

#5. Sherry Katz-Bearnot:

Title: The Medical Education of Generation RX

I realized recently that the title might be considered to be controversial, that the word “medical” might seem to signify the conflict between our medical and non-medical historical roots.

Nothing could be further from my intention.

This is a conference about Psychoanalytic Education, and I wish to speak to you today about educating young physicians about psychoanalytic ideas.

I have spent my entire career as a Consultation-Liaison Psychiatrist, and as a Psychoanalyst at the hospitals of the Columbia University Medical Center where I teach medical students and non-psychiatric residents about their patients and about their relationships with their patients. I talk to them about the mysteries of human motivation in order to facilitate communication, felicitous interaction, and even, sometimes, adherence and cure. Psychoanalytic theories about the Dynamic Unconscious can render a patient’s seemingly irrational choice understandable. Our understanding of interpersonal dynamics can foster secure attachments between patient and physician, essential for so many reasons.

In my five minutes, I can hardly illustrate the practical benefits of this type of medical education to our young colleagues, but I can assure you that this is, in fact, Applied Psychoanalysis in action.

Freud’s assertion that the “first ego is a body ego” translates into the proposition that every physician must understand the profound psychological impact of any threat to bodily integrity, and to appreciate the possible de-stabilizing effect on the patient of what might seem to the physician to be a “minor problem”.

Symptoms, such as pain or nausea, may bring associations which add to their intrinsic distress.

Visible manifestation of illness or treatment (such as hair loss, scarring, weight loss, or even subtle changes in skin tone or texture) can initiate the loss of self-esteem or initiate a complex cascade that ends in social isolation.

Any loss of ability can trigger fears of loss of competence and activate both fears and wishes about becoming dependent.

In Summary: Illness has meaning for each individual, patients and physicians alike. I teach clinicians that these meanings accrue as a result of early life experiences, including those of which one has no memory and are processed, integrated, and form the substrate of both the doctors' and the patients' reactions to the illness and its treatment. Psychoanalytic principles allow physicians to appreciate their own reactions, and those of their patients, anew.

I teach young clinicians about the nature of the doctor-patient relationship in terms of transference and counter-transference. Patients may develop the fantasy that compliance will yield a positive outcome. Regression inevitably accompanies anxiety, pain and suffering. A complementary circularity perpetuates these dynamics, as mutual idealization can be fostered with a positive outcome and mutual devaluation fostered by a negative one. This makes sense to everyone. But how to explain to the young clinician why, in the face of a seemingly positive outcome, the patient becomes angry or non-adherent? I have, in fact, argued elsewhere, that virtually all non-adherence can be conceptualized as a failure in communication, whether on a conscious or unconscious level.

For there are many ways to diagnose and treat an illness, and the decisions about how to present those choices, and discuss them with the patient revolve around the clinician's capacity to understand how to draw the patient out about her/his preferences. Here, as much as anywhere, the clinician's reaction to the patient (as lyrically described more than 50 years ago by the Hungarian Psychoanalyst Michael Balint) can be a complicating factor.

There is, in fact, an emerging literature in Medical Education on the teaching of "professionalism" to physicians-in-training. But merely providing examples of good or skillful clinical practice are not particularly helpful. As Stern and Papadakis said in their article in the New England Journal of Medicine (NEJM) last year: "mentoring is in the eye of the beholder." In fact, Psychoanalytic principles allow us to "unpack" the often deft and elegant interventions made by our medical colleagues. They don't necessarily have the language or the pedagogical structure to explain why they chose a particular strategy with a patient. We can provide both.

And here is my final point: We want our physicians to understand the utility and elegance in our point of view for reasons beyond the "public relations" aspect of putting Psychoanalysis back on the cultural map (although this is not a bad reason...) I will now remind you that "we are all patients". I don't mean this in the usual way, that we all have

character pathology and have had some form of treatment. I mean that in one's lifetime, virtually everyone develops at least one illness that will require investigation and care, whether it is symptomatic or not, visible (in itself or its sequelae) or not. Wouldn't we like to have clinicians who can collaborate with us and our loved ones?