

Psychiatrists, Physicians, and the Prescriptive Bond

April 16, 2010 | [Bipolar Disorder](#) [1], [Geriatric Psychiatry](#) [2], [Bipolar II Disorder](#) [3], [Dependent Personality Disorder](#) [4], [Alcohol Abuse](#) [5]

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Almost the first memory I have of a physician is our family doctor at my bedside, leaning over to press his warm fingers against my neck and beneath my jaw. I'm 5, maybe 6 years old. I have a fever and a sore throat, and Dr Gerace is carefully palpating my cervical and submandibular lymph nodes. In my family, Dr Gerace's opinion carried a lot of weight. It was the 1950s, and my mother did not quite trust those new-fangled antibiotics. She usually tried to haggle with the doctor over the dose—"Can't the boy take just half that much?"—but even my mother would ultimately bow to Dr Gerace's considered opinion.

"Sir Lancelot smiled and said, hard it is to take out of the flesh what is bred in the bone."

—Heywood Dialogue of Proverbs ii. viii. K2 (1546)

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Doctors counted for a lot in our family. I knew that if I wanted to stay up late to watch a television show, I first had to persuade my mother that it was a show "about a doctor." Growing up with two MDs in the family—my Uncle Morris, the ENT specialist, and Uncle Elmer, the surgeon—I could say that I was "scripted" to become a doctor. But I never felt pushed to enter the profession. Doctoring always felt like something, well—bred in the bone.

Twenty years later, I'm a medical intern, bounding down the corridor at Upstate Medical Center, trying to keep up with my 2 testosterone-crazed medical residents, Frank and Dave. When "Code Red! Code Red!" sounded over the intercom—an indication that somebody, somewhere, had just keeled over—Frank and Dave always raced to be the first ones on the scene: the ones who would "run the code." For Frank and Dave, a myocardial infarction was an invitation to adventure, mastery and derring-do. Sure, they wanted to save the patient, and often did. But you also knew that these 2 young doctors were testing themselves against some unseen God of Chaos. They were hard to work with, and nearly impossible to please—but if you were the one keeling over with an MI, you wanted Frank and Dave running your code.

Thirty years later, I am in the harvest years of my trade and calling. And I find my profession, psychiatry, driven by competing ideologies, rival theories, and divided loyalties. Yes, we have many critics outside the profession. But it sometimes feels that the real threat to psychiatry—and much of the rancor directed at it—comes from within our own ranks. Our internecine squabbles often bring to mind Yeats' line from *The Second Coming*: *"The best lack all conviction, while the worst/ Are full of passionate intensity."* How can we hold out hope for psychiatry, when it is regularly disparaged by some who continue to call themselves psychiatrists?

To be clear: Psychiatry has many sincere and well-intentioned critics whose voices need to be heard, and whose criticism is often justified. It is true, for example, that some psychiatrists have become too enamored of the biomedical model and the ubiquitous "pills for ills" that often promise more than they deliver. Some of us—ignoring our better angels—have allowed market forces to pull us far from our heritage of listening, understanding, and healing. At the same time—somewhat paradoxically—some psychiatrists have lost touch with their medical roots and allowed their skills as physicians to deteriorate.

We often hear the charge—false, to be sure—that “psychiatrists never do physical exams.” Unfortunately, many within the profession have played into the hands of these critics. I suspect that the number of psychiatrists who routinely check their patient’s blood pressure and pulse, or do a circumscribed neurological exam when the patient complains of “muscle twitches,” is much smaller than it should be. In many respects, we have actually widened the rift anthropologist Tanya Lurhmann described in her book, *Of Two Minds: The Growing Disorder in American Psychiatry*.¹ There, Lurhmann described 2 competing models of psychiatric illness and treatment: roughly, the biomedical and the psychodynamic. Lurhmann does not take sides—but she correctly observes that

These 2 ideals embody different moral sensibilities, different fundamental commitments, different bottom lines... The differences become part of the way the young psychiatrist imagines himself with patients, the way he comes to empathize with patients, and, ultimately, the way he comes to regard his patients as moral beings.^{1(p 158)}

In my view, the gap between these 2 models and cultures has widened into a chasm—hastened, perhaps, by the economic stresses and professional competition faced by psychiatrists, in the decade since Lurhmann’s book appeared. How can we bridge this formidable divide? Some see the solution in a kind of “doubling down” strategy: one that urges psychiatrists to become even more focused on neurobiology, neural circuits, and neurotransmitters, leaving “talk therapy” to the psychologists and social workers. Others have gone to the opposite extreme: belittling the real strides we have made in understanding the biology of mental illness; denouncing medication as nothing more than “covering up symptoms”; and even suggesting that psychiatry should no longer be a specialty within general medicine.

