Making of a Psychiatrist

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The author is a practising psychiatrist as well as a teacher of the subject. In this article he looks critically at the training of a psychiatrist. He highlights the deficiency of the clinical approach and hopes for the emergence of a more socially relevant psychiatry.

PSYCHIATRY as a science never had a privileged position in medical education until recently. The picture has started changing slowly though not substantially. A major reason for this is the undue emphasis on the *biomedical model* of medicine in clinical training. An integrated or *bio-psycho-social model* of medicine even today seems a distant subject. I must confess that my comment is mainly based on my own experience in Bombay and some medical institutions in Maharashtra. But people will agree about similarities in the situation all over the country, with a few notable exceptions.

When I was on undergraduate student, not long ago, our month long clinical term in psychiatry was usually designated as a "leisure term" because we used to get only an optional short question (of 5 marks) on psychiatry in the theory papers of general medicine. The insistence by undergraduate students to take 'clinics', which usually takes resident doctors on an egotrip, was a privilege shared only by our medical and surgical colleagues. Things have changed of late. Students attend the term in psychiatry, and more sincerely. However, much of the credit for this goes to the introduction of a 35 marks section on psychiatry in the medicine theory paper by the University of Bombay.

Now, it is for the teachers in psychiatry to use this opportunity to inculcate genuine psychological awareness in students who will be general practitioners and consultants of the future. Recently one of our patients suffering from schizophrenia was advised by a medical consultant to get married, as that was the only remedy. Such statements although given (presumably) with a lot of goodwill underline the lack of basic psychiatric training given hitherto to the undergraduate students.

The average student, because of these lacunae, never ever develops a sound psychosomatic approach in his future career. Hence a patient complaining of persistent functional vomiting entering a general-surgical OPD of a big hospital first undergoes a series of investigations, including 'scopy', before being referred for a psychiatric evaluation.

This attitude of looking towards a patient as a mere 'case' stems from the basic lack of psychosocial orientation. Undergraduate students are never taught essentials of doctor-patient relationship, therapeutic effects of doctor-patient interactions, communication skills which can have both good and bad prognostic implications for the patient. It will be a surprising fact for some, but these subjects are not taught even to most postgraduate students of psychiatry. Virtues of spontaneity and intution are seldom stressed. Failure to master communication skills, makes us mere 'tic-markers' on the symptom check-list. Suppose I want to examine a four year old child in the psychiatry OPD, I make him sit on a stool near me. He has to literally strain his neck to look upto me. But suppose I place him on the table before me, our eyes come on the same level; I can pat his shoulder; I can also observe the spectrum of emotions on his face and corroborate it with his words.

Unfortunately we tend to cover up our failures to communicate under the term 'clinical distance'. To keep clinical distance between a patient and a doctor is one of the vague terms in an otherwise accurate medical vocabulary. If I visit some of my recovering patients' homes as a part of the process of rehabilitation, I am branded as a 'social worker' as if a doctor cannot and should not be a 'social worker' when the patient's welfare demands it. If a consistent bond of friendship is built between a patient and a clinician, which helps the medical bond then either the clinician is labelled as having a 'counter transference problem' or is simply ridiculed. Again, everybody in theory acknowledges the need for better communication, and everybody tries to explain the 'nobleness' of our profession on that basis. But 'doublespeak' is the rule of the day.

Most undergraduate studnets never grasp objectivity of mental status examination, during their clinical term. It has been a troublesome experience for me, when our clinical (mental status) examinations are often branded subjective; whereas even if two or more cardiologists argue on presence or absence of a murmur, the objectivity of their examination is never in doubt Fluctuating signs and symptoms is as much a property of schizophrenia as multiple sclerosis. This fact is often forgotten. One of my undergraduate students was amazed to note that 'insight' and 'judgement' could be really tested. He had thought of mental status examination as a mere data of inferences.

