President's message

Making the Unconscious Conscious

By Frank Guerra, M.D., D.F.A.P.A, F.A.C.A.

I decided to become a psychiatrist after spending some five years involved in the very technical fields of anesthesiology and intensive care. I made my decision when I realized that I did not want to spend my entire career in the windowless confines of an operating theatre engaged in the technically gratifying but interpersonally sterile environment of the operating room and general hospital. I felt that my desire for communication with patients was limited by the brief time I had to spend during a preoperative assessment, largely focusing on obtaining a medical history and explaining anesthesia plans and risks. As the work became rote, my interest and excitement waned.

Becoming a psychiatrist had the effect of enriching my practice of anesthesiology by helping me to become curious about understanding the dynamics of the hospital and operating room. As a result, my ways of thinking about my practice changed. While the technical aspects of the work remained the same, the ways in which I thought about what I did and my interactions with patients and colleagues acquired a greater depth and breadth. I became a better anesthesiologist. I developed a greater interest in the perioperative encounter, using the brief pre- and post-operative visit as an opportunity to do focused therapeutic work. The excitement returned. In the ensuing years my psychiatric training has continued to inform, enrich, and enliven my anesthesia practice.

Following the completion of my psychiatric residency, the ascendency of managed care changed the ways in which psychiatrists were enjoined to practice their discipline. Many of us have, sadly, become deadened to the complexity before us, consigning ancillary practitioners to doing things like taking a psychosocial history and doing psychotherapy. Many in our field really don’t even know what psychotherapy is. We psychiatrists are no longer paid to do therapy nor are we incentivized to think in psychological ways. The fact that incentivization guides practice at all is an issue that demands lengthy consideration. We have been corralled into thinking about patients in pharmacologic terms and made to spend less time getting to know our patients and exploring their lives. The therapeutic relationship as such has been discarded in favor of a symptom/diagram approach to care.

We are skimming the surface with the illusion of the depth of our psychopharmacological thinking. We have become concrete. There is something wrong with our approach to science. The randomized, double-blind, placebo control study may be the best we can do, but it does not come anywhere close to giving us the information that we need to design the most powerful treatments. The evidence in our evidence-based treatment is only marginally good. We are not looking wide or deeply enough into what we do on a daily basis. You cannot squeeze the depth and complexity of the human condition into the Procrustean bed of psychopharmacology. By accepting the premises of the narrow viewpoint, we fail to accumulate a plethora of data that might be useful to us and helpful to our patients. We forego the opportunity for reaping the benefits of accumulated knowledge and wisdom that have propelled advances in medical care.

As an anesthesiologist, I can be certain that every dose of propofol, curare, and succinylcholine administered will have the desired effect. There is no such thing as placebo effect in operating room anesthesiology. The concerns about matching the patient to the drugs are still there. The mandate to avoid side-effects and to do no harm is still there. The result, however,

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Resident's Column

Chicken Pants
By Rachel Davis, M.D.

She was a kind, gentle woman with sad eyes, and she smiled at everyone who walked by. She had forgotten her life story, her family, and, sometimes, even how to eat. But she hadn’t forgotten the comfort of companionship, and she held hands every meal with a man who had also lost most of his memory. They helped one another figure out the complicated meal regimen. Her spirit really showed one day during her bath, not her favorite experience. I had lifted her out of the tub on the chair lift and was quickly attempting to cover her with towels to keep her warm. But she was still shivering miserably. As I started to rub lotion on her legs, she started singing quietly, “Then sings my soul, my savior God to Thee . . . It is well with my soul,” phrases from two different hymns.

Then there was the man who took great pleasure in calling out at night, “Nurse, get the chicken pants (his name for adult incontinence briefs) - I sh*t the bed!” Despite the unpleasant task and circumstances denoted by his call, we usually laughed right along with him. What can you do? It happens, especially in a nursing home. Humor is, after all, a “mature” defense mechanism.

I took the CNA course in Las Animas, Colorado when I was 16. I admired the integrity and compassion of my instructor, who now works at the Denver VAMC. She implored us to always notice the people hidden beneath their illnesses, to discover their personalities, to learn what’s important to them, and to listen to their stories. It’s very easy to be distracted by the effects of dementia and illness and to completely miss the people they once were and still are. She was passionate about this, and it stuck with me.

We get to do this as psychiatrists too. We are in the privileged position of getting to know someone that illness and harsh life circumstances have obscured. I can’t think of a more incredible and awesome job than the one we have of helping someone re-discover (or discover for the first time) that person.

Dr. Rachel Davis is one of two CPS Resident Representatives.

Fellowship and Distinguished Fellowship

We encourage members to consider the two levels of fellowship offered by the APA: Fellow and Distinguished Fellow. For the designation of Fellow, members apply directly to the APA. To be eligible, you must be a general member for five consecutive years, have board certification and submit two letters of reference from Fellows or Distinguished Fellows with your application which may be found on the APA website. The deadline for submission is September 1, 2008.

Distinguished Fellows are submitted to the APA through our district branch which reviews the applications and selects individuals to be nominated for this honor. The Distinguished Fellowship Committee of CPS, chaired by Doris Gunderson, M.D., welcomes suggestions from members of psychiatrists who are committed to excellence in the profession and might qualify. A nominee should be an outstanding psychiatrist who has been a general member of the APA for at least eight years and has made and continues to make significant contributions in at least five of the areas listed below. Excellence, not mere competence, is the hallmark of a Distinguished Fellow.

(1) Certification by the ABPN, RCPS (Canada) or equivalent certifying board.
(2) Involvement in the work of the District Branch or other components of the APA.
(3) Involvement in other medical and professional organizations.
(4) Participation in non-compensated mental health and medical activities of social significance.
(5) Participation in community activities unrelated to income-producing activities
(6) Clinical contributions
(7) Administrative contributions
(8) Teaching contributions
(9) Scientific and scholarly publications.

For 2007, CPS congratulates and welcomes new Fellow Carol Newlin, M.D., from Fort Collins, and new Distinguished Fellow Elizabeth Stuyt, M.D. from Pueblo.

Please call (303-692-8783) or e-mail (cps@nilenet.com) the CPS office with your recommendations.