Indeed, the recent controversy over “prescribing privileges” for psychologists has revealed to me an even more fundamental dichotomy than the one Lurhmann describes. Having exchanged ideas with psychiatrists both for, and against, so-called prescribing privileges for psychologists, I have reluctantly concluded that psychiatrists (with exceptions, of course) fall into 2 main camps, divided by radically different self-identities. There are those who see themselves as *psychiatrists first, and physicians second*—if, indeed, they view themselves as physicians at all.

Conversely, there are those who see themselves as *physicians first, and psychiatrists second*—I sit squarely in this camp. Some in the first camp have spoken quite candidly of their basic discomfort, going back many years, with their identity as physicians—discomfort experienced almost from the day they were told to put on that heavily symbol-laden “white coat.” I respect colleagues who feel this way, and I have no reason to believe that they are not fine, decent, and effective clinicians. But I am also saddened by them, as I see them tugging our profession as far from our core values as those who think only in terms of neurotransmitters and brain circuitry.

There is nothing more emblematic of the split within psychiatry than the debate over that deceptively simple piece of paper—the prescription. To some psychiatrists, uncomfortable with assuming the historical role of the physician, the prescription has come to symbolize the worst elements of psychiatry: “pushing pills”; selling out to “Big Pharma”; and—worst of all—refusing to deal with the complexities of the patient’s inner life. Of course, no group is homogeneous, and it is a mistake to assume that all psychiatrists in this camp think alike. Some, for example, will acknowledge the need for medication in certain “extreme” cases, such as florid psychosis or severe bipolar disorder. Most will acknowledge that, on occasion, medication can be helpful in the short run, even if it merely “covers over” the “problems of living” the patient must ultimately confront. Even so, one finds among these psychiatrists a kind of patronizing tolerance of pharmacotherapy—as if it were some slovenly, ne’er-do-well in-law, sacked out uninvited on the living room couch.

Of course, there is more than a grain of truth in their complaints. Unfortunately, many prescriptions for psychotropics are written in haste—often after the infamous “15-minute med check—and without any real understanding of the patient’s inner life or psychopathology. But this is only one side of that piece of paper—which proves to have moral, symbolic, and psychological layers usually ignored by critics.

Those who see the prescription as merely an exercise in biological psychiatry do not understand the

complexity and strength of what I call *the prescriptive bond*. To understand this bond, we first need to acknowledge the multi-layered meanings and symbolism patients attach to psychotropic medications themselves. In a seminal article, Metzl and Riba² observe that

...Symbolically speaking, medications convey a host of connotative implications that are difficult to recognize, let alone to quantify. These range from preconceived beliefs about drugs that patients carry with them into the examination room, to unspoken messages of nurturance at play when doctors prescribe (or choose not to prescribe) psychotropic medications... understanding the symbolic functions of the medications is as important as knowing their elimination half-lives or suggested dosing regimens.²

For some patients, being handed a prescription may convey, on an unconscious level, the therapist's role as "nurturing figure"; whereas for others, that same prescription may represent the overbearing authority of the punitive parent. Patients may also have idiosyncratic associations with specific drugs. I recall treating a very psychotic patient who would take only one antipsychotic—the brand name of thiothixene, *Navane*. This drug was no more effective than other antipsychotics he had taken, but in his psychotically-concrete thinking, "Navane" had been symbolically fused with an over-the-counter, bromide-based, sedative he had taken in the 1940s, called "Miles' Nervine." Nervine was nurturance for him—and thus, he would consent to Navane.

