CHILDREN'S
TREATMENT CENTER

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ON RAKES AND BOUNDARIES, OR WHO IS TO TREAT BIPOLAR DISORDER?

One day a plumber is invited to your house to repair a leaking faucet. After mending it he says: "Your refrigerator makes funny noises, would you like me to take a look at this old guy". While lying on the floor on his belly, replacing some worn off parts, which he miraculously happens to have in his truck, he notices a couple of stray ants. Lo and behold, he brings his exterminator's kit from the same truck and efficiently wipes out all unwanted faunas in your house. Next, his trained eye heeds ugly smoke coming from the your car's exhaust, then brown and crispy lawn and a missing board on your stairs. He takes care of all of that. He caustically mentions that your haircut reminds him his grandfather wedding picture and he gives you a more fashionable one – you are not surprised already that he is equipped for it. Finally, he quickly and artfully cleans an old oily spot on your coat and disappears at last, leaving you in a semi-catatonic state.

It is a fantasy, but is it a good one? Of course, my plumber saves you a lot of time in calls, trips and waiting in long lines. All services are conveniently provided in the privacy of your own home. But wouldn't you have some creeping doubts, that one person cannot possibly perform such a wide variety of services with the same finesse and professionalism?

It looks that we value our appliances more than our bodies. In our family doctor's office we can get almost all kind of medical services short of dental work and brain surgery, although, both are probably just a matter of time. Our primary care practitioners became quite skillful in endoscopies, punctures, gynecological exams etc. One of my patients complained that his PCP got quite upset when asked for a referral to a dermatologist to remove a mole. The doctor announced that he could perfectly well remove this mole and obviously was not fretful, that the cosmetic result could be less than pretty.

Let's leave the arena of medical procedures and turn to psychiatry. If learning endoscopy at least takes some time and special training, dispensing psychotropic medications obviously looks like a less challenging task. It is understandable that PCPs have to struggle with the same Frankenstein in medicine –managed care – in order to maintain revenues. When do they digress from the professional field they are trained for, and become aliens in an unknown land of psychiatry?

It became sadly habitual in my practice to see at least several patients a week, who had been treated, quite nonchalantly, for the wrong condition by their general practitioners, but, fortunately for them, having eventually escaped for the lack of improvement. A woman who was given Prozac for "depression" and after the very first dose cleaned her house non-stop for more than 24 hours. Her PCP explained her unusual activity as a side effect of Prozac. A man who was treated for ADHD with Dexedrine and almost got fired from his job for an inappropriate and grandiose behavior. He was manic and obviously getting worse on a stimulant. His "ADHD" improved dramatically after the appropriate treatment. A woman who was complaining of anxiety and was given Paxil by her PCP. Her "anxiety" was getting worse and reached the point when her therapist had to send her for a psychiatric evaluation. This lady had racing thoughts and excessive level of energy along with other attributes of a manic phase of Bipolar disorder. As the above mentioned gentlemen she improved on a mood-stabilizer and a low dose of Zyprexa. This sad list of anecdotes could go on, but the point is clear: general practitioners are not trained to make psychiatric diagnoses especially as complicated as Bipolar disorder, and take their patients complains for their face values. On the other hand, big pharmaceutical companies make them an offer they cannot refuse, encouraging them to dispense psychotropic medications. Both parties are happy since their revenues grow. In the light of everybody's prosperity, who cares that patients could be put on medications for the wrong condition? Family practitioners seem to have a cookbook recipe for everything. If patients com-

plain of anxiety they get Paxil or Xanax, for depression they get Zoloft or Prozac (depending on which drug rep paid the last visit). They get Ambien for poor sleep and stimulants for ADHD. OB-GYNs prescribe Prozac/Serafem galore, treating any complaints as PMMD. Life is so easy! From the moment the patent presents a complaint, to the moment he or she leaves the office with a sample or a script, it takes from five to fifteen minutes. How do I know? My escapees from their practitioners' offices tell me. To confuse the situation even more, the American Society of Psychopharmacology opened the door for any non-psychiatrist to take and exam and become a certified psychopharmacologist (see my commentary in PT November 1999). This exam obviously did not imply any knowledge of clinical psychiatry.