It is important to note that the average postgraduate student in psychiatry comes for his clinical training with such a background. In addition, I have often seen fresh entrants coming with a lot of dreamy notions about psychiatry. They think of it as a merely 'interesting' subject, something that is thrilling. During their period of residency their views usually get crystalised in the domain of biological psychiatry in contrast. After all the undergraduate biomedical influence tells, and that spicious by their absence in the postgraduate arena. But even a broad based psychosocial perspective is lacking. Average postgraduate students do not come to terms with the prevalent psychosocial reality of people from various stratas of society. Many students brand psychological and social angles as too theoretical and too abstract. Nor surprisingly, *psychotherapy techniques* never come higher up on the priority list for such students. Any psychotherapeutic work that the student does is only out of that perosn's own initiative and is hardly supervised. Wherever 'honorary' system for teachers is prevalent, this is likely to be 'the truth'. One of the essential therapeutic tools for a psychiatrist in our circumstances is to be conversant with

techniques of group psychotherapy. Many postgraduate students pass their examinations without even facing a single group. No wonder, patient-education is conspicous by its absence in psychiatry. Psychiatry students (postgraduate) seldom venture into explaining the essence of psychopathology in simple terms to the patient.

Not that postgraduate training is totally deficient; analysis and elicitation of signs and symptoms is taught upto the mark. At many places, training in psychopharmacology is adequate. What is not taught, is how to face many controversies in psychiatry with a balanced head. We are encouraged to take sides too early in our training. Hence we come out either as 'pro-ECT' or 'anti-ECT', to take one example. What is not realised is that such crystallisation of views essentially does not evolve from our own studies and clinical experience but as continuation of what 'boss' (i.e. senior teacher) is following over the years. Clinical training in general is more by precept than debate.

Because of our emphasis on western textbooks we tend to see many problems through their viewpoints. Let us take a concrete example of a young patient suffering from drug addiction. It is a widely noted observation that psychopathic personality traits are more common (either primary or secondary in origin) among drug addicts. Many of our urban addicts, especially from the working class, start the habit not because of these traits but because of ignorance about the whole process. Examples are coming to light from rural Maharashtra, where some unscruplous chemists had started giving unpurified heroin (brown sugar) as medicine to unsuspecting rural patients who approached them with a prescription note from the doctors. Some children in Bombay who earn money by collecting garbage have been lured by their area-goons into becoming brown-sugar addicts; many of them are in the age group between 9 and 11 years. The moral of the story is that any disease neds a dynamic question of oetiology and it cannot be rigid and purifan. We should also contemplate new equations and then try to analyse them.

I think, during our postgraduate training we let ourselves be moulded too much by our mileu. By mileu I mean the outlook of the institution in which we are trained, inclinations of our teachers and the general clinical value-systems adopted. A colleague of mine does not give an injectionof an antipsychotic depot preparation in the buttock of male schizophrenia oatuebt but prefers to give it in the arm so as not to arouse the latent homosexuality conflict which is thought to be present in schizophrenia according to the freudian school. His teacher believed in this and so does he. I personally think this to be too farfetched, though I must admit of having seen a couple of schizophrenics who had accusatory hallucinations with emphasis on homosexuality.

Most of our biases which arise from our training are because we tend to try and fit things into established, rigid models rather than using them as a base and then basing our interpretation in accordance with the unique characteristics that every patient brings in with him or her.

The entire medical training is devoid of the study of philosophical issues in medicine and a candid exposure to the student of social realities. This is all the more reflected in a branch like psychiatry where the *art and science* of medicine should meet. Usually any medico turns defensive when he hears the word 'philosophy'. Philosophical issues in medicine are both simple and complex, depending on your abilities to face them. One of the major issues, for example, is about the scope and function of a 'clinician'. Is it to be restricted to only 'clinical' situations? Should a clinician be a willing analyst of the wider sociomedical issues? Should he take an active part in community-health education? Should he attempt to make creative use of the media . . . In short, should he metamorphose a clinician with a global perspective or get tied down to consulting rooms and operation theatres? In theory, many doctors agree to the expanded role of the doctor but in practice it is hard to behave that way. We fail to understand that the so called 'busy' schedule and social interactions limited to cocktail parties, indicate a philosophical shift under the guide of practicality.

Hence any correction in the present status of training in psychiatry should be one which will influence the overall training in medicine. Only then it will be useful and different from the patch-work remedies. Unfortunately most of the experts on medical education believe that if the present structure of examination is changed then the content and quality of medical training will also change. Hence the emphasis till now has been mainly on examination reforms and widening of curriculum, on paper. Concrete plans and methods of implementation are hardly discussed as they are likely to threaten the existing biomedical structure. Well, there is something called the 'expert's paradise'.

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