In addition to the symbolism and meanings of psychotropic medications, there is also the meaning of that piece of paper itself. The prescription embodies more than a drug name and dosage. It is something that bears the physician's name and signature. It is, in a sense, a tiny part of the physician that the patient takes home—in short, a kind of *transitional object*, with all the powers and valences associated with these objects. Following Donald Winnicott and other object relations theorists, Metzl and Riba describe a transitional objects as "...imbued with meaning because they symbolize a transition from dependency to autonomy."²

And, of course, there are counter-transference implications to the prescription: for some psychiatrists, writing a prescription may unconsciously reflect anxiety over the patient's prognosis, or the psychiatrist's grasp of the case; for others, the prescription may represent the physician's hope for the patient's recovery. As Metzl and Riba observe, "...the act of prescription involves a merging of the expectations of the patient and of the doctor and thus shapes the clinical dialogue of both parties."²

There is also an important ethical dimension to placing one's signature on that piece of paper we call the prescription. I may not see Hippocrates looking over my shoulder when I sign that prescription, but I am keenly aware of a host of physician forebears, scrutinizing my decision. In my mind's eye, there is Dr Gerace, his fingers still warm on my neck; and there is Uncle Morris and Uncle Elmer, asking, "Are you sure about that? Have you double-checked the dose? Will your medicine do more good than harm?" The perverse notion—once voiced by a well-known psychologist, but echoed recently by some psychiatrists—that "prescribing is no big deal" reflects ignorance not only of psychopharmacology, but also of the *moral dimensions* of the prescribing act. When I put my signature on that piece of paper, I am putting my name and that of my family behind an implicit oath. That oath is a critical part of the prescriptive bond. That oath says to the patient,

"I accept medical responsibility for your life and health. I affirm that I understand not only the nature of the medication I am giving you, but also the medication's interaction with your medical and psychiatric diagnoses, physiology, and biochemistry. I affirm that I know the risks of this medication, which, in good faith, I have discussed with you. I also affirm that I know how to manage these risks safely; and that, to the best of my knowledge, these risks are outweighed by this medication's benefits. I accept that you have placed your faith in me; and your life, in my hands. I am honored by your trust, and, in turn, I trust you to take this medication responsibly."

Any clinician who cannot inwardly utter this oath, with confidence and conviction, has no business picking up a prescription pad—whatever the clinician's profession.

Biology versus psychology; brain vs. mind; pills versus skills; molecules versus motives—I say, enough of this Manichean mindset, and enough balkanizing of human personhood! Somehow, we

need to bridge these widely separated islands of over-simplification. Perhaps such a bridge will follow the contours of psychiatrist-philosopher Karl Jaspers' approach, which Nassir Ghaemi, MD has called, "biological existentialism."³ For Jaspers, there was no contradiction between explaining the patient's problem at the level of neurobiology; and also *understanding* it at the level of existential meanings. As Dr Ghaemi observes of Jaspers, "...His approach to spiritual and existential notions...built on, rather than negated, an appreciation for science."³

Such integration is a daunting task for psychiatrists, who are hard-pressed even to find time to see patients—much less to achieve what the poet John Keats called "negative capability": in essence, the ability to entertain 2 seemingly contradictory or competing concepts at once.

So here I stand, alongside Dr Gerace; my physician uncles; and my crazed residents, Frank and Dave. Whatever and wherever I may be 20 years from now, I know I will always remain a physician. And for all the uncertainties in American psychiatry, I am certain of 1 thing: if psychiatry is to survive as a profession, we need to become physicians of the body who are also ready to plumb the depths of the soul.

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References

1. Luhrmann TM. *Of Two Minds: The Growing Disorder in American Psychiatry*. New York: Alfred A Knopf; 2000.
2. Metzl JM, Riba M. Understanding the symbolic value of medications: a brief review. *Primary Psychiatry*. 2003;10:45-48.
3. [Ghaemi SN](#). On the nature of mental disease: the psychiatric humanism of Karl Jaspers. *Existenz*. 2008;3:1-9.

For further reading:

Gabbard G, Bartlett A. Selective serotonin reuptake inhibitors in the context of an ongoing analysis. *Psychoanalytic Inquiry*. 2000;18:673-701.

ADDENDUM: IN RESPONSE TO DR EMANUEL'S COMMENTS

I appreciate the comments from Bennie Bennie and Dr. Emanuel. Regarding the point that "a prescription pad is the most dangerous and perhaps positively effective hand held weapon ever invented..."there is more than a grain of truth to this. Interestingly, our term "pharmacology" is derived from the ancient Greek term, "pharmakon", whose many meanings include both "remedy" and "poison"! Like any powerful intervention-including psychotherapy-a prescription can do great harm in the hands of the unskilled "prescriber", or great good in the hands of the skilled physician.

