Managed Psychoanalysis: A Tale of Three Metaphors

by Samuel L. Pauker, M.D.

[The following was originally presented at a panel on Managed Psychoanalysis for the Association for Psychoanalytic Medicine on June 4, 1996 at the New York Academy of Medicine.]

What should I call this piece? My thought was "Who's Afraid of the Big Bad Wolf?"

When managed care first appeared on the horizon we were all terrified. How would it affect our work, our practice, our livelihood? It appeared that there would be no room or role for psychotherapy, let alone psychoanalysis. We were indignant that bureaucrats, secretaries business types would dictate to us what to do with our patients. We defiantly vowed to take it to the barricades. On the other hand, the rapid spread of managed care seemed like a cloud of death that would settle over all the land killing off not the first born, but the shrinks.

As managed care has gained "penetrance" in our market, a few odd phenomena have occurred, however. A significant part of the "growth" of my business, if I plotted it like a corporate earnings chart, comes from managed care failures. People who can't get adequate treatment in a managed care setting, where they get to see a psychiatrist once a month for 15 minutes, and a psychotherapist for a few carefully restricted sessions, come for consultation, in some state of inadequate treatment. They are prepared to be private patients and are extremely grateful when they get better. These are often cases involving complex combinations of psychopharmacology and psychotherapy. It challenges my expertise and training and is therefore satisfying in using all my skills to the fullest. The cases are rarely routine so the work is interesting. These cases require the freedom afforded by the "old" fee-for-service model which allow us to do what's required for the patient, offering pharmacologic management, psychotherapy of a variety of ilks — supportive, psychoeducative, and insight–oriented as the need may be, as well as family consultation, and physician liaison. As a result, my expertise at these most complex cases grows and gives me the reassurance (at least for now) that there will always be a niche for clinicians like myself, who know general psychiatry as well as psychoanalysis and its various applications in clinical settings. In a sense, I and colleagues from the analytic community who do similar work are designing the model for treatment that will take us into the 21st century. This is all gratifying, and with luck will continue to provide a living.

I was bolstered slightly by a report I acquired at the recent annual meeting of the APA in New York City. At a booth of the American devoted to informing members about how to integrate their practices with managed care I picked up a new publication entitled *Psychiatric Practice & Managed Care*. In volume 2, number 2, the March/April 1996 edition, the lead article was on "Managed Care: 15 Trends." Some were predictably distressing such as item number one: "The term Integrated Delivery Systems — one-stop shopping for the entire range of mental health services over a wide geographic area — continues to create a buzz." This was somewhat frightening as I didn't know what they were talking about.

Item number two was very encouraging, however: "Some private practitioners will remain completely independent of managed care, especially in large urban areas." Aha! Perhaps I will be/am one of these private practitioners who are continuing to find a patient base.

So my first title for this talk was "Who's Afraid of the Big Bad Wolf?"

At the May meeting of the APA I had a disorienting experience which put into question my complacency with my original title. I went to a symposium on "Managed Care and Depression: Can Quality be Assured?" Jerry Rosenbaum of Harvard squared off against Bill Glazer, the chair of psychiatry at Yale. Jerry's the "no" guy, no quality can't be assured. He starts off with conversation overheard at a hospital committee meeting. Doctor 1: "Do you order treadmill testing before prescribing exercise to men over 40 with high cholesterol?" Doctor 2: "Is the patient capitated or not capitated?"

In some way the discussion of managed care is already antiquated. The question is no longer about managed care — the issue for the next few years is capitation. Capitation means you get paid a set amount per month to take care of the needs, whatever is being purchased, for a population. If they don't need much, you presumably make more. The managed care debate aroused our ire because the companies were getting the capitated payments, premiums, and trying to hold down utilization, which we objected to. Under capitation, physicians will be getting the capitated dollars. Now the incentives suddenly change, as Rosenbaum's joke neatly captures.

Don Fowls, M.D. was the next speaker at the above–mentioned symposium. He is a senior vice–president and National Medical Director for FHC Health Systems/Options Mental Health. He is responsible for ensuring the "delivery of *customer responsive quality clinical care* throughout Options network of providers." [The italics are mine.] They highlight the kind of language that I find myself getting both nervous and angry at.

Fowls' role is to help Options accomplish its mission of "immediate access to exceptional patient care" thereby producing optimal outcome. I glaze over at this kind of talk. What's he talking about? — although this is really not so different from our colleagues in public health who have had to struggle with the allocation of care to populations, not individuals for some time. It's just that we in the private sector had other assumptions, about the sanctity of the doctor–patient relationship, the individual's right to chose their caregiver, etc.

