The Psychiatric Scene: A Resident's View*

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The American Psychiatric Association recently realized that from its inception it had denied the one element of the psychiatric community which was perhaps most important in maintaining the longevity of the organization. Prior to 1968 there was little provision for resident involvement. The APA, like many other organizations of its type, was run by the old vanguard. If a young psychiatrist was interested in influencing his profession through the organization, he had to work himself up from the bottom of the ladder which usually took many years. Often when that young psychiatrist finally reached a level of influence he was no longer young.

In 1969, in an effort to get more residents involved, the APA created a special membership category, Member in Training, and instituted the Falk Fellowship Program. The latter, financed by the Maurice Falk Foundation of Pittsburgh, provides the opportunity annually for thirty residents from throughout the country to serve on National APA Committees. It was hoped that this would inform the young psychiatrist of APA structure while providing resident input into its top levels. The program, now in its third year, has been successful but limited in reaching the total resident community. In the Fall of 1971 the APA asked six former Falk Fellows to form a Task Force to find ways of furthering resident involvement and to form better lines of communication between the resident and the APA. I was fortunate to be chosen both as a Falk Fellow and a member of this Task Force. I also served for a year as resident member of the Board of Directors of the Neuropsychiatric Society of Virginia. These assignments afforded me the opportunity to view the psychiatric scene. I would like to share with you a few of my observations.

Psychiatry is in the midst of great change. Once psychiatrists could spend half their lives in training then close themselves off from the rest of the world in double-doored sanctums to treat the financially affluent. As a profession we were rather secure. This group of patients was large enough to pay our bills. As the general public could not afford our fees, in a sense we could be selective. If we did not wish to be involved in community affairs, we could always excuse ourselves with the rationalization, “a psychiatrist should not become socially involved with his patients.” Mental illness was seen as strange, a curse, even contagious—those with mental illness were avoided. The psychiatrist was looked upon as a “mind reader,” a “mystic,” and contact with him was not desired. So for years the double-doored sanctums were not violated.

Today, the general public accepts mental illness and feels psychiatrists have something to offer them. Mental health, once a privilege, is now considered a right which they are demanding we uphold. We can no longer turn them away for lack of funds as they come bearing governmental gifts, Medicaid and Medicare. After reading Reader's Digest and Ladies' Home Journal, many even consider themselves authorities on mental illness and often come not only demanding treatment but specifying the type of treatment they expect. Psychiatrists, once secure in “doing their thing” behind closed doors, now often find themselves exposed as if practicing in a storefront window.

“Doing our thing” classically has been one-to-one analytically based therapy. It is obvious, however, that with only 23,000 psychiatrists serving a population of over 200,000,000 people, we can satisfy the needs of only a few, using our classical methods. We could change our methods, but as a group we are resistant. Increasing our manpower is difficult because our period of training is long. We defend the latter as necessary to produce a unique

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individual, capable of treating the whole person. We feel the psychiatrist should have knowledge of both the physical and emotional aspects of disease. A long period is also necessary to become well versed in the analytical method which we feel must be used to affect cures rather than render first aid. The public, however, is more crisis-oriented. They seem to be less interested in resolving their repressed childhood conflicts than in receiving advice on handling the crisis at hand. Other professionals such as ministers, social workers, nurses, and psychologists are more willing to supply such needs. They generally are more willing to experiment with new methods, and as their training period is shorter, they can more easily enlarge their manpower pool. These professionals are thus gaining status as therapists which is threatening to the psychiatric community.

We question what will be our roles in the future if the present trend continues. If these mental health professionals treat the emotional aspects of disease and our medical colleagues the physical, what will we do? Some say we will become supervisors, yet these professionals often feel they do not need psychiatric supervision. Others say we will pick up the more difficult cases, those left over, but how much status does this afford? Perhaps we will become administrators, but we are not trained in administration.

There is some confusion over our role as physicians. Psychiatrists were originally members of the medical community, versed in neurology and psychology. Over the years, however, we apparently moved away from our medical colleagues. There was hope that we were moving back when we recently began to discover a more organic basis for mental disease. The American Board of Neurology and Psychiatry, however, has discontinued the requirement for internship and no longer requires the passing of an oral examination in basic neurology. There are even some in the profession who feel psychiatrists should spend less time in medical school. So, in which direction are we really moving?

There is also some confusion as to our social role. There is a very strong caucus in the APA pressuring the organization to speak out on social issues and an equally strong group who says this is not our place. Who is correct?

With such questions of role and status, some say our profession is in the midst of an identity crisis.

How does the psychiatric resident view his profession? Young people today are generally sensitive to social issues, and psychiatric residents are no exception. They have strong feelings about the war in Viet Nam, the plight of the poor, civil rights, and many are taking active stands. Unlike many of their older colleagues, most residents do not feel psychiatrists, in their role as professionals, should speak out on such issues. Most feel that the expertise of the psychiatrist extends no further than comment on the emotional elements of such issues and that to attempt further involvement is foolhardy.

