Missing pieces

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On the first day of my third postgraduate year, I sat at a table with my entire PGY-3 class and our attending physician. This was my first case discussion of the new academic year, and the attending was someone I hadn't worked with previously. He was an older gentleman who primarily worked in private practice, but enjoyed teaching and maintained his academic affiliations. He started the discussion with a simple question: "Does anyone have a case they would like to discuss?"

The silence we were accustomed to as new interns on the first day of service fell over the group. Everyone seemed a bit apprehensive, as this attending was somewhat intimidating. He was educated at Hahnemann University Hospital, and classically trained in psychoanalysis. He had a wealth of research knowledge, and continued to publish in academic journals on a regular basis.

Finally, someone volunteered to present a case. The case involved a 45-year-old woman with a long history of depression. She had received multiple medication trials that did not result in remission. In fact, she had never experienced significant relief of any of her depressive symptoms. The case was clearly shaping up to look like treatment-resistant depression. The resident continued with the case and discussed the differential diagnosis and treatment plan. The treatment plan involved a combination of pharmacotherapy and psychotherapy—not much different from the previous treatments the patient had tried. I anxiously anticipated the response from the attending.

After listening attentively and taking a moment to gather his thoughts, the attending responded with one word: "Egregious." He was blunt, and clearly viewed the case formulation and management of this patient as "basic." It was clear to me that I, and the rest of my class, were missing something. It was something that was not going to come from a textbook or treatment algorithm. He was the first attending in some time who was challenging us to truly think.

A profound point

I ruminated on his surprising response for a moment, as the treatment plan presented was commonly seen on the inpatient unit. It was not an unreasonable approach, but it lacked depth and sophistication. However, no attending I worked with in the past ever called it "egregious." Now I was intrigued, and honestly, it had been some time since I felt excited about a case discussion. The attending's point was simple: our patients are suffering, and they are coming to us in their most vulnerable state seeking answers. When we make decisions based on FDA approvals and blindly follow treatment algorithms, we fail to see the vast untapped potential to help patients that

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Disclosure

Dr. Rossi reports no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.

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resides outside of these strict guidelines. This is not to say there is no place for algorithm-based psychiatry and FDA-approved medications; in fact, many times these will be the cornerstones of treatment.

During the discussion, this attending proceeded to make another profound statement that I continue to remind myself of each day. He said, "What would be the point of these patients coming to see you if you are going to practice psychiatry like a primary care provider?" I had to agree with him on many levels, because these patients are suffering, and they are looking for hope. If we simply offer them the same standard treatments, they are likely to get the same poor results. Our patients are coming to us because we are experts in the field of psychiatry; we owe them the respect to think outside the box. As specialists, the most complicated and difficult-to-treat cases will be referred to us. We need to possess a deep understanding of all treatment options, and know where to go when your first, second, and third options fail to produce the desired result.

The attending offered his thoughts on the case, and discussed his approach to treating this patient. He explained the importance of not being afraid to try medications in doses above the FDA-approved maximums in select cases. He explained the robust research behind monoamine oxidase inhibitors (MAOIs), and how to safely prescribe them. He explained why tricyclic antidepressants may be a more effective choice for some patients.

These were discussions I never had the opportunity to have in the past. In many instances, the possibility of using an MAOI would be quickly dismissed by my attendings as "too dangerous" or "better options are available." In this attending's view, it wasn't the danger of an adverse outcome we are facing, but the danger of missing potentially life-changing treatments for our patients. The attending concluded with, "It's sad that many of you will graduate without starting a patient on an MAOI, without titrating a tricyclic antidepressant and monitoring blood levels, and without ever really thinking for yourself." These were powerful words, and he was speaking a truth that deep down I already knew.

When I reflect on this discussion and my first 2 years of training, I realize the value in learning structured methods of treating patients. I am aware of the need to practice in a safe manner that does not put the patient at unnecessary risk. However, I also realize I am going to face difficult cases where many smart and capable clinicians have attempted treatment and failed to get the desired outcome. It's essential that as specialists we learn to use all the tools available to us to treat patients. If we limit ourselves out of fear, or blindly follow algorithms, we miss important opportunities to act boldly to help patients in their darkest moments.

Clinical Point

When we blindly follow algorithms, we fail to see the untapped potential to help patients that resides outside of these strict guidelines

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