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This Issue

Introduction

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Haven't you heard? They are planning to reform the healthcare system. Great idea! But what does it mean? At this point, no one is really sure, but many people have some pretty strong opinions on the subject. To clarify a rather murky picture, a few key concepts are getting tossed around. The *medical home model*, for example, is a method of healthcare delivery, first developed by the American Academy of Pediatrics, in which a primary care physician heads a medical team and is responsible for coordinating care and patients are referred out to specialists as needed. Prevention is a key component of this plan as well as providing appropriate support services to help patients with chronic illnesses. A good example of this model is the North Carolina Medicaid Initiative. A *single payer system* is a structure in which one entity is responsible for payment to doctors, hospitals, and other healthcare entities. An *insurance mandate* is the legal requirement that everyone obtain health insurance, which aims to protect the system from "freeloaders" and balances the costs to the system by including healthy members as well as members who frequently utilize the system. An *electronic medical records approach* is the creation of an electronic information system for healthcare records that can be accessed by hospitals, physicians, and other authorized healthcare providers. *Comparative effectiveness* is a comparison of the clinical effectiveness of different treatments, which would allow healthcare providers to make better decisions for their patients and, hopefully, reduce the costs of care and improve patient outcomes. A *health insurance exchange* is a place where people could go to select a healthcare plan. Similar to the federal government employee system, people would be offered a variety of plans and would be able to compare them online and determine which plan best meets their needs. Whether this exchange would offer a public option, which would be similar to making Medicare available to everyone, has yet to be determined.

The articles in this issue provide guidance in understanding the changes in healthcare delivery currently being debated. The outcome of this debate will have a significant impact on us as residents and how we will practice. It will also affect our patients and the care they will receive. Advocating for our patients is a critical part of what it means to be a physician, and—now more than ever before—we must assume this role.

Comprehensive Health Reform Is Within Our Reach

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The healthcare system in the United States is in crisis. To create a sustainable and equitable health system, we must cover all U.S. citizens, improve quality, and control costs. Strong leadership from lawmakers and stakeholders as well as public support makes such reform within reach.

There are compelling moral, economic, and quality reasons for comprehensive reform of the U.S healthcare system. In 2007, it was estimated that 46 million Americans were uninsured, and millions more were paying beyond what they could afford for health insurance that did not always satisfy their health needs (1). The uninsured are condemned to remain ill longer and die sooner than the insured. As a result, our economy loses more than $200 billion annually (2). Meanwhile, U.S. businesses are at a disadvantage relative to international competitors, and rising healthcare costs for workers is placing an increasing strain on families as well as the federal government. Although the United States has some of the best doctors and hospitals in the world, our health system is fraught with errors and uncoordinated medical care.

The cost, coverage, and quality challenges facing our healthcare system are inextricably linked. We cannot solve one problem without addressing the others.

First, we must commit to quality, affordable health coverage for all. In order to accomplish this, the non-group insurance market must be modernized to make health insurance efficient and equitable. Insurance companies today expend considerable resources on medical underwriting—that is, avoiding the sick—and marketing. The following three reforms will create an insurance market that encourages competition based on price, clinical value, and customer satisfaction rather than risk selection:

Eliminate discrimination based on health status. Require insurers to sell to all customers regardless of medical history and prohibit premium variation based on health status;

Offer subsidies to make a high-value insurance package affordable to everyone; and

Require all U.S. citizens to purchase insurance to balance the risk pool and prevent free riders.

Next, we must change the way we deliver care to achieve more value for our healthcare dollar and control costs over time. The following reforms will help us rein in costs and improve quality:

Establish an electronic health information system to streamline healthcare delivery, increase transparency, and make available data and decision support tools;

Use comparative effectiveness research to produce more information about what treatments work best for different patients; and

Create incentives, including malpractice reform, for patients and providers to make high-value diagnostic and treatment choices.

I believe that comprehensive health reform must be a partnership between the public and private sectors. Just as it has for decades, Medicare should continue to drive innovation in payment structure and care delivery. Competition between private insurers will enhance the federal government's role in driving innovation and containing costs.

