today's practice economics. Decisions that affect residents may be made in the room next door or miles away (Washington, D.C. comes to mind as one example), and it is difficult knowing the agenda, priorities, and power of the parties involved. The role of the mentor as a guide through this maze is crucial to the chief resident's effectiveness. Likewise, the mentor should model effective communication while also lending support for the misfires of the chief resident, helping him or her to learn from the experience and put it into perspective. The idea that the psychiatrist administrator in each clinical setting should devote time to the chief resident is a valuable one. It is likely the only way to introduce him or her to the practical reality of that arena (community mental health center vs. Veterans' Administration hospital vs. state facility, etc.). Lack of sufficient time, however, may not allow either the chief resident or the facility administrator to pursue this endeavor.

The preferability of a same-gender mentor is not well defended in this article. In fact, the article makes a good case for obtaining a male mentor if you are a female chief resident, so that the female chief can learn how men manage time, money, and talent. It may be desirable to have a same-gender support person available to help the chief resident sort through his or her gender-specific "counter-transferences," but a primary mentor should be the person who can best enhance the learning and effectiveness of the chief, no matter the gender. Segregation by gender will only insure that women remain below the higher levels of administration, since right now the reality is that primarily men inhabit those higher levels.

The reference to alternative models of psychiatry education funding is a concession to the harsh economic reality of these times. Most of the alternatives proposed by Tasman (2) would be very unpalatable to residents in any specialty given the typical student loan burden. Because psychiatry has had difficulty competing with other residencies, expecting psychiatry residents to pay tuition, forego salaries, or engage in institutional payback would jeopardize the future of our specialty. This is one of the growing headaches of today's administrators – balancing education with finances. Unless there is a major change in available funding for graduate medical education, tomorrow's psychiatrist administrators (today's residents) may face even harder decisions than the ones being made today.

According to the authors, psychiatry needs residents who are not only trained clinically but who are also educated as administrators in order to run the future business of psychiatry. The same can be said for research training and psychotherapy education in psychiatry residency. It is difficult to find the time and means to provide this learning as well, but without psychiatric researchers and psychotherapists our specialty will be diminished. The short-run accomplishment of these feats may seem impossible, but the long-range viability of psychiatry is grim without them.

An issue peripheral to, but certainly suggested by, this paper is the challenge for the residency training director.

The continuing expansion of the role of the chief resident also calls for the training director and other faculty to spend increasing amounts of time in teaching and mentoring the chief. However, this comes at a time when training programs are also making other increased demands on the time of faculty. The requirement for greater clinical productivity, more competition for research dollars, and newly mandated administrative tasks – Compliance Officer, HIPAA Officer, etc. – are all requiring additional time from faculty today. There are only so many hours in anyone's day, and as these other demands continue to expand, they increasingly conflict with each other. It becomes harder for the training director to do his or her own job, let alone recruit other faculty to supervise and teach.

In our own program, we have increased the administrative education for all of our residents in the past few years, just as other programs have been doing (3,4). We have developed a new sixteen-hour course on "Administrative Psychiatry", begun an eight-hour course on "Business and Budgeting", and strengthened our "Transition to Practice" course with more presentations on administrative topics, such as personnel administration and risk management. Part of the reason for this increased educational emphasis on administrative training for all of our trainees is our experience that former chief residents can supply only a portion of the psychiatric administrative need in our state. A survey of the lead administrators (chair, former chair, assistant chairs, hospital chiefs of service, etc.) in our own academic department found that only three of thirteen or 23.1% had previously been chief residents while in their general psychiatry training. A similar survey within the state psychiatric hospital system found that three of eight or 37.5% of the lead physicians (hospital and central office medical directors) had been chief residents during training. Because of some overlap between the two groups, the combined data shows that 13 of 19 or 68.4% of the psychiatrist administrators in our state's only academic psychiatric setting and its state hospital system never had the experience of being a chief resident. This is not to downplay the importance of such an opportunity. Those who were chief residents frequently commented on how helpful, even necessary, the exposure was to their current positions. But it is clear that in this sample, the majority of the psychiatric administrative duties are provided by people who have never been chief residents.

Finally, we would note that chief residents are not only potential psychiatric administrators in some distant future. They are administrators in their own right, even though they are still in training. Most clinician administrators are still learning every day, just as our chief residents are.

**Both authors are affiliated with the Department of Psychiatry at Indiana University School of Medicine, Indianapolis, Indiana. Dr. Schmetzer is Professor and Assistant Chair for Education, as well as Director of Residency Training. In addition, he is the Medical Director for the Indiana Division of Mental Health and Addiction. Dr. Bealke is the immediate past Chief Resident of the General Psychiatry Program and is currently a Child and Adolescent Psychiatry Fellow.*

References

1. Looney JG, Engleberg SJ, Gode RO, Knesper DJ. The psychiatric chief residency: A preliminary training experience in administrative process. American Journal of Psychiatry, 1975; 132:729-733.
2. Tasman A. The future of residency training in psychiatry. Bulletin of the Menninger Clinic, 1994: 58:474-485.
3. Borus JF. Teaching residents the administrative aspects of psychiatric practice. American Journal of Psychiatry, 1983; 140:444-448.
4. Arnold WN, Rodenhauser P, Greenblatt M. Residency education in administrative psychiatry: A national survey. Academic Psychiatry, 1991; 15:188-194.

Christopher G. Fichtner, M.D.
and
Thomas A. Simpatico, M.D.
Discussion Group:
Leading Large Scale Systems Change.
Wednesday, Oct 9, 2002. 3:30 - 5:00 p.m.
at the
APA Institute on Psychiatric Services
Chicago, IL

A REVIEW OF THE INSANITY DEFENSE

Judith J. Regan, MD, MBA, Ann Alderson, BA, William M. Regan, MD

ABSTRACT

A 12-month, demographic study of Tennessee defendants court-ordered for pre-trial forensic psychiatric evaluations was conducted to determine if clinical support for the insanity defense was evident. In addition, the frequency of agreement between the courts and the forensic evaluator's assessment was reviewed. A literature review of the use of the insanity defense in other states was completed, described and compared to the Tennessee study. For the insanity defense, precise comparisons are difficult. Yet, in general, the findings show that the insanity defense is rarely used and when used, only a small number of the defendants are acquitted not guilty by reason of insanity (NGRI). When forensic evaluators determine that clinical support for the insanity defense exists, the courts generally concur with those evaluations. In addition, defendants who have managed to successfully use the insanity defense usually are diagnosed with serious mental illnesses and have committed violent crimes.

Introduction

In the criminal process, when determining a defendant's guilt or innocence the "beyond a reasonable doubt" standard of proof is used. However, when an individual suffers from a severe mental illness, this condition can be a defense in making a determination of criminal responsibility. While determining criminal responsibility is unquestionably the most important purpose of the Insanity Defense, it is also used to hold the defendant for further evaluation of dangerousness and treatment. The defense of insanity is a frequently discussed criminal defense because an Insanity Defense, if successful, works as a complete acquittal of the defendant as "not guilty by reason of insanity" (NGRI).[1] The public becomes concerned when defendants who appear to have intentionally engaged in harmful conduct are found not guilty by reason of insanity.[2] The reasoning behind the Insanity Defense is twofold:

1. The Insanity Defense makes it possible to separate those individuals who need mental health treatment but otherwise would be subject to the usual penal sanctions, which may follow convictions.
2. The Insanity Defense authorizes the courts to hold those who do not possess the guilty mind or mens rea required for conviction an alternative to conviction and imprisonment rather than outright acquittal.[3] (However, studies show that persons found NGRI, on average, are held at least as long or longer than persons found guilty for similar crimes.)

