

# Letters

## PRESCRIBE FIRST, ASK QUESTIONS LATER?

Dr. Susan Stern's comments on the role of psychotherapy in her psychiatric practice may have inadvertently foreshadowed psychiatry's demise as a profession ("Pearls: Treatment resistance? Try psychotherapy," CURRENT PSYCHIATRY, February 2005, p. 100).

Dr. Stern shared the story of Mrs. H, who has had depression nearly half her life. The patient's condition persisted despite numerous antidepressants across several classes. Dr. Stern then tried "several medication augmentation strategies" to alleviate the depression, but nothing worked.

"Finally," Dr. Stern explained, as if she had exhausted all obvious and reasonable options, "I left her medications alone and listened to her story."

Excuse me, but had Dr. Stern not realized that Mrs. H's story might be relevant—even central—to her 20-year battle with depression and to her recovery? If this is a revelation, then psychiatry is on life support.

Too many psychiatrists have stopped listening to their patients and have become obsessed with finding the right drug augmentation strategy. Yet as Dr. Stern's piece amply demonstrates, a prescribe-first-and-ask-questions-later approach spells almost certain failure—if not disaster—for both the patient and profession.

Although psychotropics have their place, psychiatry's greatest legacy—the healing power of the doctor-patient relationship—has been allowed to slip silently beneath the waves. Your patients are hurting and they need you, not just your drugs. Put down your pens, close your



mouths, and open your ears and hearts. Listen with your "third ear," as Theodor Reik implored. The results will amaze you.

Barry D. Berger, PhD  
Clinical psychologist and president  
Mission Psychological Center, Mission, TX

## Dr. Stern responds

Dr. Berger's response to my *Pearls* article indicates a growing view

that psychiatrists in general use medications first to treat depression, with psychotherapy as a mere afterthought. Most psychiatrists I know, however, are interested in doing what they feel is right for the patient, whatever the treatment modality.

A desire to institute or change medications early in the therapeutic process may stem from various sources, including the acuity of the patient's clinical situation (in which not addressing a patient's medications would be considered negligent).

Patients often expect psychopharmacologic intervention when they see a psychiatrist. Whether this attitude stems from a fantasy of "instant cure" or is simply a resistance to self-exploration, we should use every means available to address their suffering. The purpose of my article was to illustrate that patients who are considered "refractory" or "resistant" to medications can still be responsive to psychotherapy.

Susan Stern, MD  
Instructor in psychiatry  
Columbia University College of Physicians and Surgeons  
New York, NY

## PRIMARY CARE IN PSYCHIATRY

"Prudent Prescribing" by Drs. Richard Rosse and Stephen Deutsch (CURRENT PSYCHIATRY, October 2004, p. 24-39) offers valuable advice

about when psychiatrists should start medical workups. I have some additional thoughts.

**Indications for a medical workup.** The authors illuminated the need for medical testing for patients with clozapine complications, long-term complications of atypical antipsychotics, and health problems secondary to substance abuse. Psychiatrists also might be called upon to initiate or arrange for a medical evaluation in other situations, such as when:

- the patient presents in compromised health and has no primary care doctor
- the patient presents with a seemingly acute medical condition or reports such a problem over the phone
- the patient is acutely medically ill and his or her primary care doctor cannot be reached
- an acutely ill patient has no health insurance
- the patient fears going to the emergency room.

**Psychiatry is 'primary care.'** The National Health Service Corps considers psychiatry a primary care specialty. At times, we perform a "physician extender" role when collaborating with medical colleagues. Whereas in large multispecialty groups our role may be more narrowly defined, we may need to employ a far broader range of medical skills in private practice and even more so in treating underserved populations.

We are fully licensed physicians with the same training in basic clinical diagnosis as our colleagues in other specialties. It is our duty to distinguish organic from functional causes of psychiatric presentations to move our patients toward definitive care.

**Medical screening tests.** The authors listed several medical tests psychiatrists might order. That list should also include:

- antinuclear antibody and erythrocyte sedimentation rate tests, because autoimmune conditions often have psychiatric presentations
- hormone level testing for women, as perimenopause and menopause can have an enormous emotional impact
- mononucleosis spot test/Epstein-Barr virus titers, because mononucleosis can present with depression.

**'Turf' issues.** Because we see many patients more frequently than do our medical colleagues, we might be the first to spot a medical problem. A psychiatrist might be the only clinician with whom the patient is willing to discuss fears about the symp-

tom—or the only clinician a paranoid patient will agree to see, period.

We must retain the right to start basic diagnostic workup and convey findings promptly to our medical colleagues without "turf" issues or threats of peer review for "overstepping our bounds."

Sara Epstein, MD  
Los Angeles, CA



### NURSES AS PARTNERS IN CARE

Many thanks for your warm welcome to me and my advanced practice nurse colleagues (CURRENT PSYCHIATRY, January 2005, page 3).

Nurses and physicians have long been partnering to care for patients with mental illness. Old habits die hard, however, and much needs to be done professionally and collegially to address boundary issues and physicians' concerns regarding nurses with diagnostic and prescriptive authority.

Cathy Phillips MS, CS, APRN-BC  
Lanning Center for Behavioral Services  
Hastings, NE