Politics is the art of the possible. Many approaches to solving our nation's healthcare crisis could be successful. But I believe firmly that only a bipartisan healthcare reform proposal is politically sustainable over time. To be truly bipartisan, each political party must realize its core values in the policy solution. For Republicans, this means that markets, choice, and sound budgetary constraints must play a key role. For Democrats, the proposal must benefit all Americans, especially the most vulnerable.

We can meet the moral, economic, and quality challenges of our current system through a comprehensive reform that preserves the best features of our current system but tackles its many shortcomings. Americans have made clear that they are ready for this kind of reform—a uniquely American solution that demands shared responsibility from individuals, governments, employers, and health system stakeholders.

Kyle Noonan is Health Policy Program Associate for the New America Foundation. Dr. Pope is a fourth-year resident Child and Adolescent Psychiatry Research Fellow at Children's National Medical Center and NIMH and the Editor for this issue.

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Healthcare Reform: The Single Payer System

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The U.S. healthcare system is notorious for its exorbitant costs and marginal outcomes. As evidenced by rates of infant mortality, life expectancy, and patient satisfaction compared with that of other developed nations, Americans suffer from substandard health outcomes. In 2008, an estimated 116 million Americans were uninsured or underinsured (1), and this number continued to rise as approximately 14,000 workers lost employer-subsidized health insurance coverage each day (2). This lack of coverage is associated with unnecessary and costly morbidity and mortality (3).

Simultaneously, total healthcare spending in the United States exceeds 16 percent of the gross domestic product, significantly more per capita than any other developed nation in the world (4). A publicly funded, privately delivered single payer system would offer a solution to the access and cost crises currently plaguing the U.S. healthcare system. Under such a financing model, all Americans would have access to high-quality comprehensive medical care, including mental health services and prescription medications. Similar to the Medicare program, this core set of services would be federally financed and administered by federal, state, or local boards. The care would be provided by doctors, nurses, and allied health professionals who would retain the independence they have today (5).

To achieve universal coverage without increasing costs, a single payer national health insurance program would replace the for-profit health insurance industry and eliminate current reliance on employer-based health insurance. Insurers, which are publicly traded companies whose fiduciary responsibility is to their investors and not to their customers, would no longer profit from denying coverage to high-risk individuals or denying patients access to medically necessary services, and employers would no longer be burdened with the skyrocketing cost of subsidizing employees' health insurance. A national health insurance system would save approximately 31% of current healthcare spending associated with the commercialization of care, thus permitting more funds to be directed toward assuring guaranteed healthcare for all (6, 7).

Current public financing for healthcare services already accounts for approximately 60% of healthcare costs, although much of this amount is shunted away from patient care. Under a national health insurance program, these funds would be supplemented by a modest payroll tax on employers and small increase in federal income taxes to fund healthcare services. These tax increases would replace existing employer and employee contributions to private health insurance and out-of-pocket costs borne by individuals (premiums, deductibles, and copayments). As a result, by realigning the forces directing the flow of healthcare dollars, a national health insurance program could concurrently cover the uninsured and improve coverage for underinsured Americans without increasing healthcare costs (8).

Under a single payer system, contrary to the portrayal in the infamous "Harry and Louise" commercials aired in opposition to the Clinton healthcare reform campaign in 1993, patients would retain the ability to choose healthcare providers. In fact, because private insurance plans often limit coverage to in-network professionals, individuals would enjoy even greater freedom to choose their providers and would benefit from the personal freedom of no longer being bound to one particular employer for insurance purposes. In addition, physicians and other healthcare providers would no longer have to navigate the administrative labyrinth of the fragmented third-party reimbursement system. Instead, healthcare professionals would be empowered to focus on providing high-quality coordinated patient care without fear of claims denial and other financial retribution. Such a financing system could more effectively offer incentive for evidence-based preventive care and chronic disease management by ensuring that each American would have access to a medical home. Most importantly, a single payer system would confer professional freedom to providers and the right to quality healthcare to each and every American.

Elizabeth Wiley is a first-year medical student; David Marcus is a fourth-year medical student; and Ronald Codario is a second-year resident in internal medicine.

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The Road to Health Policy: One Resident's Story

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How the air in a room with someone in the depths of depression seems stagnant—their conveyed feeling of hopelessness almost stealing your breath.