In the twenty years since President Reagan was shot by John Hinckley, the national debate over the Insanity Defense has continued. The public's response to Hinckley's successful use of the Insanity Defense has resulted in intense scrutiny of the defense. Historically, courts have relied on the M'Naughten Rule or the test for the Insanity Defense written by the American Law Institute (ALI) during the 1950s in determining whether an individual is not guilty by reason of insanity.[4]

The M'Naughten Rule is an insanity definition derived from 1843 English case laws. Daniel M'Naughten, a Scottish woodcutter, shot and killed Edward Drummond, secretary to England's Prime Minister, because he believed there was a plot against him. Mr. M'Naughten was acquitted of the crime, because his attorneys were able to convince the court that he was obviously insane and did not understand what he was doing. Later that same year, the House of Lords issued the following ruling: "To establish a defense on the ground of insanity, it must clearly be proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and the quality of the act he was doing; or if he did know it, that he did not know it was wrong."[5]

The ALI Test holds that a person would "not [be] responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law."

However, as a result of the increased scrutiny since the Hinckley trial, Congress passed the Insanity Defense Reform Act in 1984 as a way to restrict the use of the defense. The Act is a law that affects all federal courts. When the court finds that the defendant does not meet the insanity defense criterion of being unable to appreciate the wrongfulness of his conduct at the time of the offense, then the court may find the defendant not guilty by reason of insanity as a result of mental disease or mental retardation.[4] The act places the burden of proving

insanity on the defendant. The prosecution still has the burden of proving that the defendant committed the crime.

According to the American Psychiatric Association Statement on the Insanity Defense, approximately one-half of the states used the same test for the Insanity Defense that was written by the ALI during the 1950s. A third of the states used the M'Naughten Rule. Six states have chosen to use a modified M'Naughten Rule and add a reference to "irresistible impulse."[6] Five states (Idaho, Kansas, New Mexico, Montana and Utah) bar the insanity defense reflecting concerns that some defendants exaggerate their mental conditions to win "not guilty" verdicts.[7]

Because the test for insanity can differ from state to state, so may the use and outcomes of the defense. This must be considered when interpreting any study on this topic.[8] This article presents an in depth study of the use of the Insanity Defense in Tennessee through review and analysis of the demographics and outcomes of all pre-trial evaluations performed by the forensic units of the Tennessee Department of Mental Health and Developmental Disabilities (TDMDD) regional mental health institutes (RMHIs) over a twelve-month period (calendar year 2000). Particular emphasis is placed on diagnosis, criminal charges, and the correlation between the clinician's evaluation of insanity and the corresponding support of the defense from the District Attorney's Office. Further, the article reviews and compares the Tennessee findings with the findings of other state studies.

The article was based on three key hypotheses: that the Insanity Defense is rarely used; when the plea is used, it is often not successful; and when the defense is used successfully, the defendant usually has committed a serious crime and has a diagnosis of a major mental illness.

Tennessee is typical of most jurisdictions in that criteria for the Insanity Defense have changed recently (1995) and is in accordance with the Insanity Defense Reform Act. Currently, in Tennessee, the following elements are required criteria for the insanity defense:

- the mental disease or defect must be severe; and
- the accused must have been unable to appreciate the nature or wrongfulness of the act.[9]

In addition, the defendant has the burden of proving insanity by the standard of clear and convincing evidence. Although an expert, based on a comprehensive evaluation of the defendant, may give an opinion that there is clinical support for the insanity defense, there is less assurance now, than in the past, that the defendant will be adjudicated NGRI based primarily on the expert's opinion. However, the Insanity Defense can provide an acceptable defense to those persons whose mental condition satisfies the above-mentioned affirmative defense criteria.[6] When a verdict of NGRI is returned, the defendant is required to undergo a sixty to ninety day evaluation and treatment period in a state mental hospital. If that evaluation determines that the individual remains a danger to himself or others, he remains committed to the state hospital until no longer a danger to self or others. If the NGRI acquitted individual is not determined to be dangerous by the court, the court may release the person back into the community and order mandatory outpatient treatment.[10]

However, prior to July 1, 1995, insanity was simply a defense and not an affirmative defense. This earlier version allowed the use of this defense if "at the time of such conduct, as a result of mental disease or defect, the person lacked substantial capacity either to appreciate the wrongfulness of their conduct or to conform their conduct to the requirements of the law". Under the previous statute, if the evidence raised a reasonable doubt as to the defendant's sanity, the burden of proof then fell upon the state to establish sanity beyond a reasonable doubt.[11]

Methodology

Data were gathered and analyzed relative to individuals who were admitted to the Tennessee's RMHIs, during the calendar year 2000, for pretrial forensic psychiatric evaluations to determine if the individuals met clinical criteria to support the Insanity Defense. The place where the evaluation took place depended on the place and type of crime committed. One state hospital has a secure forensic unit where capital felony offenders can be evaluated. A comparison is made of the findings of the pre trial evaluations and the ultimate outcome of the case regarding the insanity defense.

In addition a number of states were reviewed who have studied the frequency and success of their state's insanity defense. The results for this Tennessee study were compared with study results from other states.

Results

Tennessee Data Review and Description

Based on the 12-month review of defendants charged with a crime and court-ordered for pre-trial evaluation to one of the state's five mental hospitals forensic units, it was determined that out of approximately 9100 individuals facing criminal charges, the total number of defendants referred for a mental health evaluation was 636 or about

7% of the total number of inmates charged. Of this number 139 were female, 496 were male, and 1 was unknown. Relative to race, 346 were African Americans, 275 were Caucasians, 1 was Asian, and 14 were unknown.

The defendants' crimes fell within one of four categories: capital, violent, non-violent, and misdemeanors. Many different crimes fall within the latter three categories. First degree murder is the one capital offense in the state system. Violent crimes included, but were not limited to, attempted first degree murder, second degree murder, aggravated kidnapping, aggravated rape, aggravated robbery, aggravated sexual battery, aggravated assault, aggravated child abuse, voluntary manslaughter, and vehicular homicide. Non-violent crimes included, but were not limited to, theft ($60,000 or more); forgery ($60,000 or more); illegal possession or fraudulent use of a credit or debit card ($60,000 or more); worthless checks ($60,000 or more); the manufacture, delivery, and sale of illegal drugs; vandalism; and promoting prostitution. Misdemeanors included, but were not limited to, disorderly conduct, public intoxication, gambling, possession of a weapon with the intent to go armed, assault, prostitution, non-support, harassment, indecent exposure, cruelty to animals, and littering. Of the total 636 defendants, 25 had been charged with capital offenses; 290 had been charged with violent offenses; 113 had been charged with non-violent offenses; 206 had been charged with misdemeanors; and 2 defendants had been charged with crimes unknown.

Over 55% of these defendants fell within two mental health diagnostic categories: 268 were psychotic, and 83 had bipolar disorder. Another 93 individuals had no mental illness diagnosis previously assigned, although they were referred for an insanity evaluation. Of the 636 referred for forensic evaluations, the number who were determined to have clinical support for the insanity defense criteria and who subsequently raised that defense was 118 or 18.5% of the total referred.

