RESIDENT'S COLUMN

by Jeffrey T. Junig, M.D., Ph.D.

Fool Me Once, Shame on … Me?

I sat at my desk, across from the third patient of another busy morning. I had been looking forward to my time in the walk-in clinic for a break from the heady world of long interviews and transference issues. But I felt a newly familiar sense of unease, even before we entered the consultation room, after reading the intake form, which stated, "Out of meds, needs Adderall." Certainly, every psychiatry resident beyond three months of training knows the feelings that are generated by such a complaint. Whether opiate, benzodiazepine or stimulant, a request for controlled substances was often a harbinger of conflict.

I broke my reverie to begin the interview. As I observed the patient, I found myself thinking that he appeared to be a straight shooter, for whatever that was worth. Often, the people requesting amphetamines in the walk-in clinic struck me as more alike than different, and the similarity contributed to my hesitancy in diagnosing attention-deficit disorder, lest I fall victim to someone's ruse. At the same time, I realized that my impression simply may have been the result of symptoms appearing in characteristic situations, coupled with my own unconscious perceptions and bias. Some hints to my bias came through as muted thoughts: Do psychiatrists overdiagnose ADD? Is ADD the result of bad parenting and too much television? Did this guy receive a formal diagnosis of ADD in the past, or is he using stimulants to gain an unfair advantage over his college classmates?

In this case, the patient certainly had characteristic symptoms. "I have trouble paying attention," he said. "I lose track of time, and I make a bunch of stupid mistakes." He reported that he was easily distracted and often forgetful. And the trump card: "When I'm off the medicine, I can't function in school." His complaints were recited as if from crib notes taken from a library copy of the *DSM-IV*.

I attempted to step from my biased position into neutrality, and I asked for more information. How long had this been a problem? How was the initial diagnosis made? Who could I speak to for corroboration of his symptoms?

"I just need the medicine," he said. "Why do I have to go through this every time I come? What happened to the other doctor?" His voice then rose, "This is a bunch of crap! Are you going to give me my medicine or not?"

I became aware of a memory from a playground long ago when a young boy with my name cowered in front of the school bully. The story has since changed a bit; this time I had the power, if I chose to wield it. Adolescent armies of fear and anger competed, over a hill and on a distant battleground, and the smoke of their battle colored my mood and distracted my attention from the truth-finding at hand. I processed my feelings on the fly as our interaction continued, the interview now in the background, "I'm afraid of this guy … I don't like him … I don't trust him … but I'm here to help him. What part of this is 'me,' and what part 'him'?"

There was much work to be done,

(Please see Shame on ... Me?, *page 50)*

WYETH EFFEXOR AD

Shame on ... Me?

Continued from page 47

the waiting room was filled with patients and, by the end of the day, I would see most of them. It occurred to me that the easiest thing would be to simply provide the medication that he requested. I was, after all, armed with my new DEA number. I was the doctor, at least during this rotation, and I enjoyed the opportunity to "make the call." What was I worried about, anyway?

"I'll tell you what you're worried about," I answered myself. "You don't want to prescribe just out of fear of confrontation." "Well sure," I thought. "But I also don't want to deny a person the necessary treatment solely because of my own preconceptions."

> Definitive answers often lie tantalizingly out of reach.

So many things enter into the psychiatric relationship, even in the short term. We in psychiatry place so much emphasis on the fine mechanics of "getting it right." We uniquely concern ourselves with patient motives, our own motives and myriad biases that potentially interfere with diagnosis and treatment. Despite a never-ending trail of possible questions, definitive answers often lie tantalizingly out of reach. In this case, beyond the question of diagnostic criteria, I was aware of a number of conflicting thoughts and feelings. I was aware of wanting to trust the patient. I was also aware of a fear of being misled and risking the violation of Hippocrates's first admonition. I had a vague sense of myriad other biases rooted in a host of memories. Finally, as a resident, there is always some anxiety over facing the opinion of one's attending, and being seen as either a pushover or as too stringent.

My neurotic battle disappeared in a cool mist of intellectualization when I realized that one luxury of psychiatry is that we often have time to make a diagnosis. We initially see a cross section of a patient's symptoms, but in time we see enough sections that a three-dimensional image appears. Stimulant abuse becomes more obvious over time, as prescriptions are lost and meds are stolen by "mysterious intruders." I remembered that sometimes a trial of a medication provided room for the benefit of the doubt in an unclear case. I contemplated, which was more shameful: suspiciously sending away empty-handed a patient who found the nerve to come to the clinic and wait six hours to be seen, or giving a one month supply of stimulants to a patient who was embellishing his story in a misguided effort to cram for an exam?

As the patient left my office, I realized that a time would come when I became more analytically and emotionally efficient. With time my diagnostic skills would improve, and I would have a better understanding of my perceptions, fears and biases. I would also have less anxiety over being mistaken. But for the time being, I realized that even in the walk-in clinic, a resident must truly know one's self. Getting to that point would be a long and careful process—and there is certainly no shame in that.

Dr. Junig has returned to residency to study psychiatry after working 10 years as an anesthesiologist and pain physician. He is currently a resident in the department of psychiatry and behavioral medicine at the Medical College of Wisconsin. ❐

NOT FOR PUBLIC RELEASE

Janssen
Risperdal
M-Tab
AP

NOT FOR PUBLIC RELEASE