

The Canary in the Coal Mine: Psychoanalysis and Health Care Policy

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My purpose in this article¹ is to make a rather counter-intuitive case: that as psychoanalysts, we have a special and unique opportunity, maybe even a responsibility, to influence, of all things, cutting edge health care policy. I believe that psychoanalytic outreach to the broader community is absolutely vital to *our* future, and perhaps even essential to the salvation of a society gone amuck with impulsivity, superficiality, and lack of insight and judgment. There are innumerable possibilities for psychoanalytic outreach—from the arts to education to corporations.

In this article, however, I'm going to describe just one arena for psychoanalytic outreach—one you may not be familiar with and may not expect. In the very weird, Byzantine modern health care environment, psychoanalysis can be used as “the canary in the coal mine”—that biological early warning system that sensed the build up of poison gases deep in the coal mines of 100 years ago, alerting the endangered miners they needed to drop everything and run. Why do we function as an early warning system? Because our core values, which create the absolute requirements of the work we do, the work we know to be so helpful to patients, is at serious odds with the trends in health care policy that will affect us all, as clinicians and patients, whether we like it or not. There are three core psychoanalytic values that I want to track as we confront some frightening trends in health care policy:

1. Privacy—we know that the privacy of communications between therapist and patient must be absolutely reliable for patients to dare to tell us the truth about themselves and their world. As a corollary to privacy, the therapy has to be protected from outside interference.
2. Individuality (individualization of treatment)—we know that psychoanalytic work is absolutely individualized. That is its strength. The uniqueness of the patient and the clinician gel in some ineffable way to make change possible.
3. Centrality of the relationship—we know better than any other group with a clinical task that the relationship between patient and therapist or analyst is central to the treatment. It is also central to treatment success in just about all other clinical encounters, but we *know* about it.

Alarming, the trends in health care policy are aimed to vastly diminish or damage exactly these core values: privacy, uniqueness of the treatment plan, and the availability and strength of a healing relationship.

The health care trends I am about to report may be unfamiliar to many of you. But I can assure you they are well on their way to being established in this country, both by government regulation and private insurers, hospitals, and other entities. There is some news here that is quite horrifying. But my intention is to offer some hope about how *psychoanalysts*, using a model of active political outreach, advocacy and lobbying, and emphasizing the innate values of our profession, may be able to influence these trends.

Before I get to specific health care policy issues, I want to share my nightmare vision of the modern medical-industrial complex. This term seems to have emerged around 1980, sparked by the rise of a new, for profit health care industry. It hasn't been used that much lately, but I find it extremely apt as I struggle to understand this brave new world.

¹ I would like to thank James Pyles, Robert Pyles, Janet Chester who educated me—and inspired me—about these issues and helped provide much of the information and perspective.

In the old days, in which we still imagine ourselves to be most of the time, there was a clinician (physician, psychologist, physical therapist, etc.) or a facility (hospital, nursing home) and a patient, and often some sort of third party payer or insurance company to foot some of the bill.

Now there are a multitude of business types and organizations taking a big bite of the \$2 trillion dollars spent annually on “health care” in the United States. They also control a large part of the *experience* of the clinician and patient. These entities range from data brokers that buy and sell health care information (such as exactly how many of exactly which drugs I prescribe each week), to outsourced reviewers, hospital conglomerates, lobbying groups, pharmaceutical companies, trade associations (one example: The Software and Technology Vendors Association, or SATVA, which particularly serves behavioral health systems) innumerable government agencies and countless other categories of business, both nonprofit and for profit.

The new medical industrial complex has its own way of thinking and speaking. Here is a sentence I took from a government Web site on privacy and Health information technology:

A critical portion of the required NHIN [National Health Information Network] prototype deliverables is the development of security models that directly address systems architecture needs for securing and maintaining the confidentiality of health data.²

What strikes me in the language of this quote, which is quite typical of the vast majority of similar Web sites and documents, is the note of dehumanized sterility. There is no mention of the patient or clinician, their relationship, or their needs for privacy.

Here’s another quote I could not resist including. After a reasonable beginning, to wit, “Mental health information is potentially stigmatizing and requires rigorous protection to protect patient privacy and give patients the confidence to share extremely personal information,” American Psychiatric Association spokesman on “informatics,” Robert Plovnick, immediately continues,

As for any discipline that addresses sensitive healthcare issues, a critical requirement for certified psychiatry EHR software would be access rules that are granular to the data element level. Certification would encourage standards development to ensure that software includes this critical functionality.

