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Geriatric psychiatry from a geriatrician's viewpoint

I can vividly remember my first exposure to psychiatry as a medical student in the USA. By drawing the short straw, I won the privilege of night call on my first day on the service. It was February and by early evening it was black and cold outside. To avoid the night, I took a seldom travelled tunnel between the hospital and the state mental facility. Alone, and frequently passing broken-down equipment from a bygone era, I felt as if I were entering another world. I took an elevator to the sixth floor. The elevator was operated by a middle-aged pale woman who wore a calf length skirt that blew around in the wind generated by the elevator's ascent. She said nothing. To this day I remain unconvinced that she was not an apparition. My patient was a severely cognitively impaired woman who was said to have neurosyphilis. My task was to replace her nasogastric feeding tube, which she had pulled out despite wrist restraints. Her nose was bleeding and she was spitting blood between attempts to bite anyone who came near her. It was a sad and dehumanising interaction for both of us. When the psychiatry resident came to help, at my request, she displayed only callousness and incompetence. The night nurse was certain to tell me this after the house officer had left. This event, among others during my training more than a decade ago, froze the worst stereotypes of psychiatry into my mind. Subsequent positive experiences in out-patient psychiatry were too weak to thaw the negative perceptions.

In July 1999, I left my role in academic geriatric medicine in the USA to spend a year as Visiting Scholar in the History and Psychopathology Research Programme in the Department of Psychiatry at Cambridge University. I spent 6 months shadowing a geriatric psychiatrist at his out-patient practice in the Psychiatric Services for the Elderly Programme at Addenbrooke's NHS Trust. To a more limited extent, I also observed on the multi-disciplinary in-patient service. What follows is a brief description about my experience on this service. Notably, my perspective is both that of an American viewing a British clinical programme for the first time, and a clinician in geriatric medicine viewing a geriatric psychiatry clinical service for the first time. My observations were limited to just over 70 patient encounters, all of which involved the same geriatric psychiatrist. I would like to highlight four global impressions of the patients and three global impressions of the clinician that, by definition, will be gross generalisations. None the less, these were impressions that have changed my image of psychiatry and done much to thaw those negative stereotypes that I believe still haunt a lot of non-psychiatrist physicians.

My first impression of the patients was that they could easily have been my panel of patients in my geriatric medicine clinic. I was surprised at how poorly their behaviour and external evidence of distress correlated with their psychiatric turmoil. You simply could not have gone through the waiting room and separated the patients with schizophrenia, depression, coronary artery disease or hypertension based on their behaviour or appearance. Granted, most of these patients were receiving treatment, but many were not asymptomatic. For example, the woman who in my mind was the most delusional, presented herself as calm, conversant and pleasant. I could have easily talked to her for 10 minutes about her arthritis, obstructive lung disease and angina without ever learning that she was literally paralysed by irrational fears of mysterious entities controlling her body. Sometimes, the only clue as to how poorly the patient was functioning at home from a psychiatric perspective was by specific questioning of a family member.

The second observation was how articulate these patients were in describing their psychiatric and emotional symptoms. Furthermore, they were surprisingly insightful about the myriad physical manifestations of their psychiatric illness. Rather than arguing that their symptoms of dizziness could not possibly be 'all in their head', these patients were likely to report that their dizziness had increased again, "probably because I have been more depressed". When they were unable to make the connection, they were at least receptive to the possibility of a psychiatric aetiology. The impact of this receptivity is enormous. Simply the fact that the patient would entertain the potential of very real physical complaints having their origin in an affective disorder, for example, provides the clinician with an enormous therapeutic advantage. A corollary of this second global observation is how rarely I witnessed a confrontational interaction between the patient and the physician. One would not have been surprised to have witnessed a half-dozen moderately adversarial interchanges between the patient and the psychiatrist among these 70 or so encounters had they taken place in a general medicine clinic in the USA.

The third observation is that these patients seemed to expect less of the health care system and were more appreciative of what they received. This includes lower expectations for deliverance from suffering and lower expectations regarding the potential miracles of science. In short, these patients appeared to have a greater capacity to endure distress and little concern that they had been singled out for this fate. There seemed to be a more general acceptance that they were suffering from a chronic condition and that long-term management of symptoms was the best that medicine had to offer. Only rarely did a patient appear to demand a quick fix. Only rarely was a patient, in fact, demanding. I am accustomed to the occasional patient dropping their extensive problems on to a physician's lap like a knotted wad of string, as if the physician could magically untangle it if only he or she took an interest. In this clinic, patients rarely handed over their problems to be solved. They

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definitely pulled out the wad of string, but they didn't push it across the table. There was a greater foundation for advice rather than edict. This foundation then gave rise to more effective negotiation about the goals and boundaries of care. I never heard the phrase: 'You're the doctor, you tell me.' I often heard the psychiatrist give a list of options and the patient actively participate in the therapeutic decision-making.