Fowls' first slide is of interest to us. It's the *only* mention of psychoanalysis during the three–hour presentation/discussion. It's a slide discussing the problems with the traditional heath care delivery system and why managed care is taking over the health care delivery in our country.

"Quality Not Assured in the Past: Providers — no outcomes, psychoanalysis, inpatient care, lack of self–governance, high costs, unproven value." I'm sure from the point of view of many proponents of the new health care system all of those criteria could be applied to psychoanalysis.

He makes a slip as he's discussing psychoanalysis: "The community views psychoanalysis as of uncertain quality and costs. Managed *fare* on the other hand" — he catches and corrects himself — "managed care.

Under treatment guidelines his slide says: "Individual therapy using cognitive and interpersonal approaches has been found particularly effective. Consider focused, active and directive techniques which support the patient's efforts to achieve clearly formulated goals. Similar considerations apply to family, marital and group therapies, etc." We know what that means. No more long–term treatments of uncertain quality and cost — read psychoanalysis.

Fowls had legitimate points. There is a national crisis. Health care costs have to be contained. We no longer can operate on the assumption of infinite resources and cost–no–object. Rationing is what's going on and it's going on through the market because its just too difficult for legislatures, and physicians bound by their Hippocratic oath to the needs of their patient can't treat populations.

So it's not the underlying assumptions of Fowls' talk that got to me. It was his tone. To me he was speaking about the end of a kind of individualism, and individual rights to decide about one's own health care which I had been trained on and thought of as inviolate. It turns out to have been just a perk of the middle class during a particularly prosperous post war era which is disappearing like national boundaries during this age of the internationalization of the market place. Workers in the U.S. must compete against sweatshop wages in Third World countries where workers consider those most minuscule of wages a way out of poverty. So how can we compete

with places that offer no health care perks to their workers? Indeed the health care that American workers struggle to get isn't even available in many of the countries we compete with.

The scary thing was in Fowls' tone. Medicine is being corporatized, but why doesn't it seem to bother him, at least a little. His talk is like a corporate board talk. He fails to empathize with my horror, and therefore seemed monstrous in return. (It didn't occur to me then that a good stiff dose of reality was what I needed). I needed a Kohutian Fowls.

So the second metaphor for our current health care changes was "Invaders from Mars." In the old horror movie classic a young boy awakens from sleep to find an alien space craft landing and sinking in a field behind his house. He goes out to look and sees town folk who seem like zombies bringing other town folk to the spacecraft. In the space ship they are injected with something in the base of the skull which turns them zombie–like, too. You can identify the fixed town folk by the two little holes at the base of the brain. The boy finally finds a school nurse who hasn't been fixed and the two get army help to foil the project. The boy awakes with a start at this point in the story and we realize it's all been a horrible dream. His parents comfort him and he lies down to sleep. As he's dozing off, outside his window he again sees an exact replica of the spaceship of his dream descending into the field behind his house.

So Fowls seemed to me like one of those fixed town folk. I notice when speaking to colleagues we maneuver around to find out how we feel about this managed care thing. Are they pro or con? Who's been fixed?

I attended one other symposium at the APA — an update on the treatment of anxiety and depression entitled "Challenges and Opportunity: Advances in the Management of Chronic Depressive and Anxiety Disorders." Psychopharmacologists reviewed the latest on OCD, chronic depression and panic disorder. Bob Michels was also on the panel, reviewing "Psychotherapeutic Approaches to the Treatment of Specific Anxiety and Depressive Disorders." It's late, many folks have left, many of our colleagues in managed care settings may not be doing psychotherapy anymore, but Bob's is a masterful outline on the relationship between psychopharmacology and psychotherapy. Some of it has relevance for us. The gist of it was: 1) The psychotherapy that accompanies the psychopharmacologic treatment of Axis I disorders has no role for psychodynamic therapy; and 2) Psychotherapy just like psychopharmacology had an infancy 30-40 years ago in which one drug and one therapy (i.e., psychoanalytically–oriented psychotherapy and psychoanalysis) was being used for everything without much specificity.

Over time, through research, we have developed drugs with greater specificity. Similarly, psychotherapy started with one method for all conditions but has gone through transformations so that we today also have greater specificity for the variety of conditions we treat.

Michels was quite emphatic: no psychodynamics for Axis I disorders. I disagree and feel that many patients once treated for their Axis I disorder often turn out to have psychodynamic issues that can and are most fruitfully worked on. Perhaps Michels wouldn't disagree. He might distinguish between the phase of treatment that is Axis I oriented and a phase that then may become Axis II oriented. In many ways this is a very helpful distinction which we should propagate. Our work suffers, in part because of the indiscriminate use of psychodynamic procedures during inappropriate phases of treatment. Companies may want to pay for the treatment of the Axis I disorders of their patients but not the Axis II. Employees may buy these policies. That's their right. Axis I psychotherapy should not be deprived because it is confused with the psychotherapy of Axis II disorders.

