

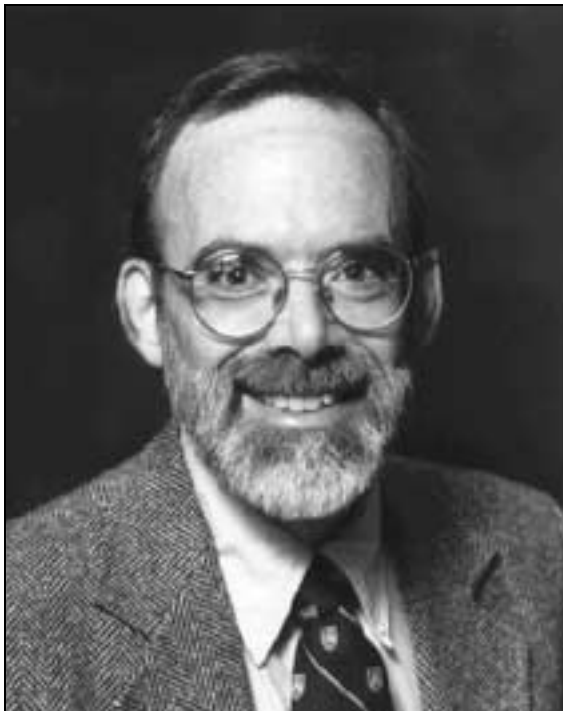


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IN CONVERSATION WITH SAMEER P. SARKAR

An American perspective: Paul S. Appelbaum



Paul S. Appelbaum is A. F. Zeleznik Distinguished Professor of Psychiatry, Chairman of the Department of Psychiatry and Director of the Law and Psychiatry Program at the University of Massachusetts Medical School. He is the author of many articles and books on law and ethics in clinical practice, including four that received the Manfred S. Guttmacher Award from the American Psychiatric Association and the American Academy of Psychiatry and the Law. He is President of the American Psychiatric Association, having taken office in May 2002, past President of the American Academy of Psychiatry and the Law and past President of the Massachusetts Psychiatric Society; he has chaired the Council on Psychiatry and Law and the Commission on Judicial Action for the American Psychiatric Association, and served as a member of the MacArthur Foundation Research Network on Mental Health and the Law. He has received the Isaac Ray Award of the American Psychiatric Association for 'outstanding contributions to forensic psychiatry and the psychiatric aspects of jurisprudence'. Dr Appelbaum is a graduate of Columbia College, received his MD from Harvard Medical School and completed his residency in psychiatry at the Massachusetts Mental Health Center in Boston.

Professor Appelbaum talked to Sameer P. Sarkar on 29 November 2001 in Worcester, Massachusetts, USA. Dr Sarkar was then studying Law and Psychiatry at the University of Massachusetts Medical School supported in part by the Eli Lilly Travelling Fellowship awarded by the Royal College of Psychiatrists.

Professor Appelbaum, thank you for agreeing to talk to the Bulletin. Our readers would be most interested in your background and in your views on many topics in contemporary American psychiatry.

You grew up in Brooklyn, New York. Tell us a little about your background and the key influences in your childhood.

Well, my father was a letter carrier, my mother a school-teacher. I was an only child and was interested, from as early as I can remember, in reading books, particularly on history. Later on I developed more of an interest in science. I probably had a fairly unexceptional childhood in a stable, loving, lower-middle-class family.

Why did you choose to study medicine?

I developed a real interest at high school and college in science in general and biology in particular, and was fascinated with learning how organisms functioned and the human body worked. Medicine seemed like the logical field to go into to satisfy that curiosity.

Why did you decide to become a psychiatrist? Did you have a role model or a mentor during your training?

I had, even going into medical school, thought about psychiatry as a possibility because the functioning of the mind has always been of enormous interest to me. When I did my clinical rotations in psychiatry that interest solidified and really my decision was made by the time my first psychiatric rotation was over. I simply realised that I didn't know where the days had gone. I would start in the morning and the next time I'd look at my watch the day would almost be over and everything had been so compelling, so engrossing that the time had just flown by.



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That was not necessarily true on all of my clinical rotations in other specialities and I realised that if I was finding psychiatry so absorbing it was probably the field for me.