What, as analysts, do we think about this kind of language and communication?

These official comments were submitted by the American Psychiatric Association to a group called the Certification Commission for Healthcare Information Technology (CCHIT) which is looking into whether there are special requirements for electronic medical records in the mental health field.³

Now, turning to three specific policy issues. They are:

1. Electronic Medical Records
2. Pay for Performance
3. Evidence Based Medicine

² Go to www.hhs.gov/healthit/privacy/

³ Official comments submitted by Robert Plovnick, MD MS, Informatics and Performance Measure Specialist, representing the American Psychiatric Association, to the CCHIT inquiry into “Expansion of CCHIT Certification to Specialties—Environmental Scan Data Report and Draft Expansion Roadmap. (answer A.3.1)

ELECTRONIC MEDICAL RECORDS

The federal government, hospital systems, academic medicine, professional associations and many other parts of the medical industrial complex are pushing for the establishment of a universal and “interoperable” electronic medical record. The key word is “interoperable”—that is, your records are meant to be accessible at every health care facility and to every health care entity at every level. Ideally, according to powerful proponents of Health IT, this system would not have an “opt out” feature. That is, even if you didn’t want your medical or mental health information included, you wouldn’t have an opt out choice. Those advocating for the system also wanted to override state privacy protections where they are more restrictive. Participation in the electronic records could easily be linked to payment for practitioners. The value of the data that would be thus obtained is allegedly inestimable—both for good, and for profit. The constantly reiterated justification is that this system would improve quality of care and help control costs. But this is what happened when Jim Pyles, the American Psychoanalytic Association’s lobbyist, and I went to testify before the Department of Health and Human Service’s National Committee on Vital and Health Statistics Subcommittee on Privacy and Confidentiality in 2005. We asked the subcommittee looking at privacy implications in a study on implementation of the plan what the evidence is to support these claims of cost control and quality improvement. We discovered—at the same moment they did—there are not any convincing studies. That is, there is no hard empirical evidence for project costs savings and quality improvement.⁴ The implementation cost for the national electronic health records is billions, maybe tens of billions of dollars.

We have positive knowledge that there is no way whatsoever to guarantee the privacy and security of such a system. Privacy breaches at the Veterans Administration stunned the country last year. At Johns Hopkins in January, personal data on 135K employees and patients was lost when a contractor didn’t return backup computer tapes and countless companies such as TJ Maxx have had similar massive data leaks. Also in January, 2007, a CD containing health data going back to 2003, covering 75,000 individuals insured by Wellpoint, was accidentally shipped to a private residence. It was found in a box of audio equipment two months later. Most astonishingly, this CD, shipped by UPS from a subcontractor of a subcontractor of Wellpoint, had been purposefully stripped of privacy protections such as passwords and encryption.⁵

As discouraging as these stories are, and as fast as the electronic health record train is rolling, we have been able to make a difference. My organization, the American Psychoanalytic Association (APsaA) has had a vigorous and effective lobbying effort regarding patient privacy. Working with our allies, taking an *analytic* focus that says that privacy can never be balanced against expediency, and with the change in control of the Congress last year, we’ve had an impact. There is considerable hope that the final information technology legislation that Congress passes will include reasonable privacy protections, as opposed to none. APsaA has developed a set of privacy principles which we use in our lobbying on Capitol Hill. These can be accessed on our Web site.⁶

We have determined that the single most critical priority is to preserve the patient’s trust that his or her health information will be used only as authorized. We know this: if the right to privacy is not protected the information will simply not exist. Patients will avoid health care, and they won’t tell the truth.

PAY FOR PERFORMANCE

The Electronic Medical Record is a key precursor to the next scheme, Pay for Performance. As far as I know this applies mainly to physicians, at least for now. Pay for Performance is the wicked spawn of a broader health

⁴ See Himmelstein & Woolhandler. (September/October, 2005). Hope and hype: Predicting the impact of electronic medical records. *Health Affairs*, 24.

⁵ Freudenheim, M. (2007, March 14). *The New York Times*.