The 118 Individuals Who Clinically Met and Raised the Insanity Defense

Of the group of individuals having clinical support for the insanity defense upon pre-trial evaluation, 80 were male and 37 were female. There were 66 African Americans, 50 Caucasians, 1 Asian, and 1 defendant whose race was not known. Regarding the defendants' ages: 46 were between 36 and 45 years of age; 31 were between the ages of 25 and 35; 16 were ages 18-25; 16 were between the ages of 46 and 55; 7 were ages 56 through 65; 1 defendant was 74 years of age; and 1 defendant's age was unknown to us. Most of the defendants (46) fell between the ages of 36 and 45 with the second largest group (31) falling between the ages of 25 and 35.

When reviewing for psychiatric diagnoses, the data showed that 67 defendants had psychotic disorders; 29 had bipolar disorders; 5 had major depressive disorders; 9 had no diagnosis listed or only a diagnosis of mental retardation; 2 had mood disorders; 2 had impulse control disorders; 2 had substance abuse disorders; 1 had dementia; and 1 had an adjustment disorder.

In comparing psychiatric diagnoses with violent crimes:

- 27 out of the 67 psychotic disorders were accused of a violent crime;
- 12 out of the 29 defendants with bipolar disorders were accused of a violent crime; and
- 3 of the 5 defendants with major depression were accused of a violent crime.

The above comparison might suggest that the seriousness of the crime contributed to decision to support the insanity defense. However, the possibility exists that individuals with mental illness who commit minor offenses are simply diverted or plead out their cases in order to avoid raising the insanity defense.

Of the number of individuals determined by forensic evaluations (118 out of 636 defendants or 18.5%) to be eligible for use of and to raise the Insanity Defense, the District Attorney's Office supported the Insanity Defense in 72% or 85 of the cases.

Another important finding came from a comparison of the number of defendants who faced criminal charges during the 12-month study period with the number of individuals who were successful in using the Insanity Defense. Out of the 9100 total cases, only 85 or .09% received support the insanity defense. [12]

Literature Review and State Comparison

A literature review allowed for a comparison of Tennessee findings with other states that are summarized as follows:

Eight States Study (California, Georgia, Montana, New Jersey, New York, Ohio, Washington, Wisconsin): According to this recent and much referenced study, funded by the National Institute of Mental Health, the Insanity Defense was used in less than 1% of the cases in a representative sampling of 967,209 cases before those states' county courts. Of these indictments, 8,979 defendants entered insanity pleas. Only 2565 or 26 percent of those who raised the Insanity Defense were

actually acquitted NGRI. Only 10% of the population raising the Insanity Defense did not receive a DSM-III diagnosis, and the large majority had a prior psychiatric hospitalization. The vast majority who were successful in raising the defense had also committed a serious offense. However, while 50% of those pleading the Insanity Defense in the surveyed cases had been indicted for violent crimes, less than 15% or approximately 350 defendants were charged with murder. The rest stood trial for robbery, property damage or minor felonies.[4,7]

Maryland Study: All defendants pleading not guilty by reason of insanity over a 12- month period in Baltimore City's superior trial court were reviewed. During that time, 143 or 1.2% of the 11,497 defendants indicted pled not criminally responsible; and 10% to 14% of those defendants were found not guilty by reason of insanity. The study found significant agreement between the prosecution and defense with only 2 cases leading to full trial where the issue of insanity was contested. The factors which influenced a decision that the defendant was not criminally responsible included: committing a serious crime, having an Axis I diagnosis, and the psychiatric hospital physician's evaluation findings in support of the insanity defense. Other demographic factors did not appear to predispose individuals to be determined "criminally responsible".[13]

Colorado Study: The subjects of this two-year study were 151 male NGRI defendants who were evaluated for use of the NGRI defense at the Colorado State Hospital from July 1, 1980-June 30, 1982. After exclusions, the final subject group was 133. The following data relate to this particular group of defendants. Twenty-seven percent of the 133 defendants were adjudicated NGRI, and 73% were convicted. A high concordance was found between results of the psychiatric evaluation and the eventual court disposition. Overall court decisions concurred with psychiatric opinions in 117 or 88% of the 133 cases reviewed. Of the 36 defendants adjudicated insane, 32 or 89% were evaluated as insane. This suggests that the Colorado courts give considerable credence to the determinations made by the psychiatric evaluators. The most frequent diagnoses were substance abuse and schizophrenia. The most frequently occurring crimes in this group were murder and robbery.[14]

Seven States Study (California, Georgia, New Jersey, New York, Ohio, Washington, Wisconsin): Data were drawn from seven states. The sample population reported upon in this study includes 8,138 defendants who were indicted for a felony and who raised an insanity defense. Approximately 14% or 1139 of all cases involved a murder charge. The majority of insanity defendants were diagnosed with a major mental illness. The success rate for use of the Insanity Defense was highest for violent crimes other than murder, followed by murder, and then other crimes. Across the seven states in the study, there was an inverse relationship between the rate of Insanity Defense used and the likelihood of an insanity acquittal when the Insanity Defense was used.[15]

Individual New Jersey and Virginia Studies: A separate 1982 New Jersey study found that 52 or less than .02% of 32,000 adult defendants represented by the New Jersey Public Defenders' office entered the insanity plea. Only 7% or 15 defendants were successful. Of the 15 New Jersey cases, which successfully used the Insanity Defense, only 3 or 20 percent involved murder. A similar number of insanity defense pleadings, were entered in Virginia during the same period. [4]

Comprehensive Study of California, Georgia, Montana and New York: The Insanity Defense was raised in slightly less than 1% of all felony indictments in these four states and was successful in only 23% of the cases. This means that the insanity defense was successful in about two-tenths of 1% of all felony indictments.[10]

A Tennessee Study: According to data captured in another study conducted between 1990 and 1997, it appears that only about 250 defendants in Tennessee were found not guilty by reason of insanity. According to the Administrative Office of the Court's "Annual Reports of the Judiciary", 524,366 Criminal Court cases were disposed of during the study period. When the number of insanity acquittals is compared to the number of cases disposed of the Insanity Defense has been successful in less than .05% or five one-hundredths of 1% of the criminal cases with dispositions. It is anticipated that the percentage would be even lower if the number of NGRI verdicts were compared to all Tennessee criminal dispositions (e.g., those cases heard in General Sessions Court).[10]

Conclusion

A major problem in studying the Insanity Defense is the various standards used. Each state in the United States has its own statute, thus making precise comparisons difficult. However, based on the Tennessee study and a review and comparison of Tennessee with other state studies, there are several key similarities that support the hypotheses of this article.

1. In the other state studies, data indicate that the Insanity Defense is rarely even used. Approximately

1% of all defendants invoke the Insanity Defense. With fewer than 1% of defendants successfully raising the Insanity Defense, Tennessee is consistent with these studies.

2. In the other state studies, only about 5% to 25% of those defendants attempting to utilize the Insanity Defense are actually acquitted because the defense was successfully used. In the previous Tennessee study the Insanity Defense was found to be supported in one percent of the criminal cases with dispositions.
3. In the other state studies, it appears that courts give considerable credence to forensic evaluation findings that defendants meet insanity defense criteria. The Tennessee study showed an agreement with the District Attorney's Office in 72% of those determined by forensic evaluators, during pre-trial evaluations, to be eligible for use of the insanity defense. Whether this would lead to an acquittal based on NGRI is not conclusive.
4. In the other state studies described, most defendants who met the Insanity Defense had a serious mental illness and had also committed a serious, violent crime. There was no indication in the studies that any other demographic factors predisposed defendants to meet the Insanity Defense. Tennessee findings are consistent with these as well.

