

Newsletter

MEDICAL STUDENT



A Publication of the American Psychiatric Association

Committee on Medical Student Education

Greetings from the Chair!

By: Linda Pessar, M.D.

One of the pleasures of reading The Medical Student Newsletter is to reflect upon the multiple points of view that psychiatry embraces, from the molecular to the communal. Santokh Sidhu discusses the complex psychological meanings of symbols and their influence on the ways we see others and ourselves. Whether a cigar is just a cigar may lend itself to idle musings, but a turban in the doctor-patient relationship may activate important assumptions that influence the transaction. Joel Mack extends the psychiatric frame of reference to discuss psychiatry beyond the

doctor-patient dyad and reminds us that our patients leave our office and must make their way in social settings that are often ignorant about and hostile to mental illness. Comprehensive attention to patient needs must include community resources and outreach and political endeavors in support of mental health. That we must see our patients in broad scope, as we must see ourselves, is poignantly brought home in Dr. Townsend's account of the impact of Hurricane Katrina on individuals with persistent and severe mental illness, and on the psychiatrists and medical students who seek to help them.

While my career in psychiatric education has shown me that some students and colleagues find the breadth of psychiatry confusing, I find it exhilarating. There is always something to capture my intellect and imagination. I am never bored.

I urge medical students with an interest in psychiatry to attend the APA Annual Meeting and participate in the PsychSIGN conference. I think you too will be impressed by the attention to basic science and clinical developments, as well as to the interfaces of psychiatry with social concerns, and with the arts.

Hurricane Katrina and the Ideal of Social Justice

By: Mark H. Townsend, M.D.

The desire for social justice for individuals with persistent and severe mental illness informs both the way psychiatrists practice and how psychiatry itself is taught to medical students. Because stigma accompanies many psychiatric conditions, others may view psychiatric patients who are not at all disabled as less than competent. Being a psychiatrist involves advocacy on behalf of almost anyone with mental illness.

In New Orleans, however, Hurricane Katrina blurred the boundary between patient and doctor, student and professor, and caused individuals who otherwise might have not understood the importance of psychiatry to advocate for accessible mental health treatment. Perhaps this is because many hurricane survivors have experienced significant anxiety and depression for the first time, while at the same time the lack of resources to treat psychiatric conditions has been starkly apparent.

At the medical schools, everyone

who was taught or treated there was made homeless by the storm. Students, residents, and faculty continued learning and teaching, but in unfamiliar places. When the medical schools returned to New Orleans in the summer of 2006, it was to a city largely without its previous psychiatric infrastructure. All returning New Orleanians, medical students and faculty included, discovered that mental health clinics and hospitals had closed and that many psychiatrists and other mental health professionals had left Louisiana. Academic psychiatry itself took particular losses: while other core clerkships—surgery, internal medicine and pediatrics—were able to resume inpatient training within the metropolitan area, none of the two medical schools' hospitals reopened.

In a variety of new settings, diverse individuals have begun rebuilding the city and its public health system. In August of 2006, the state Office of Mental Health opened a 20-bed unit within a child and adolescent hospital, the first public psychi-

atric beds in New Orleans since the storm. Patients wait for up to five days in area emergency rooms before they can be transferred to our unit. Students have learned firsthand how people who live with poverty and mental illness have endured since Katrina. Perhaps unsurprisingly, many have done so with courage, grace, and humor.

"We're participating in one another's miracles," a patient explained during rounds, when I described how I had unwittingly reunited a family by telling an airport worker, a stranger, the name of a new medical school employee. Another inpatient, with a mood disorder and physical limitations that confined her to a wheelchair, agreed to be interviewed and photographed by a national newspaper in order to give the wider crisis a personal context. "I just wanted people to understand," she told us.

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Experience Of Social Injustice In Transference/Countertransference

By: Santokh S. Sidhu , MS3

Back in the red eyed days of my second year of medical school, I remember listening to our course director explain the basic definitions of transference and countertransference. Like most of my classmates, I could understand these concepts, but mistakenly felt I was “too aware” to fall prey to such judgments. My experiences as a third year student have proven my assumptions wrong, as I’ve begun to realize the prevalence of these issues, particularly once I started wearing a turban.

My father grew up in India, wearing a turban as an expression of his Sikh faith. To Sikhs, the turban is a symbol of respect and adherence to a moral code which denounces aggression towards others. Despite Sikhism being the 5th largest religion in the world, knowledge and understanding of the faith remains sparse, especially in America. After immigrating to the US, my father failed at many attempts to procure employment due to his external appearance. Eventually, he was offered his first job with the stipulation that he remove his turban.