The fourth impression I gained of these patients is the realisation of how long the ball of string has been accumulating knots and tangles. These patients, all of whom were born before the Second World War, had emotional scars and psychiatric wounds that had been festering for 4 and 5 decades. Many of the patients were tortured by chance turns of fate, which had transformed their fortunes. Others were scarred by seemingly minor missed opportunities that none the less proved to have subsequent unforeseen shattering ramifications. These were not patients presenting last month's symptoms, most were presenting autobiographies with dozens of chapters. For the most part, the psychiatric illness tended to be a few decades older than the concomitant medical illnesses. Just the simple repetitive replaying of 'what if' over and over again was the source of many snarls and twists of regret.

With regard to the geriatric psychiatrist, my first impression was the extent to which he projected empathy in a manner that validated the patients' feelings and concerns. I remain profoundly impressed by how often his simple humane communication of understanding brought relief. I can only liken it to the absolution that a person experiences when they have been forgiven. You could often see the weight being lifted from their shoulders. Yet, he was able to do this without pulling the wad of string into his own lap. For their part, the patients did not try to give the psychiatrist their problems, they just welcomed the relief afforded through the professional validation of their feelings. Another feature of the psychiatrist's style that was exemplary was his frequent enquiries about the patient's family and social situation. These were not superficial 'how's the wife?' type questions. Often, there was the validation of the stress or relief offered by the family and a detailed investigation as to how the patient viewed the situation within a social context. The patient's family's role in illness and in healing is greatly under-appreciated in many general medicine practices.

My second impression of the geriatric psychiatrist was his confidence that the patient's symptoms were owing to psychiatric rather than physical illness. This confidence translated into a willingness to assume that the symptoms are psychiatric in origin until proven otherwise. My approach, from a general medicine framework, is precisely the opposite. I am unable to present an example where the psychiatrist was unquestionably wrong in his approach. Notably, these patients, nearly all of whom had multiple medical problems, rarely mentioned their medical problems to the psychiatrist although they were often apparent. Even while I was listening to the classic symptoms of depression, I could not help but notice the pursed lips, the clubbing, the tachypnoea, the barrel chest and the nicotine-stained fingertips, for example. Had this been my clinic, it would have been so easy for me to relegate the psychiatric symptoms as secondary in importance to the litany of chronic medical conditions. Perhaps worse, it would have been easy to simply attribute the psychiatric symptoms to an existing medical problem. My brain is simply wired this way – to disaggregate the psychiatric syndrome into discrete parts that can then be assigned to an organic disease. The geriatric psychiatrist's brain seemed to be wired in the opposite manner – to search out discrete parts of the jigsaw puzzle and piece them together into a psychiatric syndrome. This difference in diagnostic perspective was unsettling and it would be fascinating to know whether it is common and how it influences patients' outcomes.

My third global impression of the geriatric psychiatrist is really an observation of two interventions that I find to be out of my reach in geriatric medicine. The first is the frequency of use of what I would describe as prescription 'cocktails'. That is, using psychoactive medications from two or more different therapeutic classes at the same time. In general, a primary care physician assumes that if one medicine is not working for the patient's depression, then you switch to another and/or reconsider the accuracy of the diagnosis. If that doesn't work, the patient should be referred to psychiatry. Whether this is an appropriate boundary for general practitioners is an empirical question. However, I was surprised to see how often the combination regimens appeared to be effective. I was also surprised at how well these older adults tolerated these multiple-drug regimens. The second inaccessible intervention is the ability to bring the patient onto the psychiatric in-patient ward for a prolonged period of time to 'sort things out'; sometimes for as long as weeks or even months. This may be to titrate medications, to pursue a diagnostic strategy, to provide the patient a safe haven or to undertake various modes of rehabilitation.

My brief experience in this clinic was enlightening on several levels, but I have limited my comments to those impressions that were the most intense. There are myriad other field notes that I will take home with me. The experience has also suggested some areas for potential research. Just the opportunity to watch how another clinician works with patients stimulates a re-examination of your own practice style. Most importantly, however, I have a better insight into how psychiatry works when it is working well. I can discard the negative images and replace them with pictures of many patients who were helped in a caring manner. What is more difficult to reconcile, however, is the paradox that these patients were at once so much like those in my own clinic, and yet very different.

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