Further research is needed to understand factors related to the use of the Insanity Defense. Such a review might also be useful in further enhancing the collaborative efforts between law and psychiatry.

Judith J. Regan MD, MBA, is Medical Director, Tennessee Department of Mental Health and Developmental Disabilities, and an Assistant Clinical Professor, Vanderbilt Medical School, Meharry Medical & University of Tennessee Medical School/ College of Pharmacy. **Ann Alderson, BA**, is Director of Provider Relations in Tennessee Department of Mental Health and Developmental Disabilities. **William M. Regan M.D.** is Associate Professor in the Department of Psychiatry, Vanderbilt University School of Medicine, Nashville, Tennessee.

Bibliography

1. Neil P. Cohen, The Prevalence and Use of Criminal Study. 60 Tenn. L. Rev. 957, 969 (1995).
2. Singer R. G., LaFond J. Q., Criminal Law Examples and Explanations. New York: Aspen Law & Business 416 (1997).
3. David L. Raybin, Defense E. Insanity. 11 Tenn. Prac. Criminal Practice and Procedure Section 28.43 (1985).
4. American Psychiatric Association. Public Information, The Insanity Defense (1996).
5. Mark Gado, The Insanity Defense M'Naghten Rules. The Crime Library (2001).
6. Freda Adler. The Insanity Defense. Criminal Justice: The Core. (1995).
7. Callahan L. A., Steadman H. J., McGreevy M. A.. The Volume and Characteristics of Insanity Defense Pleas: An Eight State Study. Bull. Am. Acad. Psychiatry Law (19)4: 331-8. (1991).
8. Michael L. Perlin. The Borderline which Separated You from Me: The Insanity Defense, The Authoritarian Spirit, The Fear of Faking, and The Culture of Punishment. 82 Iowa L. Rev. 1375 (1997).
9. Tenn. Code Ann. Section 39-11-501 (1995).
10. Steadman, H. J.; McGreevy, M. A.; Morrisey, J. P.; Callahan, L. A.; Robbins, P. C.; Cirincione, C. Before and After Hinkley: Evaluating Insanity Defense Reform. (New York: Guilford), pp. 1-3, Table 3.1, p. 37, p. 104, 1993.
11. Tenn Code Ann. Section 39-11-501 (1991).
12. Regan, J. Alderson, A., The Insanity Defense: Tennessee's Process and Outcome. Tennessee Medicine 95(3): 118-119 (2002).
13. Janofsky, M.B., Vanewalle M. B., Rappeport J. R. Defendants Pleading Insanity: An Analysis of Outcome. Bull. Am. Acad. Psychiatry Law 17(2): 203-11 (1989).
14. Jeffrey J. S., Pasewark R. A., Bieber S. Insanity Plea: Predicting Not Guilty by Reason of Insanity Adjudications. Bull. Am. Acad. Psychiatry Law 16(1):35-9 (1988).
15. Cirincione C., Steadman H. J., McGreevy M. A., Rates of Insanity Acquittals and the Factors Associated with Successful Insanity Pleas. Bull. Am. Acad. Psychiatry Law 23(3): 388-409 (1995).

SCIENCE, POLICY DECISIONS AND SOCIAL CHANGE:
Reflections in Honor of Richard J. Wyatt

Daniel Luchins,MD

Editor's Note: Schizophrenia researcher Richard Jed Wyatt, M.D., Chief, Neuropsychiatry Branch, National Institute of Mental Health, died June 7, 2002, at the age of 63, after a long bout with cancer. One of the early pioneers in the Intramural Research Program, he championed the view that schizophrenia has a biological basis and brought research on schizophrenia into the lab. Authoring some 800 scientific publications and 6 books, his interest in the course and causes of schizophrenia led to wide-ranging studies on mood disorders, Alzheimer's disease, brain grafts for Parkinson's disease, neurochemistry, sleep and neuroplasticity. Wyatt also co-produced (with his wife, Kay Jamison, Ph.D.) a series of programs about manic depressive illness and creativity that aired on public television. In his cover story in the *Washington Post Health* section, Feb 13, 2001, Wyatt related some of his experiences battling cancer for the third time.

Following is an edited version of the lecture that Dr. Luchins gave at a day-long "Neuroscience and Psychiatry" symposium held in Wyatt's honor May 30, 2001.

The most important lesson I learned from Dick was when I did a test for anergy in schizophrenia and used a streptokinase antigen concentration 10,000 times too strong. After consulting an allergist to deal with the dozen patients with enormously swollen forearms, and being nominated for the Joseph Mengales award by my fellow clinical associates, I went to Dick's office to offer my resignation. He refused it, but asked me to reflect on what I had learned from my experience. I remember behind him on the wall was a poster that read, "When life gives you lemons, make lemonade." At first, I thought I learned to be more careful. But anyone who knows me can attest to this never having happened. Instead, I learned my lesson 2 months later when NEJM ran a letter by a consulting allergist describing the commonly observed problem created by unknowing clinicians using the wrong strength of streptokinase in skin testing. Someone had stolen my lemonade.

Since then I've tried to learn from and document failure. I've found my career has provided ample opportunity. In most medical circles it is assumed that if you can't practice, you teach and if you can't teach you do research. After 20 years of trying to do research, I took the next step down and became an administrator, Clinical Director of the Illinois Office of Mental Health. I want to speak from this personal perspective as an administrator/policy maker who has been a researcher, on how science looks from these two perspectives. I want to talk about the relationship of science, both scientific knowledge and the scientific enterprise, to policy decisions and ultimately on social change.

I will try to develop two points.

1. In the short run, scientific knowledge can influence policy decisions and create social change only when those findings are congruent with overall cultural beliefs and supported by powerful social institutions.
2. In the long run, the impact of science on policy and social change is due not only to the product of science–the knowledge, but the process–the scientific enterprise.

I will illustrate these points by contrasting and perhaps exaggerating the differences in my experience between two research projects—as a biological researcher with Dick's lab and as a service research/policy maker in my new role.

One of my first projects with Dick was a double blind placebo controlled trail of piperidine in schizophrenia. That most of you have not heard of the piperidine theory of schizophrenia may be enough of a clue that this was a negative study. Nevertheless, when I was carrying out this trial, I believed (and I had every right to believe), that if piperidine proved to be efficacious (and safe) it would be adopted by the psychiatric community, made available to persons with schizophrenia and produce some social good.

Recently, I completed a SAMHSA supported multi-site, collaborative study of homelessness prevention in dully-diagnosed, severely mentally ill individuals. The eight sites all used somewhat different strategies; we were interested in representative payeeship, others in Assertive Community Treatment, or Therapeutic Communities. The study found that to the extent they provided housing, these various programs prevented homelessness and the other features were generally irrelevant. Now, this finding is consistent with other studies in homelessness prevention. But, I would venture to suggest that it will have little impact on policy.

Why these difference?

One explanation is that the drug studies deal with real, biological science and that homelessness prevention studies with pseudo, social sciences. But, I do not believe this is the reason. Rather, it is because as a society we believe people with serious illness, even serious mental illness, should be provided with medications. There is an enormous medical establishment (40,000+ psychiatrist), available to prescribe a new medication and, the most profitable industry in the United States, the pharmaceutical industry is available to develop, distribute and promote these new medications.

On the other hand, our society does not generally believe that housing should be made available as a treatment. Physicians can write a prescription for a medication like Clozapine that might cost $5,000 - 10,000/ year but cannot write a prescription for housing even if it is a much lesser amount. The housing industry's profits are not directly tied to providing housing for the mentally ill.

