The psychiatric consultation

Several contributions in this series have focused on young doctors and other health professionals suddenly being confronted by disillusionment regarding their elders and more experienced colleagues. Here, Professor Sir John Scott relates two such events occurring early in his medical life.

'Defective' training

As medical students, my generation was well aware that its 'training' in psychiatry was defective. For many of us it was disillusioning. Unfortunate people with a wide range of personality and neurological problems were paraded before us. The mixtures of Freudian and other philosophical schools were trumpeted forth, and the basic lack of commonsense of some of these expositions was so obvious as to be laughable.

One such incident occurred when an extremely bright academic psychiatrist took a senior post within our school of medicine. We were the last class to enroll ex-service people from World War II. Many of these ex-service people were much older than us, were broadly experienced in life and were characterised by much commonsense. The psychiatrist delivered his first lecture to us, presenting a technically Freudian stance. Towards the end of his discourse he referred to various common 'foibles'. He commented that women contributed to their images in a physical sense by wearing makeup. He went on to point out that lipstick was applied by an instrument that was really a phallic symbol. The ex-servicewomen who predominated within the small section of the class in the front row looked up and began to giggle. One ex-serviceman whispered loudly, 'How the hell do you expect them to apply it, sir?' and the whole class burst into laughter.

The academic never recovered credibility within the undergraduate faculty and later moved on to a senior post in another country.

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A shattering experience

My first experience with psychiatric consultation was more painful. The country was extremely short of psychiatrists. People were 'sectioned' – i.e. admitted or committed to institutions – by one psychiatrist and one junior medical officer, preferably a registrar. These health professionals filled in the forms that led to the patient being transferred to the local mental hospital where a magistrate reviewed the situation within 24 hours. People thought to have potential for violence or self-harm were temporarily housed in cells. One of these was padded and sited close to the emergency department of the hospital where I was a registrar. On this particular occasion, I was commanded to interview a publican who had been admitted following a violent altercation with his wife. I had been taught how to be careful in such circumstances, particularly as there were only the two of us in the padded cell. The man was extremely surly and uncommunicative, but I concluded that frankly he was 'mad'. As I backed out of the cell at the end of my interview, I temporarily dropped my guard and suddenly was lifted off the concrete floor by the point of my chin. I was as close to being knocked out as has ever happened in my life. There was a perhaps a touch of prejudice in my ensuing report, confirming my impression that the man required psychiatric institutional care.

The senior psychiatrist went to see the patient a short time later, and found him to be lucid, extremely polite and almost obsequious. The psychiatric expert concluded that the man had had a temporary aberration and was really no threat to himself or to the community generally.

The psychiatrist was a man with flamboyant habits. He came up to the ward where I was doing my patient round, stood there and histrionically tore my report in two, handed the pieces to me and told me I should learn some psychiatry some time, and then stalked off. This was pretty humiliating.

The patient was released, went back to the pub and cut his wife's throat.

That psychiatrist could never look me in the face again, but he never apologised. Various aspects of innocence were shattered for me that day. MT