Besides, as psychiatric residents get less and less psychotherapy training they probably shouldn't be attempting psychodynamically–oriented interventions. Residents will get the kind of basic psychotherapeutic training that medical and primary care residents get in doctor–patient relations, recognition and handling of resistances to the medical treatment, brief supportive interventions for grief and mourning related to one's illness, etc. No one would suggest that it's a good use of a limited resource to have primary care doctors and internists do the two–year psychotherapy a patient might need.

Let's look at it from the other point of view. Say Company X comes to us and wants us to cover their employee's psychoanalytic needs. They have 25,000 employees with an average of four family members per family or 100,000 covered lives. They want us to cover all their psychoanalytic needs. Psychiatric needs (i.e. Axis I disorders) will be taken care of elsewhere. They'll pay $6 per covered life per month which would come to $600,000 per month.

Let's say we pay our members $100 per hour (really a 45-50 minute session). We could then afford to administer 6,000 hours of analysis per month.

If we see the patients five times a week for four weeks a month equals 20 sessions per month (divided into the 6,000 hours per month) we can treat 300 patients per month. That sounds pretty good though I don't know the demographics on psychoanalysis per population. It would probably cover many populations. Certain high–utilization populations might need more.

If we reduce the fee we pay ourselves to $50 a session, we can offer 600 psychoanalyses. We could fill the practices of 60 psychoanalysts with 10 psychoanalytic cases a day. If we did treatments only four days a week, that's 16 sessions a month, into the 6000 hours ($100 per hour) is 375 analyses, or 750 at $50/hour, 250 at $150/hour or 187–1/2 at $200/hour.

The problem is that $6 per covered life per month for the psychoanalytic needs of the population may not sound like too much but some folks might not be thrilled to pay $72 a year for themselves or $284 for their family of four if they weren't utilizing the service. If you're one of the few hundred who get the service you're golden — psychoanalysis for $72 a year! So who determines who gets the analyses? We, as the covering company, would have to set the criteria, of course.

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Perhaps we as the providers would like to offer something to a larger segment of the covered population. We might want to give modified, time–conserving versions of the treatment. Say three times a week for two years to some, twice a week for six months to others and once a week for twelve weeks to others. Incidentally, do we have standardized forms of analytic intervention for these formats yet? And what problems are we supposing to take care of with each kind of intervention?

Though it may sound a bit far–fetched, if we don't think it through, who will? Bureaucrats, businessmen and secretaries, with even less ability to comprehend who to O.K. for analytically–informed psychotherapies of various sorts, now assign days in the hospital for childbirth and hernia operations. This may be *our* equivalent of what Michels described for pharmacotherapy and psychotherapy. They have each evolved from a one–size–fits–all approach to a careful tailoring of approach to need. Have we? I don't think so. Can we claim to have been responsible leaders in our field if we are not gearing up our institutes to research, investigate, discuss, formulate and promulgate these guidelines and techniques?

And so as I bid a sad farewell from this cheerful article, a third and final metaphor: "Forbidden Planet." Sci–fi aficionados amongst us will remember this classic film as one of the early psychoanalytically–influenced examples of the genre. It introduced Robbi–the–Robot as the prototypical Homo Non–ID–icus, precursor of *Star Trek's* Mr. Spock and other cerebral wizards without a psyche.

In the story, a space crew investigates the mysterious wipe out of a ship and crew on a certain planet. Once there, they discover a brilliant and affable scientist, and his bursting–with–young–adulthood daughter who's never seen another guy than her father and is busting at the seams to do so.

Eventually we discover that the dad/scientist has been working on a project he'd kept secret from everyone, even his daughter, which allows him to heighten, enhance, and magnify a zillion fold his mind's power. That's how he was able to create the technological marvels, like Robbi, which allowed him and his daughter to remain alive on the otherwise barren planet.

Unfortunately, he periodically falls asleep at the wheel, while wired up to his brain enhancement gizmo and his id, released in his dreams, gets loose. Magnified to the sky it gets loose as an unstoppable invisible force which destroys whatever his unconscious aggressive impulses have been stimulated toward. Since he's worried about the guys on the spaceship hitting on his daughter and taking her away he hits on them and gets rid of them. Eventually this is realized and we understand that the Forbidden Planet is the id which resides in each one of us.

So how much of what we fear about managed care is what they do to our patients, and how much is the awkward role we would be required to fill but which we steadfastly won't fill, as allocators of a social resource, psychoanalysis and psychoanalytically–informed psychotherapy — because it's too hard, too cruel, and requires too much Solomonesque decision making over people's lives? Are we therefore leaving it to messengers from the business sector who don't know the patients or the doctors and therefore can make the cold hard choices as to who gets and who doesn't get treatment, and whom we can then shoot for their message of rationing and destroy as the embodiment of our projected extractive desires of our patients? Whew — now I've said it.

