



March 2019

Psychiatry and neuroscience

Dr. Nasrallah's "Psychiatry and neurology: Sister neuroscience specialties with different approaches to the brain" (From the Editor, CURRENT PSYCHIATRY, March 2019, p. 4-5, 8), which explored the distinctions and commonalities between neurology and psychiatry, was important and timely. It was particularly worthwhile to discuss with my medical students the accompanying Table, to better answer the question, "What is the difference between these fields?" However, I believe a critical component of this discussion wasn't mentioned: the transcendent nature of psychiatry, addressing the full complexity of the human experience beyond the clinical milieu.

In mathematics, chaos theory deals with the impossible complexity

of simplicity. From primitive initial states, self-interacting systems give rise to short-term predictability, but an unpredictable long-term. Classically, this is illustrated as a hurricane born from the flapping of a butterfly's wings. Neurology has found great clinical utility in understanding butterfly wings. However, psychiatry forsakes simplicity for complexity: it dives into the emergent systems that arise from self-interacting neurons, asking us to stand within the eye of the hurricane and understand it in its entirety. Psychiatry asks us to transcend the traditional medical focus of discrete physiological mechanisms, and ask—from the standpoint of biologic, social, and spiritual well-being—how can we calm the hurricane?

Psychiatry once had a widely-encompassing understanding of its remit: to appreciate the multifaceted experience of the human life and grant succor to the fractured or anguished soul. In such times, psychiatry was a popular destination for seniors graduating in the United States. Annually, 7% to 10% of US graduates chose psychiatry as a career, and continued to do so until the late 1970s.¹ In the 1970s, the reductive understanding of the mind increased in prominence, and the role of psychiatry transitioned to one similar to that of other medical specialties: putting patients in boxes, and chronically titrating their medications. The interest of graduating seniors waned alongside the scope of our interest: in 1977, only 4.4% of US graduates pursued psychiatry.² In 2019, 4.06% of graduating senior applications were to

the field of psychiatry.³ (This is not meant to undervalue the quality of international medical graduates, but to focus on local trends in cultural values.)

Psychiatry offers diagnostic and therapeutic avenues that are traditionally undervalued in other fields of medicine. Nephrosis may not care if a patient feels that his or her life is spiritually satisfying and their actions meaningful. However, a patient's anguish at his reduced functional status does not care for whether his albumin level is normalized—he requires that his suffering be recognized, and that we make an earnest effort to cloak "the shameful nakedness of pain."⁴

Psychiatry also makes unique demands of, and offers benefits to, the practitioner. Neurologists complete their residencies feeling that their clinical acumen has increased: "I can formulate a thorough differential now." Psychiatry asks us not only to cultivate technical proficiency, but also wisdom. The prolonged reflection on the quality and nature of human experience, and the need to guide such patients in a manner far wider and more meaningful in scope than their serotonin pathways, offers the opportunity to emerge from residency a more mindful and grateful human being.

Ultimately, the loss of this sense of scope has not been a failure of medical education. It has been a surrender of the current generation of psychiatry attendings. We have ceded responsibility for the social and spiritual care of our patients to other fields, or to no one at all. If we give up on understanding the hurricane, how can we

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Comments & Controversies

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be surprised that students prefer to chase butterflies?

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Dr. Nasrallah responds

Thank you, Mr. Steinberg and Dr. Barris, for your comments about my editorial. I genuinely enjoyed the eloquence of your letter. In computers, which we all own and use, hardware is indispensable because it enables us to exploit the software, but the richness of the software is far more interesting than the hardware for the creative productivity of humans. So what you say is correct: The brain is the tangible hardware, and the transcendent mind is the splendid software that encompasses all that makes us human, such as thought, affect, cognition, and behavior. I certainly hope that the psychiatry training programs never reduce the practice of psychiatry to prescribing pills to suppress symptoms. Our patients with psychiatric illness deserve much more than that, and you obviously understand that. But just as neurology should not be mindless, psychiatry should not be brainless. Both specialties are 2 sides of the glorious dis-

cipline of neuroscience. By the way, I am pleased and proud to tell you that 13% of the graduating medical school seniors at our university have chosen psychiatry as a career.