I could see the fear in his eyes, and I wished that I could have made it go away. But instead of comfort, I gave an uneasy laugh, along with the rest of the group, poking fun at the frightened man. From then on, seeing someone drop low and run immediately after hearing the loud bang of a car backfiring became a joke among my peers on the Southside of Chicago. It wasn't until years later that I began to associate a name with such psychological pain and suffering that I witnessed while growing up. The exaggerated startle responses, outbursts of anger, and moments when friends shared fears of not making it to adulthood I now associate with post-traumatic stress disorder.

I went to medical school specifically to become a psychiatrist. However, during my inpatient psychiatry rotation, I became disillusioned with pre-authorizations and quick discharges. Ironically, it was my outpatient family practice rotation that sparked my interest in public health and policy. The rotation was in an all-in-one clinic run by a child and adolescent psychiatrist, with assistance from several internists. The clinic offered a multitude of services, from HIV case management to comprehensive psychiatric treatment. They even had a food bank!

I liked it so much that I took the year off after medical school and worked there as an HIV case manager. Many of my clients were confronted with having to choose between healthy food and their medication because of limited income. I wrote letters of support for the clinic's funding while dealing with the constant stress of reapplying for grants as well as the fear of having to restructure the clinic's programs if the funding wasn't continued. When possible, the director and I attended town hall meetings, given by the local city council member, to help advocate for policy change. Community clinics need to be able to count on sustained funding in order to continue helping those in need. It was at this point when I rethought my career plan.

My residency director was the first to suggest that I look into health policy. He said to me, "Kahlil, the only way you may be able to affect change on as large a scale as you would like is through policy." I agreed. So I enrolled in the department's Joint Master of Health Policy (M.P.H.) program. The classes were amazing! The compatibility of the two programs was not. My call schedule took no consideration of my exam schedule. Frustrated, I realized that I was not going to finish before residency ended. Again, it was my director who suggested that I apply for the Jeanne Spurlock Congressional Fellowship offered by APA.

I applied for the Fellowship and, after completing the application process (which included an essay on my policy interests and an intense panel interview), was chosen as the 2009 recipient. The inspiration for my policy interests in the essay came from data on the sociodemographic determinants of health, produced by the Robert Wood Johnson Foundation Commission to Build a Healthier America. Interviewing on Capitol Hill began in late November 2008. I interviewed with the offices of both Senate and House members. I found a match with the office of Representative (Rep.) Edolphus "Ed" Towns from New York's 10th district.

Rep. Towns is the Chairman of the Committee on Oversight and Government Reform and has an absentee seat on the Energy and Commerce Committee. He has worked as a social worker and has a strong interest in programs that improve the social welfare of U.S. citizens and in improving our system of healthcare. Since starting the Fellowship in January 2009, I have had the opportunity to brief Rep. Towns on several pieces of legislation (including the Children's Health Insurance Program [CHIP] Reauthorization Act), worked to garnish support for several health bills, met with constituents, and I am currently helping to plan an event that addresses healthcare reform.

I have not yet had the opportunity to assist with producing any new health policies, but I recently learned that I may have the chance in the near future. However, the most important thing about the Fellowship is that at the end of each day I go home with the satisfaction that I am helping people on a much larger scale than I had ever dreamed of doing when I started this journey.

Dr. Johnson is the 2009 APA Jeanne Spurlock Congressional Fellow and a fourth-year psychiatry resident.

Healthcare Advocacy: Together We Are Stronger

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It has been my good fortune to be involved in healthcare advocacy at the county, state, and national levels. When I first got started, I wondered how best to become involved. One key to becoming involved is to find mentors. I have been graced with mentorship from Wisconsin psychiatrists who have shown me the ropes at meetings and introduced me to amazing people. My mentors have picked me up when my own self-doubt might otherwise have let me down.

My involvement with advocacy began with the Wisconsin Psychiatric Association (WPA). As Resident Representative of the WPA Board of Directors over the past 2 years, I have been a part of the task force working to oppose legislation that would permit psychologists to prescribe psychopharmaceuticals in our state. One must be well-organized and hard working to be involved in a state medical organization, but it is easy to be a hard worker when it comes to issues about which one feels passionate.