After medical school, you went to a couple of other schools: Harvard Law School and Pittsburgh School of Public Health. Did that have any defining influence on your subsequent choice of career as a psychiatrist?

I was fortunate to be able to take courses as a special student at Harvard Law School and later at the Graduate School of Public Health, University of Pittsburgh. The law school experience was particularly valuable because my work ever since has been intensely inter-disciplinary, crossing the boundaries between medicine and law, and the formal training in a law school environment helped me to see legal issues from the lawyers' perspective, to understand their concern with rights and procedure and to see how the law worked from the inside, as it were. Many psychiatrists and other physicians who haven't had that opportunity – who weren't as lucky as I was – have, I think, developed ideas about the law based on their own experience in medicine without really being able to take into account a set of countervailing interests and issues that are very important in our society. So, the law school training, although it only lasted a year, was of critical importance in my career development. Later on the ability to take courses in a school of public health helped me move with greater assurance into empirical research on issues in law and psychiatry. For the most part until the 1970s, most writing in this field was impressionistic and based on opinion rather than data. There were in fact relatively few data on which one could rely; I saw that as a major failing, and determined on trying to address the empirical questions that, although they don't determine policy issues, certainly inform and influence policy-related decisions. Training in epidemiology and statistics and the like in public health was very important to me.

Law and psychiatry aside, what other areas of interest do you have in psychiatry?

I have a strong interest in the phenomenology of psychotic disorders. It was working with psychotic patients as a medical student that really intrigued me and led me into psychiatry, and although I've gone in other directions for the primary focus of my career, I recently have had the opportunity to take some sabbatical time to explore in depth the phenomenology of delusional disorders and to use a data-set that I was fortunate to have to examine some aspects of their phenomenology. So as a side interest it brings me back to what intrigued me about psychiatry in the first place.

One of the areas where the impact of 'managed care' in the USA has been felt most widely is the practice of analytical psychotherapy and the cutbacks in the public sector psychiatry. In Britain we are fairly ignorant about the managed care system. Would you give our readers a kindergarten version of the system and how it has affected the practice of psychiatry in the USA?

Managed care has been with us for a little more than a decade now in its current form. It involves a tight oversight, largely by for-profit corporations, of access to and payments for mental health services. From a practical point of view, patients or their treaters are frequently required to obtain advance approval before beginning psychiatric treatment and to obtain repeated authorisations along the way, sometimes as frequently as every two or three out-patient sessions. There is a similar approval and concurrent review process for in-patient care as well. This has had a number of results for American psychiatry that are certainly less than salutary. First, in terms of the kind of treatments that are authorised, managed care companies have been loath to authorise payment for psychotherapeutic treatment of any sort but the briefest interventions, and so practitioners who use dynamic psychotherapies tend to be particularly disadvantaged. In contrast, managed care tends to look favourably on interventions with medications, believing that patients need to be seen less often, for shorter periods and for shorter overall duration when psychopharmacologic interventions are primary. Many psychiatrists these days therefore find themselves exclusively doing relatively short (which is to say 15-minute) medication visits as opposed to being able to treat patients with psychotherapy and seeing them more frequently.

The other major problem has been a progressive diminution in the payments for psychiatric care, even when such payments are authorised. Over the years the managed care companies have steadily ratcheted down the rates that they pay for all kinds of care, in-patient as well as out-patient, to the point now where in many academic and other organised settings, it costs more to provide the care than the reimbursement provides. That has led to clinics closing, in-patient units closing and practitioners cutting back on their practices, and I think we are now beginning to see a crisis in access to mental health services in the United States that is likely to get a good deal worse in the next few years.

Has any good come out of managed care? Has it encouraged clinicians to be more self-critical or use more evidence-based therapies?

Certainly the bad outweighs the good by an enormous ratio. However, managed care came along after a period in the mid-80s that was characterised by abuses in some areas of psychiatry, in some parts of the country. In particular, for-profit hospital chains had moved into the provision of psychiatric care, especially for children and adolescents and found it to be an extremely lucrative market. There were a number of investigations and lawsuits alleging unnecessary hospitalisation after these hospitals had become entrenched, and I think the bad press that resulted from this tainted not just the for-profit sector, which perhaps deservedly should have been tainted, but the rest of psychiatry as well. To the extent that these kinds of abuses have gone by the wayside, I suppose one could see that as a positive outcome.

