President’s message

Questions

By Frank Guerra, M.D.

“Not everything that can be counted counts and not everything that counts can be counted.”
Albert Einstein

“The intuitive mind is a sacred gift and the rational mind is a faithful servant. We have created a society that honors the servant and has forgotten the gift.”
Albert Einstein

“Everything should be made as simple as possible but not one bit simpler.”
Albert Einstein

I have been thinking about questions. I have been reflecting on the nature and purpose of the questions that we ask as psychiatrists. I have been wondering about how our approach to our clinical work has changed over the last thirty years.

I have noticed a change in the quality of our professional discourse. We have, I believe, come to spend a greater part of our professional thought and communication describing symptoms rather than people. Our vocabulary has become constricted in the process. Our language has become simplified without necessarily improving our understanding of the nature or treatment of mental illness. Many argue that the splitting of treatment has been detrimental to the overall care of patients. I think there are few among us who would disagree.

One of the profoundly disturbing aspects of modern biological psychiatry is the way in which we have changed the quality and quantity of the questions we ask. Given the time limitations we have allowed to be imposed upon us, many now find themselves constrained to focus our inquiries in specific ways aimed at deciding which is the best drug to start, stop, add, subtract, or change. In becoming symptom/medication oriented we have allowed ourselves to lose vast amounts of information. We have impeded the patient’s ability to bring her own sensibilities into the dynamic of the therapeutic relationship. We have thwarted the possibility that the therapeutic enterprise might become a relationship in the fullest salutary sense. In so doing, we have abandoned the powerful potential of the therapeutic encounter and its vicissitudes as an engine of psychological change. In its place we have inserted incomplete theories of brain function that provide us with comfort much of the time while providing patients with relief only some of the time.

There is a story of a man who goes to his tailor for the final fitting of an expensive suit. Noticing that the left sleeve is too long, he is told by the tailor that it is a simple matter of stretching his arm a bit. This throws the collar off; leading the tailor to point out that if he tilts his head forward and to the left the collar will fit perfectly. This maneuver results in the right pant leg becoming too short which is easily solved by a slight bending of his right knee. Satisfied that this expensive suit now fits properly, he proudly leaves the shop. A couple notices him passing on the street. The woman turns to her husband remarking on the misfortune of the poor crippled man. The husband replies, “Yes, but that suit sure fits great!”

Unlike the gentleman in the story, we have not been fortunate enough to have satisfied ourselves with an ill-fitting suit. Rather, we have been issued straitjackets which most wear recognizing their liability and which some wear with pride.

As psychiatrists we have been taught that the therapeutic encounter should be focused on the needs of the patient. We learned that our own personal gratification is not what we get paid for. We were educated to consider that self-serving emotions and motives are to be understood as countertransference and need to be reflected.
Resident’s Column

All I Need to Know, I Learned in Kindergarten (Except the Following, Which I Learned in Psychiatry Residency)

By Rachel Davis, M.D.

The following are simply my own reflections, observations, and opinions and are not necessarily evidence-based.

1. The therapeutic and diagnostic instruments of an internal medicine doctor include the stethoscope and the otoscope. A surgeon yields the scalpel. A supervisor pointed out to me that, in psychiatry, WE are the instruments. The knowledge and skills that we have as psychiatrists must be used as carefully as a sharp scalpel. The damage one creates with carelessness, negligence, or anger may not be as immediately evident as a nicked aorta, but has the potential to be just as catastrophic. We must remember this not only with our patients, but with our colleagues.

2. People with mental illness often receive substandard or grossly negligent medical care.

3. It’s crucial to involve family members in a patient’s care.

4. I’ve got a bit of an ego. I’m not alone in this. We should probably figure out more productive ways to massage our egos than to continue to foster an environment of competitiveness, sleep-deprivation, and self-neglect.

5. The class below you always has it better and doesn’t really know what it’s like to work hard.

6. Psychiatry residency is actually a lot of fun.

7. Mental illness is still very stigmatized, even among mental health professionals. We advise our patients to consider their illness in a manner similar to a “physical” illness such as heart disease or diabetes. Yet we are often fearful of talking about our own experiences or family members’ experiences with mental illness with each other due to embarrassment or fear that the information may be used against us (and the fear is often well-founded).

8. I’ve had more attendings who are eager to teach, compassionate, exceptionally intelligent, and actually care about their patients during my psychiatry rotations than during any other rotation.

9. It’s very hard for those in other medical specialties to recognize delirium in a person with mental illness. Actually, it’s hard for those of us in psychiatry sometimes, too.

10. A single encounter with a patient (such as during an emergency room visit) can actually impact his or her life.

11. Compassion is underrated.

12. It is easy to develop tunnel vision within an academic institution, to be familiar with research and technology investigated at one’s own institution but not at others.

13. Cytochrome P450 testing provides very useful information in a sub-set of our patient population. Medicaid, Medicare, and many private insurance companies cover this testing. Many physicians are unaware of this.

14. When I’m tired and sleep deprived, I don’t care as much as I’d like to. I’ve finally realized that this isn’t a character flaw I need to fix.

15. Some rotations (including psychiatry) prefer (or require) that we don’t wear scrubs the morning after call because it’s unprofessional. Quite frankly, I’d rather it be very obvious to my patients that I’ve been up all night. I’d rather them know that my slow cognition, greasy hair, and tendency to bump into things is due to the fact that I haven’t slept for more than 24 hours than to presume something else is wrong!

16. I’ve heard that, when addressing an agitated patient, it is best to begin speaking to them in the same tone of voice he or she is using in order to acknowledge that you appreciate the gravity of the situation. You should then gradually soften and slow your voice. (I think I heard this at the APA, but I haven’t tried it yet. I just picture the reactions of all the other staff and patients as I begin to yell loudly with the patient . . .)

17. Some of the more useful conversations I’ve had about psychiatry have been with my brother who suffers from Bipolar Disorder.

Dr. Davis is a CPS Resident Representative.