Having gained confidence that I could make a difference at the local or state level, I sought involvement with the American Medical Association (AMA). I attended my first national AMA Resident Fellow Section (RFS) meeting as a psychiatry intern. Involvement with AMA RFS committees is an excellent way to make a very large organization, such as AMA, more personal. My participation in the AMA RFS Legislative and Advocacy Committee (LAC) has done just that for me. Our main charge is to stay abreast of recent debatable legislative healthcare issues, make certain that our members are informed about said issues, and implement new AMA policy when necessary. Our activities thus far this year have included drafting a resolution on President Obama's proposed healthcare reform model and disseminating issue briefs on the State Children's Health Insurance Program (SCHIP), the 20/220 pathway for loan repayment, and comparative-effectiveness research. Another one of our undertakings was hosting the annual AMA Student, Resident, and Fellow Lobby Day in Washington, DC, and we were very pleased with the more than 300 trainees who showed up for the event on Capitol Hill this spring.

You might ask, why bother with all of this? First, meeting colleagues from across the nation has enhanced both my education and practice. Working with colleagues from across specialties creates a sense of collegiality, which I find translates into my clinical work when collaborating with other providers. Second, work with individual patients seems to take on new meaning when I am able to put it into the larger context of healthcare systems and policy. More importantly, we as physicians must be "at the table" when it comes to healthcare policy. This is an immensely exciting time to be involved in organized medicine, given that healthcare reform might be just over the horizon. Many stakeholders (insurance companies, businesses, hospital organizations, government, patients, and providers) want the final say as to how healthcare reform will play out. If physicians are not part of the discussion, the doctor-patient relationship could be at risk. We as psychiatrists know more than most the importance of this relationship, and thus we must defend it with passion, clarity, and integrity.

In addition to this online edition of the Resident's Journal, there is an e-mail portion delivered each month. This month's e-mail highlights antidepressant treatment and pregnancy and dynamic psychotherapy and borderline personality disorder.

Delivered from Distraction: A Book Review

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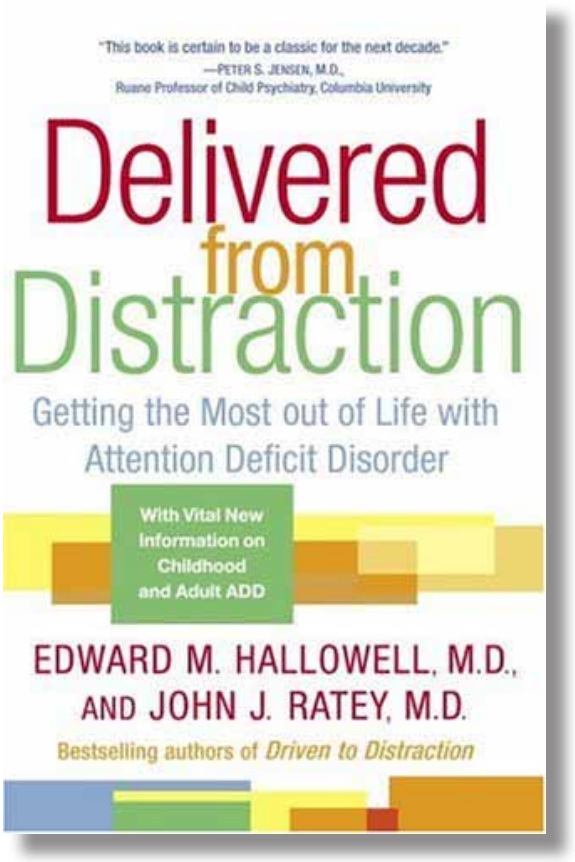
Delivered from Distraction: Getting the Most out of Life with Attention Deficit Disorder, by Edward M. Hallowell, M.D. and John J. Ratey, M.D. New York, Ballantine Books, 2005, 416 pp., $15.00 (soft cover).

As much as we try to empathize with our patients who have attention deficit hyperactivity disorder (ADHD), it is often difficult to step inside their shoes and experience life from their perspective. I am so thankful that my psychopharmacology supervisor suggested that I read *Delivered from Distraction*, by Drs. Edward Hallowell and John Ratey, the follow-up to their previously published *Driven to Distraction*, which enabled me to truly get inside the "ADHD brain" and more authentically connect with my patients.

