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When bad men combine, the good must associate; else they will fall one by one, an unpitied sacrifice in a contemptible struggle. — Edmund Burke, Thoughts on the Cause of the Present Discontents.

Perhaps the most dangerous thing about psychotherapy is that it is too satisfying for too many people too much of the time for too many reasons. With the present rate of proliferation of therapists and therapies, and the current disdain for the fine art of diagnosis, we seem destined to spend ourselves quibbling about who does what to whom.

The explosion of progress in the last fifty years is totally dwarfed by the explosion of problems "crying for solution." Currently it is fashionable to look for and expect a cure for anything "bad" and a distribution system to make available to all, anything "good." Psychotherapy is about as well defined as "quality medical care" and just as highly touted. To challenge what is meant by either is like being against progress and relevance, innovative solutions and creative programs. We are so busy being "with it" that we seem in danger of trading our integrity as physicians for popularity as social reformers. We are so invested in concern about poverty, racism and violence that we have left our public clinics and public hospitals and the patients therein to the care of indigenous workers and other professions.

Psychiatrists have popularized psychotherapy, deprecated the somatotherapies, and made it as profitable as it is prestigious to be

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a psychotherapist. We didn't spearhead the mental health movement, our friends and admirers did that, but psychiatry went down the line with them as technical advisors alleging that great things could be done for society if there was only enough money and manpower for new programs. Money was appropriated and new manpower developed among the other traditional mental health professions, psychology, social work and nursing. And still there remained great unmet needs. Newer programs followed — to train housewives and clergymen and hospital attendants and indigenous workers.

On another front was the struggle to gain acceptance of coverage for mental disorders under health insurance. This has been largely successful in the Washington metropolitan area where the federal employees program and Medicaid do include coverage for psychiatric services, or perhaps I should say, for mental disorders, for there is the rub. It may take a psychiatrist to practice psychiatry but apparently anyone can practice psychotherapy.

Somewhere along the line, psychiatry began to depart from the medical model and here, as in other facets of society today, we threw out the old and substituted nothing. It is now nearly impossible to get any kind of a consensus on what is to be included in the label "psychotherapy" and how it is to be defined; what is to be included in the label "mental disorder" and how it is to be defined; who is to be included in the label "psychotherapist" and how he is to be paid.

First in our clinics and now in our hospitals, we are encouraging more and more people to take a more and more active role in what — for practical reasons — we still call *treatment of patients*. I emphasize this because just as Thomas Szasz calls mental illness a myth and continues to teach in a medical school, the practitioners of the non-medical models still call their clients patients, at least on health insurance forms. I may be deluding myself but I continue to maintain that I practice in the medical model although I call it family therapy and make much use of the family interactional model. I also prescribe medication as indicated and recommend hospitalization occasionally.

But what of the non-medical psychotherapist? In today's world of equal rights and concern for the poor and the minorities, we can hardly take the position that therapists who are good enough to treat our deeply troubled, multi-problem inner city masses aren't good enough for the more functional, better off suburbanites. I formerly held (or only rationalized?) that only the medical therapist was fully qualified to practice independently because only he had the requisite medical background to provide the ongoing medical surveillance necessary. That position is untenable on two counts. One, it is the clinic patient, the poor person, who really lacks the ready and continuous access to general medical supervision; the middle class pa-

tient h[illegible] or can easily be sent [illegible], his own internist or general practitioner. Secondly, since the American Board of Psychiatry dispensed with the requirement for an internship, I am dubious about what will be the quality of the medical expertise of the new crop of psychiatrists. This leaves me with my remaining reason for distinguishing between the psychiatrist and even the very well trained and competent non-medical therapist, the simple fact that psychotherapy is only one of the treatment modalities for mental disorders.

Despite its overwhelming popularity, there is little hard data to prove the effectiveness of psychotherapy. Certainly it has contributed little to our most favorable statistic — the declining mental hospital population. This must largely be credited to the drugs and to changes in community attitudes and services.

It used to be taught that psychotherapy was work for the patient as well as the therapist. To make a good therapy case it took a well motivated patient with considerable ego strength consciously willing to undergo psychic discomfort for long range goals. Now, with health insurance, we see that a well motivated therapist is sufficient. In fact, although there are still large numbers of people who find psychiatry threatening and the therapy process alien, there are greater (and growing?) numbers who, once introduced to it, find therapy quite pleasurable. The process of keeping regular appointments with an impressive expert for the purpose of concentrating on the self, offers quite a lot of gratification.