⁶ Go to <http://www.apsa.org/AboutAPSAA/PositionStatements/tabid/191/Default.aspx>. Click on “Essential Privacy Principles”

policy trend called clinical practice guidelines, which detail “standards of care” for particular symptoms or disorders. Government and other payers and entities have developed a variety of practice parameters that are or will be tied to reimbursement incentives for physicians. One list I saw had about 115 measures, and included specific directives about patient care—such things as a yearly pap smear, certain parameters for monitoring appropriate blood tests for diabetics at particular intervals, etcetera. The only mental health related parameter on that list was that every patient presenting with depression (major?) be placed (immediately) on an antidepressant.

At first glance, Pay for Performance schemes have some appeal to physicians, not just health care technocrats. They’re seen as ensuring a minimal quality of care and allowing doctors to monitor their own performance vis-à-vis accepted practice standards. The idea is that the doctor who follows the standards (and employs electronic records to allow her work to be tracked) gets paid more by the third party payer.

Here are just some of the problems with Pay for Performance:

- Care is standardized and routinized, not individualized.
- Minority and poor communities are often less compliant with treatment, and therefore doctors working with this population will be penalized.
- It is often patient compliance that is being measured rather than physician skill or thinking. The patient has to meet the compliance parameter—come for a follow up appointment, get a test, etcetera.
- There is something deeply disturbing about a third party providing financial incentives for a doctor to make specific, cookbook driven medical decisions. This seems to me to introduce an outside corrupting factor into the clinical relationship, which could have tremendous unforeseen consequences. The whole nature of the doctor-patient relationship is changed. This dire alternation of the clinical relationship isn’t new—it began over two decades ago when managed care company’s profits rather than clinical need determined the amount and type of treatment a patient received. Recall the Orwellian term “medical necessity” which was used as a befuddling euphemism for “what we’re willing to pay for.”

A study reported in the *Journal of the American Medical Association* in 2005 reported that despite \$2 billion in expenditures by the Center for Medicare and Medicaid Services to promote use of performance guidelines, there was no correlation between quality improvement and programs or expenditures.⁷

EVIDENCE BASED MEDICINE

The third and final health care trend I want to discuss is Evidence Based Medicine. In mental health fields this is sometimes called “evidence based therapy” and the principle is the same. This grand idea is a decade or so old, and a growing force. The idea is that practitioners should only be “doing things” for which there is “evidence.” Evidence is almost always construed to mean *randomized controlled studies*. Obviously this creates a huge problem for any treatment that relies on an understanding of the individual for the development of a unique treatment plan. Psychotherapy, psychoanalysis, pain management, and acupuncture are obviously problems in this kind of system, but we know that every treatment regimen should be individualized, no matter what the disease or type of doctor.

Here are some scary and true stories:

- There was a movement by some members of the Division of Clinical Psychology (Division 12) of the American Psychological Association to press the APA to take the position that if a psychologist sees someone who comes with a problem for which there exists an "evidence-based" therapy ("evidence"

⁷ Snyder & Anderson. (2005). Do quality improvement organizations improve the quality of hospital care for medicare beneficiaries? *Journal of the American Medical Association*, 293. Also, Health care quality programs under fire. (2005, July 6). *Wall Street Journal*.

being defined narrowly as randomized controlled trials) and treats that person with any other approach, the psychologist would be deemed unethical and would be vulnerable to malpractice action. So people coming to analytically oriented practitioners for anxiety disorders, for example, would be able to bring charges that the therapist was not using "best practices." While this movement was successfully halted by the APA, it isn't dead.

- Last month, a colleague of mine in Wisconsin had a patient in analysis and got a call from a reviewer for the patient's insurance company, who said that unless the analyst could provide him with a placebo controlled randomized study proving that psychoanalysis worked, coverage would be stopped, which it was.

A number of analysts are trying to respond to this challenge. APsaA has some materials on our Web site about empirical evidence for psychoanalytic treatment efficacy and construct validity. A recent landmark study by Milrod et al., published in the *American Journal of Psychiatry* (February, 2007), demonstrated the effectiveness of psychoanalytically informed manualized treatment of panic disorder in a randomized control study. All these efforts are worthwhile, but in the end our work does not lend itself to these sorts of studies. It's like trying to play baseball using the football rulebook.