American psychiatrists have long struggled with government interference, be it in the form of



malpractice cases or limitation on confidentiality, the Tarasoff kind of situation, and the rationing by managed care just attended to. How does the American Psychiatric Association, as the main body of psychiatrists in America, negotiate these slippery slopes?

The APA is the major advocacy voice for American psychiatry and a great deal of our resources are devoted to advocacy at the federal and state levels on issues of concern to our members and to our patients. Our ability to be effective as advocates – whether arguing for reasonable limitations on psychiatrists' liability for violent acts committed by their patients, which we have done; working with the Government to try to craft more reasonable regulations protecting the confidentiality of psychiatric records, with which we are involved at the moment; or lobbying our Congress to develop legislation that would limit some of the worst abuses associated with managed care, which is another current preoccupation – depends on our appearing to be something more than just a self-interested guild. So APA has (I think, very consciously and appropriately) tried, in developing the positions for which it advocates, to recognise that sometimes there are competing interests and that those interests need to be balanced or otherwise taken into account in a reasonable way when policy is made. That's not always easy for a professional organisation to do, because our members – understandably – expect us to represent their interests and concerns. But if we are to have an impact on the legislative or regulatory process, we need to acknowledge that politics is the art of compromising conflicting interests and to be willing to strike the best balance we can on behalf of our members and our patients.

One of the things the APA is dealing with now is the Patient's Rights Bill, which is in front of Congress at the moment and which deals with the issue of 'parity'. For our readers, will you please explain what is the APA's position on parity, and perhaps explain the concept of parity for psychiatric patients?

Well, there are two major pieces of legislation that are preoccupying us right now in the US Congress. First, there is what is called Patient's Rights Legislation, which essentially is a package of rights that would be granted to patients *vis-à-vis* their managed care companies or other insurers. These include the right to have an external appeal, for example, of a denial of coverage by a managed care company, something that is in our view extremely important because the companies themselves, most of them being for-profit entities, have every incentive to hold on to premium dollars rather than authorise them to be paid out for patient care. The bill is stalled in Congress at the moment because of a dispute between the Senate and the House regarding whether one of the rights patients should have is to sue managed care companies, or other insurers, for negligent decisions that lead to harm. At the moment these entities are the only ones in the American economy who are exempt from liability for their negligent acts, and I think our members feel very strongly that they don't deserve that special protected position.

The second piece of legislation deals with what we call parity or, better probably, non-discrimination in mental health coverage. Insurers in this country nearly uniformly place a variety of restrictions on coverage of mental health care that are not placed on coverage of other forms of medical care. So, patients may face limits on the number of out-patient sessions that would be covered by their insurer, on the number of in-patient days that they can utilise, they may have differential rates of co-payments along with their insurance for their care, or different deductibles that they are forced to pay out of pocket before the insurance even kicks in. All of these are irrational and discriminatory against mental health care. There is now a bill in Congress, about which we have considerable hope, that is aimed at rectifying this discrimination, at least for private insurance. Unfortunately, even if this bill passes, our federally sponsored Medicare plans will still discriminate against psychiatric treatment by forcing patients to pay a higher percentage of the costs for their out-patient visits and retaining a lifetime cap on the number of hospital days. So we have a long way to go to get truly non-discriminatory coverage in this country and that's part of what we're fighting for now.

Let us take a step sideways, and talk about non-consensual treatment. In your opinion, what should be the governing principle behind non-consensual treatment of the mentally ill: unfettered paternalism or patient autonomy? I know it's a difficult question but I also know it is dear to your heart.

I hope I would end up somewhere in the middle. Most mentally ill people, our research suggests, have adequate capacity to make their own treatment decisions, and I feel strongly that they should be allowed to make those decisions for themselves. That is true for many severely ill people, even people with disorders like schizophrenia. The exception should come when an individual is so disordered as to be unable to make a competent decision and to be at risk as a result, and it's in those circumstances when I think society is warranted in providing some mechanism to allow a substituted decision to be made on the patient's behalf.