Folklore has always recognized that people enjoy talking about themselves to an interested audience. In this geographic area where we have a sophisticated population with health insurance coverage and sick leave, psychotherapy is practically a fringe benefit. If it gains any more acceptance, we may have launched the shorter work week.

Now we have more problems. We have just had our first round of revelations about Medicaid payments including over $100,000 in one year to a psychiatrist. This was quickly followed by reports of large Blue Shield payments to others. Some of these will prove appropriate, some dubious, and some may turn out to be fraudulent overutilization. But where will the lines be drawn, and who will do it? Have we already defaulted on our responsibility and our claim to police our own ranks? I think so. I think for reasons of convenience, disinterest, preoccupation and business, and a reluctance to risk unpopularity, criticism and enmity implicit in taking a stand, we have compromised, appeased and adapted.

Since I am concerned about my integrity, not the other doctor's and certainly not yours, I am now forced to rethink about my own practices as a psychiatrist. First, in dealings with the Third Party I can no longer hide behind the rationalization that the insurance contract is between patient and

carrier and not my concern. He who pays the piper will inevitably call the tune. I am unwilling to have the computer determine the treatment of my patients on the basis of some norm for the diagnosis, without active — even if unsuccessful — intervention on my part. I must at least try to avoid getting into the bind where I make the diagnosis fit the treatment plan, or treat the patient inadequately.

Since the subscribers are the buyers both of the insurance and my services, my services should include educating them so that they can make knowledgeable choices. For me this means that I have begun to inform my patients that Family Therapy, as I do it, mostly seeing couples, is not openly covered by most carriers. For my part, I will now indicate on the statements who is seen, after serving notice to the major carriers that this is a reputable, accepted psychotherapy technique, and request that they inform me if they intend to disallow it so that their customer can decide whether to change insurance plans or change doctors.

Further, I see a responsibility to work through to a clearer definition of my own services in terms of what I mean by mental disorder and what I include in psychotherapies and somatotherapies. I may not personally use all modalities of treatment but I know I am better qualified to judge their validity than some clerk in an insurance office. Toward that end, I am drafting a working paper to be submitted to the local psychiatric society proposing that we take the initiative in telling the insurance carriers what we consider customary and reasonable psychiatric services, instead of waiting to react to what they adjudge to be "overutilization" or fraudulent claims. In addition to the commonly accepted somatotherapies and psychotherapies, I would propose and plead for a category for new and experimental therapies for which a protocol might be advisable. This is not a new idea, following as it does along the lines of the relative value fee scales, but psychiatry has been remiss in not putting one forward in my area.

Much more difficult will be attempts to define "mental disorder," but here again, I prefer the initiative even if I have to be a single voice on the record. I do not wish to sit by as we largely did with alcoholism until the courts adjudicated it to be a mental illness. We can surely at least take action to insist upon adding drug abuse to the allowable diagnosis for treatment rather than hiding behind some euphemism such as the "underlying psychiatric disorder."

Then there are the matters falling under the headings of peer review, standards and ethics. Much of this is already spelled out and more will be, but largely under pressure from the outside — chiefly carriers, governmental groups and patients. In my experience, it has not been customary, nor expected, for physicians to initiate inquiry. I think this has been an error of ommision that has badly served

ourselves and badly damaged our public image. This is particularly true in psychiatry and especially in psychotherapy where, by trade, we use our professional skills to establish significant, often intensive, relationship with another person at very time when his defenses and controls may be most vulnerable.

Recently in our society we had a case which involved allegations that the psychiatrist had engaged in sexual relations with patients. The membership voted against the recommendation of the ethics committee and the Council that the member be disciplined. I do not dispute the decision, but I do consider it ducking the issue. Do not most by-laws of medical societies provide for appeals to the membership or for approval of the membership? Should not the two questions be separated so that the peer group is asked to rule on the ethical question as well as the guilt?

In the case I mentioned, I think that the membership, or at least the miniscule portion of it that turns out for such meetings, should have been asked to take a stand, for the record, either that sexual relations between psychotherapist and patient, while a doctor-patient relationship exists, do constitute exploitation of the transference and unethical behavior, or do not. In this way, a vote against disciplining the member for lack of satisfaction that the allegations have been proved, will not be misconstrued as endorsing such behavior. This course could serve to educate members as to the local society's stance since that is the standard by which we are to be judged.

But I would prefer to go one step further. I would like to see it become customary for our professional groups to initiate inquiry about members when they, in their professional activities, are subject to adverse publicity or are privately criticized to others of us, in order that we can knowledgeably defend a member whom we exonerate, or take a stand against dubious or unacceptable practices. Until then, the notion of policing our own member seems spurious. We generally wait until someone else catches him stealing from the poor box. After he's been tried, convicted, exhausted all possible appeals, and on his way to jail, we convene to reprimand him.

