

A CL Psychiatrist's Reflections in the Era of COVID-19: Overcoming Systemic Narcissism and Embracing Humble Empathy

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Psychiatry has long been a specialty that has struggled with its identity. In the post-Freudian era, psychiatry has been attempting to re-establish itself as a legitimate scientific field in the realm of medicine, a field beyond mere speculation and theory. The Prozac era brought with it a semi-scientific approach and a deeper understanding of neuroscience but still more questions than answers. In an effort to calibrate research, a series of diagnostic manuals have continued to expand to hundreds of diagnoses. Critics have pointed out the collateral damage of these shifts such as the pathologizing of normal behavior, shotgun approaches to medication treatment, and a *bourgeois* activity for the worried well. These shifts in the focus of psychiatry from psychoanalysis to medication and a standardization of diagnosis have attempted to shed the dark sides of the psychiatric past. As a result, the field of psychiatry could be compared to the religious landscape where practitioners tout differences that put them at odds, ignoring the major antique themes and practices that create a clear through line.

This historical context sets the tone for the approach psychiatry is taking in our current COVID-19 pandemic. Across the world the medical field is preparing for and addressing the predicted and occurring public health crisis. Psychiatry struggles to find a specific role in this setting. Some see their role squarely in the realm of mental health alone, clearly uncomfortable with providing traditionally "medical" treatment. Because patients with psychiatric illness utilize a disproportionate percentage of medical resources, psychiatrists have the real potential and capacity to offload other medical services such as the emergency room with more rapid and efficient care that could free up personnel and resources to better address COVID-19 patients. Other psychiatrists prepare to be retooled to work on intensive care units, fearing the worst. On the other end of the spectrum, a few favor drawing down psychiatric services with the goal of "flattening the curve."

The hidden narrative in this scenario is that psychiatry is a non-essential field and practitioners have become a part of the general public with a mandate to diminish contact alone, ignoring their primary medical training. This is a natural tendency given the close relationship between the field of public health and psychiatry, since the creation of integrated care which takes a population-based approach to mental health. There are many that adamantly take issue with this approach with the view that addressing mental illness has an equal value and a priority even at this time in the midst of a pandemic. The resulting action in the wake of this view appears to be "business-as-usual." Significant fears of psychiatric decompensation and epidemiologic evidence of suicide deaths are given as ample evidence to justify this view and resulting practice. It seems that there is an underlying insecurity in this view born out of the previously described "dark history" abutting the current question that public health policy has made many professions and businesses ask of themselves: What is essential and non-essential work?

It seems that there are some assumptions and biases underlying our broader approach to this crisis that do not align with the most fundamental part of our oath, to first do no harm. Medical training and the individuals it attracts seem to self-select toward ego-serving and at times detrimental self-sacrifice. This becomes particularly evident in efforts to prove our equal value

to internal medicine doctors. These factors may be driving us to make decisions that place our patients and our community at significant risk in this particular context. Psychiatrists owe it to their patients and community to think in terms of what are the essential functions that are absolutely necessary to be done in person, rather than thinking in terms of who has been deemed to be “essential personnel.” Our efforts to remain “essential personal” may be missing the big, global, picture.

A construction manager was issued a letter drafted by the company’s lawyer stating that they all are essential personnel to enable their workers to continue to work on residential projects in the midst of this pandemic. Most would gawk at this definition. This line between necessary and eventually expendable is not only fuzzy but also ethically wrought with assumptions and bias. Humans need to eat but do they need restaurants? Acceptable living conditions are clearly subjective if we examine homes across the world. The more dedicated the worker, the more essential she imagines her work to be.

For the health of the population, I see this as a time when all members of society share a responsibility to determine which pieces of our lives and work truly necessitate risking transmission. This involves a good deal of critical thought and self-reflection, a skill set squarely in the realm of a psychiatrist’s expertise. Certainly some, but not all, of our work falls into this category currently. But it will take some substantial humility to be a doctor, dedicated to the health of our patients, and take a back seat in this pandemic by curbing the care psychiatrists provide. There is a strong argument to be made for pulling way back into bare-bones, urgent/emergent psychiatric care only. Our role as CL psychiatrist holds us in this grey zone where we have become accustomed to the ambiguity, daily questioning our place. With experience and comfort we can lead our fellow psychiatrists forward.

During these difficult times, one of the few things that has made me feel better is being able to connect with my patients in some way. I do love this work, and value it highly. And, I just think that at this particular moment in time in this ever-changing pandemic landscape, any work that can be done remotely should not be happening in person if at all for a brief window. Of course, we have a really meaningful role to play as psychiatrists in this, and most of this will happen overcoming months to years of containing all of the affect around this global existential crisis and grief. But that doesn’t mean that we should or need to be physically present. Rather our psychological presence and support is one of the few consistent historical threads that runs through all of psychiatry regardless of the sect.

I keep thinking, what if we could have gotten over ourselves weeks ago, months ago? Shut down outpatient work to crisis management only, imagine where we could be now. We could be fully functional with tele by now, providing better care to our patients and taking ourselves to whatever extent we can out of the community transmission pool for everyone’s sake. How many less people would have contracted COVID-19 in the first place? What have been the costs of business-as-usual? Not surprisingly, other medical specialties have taken more extreme measures earlier on, perhaps because they more fully appreciate the public health and medical risks, stopping all “elective” appointments and procedures. Ironically our desire to demonstrate our value as equivalent to internal medicine doctors in this pandemic is displaying the divide in our training and self awareness. Maybe if we can get back to the core skills and values that make a psychiatrist a psychiatrist, we can resolve not only how to conduct our practice in this pandemic but also disentangle our identify from our past. Self-reflection, humility, and empathy

underlie our listening ability, our ability to connect, and our ability to heal with our presence. This is no ordinary skill and does not need to prove itself. At the same time, knowing when to sit still and be patient may be the true heart of psychiatry.

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