This easy-to-read, patient-centered book is divided into short manageable chapters, with topics such as diagnosis, genetics, treatment with and without medication, finding the necessary and right doctor, and sex and drugs as they relate to ADHD. The first chapter, "The Skinny on ADD, Read This If You Can't Read the Whole Book," provides a wealth of information that is helpful to both patients and family members. The chapter is written in a question and answer format, and the authors succinctly answer the most common questions about ADHD, dispel myths, and foreshadow the chapters to come. The authors also beautifully describe the problematic aspects of ADHD and stress the importance of the patient finding his or her interests and talents, such as "originality, creativity, charisma, energy, liveliness, an unusual sense of humor, areas of intellectual brilliance, and spunk" (p. 4).

As a third-year resident, I often find myself identifying the symptoms and pathology of patients to the exclusion of other things. This book has helped me recognize the significance of supporting patients' strengths and not simply intervening when weaknesses are identified. It is clear that Dr. Hallowell, a physician who himself has been diagnosed with ADHD, has found a voice with which to speak to his patients about ways to manage their symptoms and "find the buried treasures."



After spending a weekend leisurely reading, I recommended this book to two of my patients in the outpatient clinic. One of them came in the following week and said: "Thank you so much. I can't stop reading this! The authors know exactly what I am going through, and maybe how I can feel even better." The 29-year-old patient with newly diagnosed adult ADHD had already benefited tremendously from starting an extended-release drug treatment, but we still needed to tackle the many negative cognitions stemming from years of criticism by the patient's teachers, family, and spouse. In addition to the work we did in our sessions, this book became a resource that provided the patient with hope. I have also found the book particularly beneficial for patients' loved ones to read before a family meeting, serving as a launch pad for discussion.

Although at times the book can feel slightly "hokey," as many self-help books often do, I very rarely found myself rolling my eyes. It could have probably been shorter, since the authors sometimes repeat themselves, although this may be just what their target audience needs. Readers can pick and choose from the clearly titled chapters to learn about their individual issues and concerns. The pros and cons of particular medications, possible alternative treatments such as omega-3 fatty acids and cerebellar stimulation, importance of diet and exercise, and a five-step method for creating a satisfying life are described in a language that patients can understand but that also conveys information correctly and appropriately. In addition, there is a useful appendix full of resources for patients, with specific advocacy and support groups by state, and other recommended reading material.

Delivered from Distraction is a book that I can recommend to my patients with full confidence, knowing that it will provide both patients and their families with one more tool to overcome their symptoms and achieve success.

We would like to invite all residents to participate in a focus group taking place at the 2009 APA Annual Meeting in San Francisco. Editor-in-Chief Robert Freedman, M.D., along with the Committee of Residents and Fellows and select Deputy Editors, will solicit thoughts on the Residents' Journal and ideas on how *The American Journal of Psychiatry* can be of further use to residents. The meeting is scheduled for Tuesday, May 19, 2009 (Moscone Center; Room 226, Mezzanine Level; 2:00 pm–3:30 pm). For further information please contact AJP@psych.org

For information on the 2009 APA Annual Meeting, including registration and housing, visit
http://www.psych.org/MainMenu/EducationCareerDevelopment/Meetings.aspx.

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Saturday, May 16	10:00 am - 5:00 pm
Sunday, May 17	10:00 am - 4:30 pm
Monday, May 18	10:00 am - 5:00 pm
Tuesday, May 19	10:00 am - 5:00 pm
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Committee of Residents and Fellows

The Committee of Residents and Fellows (CORF) is a permanent standing committee of APA. The Committee is composed of seven psychiatry residents, each representing one of the seven geographic areas into which APA divides the United States and Canada. Additionally, representatives from APA's three fellowship programs participate as active members. Each member is nominated by his/her residency training program and serves a 3-year term.

Since 1971, the Committee has represented resident opinions and issues within the Association and has established effective and meaningful liaisons with many components of APA, as well as with many other organizations that are involved in training and the profession.

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