I found two recent experiences along this line discouraging confirmation of this. In one, the outlined course was followed and the society concerned met in a special meeting to affirm a reprimand for admitted charges after the exhaustion of all legal appeals — now several years after the complaint was filed and during which the laws were changing. To me this smacked of that old story about the man who murdered his parents and then threw himself on the mercy of the court because he was an orphan.

In the other, consistent with the position I deem responsible, I took the action of formally making the motion that the Chairman of the Department be asked to investigate the allegation that a fellow staff

member had collected $106,000 in Medicaid payments during a twelve-month period, during which he was said to have held a half-time job with the local health department. These allegations were front page news in the morning newspaper. Presuming our colleague to be an ethical practitioner, I would have liked to have had the department take note of this adverse publicity and offer him an opportunity to acquaint us with the correct facts or an explanation if possible. Given the number of hours in a day and the local rate of Medicaid payment, the total remuneration seemed inconsistent with good psychiatric practices and the contractual agreement for physicians participating in Medicaid.

The matter is of course under investigation elsewhere and given the usual rate of such proceedings, we seem to negate entirely the notion of policing ourselves if our action is always to be delayed until the ponderous wheels of justice have reached the point of unappealable judgment. Nonetheless, I was more dismayed to learn that several of my colleagues took the position that how a man makes money in his medical practice outside of our hospital is not our concern. I vehemently reject that position, for me it is untenable.

The Medicaid case points up, of course, another problem for the future of psychotherapy if everyone can afford it. The elderly, for example, do not make proportionate demands for psychotherapy consistent with their numbers. I can easily make a case for the desirability of encouraging them to utilize outpatient service in the hope, or on the theory, that supportive psychotherapy in the community would decrease the mental deterioration that leads to mental hospitalization for so many old people. But before we get to widespread use, should we not see the problems it would also bring? If we don't, are we not setting the stage for another round of revelations in which the psychiatrist is pictured by the press as exploiting hopeless elderly people with treatment they can't use for inordinate profit at public expense?

I have one elderly patient who started in psychotherapy with me seven years ago, and my best efforts have not averted a gradual downhill course. Mrs. X. now has such severe memory impairment that it is unlikely that she can mobilize her failing energies for other activities and she has become dependent on the supportive psychotherapy. To terminate her seems destructive, to continue her seems somewhat inappropriate. Not that psychotherapy isn't useful, but that these particular services could be provided equally by a non-medical therapist (the patient has an excellent internist looking after her medically), or even a sympathetic clergyman who could give her regular time. But she started with me and resists a change and a consultant concurs that she should continue.

One, or even a few such interminable cases, (especially if, as in this lady, there is no financial problem and no Third Party to

consid[illegible] is well and good, but should this become the standard for psychiatric care available to all? In a sense this raises the general problem first noted by Freud — therapy, terminable or interminable. It is not only the elderly who can become established in supportive psychotherapy. Termination in psychotherapy seems to me like toilet training. If you catch the subject at the ideal moment which is "the soonest he is ready for it and before the pleasurable quality has been too long enjoyed," to paraphrase a comment by Therese Benedek. But, for psychotherapy — too soon, it won't work and too late, it won't happen.

I have alluded to the matter of the non-medical therapist elsewhere, but not really dealt with it. There is some merit in the argument put forth by some of them that it is not their merits as psychotherapists that psychiatrists question, but their competition. We use them and their expertise, as I have mentioned, to the fullest in salaried positions, and then challenge their competence when they want to move out into the community as private practitioners of psychotherapy. I now think that with current trends, there is a valid role for them in the private sector as well. This does not change the position I took some years ago in congressional hearings on the D.C. Licensure of Psychologists Bill, to wit, that the public need was, and is, for protection from untrained quacks. I recommended rather that there should be a bill to license all non-medical psychotherapists with standards and boards to be drawn up by each of the professions involved. I would go further now and add that I am neither for nor against their inclusion in any insurance program as a separate, non-medical service that indeed can contribute to health maintenance. I see this as a matter that should be decided between the public, the carrier and the other disciplines. I think our services can stand on their own merit, and if they can't, they should fall.

The medical model has been maligned. It is not malicious, nor is it inadequate to the psychiatric practice of psychotherapy in many modes. I think the time has come to stand up and be counted rather than to stand by and be dishonored and dismissed.

The only thing necessary for the triumph of evil is for good men to do nothing. — Edmund Burke, Letter to William Smith.

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