My next question is somewhat linked, and is about civil detention of the mentally ill. Do you think that risk should be the primary determinant or capacity?

Well, in the early 1980s the American Psychiatric Association, under the guidance of Dr Alan Stone, who is really the founder of modern studies of law and psychiatry in the USA, produced a model bill for civil commitment, which argued that states should shift the focus from dangerousness *per se* to patients' capacity as the determinant for whether or not they would be hospitalised (Stromberg & Stone, 1983). That is, unless patients were incapable of making the decision for themselves, the model law argued that they should not be compelled into hospital. In the USA today, every state has criteria for involuntary hospitalisation of people who are dangerous to themselves or to other people, regardless of capacity in almost all cases. I think whatever the

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theoretical reasons are to focus on capacity in these determinations – and I think there are strong reasons to do so – it is unlikely that we will see many jurisdictions swinging quickly into line. The reason, I think, is fairly straightforward: the psychiatric system has always been looked to as the container of last resort for people who are a threat or disturbing to society and cannot be contained in any other way. I think legislators have demonstrated their reluctance to give up that ability to use the psychiatric system simply for containment, so although we may wish it were some other way I think it is unlikely that we will soon see an abandonment of that position.

The second part of the question was about this not-so-recent preoccupation with risk in UK psychiatry, and I guess to some extent in US psychiatry as well. Should we oppose this trend, and if so, what advice could you offer us? You have answered part of that question before, but from the perspective of a clinician, what would you say?

You know, in the USA we became very concerned with the risk that was represented by our patients in the mid-1970s, when we had the first of what has since become a series of court decisions that held psychiatrists and other mental health professionals liable for violent acts committed by patients, even out-patients, who they knew (or should have known) represented a severe risk of violence towards others. There was a good deal of concern expressed by psychiatrists at the time, that imposing this burden would mean the end of psychiatry, both because it was thought that many people with severe mental disorder would be shunned by psychiatrists who were afraid of being sued, and because it was feared that the large number of lawsuits that would result would drive psychiatrists out of practice. In fact, the result has been very different. It has turned out that the duty to protect third parties has not been that difficult for psychiatrists to live with. Evidence suggests that even before the court decisions came along, responsible psychiatrists were feeling obligated to protect people who might be endangered by their patients, and were doing so and continued to do so. The number of such cases is relatively small. The number of lawsuits that resulted from a failure to protect is still smaller and I think from an ethical perspective it's difficult to make an argument that any physician, knowing that a patient represents a danger to others, should not act in some way to intervene. So, we have had somewhat less adverse effects than were anticipated at the time that responsibility for patients' violence was shifted to us.

One of your major research interests is the capacity to consent to treatment or participate in research by the mentally ill. Are there any other areas you plan to explore in the future?

I don't think we have, by any means, finished investigating issues related to informed consent, and my focus at the moment is on informed consent to research. This is an issue that has been getting increased attention in the

past 7 or 8 years, and I am quite sure that we haven't worked out all of the issues related to who should be permitted to consent to research, what methods may be impermissible to use with human subjects and how the informed consent process should be structured to ensure that patients truly understand what it is they are entering into. I am, in addition, part of a new initiative funded by the MacArthur Foundation examining a rather different area of law and psychiatry, and that is the use of mandated treatment in the community. I expect that over the next several years I will be involved in a number of research efforts spinning off from that initiative, examining not just formal but also informal means of using leverage over psychiatric patients to get them to comply with treatment recommendations.

So this is really beyond out-patient commitment?

This goes beyond out-patient commitment and considers issues such as the use of the criminal justice system to compel treatment, the use of housing and the conditions that are placed on access to subsidised housing to compel patients to remain in treatment, the use of controls over the welfare benefits that are paid to patients, and the like. I think our first effort in this area will be to determine the extent to which all of these, and other forms of leverage, are used, so that we have some general, almost epidemiological sense of just how common these practices are and the circumstances in which they are employed, before we move to what I hope will be a second stage that examines their efficacy.

What would you say has been your proudest achievement?

