Similarities and Differences in Psychiatry and Medicine

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This month, guest editor Stephen H. Dinwiddie, MD, presents a collection of useful articles dealing with important medical aspects of psychiatric practice, particularly in the inpatient setting.

In his editorial, Dr. Dinwdie addresses the limitations of evidence-based medicine in consultation psychiatry; the same is true for the treatment-resistant patients who are frequently seen in psychiatric practice (see page 55). His review of the history of somatoform disorder (see page 78) brings us up-to-date with the conceptualizations of the disorder while highlighting the difficulties involved in treating it. He also offers a proven treatment approach that can be helpful.

The article by Michael J. Marcangelo, MD, on the role of psychosocial evaluation in organ transplantation and bariatric surgery (see page 66) clarifies just what the possible contributions and limitations of psychiatric evaluation can be. The article by Larry S. Goldman, MD, on the role of the consulting psychiatrist in the assessment of patient decision-making capacity (see page 72) examines an often difficult situation for the consultation psychiatrist.

There is also an excellent article on the cardiac effects of psychotropic medications (see page 58) that every clinical, practicing psychiatrist can benefit from studying. Written by Marley Doyle, MD, and Lisa J. Rosenthal, MD, FAPM, it is a valuable review I suggest you will want to keep on hand for future reference.

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A ‘CREATIVE MESS’

I find that one of the fascinating aspects of psychiatry is that it covers so much ground, ranging from the study of basic proteins in the central nervous system, to the impact of social and cultural factors.
Psychiatry differs from other fields of medicine by the fact that the disorders we treat tend to overlap with behavioral dimensions, such as anxiety, depression, and psychosis, which can be present across many diagnostic categories and lead to our giving multiple diagnoses, or to viewing the disorders as a composite of severity dimensions from many symptoms.

Actually, our treatments, though US Food and Drug Administration–approved for various diagnoses, really affect behavioral dimensions (eg, anxiety, impulsivity, emotional instability, depression, and psychosis). In the forthcoming Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), an anxiety severity dimension has been added to all mood disorders. Why? Because anxiety severity strongly predicts outcomes such as treatment response and suicidal behavior risk, perhaps more than any symptoms that make up the diagnostic criteria for mood disorders.

If you like “creative messes,” psychiatry is a great field for you.

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If you like things predictable and orderly, find a specialty where you can look into a scope.

Psychiatry is a branch of medicine, so we need to stay abreast of fields such as neuroscience and cardiology, but because our branch of the science overlaps other fields such as sociology and law, Psychiatric Annals seeks to bring you information to help you span those areas. I believe Dr. Dinwiddie and colleagues have done so handily in this issue, and I look forward to our bringing you more such poly-mathic papers in the future.

From classical literature, to temperaments such as optimism, pessimism, negative affect, to the function of cytokines, glia, neurogenesis, and oxidative stress in the brain, to mindfulness: What a wonderful playground we have in psychiatry! On top of it, we can help people, especially those who have the misfortune to suffer from severe mental illness, to enjoy meaningful lives and cope with what Shakespeare referred to in *Hamlet* as, “The slings and arrows of outrageous fortune.”

It’s a great way to spend our consciousness for whatever time we have. And can you believe it? We sometimes even get paid money for doing it.