Due to their sensitivity to social issues most residents agree with any move to offer services to the general public. They do not favor giving up one-to-one patient contact, however, as such a move may be sacrificing quality for quantity. A large percentage of residents also plan to enter private practice, a desire which may seem to contradict their social stand. Allen Axelson, a fellow Task Force member, in his paper, “The Changing Face of Psychiatry—The Resident’s Response” (unpublished), points out that residents may feel guilty with this decision. I think residents are just practical and are responding to economic pressure. For one in training for twenty-five consecutive years, financial rewards are inviting.

Residents do wonder what their future roles will be. They are aware of increasing governmental intervention. This awareness was heightened by recent steps to cut National Institute of Mental Health training grants. They question if we are not headed toward socialized medicine. Most training programs emphasize the analytical method which residents find intellectually gratifying, but they wonder if this is what the public will desire in the future. Most, therefore, favor maintaining an analytical core to psychiatric training but providing exposure to group, family, and other more current therapeutic methods. They also desire training in administration and community psychiatry. Residents feel they will need a wide range of skills to function effectively in the future.

Unfortunately, many departments of psychiatry are resistant to change. The resident, seeing himself as a consumer and, therefore, having the right to constructively criticize the product, is pressing for more resident involvement in curriculum planning. Many departmental chairmen have seen this as threatening. They feel the resident is just striving for power. I do not feel this is the case. Most residents I have met are only concerned about the effectiveness of their programs and could care less who runs the show. Many faculty members have commented that the residents are unable to know what is best for them. They feel those more experienced in the profession should plan the curriculum. The residents, however, often find such faculty members out of tune
with their needs. Perhaps the best solution is a joint effort.

Psychiatric residents basically see themselves as physicians, not social scientists. Most are against the drop of internship requirements. They believe that psychiatrists must not only have knowledge of both the physical and emotional aspects of disease but have had experience in managing both aspects. They find the role of primary physician, the involvement with life and death, and the challenge of the emergency room during internship invaluable in helping them keep the prospective of total patient care.

Residents are not as worried about status as their older counterparts. Most welcome the help of non-medical professionals. They are dismayed, however, when they find such professionals attempting to make medical decisions in which the latter have no expertise. Residents are convinced that discoveries of the organic basis of mental illness will continue and thus, it is most important that treatment be viewed from a medical standpoint. Any move away from the medical model, they feel will be detrimental to patient care. Residents see the psychiatrist as a key figure in any therapeutic endeavor due to his unique perspective of the total patient—a perspective necessary for effective treatment.

Until recently there was little interest in organized psychiatry among residents. Their main concerns centered around their residencies. Residents are still basically involved with curriculum, salary, vacation, call schedules, or “how to survive the three years.” Increasingly, however, they are recognizing that psychiatry is “a new ball game.” With current trends toward governmental intervention and public pressure, they recognize the need for organization to survive. They were impressed by the APA’s recent lobbying effort which at least temporarily stalled some of the NIMH cuts. Residents also feel psychiatrists need better communication within the profession and hope that the APA can facilitate this. There is a trend, therefore, toward resident involvement in APA. Many residents, however, are disappointed as they often find the organization somewhat inefficient. Tiah Foster, another Task Force member, in her paper, “A Gap Between the Resident and the APA,” states, “At times the APA seems to be like a doddering, aged, dowager duchess.” It does seem that various elements in the structure spend a lot of time spinning wheels, getting nowhere. There are numerous meetings but often few tangible results.

Residents would like to see the APA improved. The members of the APA upper echelon agree and challenge the resident to offer suggestions. American Psychiatric Association leaders in general believe that the organization needs new life, and they hope the resident will supply this.

Residents desire efficiency in their profession and agree with suggested certification by the American Board of Psychiatry and Neurology. They are troubled, however, that often the knowledge required by the American Board is not supplied in their residency programs. Perhaps the APA can intercede and provide more continuity.

After eighteen months observing the psychiatric scene, I am optimistic about the future. We do have a lot of problems as a profession, and we will need to put forth much effort to solve them. One of the most important tasks ahead is the reevaluation of our training programs. Are they adequately preparing the resident for the future? The APA also sees this as a major priority and recently applied for a federal grant to support a three-year study project on the education of psychiatrists. I feel we need to resolve role conflicts with our non-medical colleagues. There is enough work for all. We need to place less emphasis on status and more on professional efficiency. Really, what difference does it make who runs the show as long as the patient gets well? Perhaps economics is behind some of our bickering, and we should reevaluate our respective pay scales. I feel residents have a lot to offer. The establishment should not be turned off when residents speak out. Their verbalizations are generally not calls to battle, but cries for help. Residents are basically physicians, and I feel they will move the profession back into the medical community. The APA has a lot to offer, but any organization is only as strong as its members. All of us in the psychiatric community need to become more involved. Now more than ever before, we need to unite through our various professional organizations to pool our efforts to face the demands ahead. With such united effort, I know we will succeed.

REFERENCE