This is point one: to produce social change, scientific findings need to be consistent with broad cultural values and their policy implications need the support of strong social institutions. But, values and institutions are not static, over time they change. Which gets me to the second point, the importance of the scientific enterprise and not simply scientific knowledge in shaping social changes.

In 1977 when I started working for Dick, it seemed important to establish the biological basis of serious mental illness. The piperidine trial like most of the work in Dick's lab was in keeping with this biological paradigm. However, outside intramural NIMH and a few academic centers, psychoanalytic, behavioral and social models of mental illness held sway.

Today, this biological approach is the dominant paradigm, not only in scientific and professional circles, but also in our society at large. For example in the 1996 General Social Survey, a biological or chemical abnormality was the most commonly cited explanation for schizophrenia; offered by approximately 50% of the general population.

What has led to this cultural change. I think it is simplistic to say, "the biological hypothesis has been proven to be true". As scientists, we know science does not prove anything. At best, studies "do not support the null hypothesis". So why is it that our failure to establish that schizophrenia is due to the pink spot, the mauve spot, methylation, high PEA, low MAO, enlarged ventricles or small hippocampi should convince the public that schizophrenia has a biological basis. Here the role of the scientific enterprise needs to be understood. The literally billions of dollars and thousands of careers dedicated to the biological hypothesis have not only changed the terms of scientific debate but have also created important social institutions that control significant resources dedicated to this proposition. When I was a psychiatric resident, except for a few notable exceptions, chairmen of psychiatry departments were psychoanalysts. Today, acceptance into analytic training would be more a gravestone than a milestone in ones academic career.

Point two: When science promotes cultural and social changes, this is due to the scientific enterprise and not just scientific knowledge.

With this thought in mind, let me turn to my current efforts to use science to address the problem of homeless mentally ill. Although our initial SAMSHA grant revealed the obvious, we obtained another two year SAMSHA grant to create a continuum of services for homeless mentally ill mothers, including: identification at warming shelters, crisis management, intensive case management, Assertive Community Treatment, supported housing, all the way to residential treatment for the mothers with a therapeutic nursery on site. The actual amount of money was small ($80,000/year), but coupled with the prestige of doing federally funded research, it acted as the "stone in the soup" to bring together various community agencies and administrators in the Office of Mental Health. In July 2001, Federal funding will end, but the State will continue the program and hopefully HUD dollars will be used to expand it. Will it be the scientific knowledge produce by the project or the institutions created by the scientific process that will be the more important factor in shaping how Illinois deals with homeless mentally ill mothers? This is an easy question, because there will be no research findings. We have decided not to submit a proposal for the three year evaluation phase of the study.

Thus, as an administrator as opposed to a researcher, I view scientific knowledge from a different perspective. By themselves, scientific findings may have little relevance to policy decisions. Their value is determined by whether there exists the appropriate cultural, social, and political environment to support policy initiatives. As an administrator I try to harness the scientific enterprise, not simply to create more scientific knowledge (the articles and future grants that are dear to me as a researcher), but to change the cultural and social environment, so the scientific knowledge can support policies that might produce a social good.

Dr. Luchins is the Clinical Director at the Illinois Office of Mental Health, and an Associate Professor of Psychiatry at the University of Chicago.

MANUSCRIPT REVIEWERS:

Psychiatrist Administrator is currently seeking psychiatrists interested in serving as manuscript reviewers for the journal. If you are interested in serving in this capacity, please contact (or send inquiries to):

Sy Atezaz Saeed, M.D., Editor
Psychiatrist Administrator
Department of Psychiatry and Behavioral Medicine
University of Illinois College of Medicine at Peoria
5407 North University Street, Suite C
Peoria, Illinois 61614-4785
E-mail: sasaeed@uic.edu

DR. FICHTNER RECEIVES HIGHEST HONOR

Tampa, FL – The American College of Physician Executives recently awarded Fellowship – one of its highest levels of achievement – to Christopher Fichtner, MD, CPE, FACPE. Dr. Fichtner is Chief Psychiatrist & Medical Services Coordinator at the Illinois Department of Human Services in Chicago, Illinois.

CERTIFICATION IN PSYCHIATRIC ADMINISTRATION AND MANAGEMENT

On May 21, 2002, the Committee on Psychiatric Administration and Management of the American Psychiatric Association certified nineteen individuals as having passed the examination and met all other requirements for certification in Psychiatric Administration and Management. They are:

Sanjay S. Chandragiri, M.D.
Throop PA

Richard L. Cruz, M.D.
Chads Ford PA

Kayla L. Fisher, M.D.
Roanoke VA

Charles R. Freed Jr., M.D., M.H.A.
Chatanooga TN

Steven P. Kouris, D.O., M.P.H.
Rockford IL

Arthur Lazarus, M.D., M.B.A.
Prospect KY

Patricia Lifrak, M.D., M.B.A., C.P.E.
Hockessin DE

D. Sreedharan Nair, M.D.
Bloomfield Hills MI

Kenneth Clayton Nash, M.D.
Wexford PA

Paulo J. Negro Jr., M.D., Ph.D.
Columbia MD

Peter N. Novalis, M.D.
Columbus GA

Mark A. Putnam, M.D.
Chester Springs PA

Nadimpalli V. Raju, M.D.
West Bloomfield MI

J. Mark Rowles, M.D., M.P.H.
Decatur GA

Alan L. Schneider, M.D.
Sherman Oaks CA

Maurice Andrew Sprenger, M.D.
Decatur GA

Ravindra P. Srivastava, M.D.
Albany GA

Elizabeth M. Tully, M.D.
Boulder City NV

Martin K. Williams, M.D.
Goldsboro NC

Is There An Ethical Way?

Column Editor: H. Steven Moffic, M.D., Chair, Ethics Committee

COLUMN INTRODUCTION:

In the AAPA's new list-serve, an interesting discussion ensued on the legal and ethical ramifications of hiring nurse practitioners to (only) do physical examinations and histories for inpatient admissions. In the situation discussed, physician supervision is spelled out in a contract with General Internal Medicine. With permission from the respondents, the relevant discussion on the ethical issues is excerpted.

ETHICAL QUESTION:

Is it ethically appropriate to hire nurse practitioners full-time to do inpatient physical examinations and histories?

RESPONSE 1: Congratulations! Now that we have descended to the level of having "co-signers" for the absence of a directly examined patient by a physician, I hope, in the interest of ethical candor, that the patients will be told that they didn't have a physician examining them. I have always believed the old financial-world adage, "the definition of a co-signer is a jerk with a fountain pen." – Sincerely, J.C. Schoenholtz, MD, Clinical Professor of Psychiatry & Behavioral Sciences, New York Medical College.

RESPONSE 2: Co-signing is a long tradition in academic centers. Our attending physicians are still accountable for the findings on physical or any other type of patient examination, just as they are and always have been in the case of resident supervision…

As I said, we have never done this before and are proceeding cautiously. We may or may not find that qualified NPs, focused on a single task, actually do a better job on the physical exam part of a work-up than do busy, overworked on-call psychiatric residents. Sincerely, Roy Varner, M.D., U. of Texas, Houston Medical Dept. of Psychiatry and Beh. Sc., Professor of Psychiatry and Medical Director, Harris County Psychiatric Center.