In summary: with the increased rationing of medical care, we scurry to keep our services outside the affected arena. We can do this by:

1) Keeping psychotherapy/psychoanalysis outside the medical arena of capitation- - i.e., demedicalization;

2) Continuing to cover the upper end market — which will continue to enjoy the perks of free market individualism. This is what many of us are doing now; and

3) If we're good guys, we may want to figure out what abbreviations of the pure drug (psychoanalysis) can be adapted to the health care system our middle–upper middle class patients, friends, relatives, and colleagues will be obliged to accept.

The main metaphors for the paradigm shift in our thinking and existence, I propose, only somewhat facetiously to be:

- Who's afraid of the Big, Bad Wolf? — denial, transient adaptations
- Invaders from Mars — paranoid rejection
- Forbidden Planet — projective identification, followed by introspection, interpretation, recognition and working through.

As the prophet Bob Dylan said many years ago in reference to another major paradigm shift in our thinking about ourselves and society

"...your old road is rapidly aging
please get out of the new one
if you can't lend your hand
for the times — they are a changin'."

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Consolidations, Mergers Characterize Today's Health Field

by Robert J. Campbell, M.D.

On June 17, 1996, New York University, NYU Medical Center, and Mount Sinai Medical Center announced an agreement to combine their medical schools, hospitals, affiliated institutions, and regional health systems. This merger will create the largest academic medical center in New York (see chart).

Two weeks later, Long Island Jewish Medical Center and Beth Israel Medical Center — both affiliated with the Albert Einstein College of Medicine at Yeshiva University — announced plans to create a partnership under a single–parent corporation. Together, they train 1,082 residents and many medical students, who rotate through the centers at various times from Einstein.

On July 24, The New York Hospital and The Presbyterian Hospitals Health Care System, will include more than 20 hospitals and have combined annual revenues of more than $2.5 billion.

A unique feature of the New York–Presbyterian merger is that the medical schools affiliated with the two hospitals will remain separate. The clinical faculties of Cornell University Medical College (CUMC) and Columbia College of Physicians and Surgeons (P&S) will form a 2,800–physician alliance among their faculty doctors, the first of its kind in the nation. The alliance will negotiate patient care contracts with HMOs and other insurance entities. It will start with 2,800 physicians but may eventually include 8,000 physicians located at more than 20 hospitals affiliated with the medical schools.

Conventional wisdom holds that too many residents are being trained. If residency programs shrink in response, the effect could be most dramatic in New York, whose academic medical centers train the most residents in the country.

The three announced mergers reflect the current transformation of the role of the hospital. A hundred years ago, a development of diagnostic and therapeutic technologies began, and those technologies vastly increased the possibilities for medical interventions that were performed in hospitals. The acute care hospital soon became

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	NYU	Mt Sinai	Total
MD students			
MD/PhD students			
GME students			
Clinical faculty			
House staff, fellows			

Major Changes for Medicare Program in '97

by Seth P. Stein, Esq.

In January, 1997, NYSPA sent out its ninth annual Medicare Memorandum describing the most dramatic changes in the Medicare program since implementation of the national Medicare fee schedule in 1992. For 1997, Medicare has dropped coverage of the CPT psychotherapy codes (90842, 90843, 90844, and 90855) and replaced these codes with 24 new psychotherapy codes (G0071–G0094). These codes are Medicare codes only and are not part of CPT.

The 24 new G codes are fully described in the NYSPA Medicare Memorandum. These new codes differentiate between psychotherapy with medical management and psychotherapy without medical management and differentiate between inpatient and outpatient services. Thus, for each length of psychotherapy session (20–30 minutes, 45–50 minutes, and 75–80 minutes), there are four different codes: outpatient with medical management, outpatient without medical management, inpatient with medical management and inpatient without medical management.

The new G codes for psychotherapy without medical management will be used by all mental health providers including psychologists and CSWs. However, only physicians may use the G codes with medical management. HCFA has assigned substantially higher RVU values to the psychotherapy codes with medical management. It is anticipated that 80% of all psychotherapy codes billed by psychiatrists will include the higher medical management psychotherapy fees.

The key question is what does HCFA mean by the psychotherapy with "medical evaluation and management services." The following list from HCFA is helpful, but not exhaustive:

> Medical management of psychiatric patients, medical diagnostic evaluation, drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations, review of activity therapy reports, the supervision of nursing and ancillary personnel, the programming of all hospital resources for diagnosis and treatment, an

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