Unlike other medical specialties, which always try to answer the question "what is it?" the main psychiatric question remains "why so?". I came across a patient who had fired two psychiatrists. Her medications for depression are monitored by her GI specialist. After her unsuccessful forays into psychiatry she inevitably goes back to him. This patient has major personality disorder, which fuels her depression. She gets angry when confronted with her issues and wants to have a magic pill, which would clear away her troubles. There is no way her GI provider can be aware of it. Unlike the struggling family practitioners, he has one of the busiest practices in our area and by and large is indeed one of the best in his field. What is driving this competent physician to provide services he is not trained for? He does not do it for financial reasons. Does he do it, because the patient is looking at him with pleading and trusting eyes and tells him how evil and callous psychiatrists are? It certainly feels good to be put on a pedestal and win respect and admiration of the patients. We all work hard, and our battered egos could benefit from some patting on the back. I am wondering: does this good doctor ever question whether his fund of knowledge is sufficient to cope with something he never learned to treat? He knows when to prescribe medication for an upset stomach, when to send for an MRI, even when to ask for a second opinion. Unfortunately, he neglects to ask for the first opinion of a psychiatrist.

Unlike medical doctors, providers offering only therapy do not have a license to prescribe medications. They find their inroads offering psychiatrists unwarranted advice about treatment of patients they share. The same Frankenstein of managed care stepped into our field, causing the split of the treatment between the two parties: a therapist and a medical doctor. Freud would probably have a stress ulcer or a shock reaction should he live long enough to learn about side effects of HMO's, causing an additional neurotic conflict on the top of original psychiatric disorder. But life is life, and we learn the team approach, which is about not stepping on each other toes. In the ideal world both parties stay within their boundaries, talking either about medications or about therapy issues. In reality, it is not uncommon for a therapist to call a psychiatrist and say:" Why wouldn't you try Wellbutrin instead of Effexor for Mr. A?" This therapist does not know exactly what is the difference between these antidepressants, but her other patient likes Wellbutrin. So the therapist decides, that everybody should like it more. The following example presents a true and sad case. A therapist decided to take upon herself medication management for her patient because the latter did not like the direct approach of her psychiatrist. This patient always used splitting as her main defense mechanism and the therapist fed directly into it, missing what was crucial for her own work with this patient. She suggested that the patient switch to a different psychiatrist, who was amenable to the therapist' plan and, without seeing a patient, based on the therapist' report only, changed medications. Patient developed side effects from this "blind date" intervention.

In the field of child psychiatry the army of connoisseurs is growing even larger. Almost all child workers, including teachers and custodians "know" how to diagnose ADHD and what to do about it. Luckily, in Connecticut, there is a law, banning teachers from giving psychiatric advice. This is a very recent development. Before it happened some teachers used to tell parents to put their children on Ritalin, threatening with disciplinary actions if their recommendations were not taken seriously. Parents became scared at worst and furious at best. In both instances it did not help children to benefit from their education.

Interestingly enough, there is an inverse dependency between complacency and professionalism. The less the fund of knowledge, the more authoritarian the person appears to be. Unfortunately, if non-medical people are just bothersome with their intrusions, each medical mistake might turn into malpractice. Humble psychiatrists prefer not to prescribe Lanoxin or Prednisone: they do not want to pay the price for the lack of competence in a different field. Why do so many non-psychiatrists want to treat psychiatric conditions, especially as complicated as Bipolar disorder, remains esoteric.

Do not misunderstand me: in the line of my work as a practicing psychiatrist and school consultant I meet many exceptional professionals in education, psychotherapy and medicine, from whom I learn as well as they, hopefully, learn from me. It makes us a strong team.

On the other hand, overstepping professional boundaries always reminded me of stepping on a rake. If we step on a rake the handle hits us painfully on the forehead. To step or not to step - that is the question.

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