Asking someone to change his ethnic appearance for a job might have been commonplace in the ‘70s. However, as an American-born citizen who was raised to fit into the world in which I would be living, without a turban, and with no accent or cultural gap, my father’s experiences seemed inapplicable in my own

life. I blended seamlessly into my surroundings with friends and many activities. Looking back, I realize that I altered others’ ability to relate to me simply by changing my appearance.

When I began wearing a turban, only my appearance changed--not my accent, morals, diet, or personality, yet people instantly perceived me differently. Now some people claim to have difficulty understanding me, as a glance at my turban is automatically associated with poor English, even though that is far from the case. One of my patients asked me if I’m a covert Al-Qaida operative. I laughingly denied, hoping no other patients or co-workers overheard her. Some patients go so far as to refuse my care because of their false assumptions. Whether they view me as inherently closed-minded, violent, or a womanizer, they often hold true to these thoughts despite any efforts to convince them of the contrary. What boggles my mind about transference is that I’m the same person as before, yet the stereotypes and feelings patients have towards me are now different.

Although I knew people would perceive me differently, I didn’t foresee how much the turban would teach me about my own perceptions. I found myself trying to guess what others are thinking about me and react accordingly. Rather than seem serious or hyper-religious, I constantly expend energy to appear laid-

back and relaxed. Often I joke about my appearance in an effort to ease imagined tension, even if those around me give no indication of feeling uncomfortable. When feeling uneasy around a patient, sometimes I unintentionally disclose information about myself that isn’t pertinent to the interview. I might tell a young female patient that I have two older sisters in an effort to seem “softer.” It isn’t just that I feel more strain; it’s as if my view of the world has changed. In light of all these changes, I’ve recently sought the company of those whom I *deem* to be different. Something about struggling as a “collective whole” makes me feel less vulnerable. Shouldn’t I feel comfortable around all who are kind to me, regardless of identity?

In covering my head every day, I am now aware of previously unconscious thought processes. I have learned volumes about how my behavior is driven by others’ perceptions of me. For physicians, this is a lifelong process of introspection and change. Transference and countertransference certainly exist, yet it only become obvious when one takes the time to look!

Santokh Sidhu is a MS3 at Wright State University Boonshoft School of Medicine. His email is shawnsidhu@yahoo.com

PSYCHSIGN: Psychiatry Interest Groups

By: Jeanne Goodman

PsychSIGN is a student led organization founded in October 2005 with the support of the American Psychiatric Association to foster the involvement, organization and implementation of student psychiatry interest groups at individual medical schools throughout North America. The first national PsychSIGN conference was held in conjunction with the 2006 APA meeting in Toronto. Over 100 students from over 60 North

American allopathic and osteopathic medical schools attended and engaged in various discussions regarding the pursuit of a career in psychiatry.

We are now announcing the 2nd annual PSYCHIATRY STUDENT INTEREST GROUP NETWORK (PsychSIGN) CONFERENCE! The conference will take place in San Diego on May 19, 2007. Featuring keynote presentations by noted clinicians, educators and scientists, small group sessions with residents and a chance to meet

other students from around the country, the conference promises to be stimulating and fun! Housing and program costs will be covered by the APA and transportation funded by individual schools.

PsychSIGN conferences are an important means for medical students to come together and share their hopes, questions and concerns about psychiatry. Applications at www.psychsign.org. Deadline to apply March 30, 2007. See you in sunny San Diego!

Leaving the Hospital - My Community Psychiatry Elective

By: Joel Mack, MS4

Having been told wonderful things about the city of Portland, Oregon, I thought it would be an ideal place to pursue a fourth-year elective. My anticipation of exploring the city's natural beauty, great restaurants, and thriving music scene really kicked in as I put on my iPod and stared out the window during my cross-country flight from my hometown of Buffalo, New York. Doing a month-long community psychiatry elective sponsored by Oregon Health and Science University (OHSU) would provide an opportunity to work within another psychiatry department and think about what I was looking for in a training program as I embarked on the residency interview process. Sitting on that plane, I had no idea how great an influence the next month would have on my attitude about psychiatry.

During my third-year psychiatry clerkship, I had worked on a general inpatient unit and in the psychiatric emergency room. The patients I encountered were typical of those seen in a hospital setting: acutely psychotic and/or at high risk of harming themselves or others. The patients would be "stabilized" and discharged back into the community, usually within days to weeks. What happened to them once they exited the hospital, leaving the inpatient milieu to reenter the world, was not entirely clear to me. After working in the community setting in Portland, I began to grasp the challenges faced by mentally ill patients once outside the hospital and that the inpatient unit and ER I had worked in previously were only a small part of the mental health system.