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Perspectives on motherhood and psychiatry

I very much enjoyed Drs. Helen M. Farrell's and Katherine A. Kosman's recent article "Motherhood and the working psychiatrist" (*Psychiatry* 2.0, *CURRENT PSYCHIATRY*, March 2019, p. 40-43). I would love to see a series of similar articles and opinion pieces highlighting different perspectives from other practicing psychiatrists who are also parents—in particular, mothers. I completely relate to the dilemma you pose about the multiple duties one has as both a mother and physician, as well as feeling the pull towards honoring our understanding of attachment in the face of conflicting responsibilities. I imagine it's an experience to which many can relate.

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I doubt that anyone—male or female—would argue against the points made by Drs. Farrell and Kosman's "Motherhood and the working psychiatrist," which emphasized the need for breaking down the barriers that continue to exist for female physicians who choose to balance their careers with motherhood. As a female psychiatrist who has known since high school that I would

choose to remain child-free, I would like to add a different perspective to this discussion and possibly help represent the 20% of women, age 40 to 44, with an MD or PhD who are also child-free.¹

While Drs. Farrell and Kosman referenced many assumptions made about working physician mothers, I have not been able to move through medical school, residency, and my career without battling certain assumptions as well. Although every mother is a woman, logic dictates that the converse—every woman is a mother—is certainly not true. However, when interviewing for residency, I was paired specifically with a female attending who had children, and I was told that I could ask her questions about how to balance work-life and raising a family, despite the fact that I did not say or indicate that I had any interest in having such a conversation. There is also the assumption (sometimes more explicit than others) that those of us without children are missing out on something—that we are not included in the "having it all" category. However, in my mind, "having it all" means having the choice to remain child-free, to focus more intensely on my career, to travel when I want, and to own a white couch—without feeling the social obligation to fulfill a role in which I really have no interest.

Cherishing that ability to focus more on my career, however, does not imply that I am boundlessly able and willing to take extra calls, work holidays, or cover for all my colleagues with children (which is also a common assumption). And while I may not be a caregiver to children, that should not detract from the devotion

and time I want to spend helping my parents, relatives, and friends.

The article also made the case that facilities, medical schools, and residency programs need to implement policies and procedures that guide the development of accommodations, such as flexible scheduling and lactation rooms, to meet the needs of trainees and physicians without having to jump through hoops or rely on colleagues for coverage and other assistance. Having been in situations where such policies and procedures were not in place, I can affirm that the absence of such guidelines leads not only parents but also child-free physicians to feeling unnecessarily stressed. There was no clear coverage in place when fellow classmates in my residency program went on maternity leave. Essentially, everyone else was expected to step up and take on the additional caseloads, leading the pregnant classmates to try to time things around rotations where there

were lighter demands or more residents assigned—not a simple task by any means.

Post-residency, there have been continued challenges. At one point, I was working in a clinic with 2 other female psychiatrists, one of whom was making plans to take maternity leave. During a meeting with our supervisors, the other physician and I were told that we were taking on the third doctor's patients (without any extension of our own hours or reimbursement) while she was on leave. In addition to disgruntlement over the extra work being sprung on us, I pointed out that this would, in effect, make the third physician's role obsolete. If 2 of us were able to do the work of 3, what would be the point in keeping her position when she returned? I was assured that this wouldn't be the case. We dealt with the weeks of covering additional patients, and when she returned from leave, she was asked to shift some of her hours

to a different (and, in my opinion, less desirable) clinic.

So, yes, it is incumbent upon facilities and training programs to take responsibility and to remove the barriers that make the jobs of female physicians with children even more challenging than they need to be. This can benefit not only those physicians and their children, but also their colleagues and, ultimately, the patients, who often bear the brunt of stressed, burnt-out physicians and disorganized programs. While I am not going to take a stance on whether it truly takes a village to raise a child, I certainly do not think that it should take a village to organize maternity leave and lactation rooms.

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