Let me tell you about a now famous challenge to evidence based medicine. This was a paper published in the *British Medical Journal* in 2003, titled "Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomized controlled trials."⁸ The authors did an extensive search of the literature and found that there were *no* randomized controlled studies proving that parachutes are a successful intervention in conditions of gravitational challenge. In fact, observational data suggested that parachute use itself has been associated with morbidity and mortality. The authors conclude: "We think that everyone might benefit if the most radical protagonists of evidence based medicine organized and participated in a double blind, randomized, placebo controlled, crossover trial of the parachute."

Another interesting thing about evidence based medicine: we have discovered that there is no empirical evidence that it improves cost or quality of care. As you recall, evidence that the electronic medical record will improve quality and control costs is also missing.

These three trends are tied tightly together. Pay for performance is dependent on standards derived from evidence based medicine. Evidence based medicine and pay for performance cannot be implemented without electronic medical records. The enormous cost of establishing electronic medical records cannot be justified without inventing uses for the data (thus EBM and P4P). Although the linkages seem obvious, I have been unable to find any paper (either scholarly, journalistic, or policy) that links the three. To me, this suggests there is a serious deficit in the *systemic* thinking within modern healthcare policy or a hidden agenda.

Let me close with a call to action and a message of hope. As analysts, we understand more about the healing relationship, the absolute necessity of privacy, and the uniqueness of each patient and his or her treatment than any other group involved in health care. We can speak up on these issues as analysts in the press (write letters to the editor!). We can get involved in our associations' lobbying efforts. We can educate congressmen and senators as well as state legislators about these issues. We should support the campaigns of politicians who are in the forefront of fighting for the privacy and other patient rights.

Our strongest allies on Capitol Hill are, on the House side: Ed Markey, Massachusetts; Lois Capps, California; Frank Pallone, New Jersey; Pete Stark, California; Lloyd Doggett, Texas; John Dingell, Michigan; Patrick Kennedy, Rhode Island; and Ron Paul, Texas (the only Republican on the list). On the Senate side, our strongest

⁸ Smith & Pell. (2003). *BMJ*, 327, 1459-1461.

allies have been Patrick Leahy, Vermont; Ted Kennedy, Massachusetts; and Debbie Stabenow, Michigan, a social worker. Hillary Clinton had sponsored a Health IT bill not favorable to patient privacy but since seems to be coming around.

There are two other fine groups I can recommend that would welcome your involvement. One is Patient Privacy Rights (www.patientprivacyrights.org), an activist group campaigning for patient privacy via media, courts, and legislatures. The second is the Citizens' Council on Health Care (www.cchonline.org), a patient/consumer advocacy group with strong privacy focus.

The 2008 political campaigns just gearing up are an important opportunity for us to influence potential candidates and platforms. The best way to talk to politicians about these policies is to cite specific anecdotes about your patients or your practice. Or, point out the consequences of these policies on the politician's own privacy and mental health care! You can follow APsA's political advocacy efforts on our Web site at www.apsa.org.

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RESOURCES FOR PSYCHOANALYTIC HEALTH CARE ADVOCACY

American Psychoanalytic Association-www.apsa.org for updates on our lobbying efforts

NASW www.socialworkers.org/advocacy/alerts/

Clinical Social Work Association (successor to the Clinical Social Work Federation) www.cswf.org

THE MODERN MEDICAL INDUSTRIAL COMPLEX

(partial list of players taking a piece of the \$2 trillion health care pie)

Center for Medicare and Medicaid Services (commonly known as CMS)

Other government agencies in and out of HHS

Such as Office on Information Technology (\$118 million budget)

Academic medical centers

Pharmaceutical companies—R and D companies

Generic Manufacturers

Pharmacy chains (e.g. Walgreens and CVS)

Data miners, aggregators and sellers (IMS)

Consultants

Tertiary reviewing services

Insurance companies

Hospitals and nursing homes, chains, associations

Professional associations

Patient advocate associations

NIH

Device manufacturers

Home care service companies

Health IT developers

Health policy think tanks and public health schools

HMO's

Billing companies

Vendors of all kinds for all kinds of goods and outsourced services

Tech companies –Revolution Health, Google, WEBMD

Lobbyists and trade associations for all of the above—e.g., Health Care Leadership Council representing major pharmaceutical companies, hospital systems, etc

The American Health Information Technology Community (a quasi governmental advisory board)

“Bounty Hunters”—private auditors hired by CMS to find Medicare “fraud”

Watch your government think: go to www.hhs.gov/healthit/privacy/