Well, I think the piece of work that I take greatest pride in is a book I wrote in 1994 called *Almost a Revolution: Mental Health Law and the Limits of Change*, in which I looked at several of the major legal initiatives that in one way or another regulated psychiatric care, beginning in the 1960s through the early 1980s, and then asked what we knew about their impact 20 years later. It's the favourite of my books because it exemplifies what I have always thought of as the way policy analysis should be done and policy decisions made – that is, beginning with a historical understanding of how we came to be where we are, and proceeding to examine the data on the effectiveness of the approaches we've employed and using this data to help influence where we go in the future. So, if I had a pet accomplishment I think that book is it.

What about your accomplishment within the APA in terms of advocacy and policy?

We've done a number of things over the years that I've been proud of. In the 1980s we developed a model statute regulating psychiatrists' liability for their patients' violent acts, which I think was helpful and influential in many of our states as they developed legislation in this area. We have also generated task force reports on a number of issues, for example psychiatric participation in



sentencing and the use of psychiatric diagnoses in the courts, that I think have been helpful as well. Perhaps the report that I'm personally proudest of relates to peer review for forensic psychiatric testimony, recognising the need for some sort of quality control over what psychiatrists testify to in court. In the late 1980s I began to raise the question of whether we might not be better off regulating ourselves rather than having other people oversee us; and although I think many people believed that it was infeasible to come up with a process for peer review of testimony, in fact we developed one on the Council of Psychiatry and Law of the APA, which was subsequently turned over to the American Academy of Psychiatry and Law, which has been doing peer reviews to this day. So, it is a model that has the potential for a great deal of positive impact on our field, and I am quite proud of that.

The British and American professional organisations are divergent on many ethical issues, such as consent, capacity and so on. The most prominent, or perhaps the most political of them all is the issue of the death penalty in some states. Tell us about the APA position on the death penalty, and how the members who personally support the death penalty counter what is now almost universal European outrage.

I think it's fair to say that American psychiatrists, like Americans in general, are split on the question of the death penalty, with many opposing it strongly and others seeing it as a useful form of both retribution and deterrence of serious crimes. As the umbrella organisation for all of American psychiatry, the APA has generally avoided taking positions on issues that would fracture our membership and the death penalty has been one of them. However, within the past year the APA Board has endorsed a proposal that was initiated several years ago by the American Bar Association, calling for a moratorium on the use of the death penalty until procedures that are fair and generally recognised as being so can be implemented; and that's where we are right now.

How do you see the future of psychiatry in the USA, given all we have talked about so far, both during your leadership of the APA and beyond?

We are in a paradoxical position right now in American psychiatry. Our research laboratories are producing incredible new understandings on a regular basis of the aetiology of mental disorder and treatments for mental

disorder. The 1990s were formally denoted as the 'decade of the brain' in the United States, and it was an apt title because it was a period of enormous progress in the development of new measurement techniques for brain activity, imaging techniques, genomics and the like. What's paradoxical is that at the same time as we have been making these enormous advances, it has become harder and harder to access good psychiatric care and to provide good psychiatric care for the patients on one hand and the psychiatrists on the other. Our investment in the care system has not kept pace with our investment in research. I have to believe that the problems that we are having now, in the way we organise and finance mental health care and medical care in general, is a transitory phenomenon and that we will, after what will undoubtedly be a difficult period, come up with means for making accessible to all of our citizens with mental disorders the benefits that our laboratories are producing now and are likely to continue to produce.

Let us finish on a different note. What are your interests outside of medicine and law?

Well, I enjoy the outdoors, hiking and biking. There aren't as many weekend days as there used to be available for that with my APA obligations, but I hope to get back to that. On a somewhat more sedentary note, I collect postal history and am interested in philately in general.

As one of the youngest APA presidents – you are not even 50 yet – you haven't got much left to achieve professionally. What should we look forward to next? Public office?

My primary identity is as a researcher and, if I dare to use the term, I hope as a scholar. When my APA presidency is over I should like to invest more of my time in research and writing. One of the things that I did earlier in my career was to write about psychiatry and mental health policy issues for a general audience in some of our magazines and newspapers, and I think I should like to be able to do more of that as well. Public office? No.

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