RESPONSE 3: I agree that APRNs can be very helpful in many situations. My only concern with the strategy discussed is "Who is responsible for the examination?" You state "We have every reason to believe that NP help with SOME of our routine admission physical examinations, all under supervision of both internists and psychiatrists". I believe you must be clear. If the internist is truly the supervisor of the APRN then I believe the internist must co-sign. If the psychiatrist is the co-signer, the fact that an internist is supervising in some vague way has little relevance to the physical exam being performed. The other approach is to credential the Nurse Practitioner to do physical exams based on the NPs education, training, experience and current competence and forget about the co-signing entirely if permitted by state law. Clarity will help when done before a problem situation arises. Charles Riordan, M.D., Hospital of Saint Raphael, New Haven, Connecticut

RESPONSE 4: Since the word "ethical" was mentioned by Dr. Schoenholtz, what do other psychiatrist/ administrators besides Dr. Varner feel about the ethical issues in co-signing for patient matters without examining the patient, whether that be nurse practitioners, residents, or other clinicians? Thanks, Steve Moffic, Chair, AAPA Ethics Committee

RESPONSE 5: In my view, there is no ethical (as distinct from legal or regulatory) problem, as long as the following quality of care provisions are made: 1) cosignature is not beyond the field of expertise of the cosigner. 2) the cosigner clearly understands the level of skill of the trainee or midlevel practitioner.

How to determine #2?: Regular formal case-based supervision that defines the individual parameters of cosignature, e.g. – at one hypothetical extreme, some people will need to present each situation prior to cosignature, at the other, a random sample (or, usually, particularly difficult) cases will be discussed, with attendant review of chart documentation. Hunter McQuistion

RESPONSE 6: Why is it that we have to contort our reasoning (such as in the above) whenever we attempt to find out whether something is ethical?… In the NP argument, the "lie" is that the patient believes that a physician's training was behind the eyes and hand of the examiner. The "ethical" question is only whether what we do is based on *inclination* or out of *duty* (i.e., out of a legal obligation). Using NPs is not done out of duty. While all professionals deserve respect for their training and for what they can contribute to each other, with all

due respect, an NP should supervise an NP, a physician should supervise a physician, a social worker, in turn, would supervise a social worker. Once we start down the path of commingling "expertise's" there will be none at all. JC Schoenholtz, MD

RESPONSE 7: I have enjoyed, and been challenged by, the numerous responses to my initial response to the original inquiry…

I don't find ethical problems with the way we are headed so far. Roy Varner, MD, U. of Texas, Houston.

RESPONSE 8: I am concerned that you are not aware what the legislation that enables NP's to practice autonomously in states allows them to do legally. By limiting or exceeding the limits set by the legislature, you will be placing your program and yourself in legal jeopardy. V. Manohar

RESPONSE 9: I am very much aware of what the law allows them to do legally, in other words, the possible scope of practice as defined in their licensure regulation. I had said that I did not, as yet, understand the boundaries and scope of required MD supervision, especially relevant to their AUTONOMOUS practice. We plan to use them in only ONE way: to do an admission physical exam with non-ambiguous supervision and accountability by the patient's attending MD…

We are working with appropriate legal counsel, thank you, on the matter of NPs, and I continue to feel that we are taking a more than conservative approach. Roy Varner

RESPONSE 10: I assume that you didn't mean to be uncollegial by your dismissive "thank you" statement that you're working with legal counsel. However, I have been raising ethical issues, not "legal" ones, and I don't think we should rely on the legal profession (or any other) to keep our ethics in line, such as indenturing NPs to do what we have been asked historically by the grantors of our licenses. Most respectfully, and fraternally, J C Schoenholtz, MD

RESPONSE 11: I still don't understand the ethical dimension of the single privilege issue for NPs that I have been trying to clarify… As to the implication that I might have seemed uncollegial in the last note, I really don't mean to be. Roy Varner, MD

RESPONSE 12: My point exactly is that if one hires NPs to do what NPs are allowed by law to do, it's ethical. If they are restricted, by us, we're not only disrespecting their legal rights, we're setting ourselves up for restraint of trade complaints. I'm not happy about the fact that NPs have been given so much clinical leeway, with such comparatively little training. But that's what they (and managed care) got for them – legislatively. When we play the game, however, we join the managed-care movement in cheating patients of the clinical acumen doctors are trained to have. And don't continue to point out that doctors are overworked, so they need to exploit nurses to make it easier for them to make more money per unit time. It's terrible. – JCS

RESPONSE 13: And who will be responsible for assessing the work that they do, handle discipline/ethical issues, evaluate complaints about their clinical work and recommend or deny re-appointment or recommend restrictions or modifications of their privileges?…

This can be used if appropriately structured for UR and case management if you have capitated contracts to get the most out of the squeezable dollar. Roy Varner, MD

RESPONSE 14: To me, so far the salient ethical issue for a psychiatrist administrator is what's best for patients given the organizational (inpatient or outpatient) and financial parameters, so in this situation, is there any comparative data on NPs doing an admission physical exam, or is this hospital considering some evaluation of how the NPs will be functioning? Steve Moffic, M.D. Chair, AAPA Ethics Committee

RESPONSE 15: I agree with you, although I also think the response on "indenturing" and guild issues is interesting as well. From a process standpoint, I see a tension in the discussion between a desire to identify "the core ethical issue(s)" on the one hand, and the multiple ethical perspectives and considerations generated in a group discussion by a specific case. Chris Fichtner, M.D. AAPA President

RESPONSE 16: Sorry Steve: The issue cannot be combined as you have done… The only issue here is that, having been granted the licensed legal right to do "such" physicals, do we have the ethical right to indenture them to do only such physicals, or have we opened the door to having them perform all the rights given to them by the legislature; namely the right to prescribe?…

All this in the name of "improved patient care"? (Or is it to serve at the feet of managed care for private economic gain?) – JC Schoenholtz, MD

RESPONSE 17: Maybe it's even bigger than just the specific NP debate: psychologists wish to treat patients with medications, expanding roles for PAs in some parts of the country, broad application of psychotherapist licensure, to name a few; but most important, in terms of the ethics issues, would be psychiatrists (i.e. physicians) roles and relationships with such practitioners. For example, in the New Mexico psychology prescribing case, that law apparently requires "oversight" by a physician, and not necessarily a psychiatrist at that. Might not there be ethical implications for any physician who agreed to accept a proposal to do such oversight?…

Things might well play differently in another venue, such as an open staff, for-profit psych. or general hospital where most practitioners apply for privileges and earn their living by charging patients directly for services rendered….

We oppose any effort by the Administration to hire such LNPs off the street and put them to work outside medical staff boundaries. We expect no resistance whatever. Again, private, for profit situations might pose more risks and uncertainties. Roy Varner MD

RESPONSE 18: Ethics becomes secondary when the unabashed "physician dominated" issue is challenged from the standpoint of economic gain by a plaintiff… I think it's a can of worms. JC Schoenholtz

RESPONSE 19: I have chosen to go the route of hiring a nurse practitioner because of the considerable difficulty I was having hiring a psychiatrist. I plan to have her accept referrals largely from our therapists and the MBHCOs, specifically, patients who have depression and anxiety disorders who have not been previously treated with psychotropic medication, or who have responded well to a medication either in the past or currently. Referrals from PCPs, i.e., patients who have generally already been tried on two or three agents, will come to me. Best regards, Gordy Clark, M.D.

RESPONSE OF EDITOR: Surely, the potential complexity of ethical decisions for psychiatrist administrators is well illustrated in this rather superficially simple scenario. Deciding to try nurse practitioners to perform inpatient physicals and histories evokes consideration of a wide variety of our ethical principles. These relevant principles seem to be those relating to the roles of the mental health disciplines, honesty, the law, collegial relationships, the freedom of choice of the psychiatrist administrator, and finally, and perhaps most importantly, what is best for the patients.

