The Psychiatrist *As* Physician

By **Dr. Earl Hardin**

Gabrielle prompted me to write again for ***Catharsis!***, suggesting I draw from my work experience. From 57 years of a broad spectrum practice, what could I possibly squeeze into one page?

Ultimately I thought of something. A very small component of my experience was occasionally tuning into the medical problems of my patients. You see, in the ten minutes of a rushed appointment with a GP or a clinic doctor some people are simply not able to encapsulate or enunciate in detail the features bothering them.

On the other hand, in an appointment with a psychiatrist, which may be an hour long, there is the opportunity to fully describe problematic symptoms pointing to obvious conditions. So from time to time I would coach patients about what to say to their doctors, or if I thought it was not going to realize results, I would sometimes phone the doctor if I knew him or her, or send a letter, or type out a note to be taken to a clinic if the patient had no doctor.

HISTORY OF HOSPITAL AFFILIATION In the 1960s VGH and Shaughnessy had the only general hospital psychiatric departments in Vancouver. Most psychiatrists in private practice were on the VGH staff. We would do everything: size up patients in Emergency, admit to and treat in our inpatient units if they needed it, even do physicals before ECT which was our best treatment modality at that time. If our help was wanted on a medical ward we were there. That was an era in which general practitioners still looked after their patients in the hospital. Since I'd interned at VGH many knew me, specialists, too. Back then they'd been my mentors and now with my new specialty they welcomed me everywhere in the hospital.

I actually was able to continue admitting my own patients to VGH psychiatry inpatient wards, right until compulsory retirement at 65. Even after that, I continued a habit of visiting my patients when they were admitted for psychiatric treatment, but also for medical and surgical care, whether at VGH, St. Vincent's, St. Paul's or UBC, but especially the Louis Brier seniors facility. I believe patients felt valued by that. I almost always got to commiserate with the doctors providing care, even when the hospitalists assumed that role.

BALANCING As I said, this was only a small component of my practice. The bulk was full time in the office, employing a range of pragmatically chosen psychotherapy techniques and utilizing the most appropriate neuroleptics available. For many many, I also provided long-term care with periodic appointments, usually essential but sometimes just prudent. Good secretaries were a help. For example, a wondrous assistant looked after my office partner Bill Brown and myself for three decades.

My main UBC teaching commitments were psychotherapy tutor with a different resident each year, evening on-call Emergency supervision in rotation, and group lessons on interviewing with medical students. There also seemed to be plenty of time for organization activity, mostly but not only BC Psychiatric Association and APA Western Canada District Branch.

All the while there was a fortunate full parallel family life, companionship with friends and extended family, and recreational and cultural joys. As well, ample vacations and travel, often in conjunction with the APA Annual Meetings.

AN EXAMPLE OF PARTICIPATION IN A MEDICAL MATTER One illustration was concern over a 40 year old patient's abdominal pain. It was obvious to me she was experiencing intermittent biliary colic. Her very good GP had referred her to the best gall bladder surgeon who examined her, but went no further. I prompted her GP to phone him, but still no action. A detailed letter I wrote to the surgeon got no result, either.

Finally she phoned to let me know she was taken twice during a past week from her home in Burquitlam to the Royal Columbian Hospital, but discharged after hours when the pain subsided somewhat. I told her that if it happened again, especially in the daytime, to tell her husband to drive her to VGH and let me know the moment they arrive. When the call came, I strode up the hill to the hospital, spotted an Emerg doc whom I knew smoking a cigarette in front, and told him about the dilemma. By the end of the day I learned our patient had been immediately taken to the OR where a different surgeon successfully removed a gall bladder so gangrenous it was on the verge of bursting.

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Most situations of this kind were not so dramatic, but over the years there were other instances where my prompting benefited a patient whose medical issues were not being dealt with adequately.

LETTERS TO SPECIALISTS Also from time to time I would get a notion about a patient's medical condition, convey it to the general practitioner with the expectation a referral would be made to a specialist, and that usually worked, so far. But if time would go by with no result, I'd sometimes compose a letter to the specialist, of course with a copy to the GP.

However, when I'd be involved in that chart review the College would do periodically, those letters would be noticed. More than one Registrar or Deputy Registrar had told me not to do that: "**It's not what psychiatrists do**," they said. During the last chart review in the spring before I retired, I received the same criticism from the assessor because I still occasionally felt compelled to write those letters. And, at a conference shortly thereafter, the assessor's committee chair scolded me again, in person. This was a psychiatrist 40 years my junior and whose clinical and teaching experience I understood was based only in one suburban hospital. I was not offended, however.I never knew if they really believed that criticism or if it was just another of their ways of telling me, as well as telling me directly, that they didn't like us working past the age of 70.

I finally did retire in January, 2020 at 86.

~**Earl Hardin** MD, DLFAPA

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