I appreciate Dr. Emanuel's call for humility in the practice of psychiatry, and in medicine generally. I do realize that the "oath" I proposed could convey an unintended sense of omniscience on the part of the physician-which would certainly be misplaced! To clarify: the oath is described as "implicit" and "inwardly uttered". I did not intend it as an actual speech the physician makes, upon handing the patient the prescription. I intended it as an expression of the standard to which a good physician should hold himself or herself, and as an acknowledgment of the immense responsibility we must take for our patient's wellbeing.

That said, I do stand by the essential ideas contained within that oath. Dr. Emanuel is quite right that we don't possess perfect or ultimate knowledge, either of our treatments or of the disorders they are designed to treat; he is also right that "...our general knowledge of these medications, as well as the underlying physiology and biochemistry of their disorders is limited at this time and our knowledge of the response of their particular physiology and biochemistry is even less certain." And yet, a well-trained physician-psychiatric or otherwise-should have a sound understanding of "...the nature of the medication" being prescribed, as well as the medication's interaction with the patient's "medical and psychiatric diagnoses, physiology, and biochemistry." Let me illustrate with a clinical example.

We are seeing a patient with bipolar disorder, and we have just prescribed lithium carbonate. We may not know the precise mechanism of action of lithium-hypotheses abound-- but we do have a good idea of its "nature". We know it is a naturally occurring element that has chemical properties quite similar to those of sodium; indeed, we know that lithium and sodium are reciprocally related, in the sense that if the patient's serum sodium level is abnormally low, his serum lithium level will probably rise, and that this may lead to lithium toxicity. We know that if our patient has underlying brain damage, he or she is likely to experience cognitive side effects from the lithium at lower blood levels than someone without such damage-even though the laboratory tells us that the lithium level is "therapeutic". We know that the lithium will interact with the patient's thyroid and kidneys, and that we will need to monitor the function of those organs very carefully. We know that if our patient is elderly, and has reduced renal function, we shall have to adjust the dose and blood level accordingly. We know that when our bipolar patient is in the depressed phase of her illness, she may be managed on lower lithium levels than when she is in her manic phase; indeed, she may not be able to tolerate the same lithium level when depressed as she can when manic.

I am sure that, by now, Dr. Emanuel sees where I am going with this. If pressed, I could go on rhapsodizing about lithium for two or three more pages, but by then, most readers will have clicked to the next website. Most knowledgeable psychiatrists could describe the "nature" of lithium in similar fashion, particularly those with a strong interest in psychopharmacology.

But our knowledge, as psychiatrists, is not limited to how lithium works at the somatic level alone. We also know that our bipolar patient may not be eager to give up her "high" periods, especially if she has bipolar II disorder and gets a great deal of work done during her milder hypomanic periods-or happens to enjoy the social and sexual encounters she has during those periods. We know that she may greet our recommendation to take lithium with anxiety, reluctance, or outright denial that she "needs" a mood-stabilizing medication. We know she may believe she can "control" her mood swings by means of meditation, or "natural remedies", or "will power", or by "avoiding stress". We know that there are grains of truth within some of these beliefs, but also that they conceal greater amounts of denial and wishful thinking. We know that the patient may desperately need to believe that she will "outgrow" the need for the lithium, or that her illness will "burn out" over time, and that these beliefs may be barriers to treatment. In short, we are aware not only of the physical and somatic issues involved in prescribing this medication, but also of the fears, fantasies, and fallacies our patients with bipolar disorder may entertain. We also know that our patient has healthy, resilient, and adaptive parts of her ego that will allow us to help her on an educational and psychotherapeutic level-and that she is much more than merely a person with a disorder. She is also a creating, aspiring, imagining being, with her unique hopes, dreams, and loves.

In short, what is blithely called "prescribing" by some mental health professionals is, in reality, a comprehensive appreciation of the human person in all his biological and psychological complexity-- along with a commensurate sense of how high the stakes are, for both patient and physician, in dealing with very serious illnesses. Dr. Emanuel is quite right to counsel humility. But we must also set the bar very high-perhaps immodestly high-with respect to the standards we set for ourselves, as physicians and healers.

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