As to the initial decision to use Nurse Practitioners for the physicals and history that, as described by Dr. Varner, clearly seems to be ethical according to Section 5, Annotation 4:
Annotation (4). Given both the unique as well as occasional overlap of skills and training of the different mental health disciplines, the psychiatric administrator should strive to make the most cost-effective use of the apparent strengths of each mental health discipline.

Likewise, the ethical standard for honesty seems to have been met, including being open in conveying information on this list-serve, per Section 2, Annotation 1:
SECTION 2 "A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception."
Annotation (1) For Psychiatric Administrators. To deal honestly with patients and colleagues, the administrator needs to try to be aware of the psychological factors that may prevent that. Such factors may include dependency, narcissism, and guilt. To monitor and help maintain such honesty, advisory committees and consultation with more senior administrators in other settings is advisable.
As to telling patient, that would actually be the ethical responsibility of their clinicians, not administrators.

The importance of knowing the relevant laws in this case is specified in Section 3 of our principles.
SECTION 3 "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient."
Collegial relationships came up in the tone of the list-mail interchange. The Preamble states there is a responsibility "to other health professionals." In this regard, careful and respectful constructive criticism and interchange would be ethical behavior.

As to the psychiatrist administrator's freedom of choice, in this case to use the nurse practitioners as related, that is addressed by Section 6, Annotation 1, and Dr. Varner seems to comply with the principle:

SECTION 6 "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services."
Annotation (1) For Psychiatric Administrators. When psychiatric administrators are responsible for a third-party influence on the doctor-patient relationship, such as in a community mental health center, state psychiatric hospital, or managed care system, the administrator should strive to select the best clinicians possible for the staff or network.

Finally, there is the ethical consideration of how Dr. Varner's decision may effect the treatment of the patients. Most relevant may be Section 1, Annotation 4:
SECTION 1 "A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity."
Annotation (4). To substantiate that competent psychiatric services are being provided, the psychiatric administrator should support and/or foster the development of relevant outcome studies and strive for continuous quality improvement.

Given that Dr. Varner's plan seems to be an innovative one, it seems that this ethical principle could be met by some sort of outcome study, which would assess the quality of the nurse practitioners tasks.

Therefore, it seems that planning to use Nurse Practitioners for inpatient physicals and histories meets our ethical principles up to this point in time.

Welcome! New Members

May 2002

Ravindra Amin, M.D.
Parukutty M. Kirshnan, M.D.
John Osei-Tutu, M.D.

June 2002

Charles R. Freed, Jr., M.D.
Alan D. Schmetzer, M.D.

July 2002

Patricia D. Kifrak, M.D.
Kenneth C. Nash, M.D.
Manisha Punwani, M.D.
Martin K. Williams, M.D.

CALL FOR PAPERS

The ***Psychiatrist Administrator*** invites articles on all areas of psychiatric administration and management with a focus on the roles and perspectives of psychiatrists in leadership and management roles. Please make submissions and inquires to:

Sy Atezaz Saeed, M.D., Editor
Psychiatrist Administrator
Department of Psychiatry & Behavioral Medicine
University of Illinois College of Medicine @ Peoria
5407 North University Street, Suite C
Peoria, Illinois 61614-4785
Tel: (309) 671-2165
Fax: (309) 691-9316
E-mail: sasaeed@uic.edu

INSTRUCTION FOR AUTHORS

The *Psychiatrist Administrator* is the official publication of the American Association of Psychiatric Administrators (AAPA). Established in 1961, AAPA is the premiere educational, networking, and support resource for psychiatrists interested in administration and management. The AAPA promotes medical leadership and medical excellence in behavioral healthcare systems, including services for mental illness, substance use disorders, and developmental disabilities.

The choice of "Psychiatrist Administrator" is intended to distinguish the NewsJournal from other publications in mental and behavioral health administration in terms of its focus on the roles and perspectives of psychiatrists in leadership and management within evolving systems of care.

The purpose of the NewsJournal is to provide up-to-date, accurate, and easily understandable information to our readership and to contribute to the body of scholarly work in the area of psychiatric administration and management. Your article should be written in a clear, straightforward style that is pleasant to read.

PREPARATION OF MANUSCRIPT

Manuscripts should be typewritten on standard (8 1/2" x 11") white paper with 1" margins on all sides. The entire manuscript, including references and figure legends, should be double-spaced. Each element of the manuscript should begin on a new page: title page, abstract, text, references, tables (typed 1 per page), figure legends. Number pages consecutively through the manuscript. Manuscripts should be no more than 3000 words of text (not including references or tables).

A separate page should be included giving the title of the paper, the names, titles, and affiliations of each author, and the mailing address, email address, and phone and fax numbers of the corresponding author. Any grant support requiring acknowledgment should be mentioned on this page. Acknowledgments other than those of grant support should be put at the end of the text.

An abstract should be provided, preferably no longer than 200 words.

Tables should be typed double-spaced one per page. Provide a clear, descriptive title for each table. Tables should be numbered consecutively as they appear in the text.

Figures should be numbered consecutively as they appear in the text. Illustrations - line drawings, graphs, or charts - should be of camera-ready quality.

References should be numbered consecutively as they are cited in the text, with reference numbers typed as superscripts. References should be typed double-spaced beginning on a separate page after the text and acknowledgments. The NewsJournal uses the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (Vancouver group) as its guide for reference style. Abbreviations of journal names must conform to Index Medicus style; journals not listed in Index Medicus should not be abbreviated. List all authors when there are no more than six; for more than six authors, list the first three, followed by et al.

MANUSCRIPT REVIEW AND EDITING

Manuscripts are reviewed by the editor, editorial board members, or other reviewers. Manuscripts may be edited for clarity, style, conciseness, and format. The edited manuscript will be sent to the corresponding author for approval. Authors may be asked to respond to editorial queries or make revisions.

Authors will receive page proofs before publication. The author should return corrected proofs to Frances Roton, Executive Director AAPA, within three days of receipt; delays in returning proofs may result in postponement of publication.

MANUSCRIPT SUBMISSION

Manuscript submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere.

Three copies of the manuscript should be sent to Sy Saeed, M.D., Editor, Psychiatrist Administrator, Department of Psychiatry & Behavioral Medicine, University of Illinois College of Medicine @ Peoria, 5407 North University Street, Suite "C", Peoria, Illinois 61614-4785. The manuscript should be accompanied by a transmittal letter giving the name, address, email address, and phone numbers of the corresponding author. The letter should indicate that all authors have seen and approved the manuscript and that the manuscript has not been published or is not under consideration for publication elsewhere. A disk copy of the complete manuscript, including tables and references, should also be submitted. Please label the disk with the name of the first author and title of the article and indicate what hardware and software were used. **You can also submit the manuscript electronically by sending it as an e-mail attachment to the editor at sasaeed@uic.edu.**

If you have any questions about specific details not covered here, please e-mail sasaeed@uic.edu.

