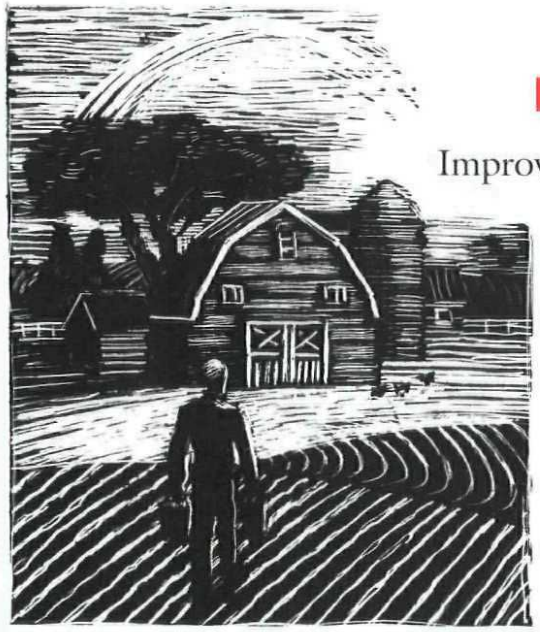
# TRENDS & Ideas



MENTAL HEALTH

## Improving Rural Mental Health

Two recently developed curricula give volunteers and professionals tools to help rural elderly who may have mental-health problems, reports *Rural Health News.* The program Mental Health and Aging: Training for Service Providers, developed by Share DeCroix Bane, director of the National Resource Center for Rural Elderly at the University of Missouri–Kansas City, provides a general how-to manual for rural providers. Embracing the Rainbow, a program by Randall Scott at the Arizona Center on Aging in Tucson, AZ, deals with mental health and cultural issues specific to the Southwest.

Mental Health and Aging includes a textbook, instructor's manual, and hand-outs. Recognizing the fact that in rural areas professionals are scarce and community groups must work together to expand the available services, the program begins with a two-day workshop for community people who work with the elderly: lay ministers, family case managers, and staff and volunteers from senior centers, meals-on-wheels programs, mental health centers, nursing homes, and hospitals. The training does not have to be given by a mental health professional.

Embracing the Rainbow is conducted as a one- or two-day workshop and includes materials on aging, communication, mental health problems, crisis intervention, and treatment alternatives, as well as special sections on Anglo, Hispanic, and Native American cultures.

*For more information on Mental Health and Aging, contact Share Bane at 314-235-1026; for information on Embracing the Rainbow, contact Sandy McGinnis, 520-626-4854.*

END-OF-LIFE CARE

## Physicians Unskilled in Discussing Advance Directives

Although physicians are increasingly urged to spend time discussing end-of-life care with their patients, that advice may in fact be pointless because few practitioners have the skills needed to make the discussions useful. This is the conclusion of a study conducted by James A. Tulsky, MD, et al., and reported in *Annals of Internal Medicine.*

Tulsky and his colleagues audiotaped 56 attending internists as they discussed advance directives with an equal number of patients at five outpatient primary care practices in Durham, NC, and Pittsburgh. The patients were either 65 years old or older or suffering from a serious illness.

The researchers found that the median length of these conversations was 5.6 minutes and that the doctors did most of the talking (a median 3.9 minutes). And the discussions were usually rather abstract: 93 percent of the physicians tried to elicit patient preferences on advance directives by posing hypothetical scenarios; in fact, 39 percent told patients that their current health was not the reason for the conversation. In addition, the language most doctors used was vague.

The most frequently discussed scenarios were of two kinds: "dire," in which further care would be futile, and "reversible," in which further care would lead to recovery. Most patients said they would want aggressive treatment if their conditions were thought reversible and would not want it if their conditions were dire. Unfortunately, said Tulsky and his colleagues, because end-of-life cases are rarely so clear-cut, discussions so narrow can benefit neither the patient nor the physician.

Finally, the researchers found that in only 34 percent of these conversations did doctors attempt to elicit patients' values concerning end-of-life treatment, although the patients themselves seemed eager to discuss them.

In trying to account for difficulties involved in carrying on these discussions, the authors mentioned the emotionally challenging nature of the topic itself, limits on physicians' time, and their lack of training in communication skills. The researchers said doctors must learn these skills if end-of-life care is to improve.

Illustrations by Sim Gellman

PHYSICIANS

## Discounts at the Doctor's

When doctors discount their fees for patients who pay cash up-front, the savings can be substantial–as much as 70 percent, in some cases. So writes Anita Sharpe, reporting in the *Wall Street Journal*.

As unwieldy as the health insurance system has become, some doctors are willing to cut their fees in exchange for immediate payment, thus getting their money sooner and avoiding the administrative headaches of dealing with managed care companies. In many cases physicians actually receive a higher amount than they would receive in reimbursement from a managed care company, even charging discounted fees, since insurance companies and health maintenance organizations generally negotiate their own discounts with healthcare providers.

Patients who do not have health insurance or who have high deductibles can particularly benefit from discounted fees. When Karen Sinclair needed a breast biopsy, she was between jobs and had to pay for the surgery herself. North American Care, Inc., a physician-run service that acts as a middleman between patients and healthcare providers who will reduce their fees for payment in advance, negotiated a fee of $1,400 for the hospital, surgeon, and pathologist, far less that the customary retail price of $5,200. Other examples of discounted rates include prenatal care and delivery for $5,500 instead of $11, 270; a knee revision for $22,000 instead of $38,200; and a hip replacement for $35,000 instead of $63,700. North American Care says its discounts range between 20 percent and 70 percent off a provider's "normal and customary" charges.

In Seattle, a group of physicians has formed SimpleCare, which also discounts fees in exchange for up-front payment. Patients can save additional money by choosing briefer office visits: a 10-minute appointment costs $35, while a 20-minute visit runs $65. SimpleCare advises patients to purchase health insurance for catastrophic illnesses, but the reduced rates for routine care can enable them to purchase lower-cost, high-deductible plans.

ALTERNATIVE THERAPIES

## More Medical Schools Offering Courses to Students

With patients increasingly expecting their physicians to advise them about alternative therapies, medical schools need to begin training students consistently about the value and limitations of these treatments, according to the findings of a survey reported in the September 2, 1998 issue of JAMA.

Nearly two-thirds of all medical schools–64 percent–in the United States offer at least one course in alternative medicine or include the topic in required courses, the survey discovered. Of those offering alternative therapy study, the majority–63 percent–offered one course while 37 percent had two or more classes.

Of 123 courses reported, 68 percent were stand-alone electives, 31 percent were part of required courses, and 1 percent were part of an elective.

Common topics were chiropractic, acupuncture, homeopathy, herbal therapies, and mind-body techniques, according to curriculum provided by 29 of the medical schools. Several offered courses on spirituality and faith.

The survey discovered great diversity in content, format, and requirements in alternative therapy courses at medical schools. Researchers concluded that a curriculum on alternative medicine is at an early stage of development and has few guiding principles. Course directors' interests and local practitioners' availability frequently determine what courses medical schools offer–an approach that fosters instability and prevents a planned, coherent curriculum.

Researchers sent surveys to academic or curriculum deans and faculty at all 125 medical schools in the United States. A total of 117–94 percent–responded.