REFLECTIONS

A change of mind

Stephane Auchincloss

It seemed the time for a mid-life crisis. I hadn't had one for a while, and all my previous ones had been of the personal rather than professional kind. It was definitely time for a change. I had been in medical publishing for 15 years, in the United Kingdom, Australia, Canada and Europe, while also working part-time in general practice. My youngest was just approaching full-time school age, so now was the time to decide what to do for the remaining 20 to 30 years of working life.

I enjoyed my role as medical editor of *Australian Doctor*, a newspaper for 20,000 GPs, but couldn't see myself still there in my 60s. Should I return to hospital medicine and finish my physician training? This now seemed surprisingly uninspiring. What I had found fascinating as a young doctor now looked a bit routine, and I had to admit that to become a physician, despite having my British Membership of the Royal College of Physicians, would require going back almost to the beginning again. I had been away from it too long. If I had to do that, why not do something completely new and challenging?

If I had been sensible and just had my eye on the relative values study and the dollars, I would have chosen to train as an ophthalmologist or an orthopaedic surgeon or perhaps a urologist, but instead I chose psychiatry. I have never understood why doctors who replace knees or look up cystoscopes should have more value than a doctor who intervenes when a patient is suicidal, or effectively treats the black dog of depression, or relieves the frightening and bewildering symptoms of psychosis.

My reasons for choosing psychiatry were complex. Like most life-changing events, this one was not an epiphany but rather a slowly increasing interest in how people deal with life. This had been brought to my attention when working with an extraordinary woman I had known for some years. She married young, had one child and then a devastating, chronic disease had hit. Her husband also developed a life-threatening illness in his 30s. Just weeks after this woman had lost a much-loved brother to cancer, she was speaking with great sympathy about a staff member who required time off work because of stress. Compared to her own life events this staff member had suffered very little, yet my friend never had stress leave and had soldiered on regardless. It made me contemplate the mysteries of resilience.

I've always been fascinated by military history and cut my teeth on stories of great valour. Florence Nightingale, Marie Curie and Edith Cavell were my heroes. But what separates the Weary Dunlops of the world from those who cannot deal with adversity? *Angela's Ashes* says (or asks) it all: how did Frank McCourt pull himself out of grinding poverty and poor parental attachment to become a functional and successful human being? Would the answers lie in psychiatry?

I found psychiatry in general practice challenging and interesting. In my *Australian Doctor* role I had to read all the mainstream journals but found psychiatry journals the most compelling. Psychiatry seemed to be going through a major change regarding its position as a neurobiologi-

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cal speciality, and coupled with the fact that I have always found people endlessly fascinating made it seem the logical choice. Urology didn't stand a chance.

I approached a colleague who had done psychiatry relatively late in life and he was extremely encouraging, but discovering the training program was five years was a shock. His best advice was that it's harder than you think, start studying from day one, and take enough holidays to keep sane. He also correctly advised me that the worst part is "on call".

I spoke to a current registrar who told me it was a terrible job, and I came away thinking I had ended up counselling her rather than the other way around. She resigned two days later, so I think I caught the end of her mid life crisis!

Securing a training post, organising a replacement for myself at *Australian Doctor*, and reorganising the family around a full time job without my usual degree of control took the next six months. This was off-set by the realisation I would no longer have to travel to Sydney two to three times a month. The children thought it sounded like a good exchange, but I was anxious. It had been 18 years since I had last worked as a medical registrar. What would it be like being at the bottom of the medical hospital heirachy after years of running my own business and controlling my own time? I knew I had changed, but had the hospital?

The only blip on the family horizon was when I informed my mother of my new career choice. She fixed me with a beady stare, pointed her finger and – in great maternal fashion – wagged it with the words, "Well just don't try and analyse me!" She has never mentioned my work since.

Some time later I was reading Professor David Maddison's article on psychiatry's "Liaison with medicine, bride or mistress?", and found he had a similar problem with a family member. I was struck how "the more things change, the more they stay the same". I know I have no hope of redeeming myself with my mother, as she wants a real doctor for a daughter, not one engaged in a dubious specialty.

My first six months of training were the steepest learning curve of my life. It was wonderful to be back in the hospital environment and exposed to colleagues on a daily basis, something I had sorely missed in general practice. Other highlights were understanding that what patients said was more about them than about me, and listening and watching as I never had before.

I began psychiatry being completely biologically minded, overwhelmed by the amount of new information on neurobiology. But this intensely reductionist stance has been supplanted by an understanding that even biologically-based psychiatric disorders are influenced by social and psychological aspects.

The philosophy of psychiatry has intrigued me, and I was unaware of how important this would be in the curriculum. The history of psychiatry was now more understandable. I had not understood previously why psychiatrists continued to quote Freud, while physicians didn't still genuflect to Osler.

With my new understanding of Engel's biopsychosocial model has come a fascination with the mind/brain interface. It is impossible to have a mind without a brain, but what makes the mind separate from the brain?

I attended the American Psychiatric Association meeting in New Orleans this year and found the conundrum was exercising some great minds and brains. Listening to Kandel, Sapolsky, Hymen, and McHugh was a revelation. I attended all the sessions I could on the mind/brain dichotomy, and some on the nature of consciousness. I feel overwhelmed by the whole concept, and find myself endlessly trying to understand the different approaches to the concept. Kendell, in a recent editorial in the *British Journal of Psychiatry*, has helped a little by his observation that neither minds nor bodies get sick, but people do.