AAPA COUNCIL MEMBERS
Executive Committee

PRESIDENT
Christopher G. Fichtner, M.D., CPE, FACPE (2001-2003)
Chief Psychiatrist and Medical Services Coordinator
Illinois Department of Human Services
Office of Mental Health
160 La Salle Street – 10th Floor
Chicago, IL 60601
O: 312-814-2720
Cell: 847-910-4998
H: 847-509-1836
FAX: 847-509-1834
Email: cfichtne@yoda.bsd.uchicago.edu

PRESIDENT-ELECT AND BYLAWS COMMITTEE CHAIR
Thomas W. Hester, M.D. (2001-2003)
1250 Punchbowl Street
Room 256
Honolulu, HI 96813
O: 808-586-4780
Email: twhester@amhd.health.state.hi.us

SECETARY & MEMBERSHIP COMMITTEE CHAIR
William G. Wood, M.D., Ph.D. (filling vacancy to 2003)
1644 Leckie Street
Portsmouth, VA 23704
O: 703-472-4686
FAX: 757-397-8543
Email: wgwoodmd@aol.com

TREASURER & FINANCE COMMITTEE CHAIR
Wesley E. Sowers, M.D. (2001-2003)
Medical Director
Allegheny County Office of Behavioral Health
206 Burry Avenue
Bradford Woods, PA 15015-1240
O: 412-622-6717
Alternate Office: 412-350-3716
FAX: 412-622-6756
Pager: 412-765-5844
H: 724-934-2201
Email: sowers@connecttime.net

IMMEDIATE PAST PRESIDENT AND NOMINATING COMMITTEE CHAIR
Gordon H. Clark, Jr., M.D. (2001-2003)
Integrated Behavioral Healthcare
1 Forest Avenue
Portland, ME 04101
O: 207-761-4761
H: 207-846-3683
FAX: 207-780-1727
Email: ghclark@maine.rr.com

COUNCILORS (including committee chairs) (2001-2005)
Andrew Angelino, M.D.
Department of Psychiatry
Johns Hopkins Bayview Medical Center
4940 Eastern Avenue A4C – 461A
Baltimore, MD 21224
O: 410-550-0197
FAX: 410-550-1407
Email: aangelino@jhmi.edu

David Fassler, M.D.
Otter Creek Associates
86 Lake Street
Burlington, VT 05401
O: 802-865-3450
FAX: 802-860-5011
Email: dgfoca@aol.com

Shivkumar Hatti, M.D., MBA
600 N. Jackson Street
2nd Floor – Suite 200
Media, PA 19063
O: 610-891-9024/104
FAX: 610-892-0399
Email: [redacted]

PUBLIC AND FORENSIC PSYCHIATRY COMMITTEE CHAIR
Beatrice Kovasznay, M.D., MPH, Ph.D.
44 Holland Avenue
Albany, NY 12229
O: 518-474-7219
FAX: 518-473-4098
Email: cocdbmk@omh.state.ny.us

Arthur Lazarus, M.D. (2002-2006)
6830 Windham Parkway
Prospect, KY 40059
O: 502-228-2480
FAX: 502-292-1788
Email: arthur.lazaus@pfizer.com

Louis Mini, M.D.
Abbott Laboratories
Dept. R42C, Building AP 30-2
200 Abbott Park Road
Abbott Park, IL 60064-6148
O: 847-938-8780
Email: Louis.Mini@abbott.com

ETHICS COMMITTEE CHAIR
H. Steven Moffic, M.D.
Department of Psychiatry
Medical College of Wisconsin
8701 Watertown Plank Road
Milwaukee, WI 53226
O: 414-456-8950
FAX: 414-456-6343
Email: rustevie@earthlink.net

Paula G. Panzer, M.D.
500 West End Avenue
Suite GR-J
New York, NY 10024
O: 212-799-8016
FAX: 212-472-8840
Email: pgp1@columbia.edu

Malini Patel, M.D.
27 Devonshire Drive
Oakbrook, IL 60523
O: 847-742-1040
FAX: 847-429-4938
Email: dhs5943@dhs.state.il.us

APA Assembly Liaison
Raman C. Patel, M.D.
Bronx Lebanon Hospital
1276 Fulton Avenue
Bronx, NY 10456
O: 718-901-8883
FAX: 718-901-8863
Email: ramancp@aol.com

Pedro Ruiz, M.D.
1300 Moursund Street
Houston, TX 77030
O: 713-500-2799
FAX: 713-500-2757
Email: pedro.ruiz@uth.tmc.edu

Steven S. Sharfstein, M.D.
Sheppard &Enoch Pratt Hospital
PO Box 6815
Baltimore, MD 21285-6815
O: 410-938-3401
FAX: 410-938-3406
Email: ssharfstein@sheppardpratt.org

ACADEMIC PSYCHIATRY COMMITTEE CHAIR
Wesley [redacted]
Medical
Allegher [redacted] oral Health
206 Bur
Bradfor
O: 412-
FAX: 4
H: 724-
Email: minniemut@aol.com [redacted] sowers@ccbh.com

PRIVATE PRACTICE AND MANAGED CARE COMMITTEE CHAIR
William G. Wood, M.D., Ph.D.
1644 Leckie Street
Portsmouth, VA 23704
O: 703-472-4686
FAX: 757-397-8543
Email: wgwoodmd@aol.com

AAPA/BMS FELLOWS
Hagit Bat-Avi, M.D.
353 E. 17th Street
#8G
New York, NY 10003
O: 212-844-1942
Email: hbatavi@yahoo.com

Raymond J. Kotwicki, M.D.
850 Piedmont Avenue, NE
#2605
Atlanta, GA 30308
O: 404-727-5157
Email: rkotwicki@hotmail.com

WEBMASTER
Tom Simpatico, M.D.
1150 Terrace Court
Glencoe, IL 60022
O: 773-794-4207
H: 847-835-5631
Pager: 773-260-5650
FAX: 773-794-4141
Email: t-simpatico@nwu.edu

NewsJournal EDITOR
Sy Saeed, M.D., M.S., F.R.S.H., Chairman
Department of Psychiatry & Behavioral Medicine
University of Illinois College of Medicine at Peoria
5407 North University
Suite C
Peoria, IL 61614
O: 309-671-2165
FAX: 309-691-9316
Email: SASAEED@UIC.EDU

ARCHIVIST
Dave M. Davis, M.D.
Piedmont Psychiatric Clinic
1938 Peachtree Road, NW
Atlanta, GA 30309
O: 404-355-2914
FAX: 404-355-2917

AACP LIAISON
Charles Huffine, M.D.
3123 Fairview East
Seattle, WA 98102
O: 206-324-4500
FAX: 206-328-1257
Email: chuffine@u.washington.edu

ACPE LIAISON
John M. Ludden, M.D.
Harvard Medical School
126 Brookline Drive
Boston, MA 02215
O: 781-259-8555
FAX: 617-421-6219
Email: healthcare@ludden.net

EXECUTIVE DIRECTOR
Frances M. Roton
PO Box 570218
Dallas, TX 75357-0218
O: 800-650-5888
H: 972-613-3997
FAX: 972-613-5532
Email: [redacted]

Workshop 22

Ethical Principles in Psychiatric Administration:

Issues, Challenges, and Dilemmas

H. Steven Moffic, M.D., Sy Atezaz Saeed, M.D.,

Steven S. Sharfstein, M.D.

Thursday, October 10, 2002 1:30 - 3:00 PM

at the

APA Institute on Psychiatric Services

Chicago, Illinois

aapa
Founded 1961
AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS
"Promoting Medical Leadership in Behavioral Healthcare Systems"

Central Office • P.O. Box 570218 • Dallas, TX 75357-0218

First Class
US Postage
PAID
Mesquite, TX
Permit No. 308

For Membership Information or Change of Address
contact Frances Roton, P.O. Box 570218, Dallas, Texas 75357-0218