The elective involved working in various settings, including the administrative offices of the city's community-based behavioral healthcare organization, an urgent walk-in clinic, and an Assertive Community Treatment (ACT) team. This variety allowed me to see how services were delivered to the un-

derserved from three different, but important, perspectives. My administrative duties involved accompanying the medical director of the behavioral healthcare organization as she attended meetings, met with community leaders, and discussed the overall mission of the organization. The plush conference rooms that I sat in on those days seemed a world away from the shelters and housing units I visited as part of the ACT team. However, I realized that without securing funds, maintaining community relationships, and lobbying lawmakers at the executive level, it would be impossible to maintain the community mental health centers, housing units, and other services necessary to support the seriously mentally ill at the "street" level.

Working within Portland's community mental health system showed me various ways that psychiatrists contribute to the community, but it also brought to light some of the daunting challenges they face. Providing treatment required not only seeing patients, but also navigating larger systems that included insurance companies, local hospitals, law enforcement, group home managers, and numerous other entities, each of which had their own view on how things should be done. Budget cuts and dwindling funds for mental health programs were common. Efforts to improve public mental health programs often met resistance from people who did not understand the devastating illnesses affecting many of the city's underserved. I realized that chronically mentally ill patients are often discharged from hospitals into communities that are not adequately prepared to care for them. They end up homeless, in jail, requiring expensive hospitalization, or even dead.

Just a month before my arrival, a 42 year-old schizophrenic man died of internal injuries after an altercation with police because he appeared

"suspicious" to officers. They were not aware that he was schizophrenic. This was front page news for months after the incident. Why weren't the officers better trained to deal with mentally ill citizens? What could be done to raise public awareness about mental illness? How could the system be changed to prevent another similar occurrence? These were some of the questions at the forefront of public discussion.

I had the opportunity to discuss these and other public psychiatry issues at length with the knowledgeable, compassionate psychiatrists that I worked with during my rotation. My preceptors were eager to teach me about Portland's public mental health system and the roles they, as psychiatrists, played in it. For some of them, these roles began as psychiatry residents at OHSU, where a formal public psychiatry curriculum has been part of the training program since 1973. As a visiting medical student, I was able to sit in on the didactic sessions for the residents in this portion of their training. I participated in discussions about topics such as cultural competency, managed mental health care, and the stigma associated with schizophrenia, realizing that as a future psychiatrist it would be my job to address these issues.

My community psychiatry rotation instilled in me an increased sense of purpose that I will carry with me into residency and beyond. I plan to utilize my position to increase public awareness of mental illness, advocate for those affected by it, and provide care that keeps patients in the community and out of the hospital. I hope that sharing my experience will encourage others to do a rotation in public psychiatry or to find their own way to learn about the provision of mental health care in the community, where it is so important.

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Katrina and Social Justice, *continued*

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Medical students have themselves been principal drivers in restoring medical education to the region. After all, the third-year students who have so far rotated through the psychiatry clerkship began their education on the old campuses downtown. They are optimistic, and they collectively remember how the system worked before. For example, the first colleague to contact me after the storm was a recent graduate, seven weeks into his internship when the levees broke. The city had flooded, the university servers were down, the pagers and cell phones didn't work, but for some reason we could text and he had my number. Over a landline he asked, "Dr. Townsend, what usually happens in situations like this? When do we get back to work?"

In Baton Rouge, the closest city evacuees came to when they headed west, third year medical students on psychiatry gravitated to the main mental health center and began to work with

patients in the relief camps even before the clerkship formally resumed. As teaching sites became available nearer to New Orleans, they quickly recreated the familiar academic team—attending, resident, student—in new settings, sometimes with the entire team relocating in the middle of a rotation.

But it is in New Orleans now that I am most impressed with the resiliency of the students and residents I work with, and the faculty who teach alongside me. Individuals with mental illness and their families are having difficulty securing prompt treatment, and the slow pace of recovery can be discouraging to psychiatrists who want the city to be as it was. We continue to work for social justice for the persistent and seriously mentally ill, but we have developed new appreciation for the hardships of the displaced.

Dr. Townsend is a Professor and Vice Chair for General Psychiatry at the LSU Health Science Center in New Orleans. His email is MTowns@lsuhsc.edu.



Match in Psychiatry?

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