The Winding Path of Our Profession

Jan Fawcett, MD

This month’s issue of Psychiatric Annals, guest edited by Philip G. Janicak, MD, presents some instructive case reports concerning schizophrenia. Dr. Janicak has put together a group of cases that illustrates the winding path practitioners often take in the diagnoses of this disorder and its associated comorbidities.

As Dr. Richard Josiassen discusses in his case, “64-Year-Old Male with Undifferentiated Schizophrenia, Lengthy Institutionalization, Water Imbalance,” (see page 315) the patient was institutionalized for close to half a century before discharge into the community. This wasn’t because of the severity of his psychosis, but because it took that long to diagnosis and regulate his case of severe hyponatremia. That patient was fortunate in that doctors were willing and able to take the time to investigate his case. Recent news items show that that type of persistence in psychiatry might be becoming more of the exception than the rule.

A recent New York Times article featuring Dr. Donald Levin’s take on the changes in the practice of psychiatry, “Talk Doesn’t Pay, So Psychiatry Turns Instead to Drug Therapy,” has led to much comment among myself and my colleagues. When doctors have to stop talking to their patients in order to be able to earn a living, it raises the question: Where is the field going?

When I began my career, fresh out of an NIMH research fellowship following my residency, excited to believe that the norepinephrine depletion hypothesis of depression would yield an answer to one of mankind’s greatest scourges, I naively believed that science would guide medicine and psychiatry to conquer disease. I think I still believed this when I became a chair of the department of Rush Medical College, a brand new medical school, in 1972.

As years went by, the stark truth confronted me: Medicine was totally controlled by economics, not science. If I wanted to really improve medicine and psychiatry, I should have become a billionaire, a Warren Buffett who could leverage massive financial support for research and care. But alas, it was too late. I was too far down the path, too committed to research and its clinical application. I couldn’t even muster an interest in medical politics to try to have some influence. My die was cast. So I content myself with doing what I can to help patients through clinical research, and one at a time through treatment. I try to promote a healthy appreciation for consciousness and creativity in myself and my patients — after their overactive amygdalae and cingulate cortices are brought under control.

So where are we going with the field of psychiatry? Will genetics, neurobiology, and neuroimaging solve the disorders we treat? Will everything resolve itself to neurobiology? Are we left to do the best we can to treat our patients until some great savior brings the decisive truth?

What about psychotherapy, learning theory, and the way we experience consciousness? Will that be handled by interactions with computers much more intelligent than we could hope to be? Will psychiatry be allowed to influence positively the way humans experience life? Or will we become plumbers patching the leaks and opening up plugged drains more effectively with computer diagnosis and increasingly efficient drug delivery?

I don’t feel very comfortable with the reality that we are molded by economics. At this point, I have been able to practice the way I thought it should be done, despite the bean counters. I think there is still room for that. But where are we heading?

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