Yet in the hospital I have been surprised by the continued schism between the rest of medicine and psychiatry. Despite our new credentials, the rest of medicine still has to catch up on the progress in psychiatry. I still see patients with psychiatric conditions who are treated differently because of the stigma of their illness.

Partly because of the unwillingness of other disciplines to apply their skills to people with apparent mental illness, I have witnessed porphyria misdiagnosed as psychogenic vomiting, an alcohol-dependent patient with Marchiafava Bignami syndrome sloughed straight to the psychiatrists ("definitely not medical"), a patient with a brain abscess needing a psychiatric consult because of "irritability", and an "hysteric" who turned out to have a delirium because of a drug overdose.

It leaves me convinced that psychiatrists must have a solid grounding in medicine. With my past medical experience, I find consultation-liaison most fascinating: for example, how to sort out depression in the medically ill, manage delirium, diagnose dementia and what to do with the "overdose patient".

I also believe that psychiatry is becoming the "new neurology", with some things I would have handled as a medical registrar 20 years ago now being managed by psychiatry. The psychiatrist's role in so many medical and neurological aspects of illness is

a revelation. Somatisation, chronic pain and the "new" illnesses like chronic fatigue syndrome prove we'll never be out of a job.

Tolerating the uncertainty of diagnosis in psychiatry has been difficult, coming from the "disease" standpoint of internal medicine. Psychiatry's classification based on description and syndromal classification is initially difficult to conceptualise. It is a little like going back to when all oedema was described as dropsy, before there was any understanding of heart failure or renal disease. While I understand we can't yet classify all mental illnesses according to aetiology, I still find classifications systems such as those for depression difficult to understand. It's a little like the following patient/doctor exchange:

"I'm short of breath, Doctor."

"Yes, you're short of breath."

"What sort of shortness of breath do I have?"

"Major shortness of breath."

"Is it serious?"

"You have moderate, major shortness of breath."

"What has caused it?"

"Well it doesn't really matter, but it could be either a heart attack or perhaps a pulmonary embolus, or it might be because you are very aware of your breathing because of the way you think about things, or it may be because you just ran a long way."

"I see (I think). What should I do about it?"

"Well, we have a number of ways of dealing with your shortness of breath. We can sit you down and talk to you for a while, or we can do a coronary artery bypass, or anticoagulate you. Which would you like?"

Clearly this is a tongue-in-cheek approach to DSM-IV, but I can understand why our medical colleagues get a little confused by our current classifications. Leaders in psychiatry, such as Professor Gordon Parker, are attempting to address the difficulties of diagnosis in depression by suggesting alternative systems of classification which are not unitary. His arguments for such changes are compelling, especially when discussed in terms of treatment outcomes.

After three years of training I am getting an embryonic understanding of what being a psychiatrist means. "Psychiatrist" literally means "healer of the mind". Compared to any other branch of medicine, I can think of nothing more important or more difficult. A nephrologist needs to understand the kidney, a cardiologist the heart and a urologist the dangly bits. But a psychiatrist needs to understand not just the brain but the mind as well. Our territory is human behaviour, emotions, memory, learning, cognition and drives.

My reservations about returning to the medical heirachy have been unfounded, as I have been generally greeted with extreme generosity and goodwill. The only doctors who have problems with a psychiatrist in training of more mature years seem to be those who have their own insecurities.

The training has been enjoyable and exciting. The exams loom large but despite an ageing brain I am working hard. On-call is demanding, but really no worse than when I was younger when I found it equally onerous. I still believe working all night and then working the next day is insupportable, ethically, medicolegally and administratively.

Psychiatry used as an agent of social control has also been a shock. I was unaware of the degree of violence and illicit drug use that I would be exposed to, nor how well I would get to know the police and the security guards. I have been assaulted physically, and verbal abuse is absolutely routine. I have had death threats made against me and my family. So, I am less than impressed when the hospital chief executive and the state health minister both say there are no concerns regarding violence in public hospitals. They both need a reality check, and attending one night I am on call might be useful. The only ways to change the opinions of administrators and politicians is with education and the threat of legal action. With the recent deaths associated with psychiatric patients in New South Wales, I would expect both are possible.

The College and the training program have been a breath of fresh air, being uniformly professional and helpful. I have only one gripe. The College believes it takes five years of postgraduate study in addition to undergraduate medical training and junior hospital posts to train an adequate psychiatrist, but seems reluctant to promote the role of psychiatrists as the logical leaders of multidisciplinary teams. The administrators of some mental health services do not respect the unique qualifications, experience and skills of psychiatrists, assigning them the status of a generic mental health worker. The failure of psychiatrists to take a stance in this area belittles the Fellowship they have worked so hard to achieve.

I have been blessed by supportive colleagues who have shared their enormous experience and knowledge with me. They have also communicated their enthusiasm and taught me about humanity and humility. I know I have a lifetime of learning ahead, and know that I might never really understand resilience, but will continue trying. And I promise solemnly not to analyse my mother!