Controversies
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Any time seems to offer an opportunity to discuss the Psychiatry-Medicine relationship. This age, with continuous new advancements, but also doubts and incertitude, creates an unusual moment for this topic. For sure, there were phases when the relationship was serene, for being so evident, as well as for being denied. However, although currently there are no more serious questions about the Psychiatry-Medicine relation, some problems remain during execution of the relationship. Psychiatry came into Medicine to enrich, but at the same time it disturbs, and generally it does disturb the doctors.

We mention some necessary factors to study the Psychiatry-Medicine relationship:

- the negative impact of the medical technical sophistication and correlated patient;
- excessive specialisation of Medicine and, consequently, a progressive disregard for the patient as an unitary, unique and total person;
- the hospital aggrandisement (hundreds, thousands of patients), where the patient, being lost in a puzzle of devices, technicians and doctors, becomes just a number;
- the excessive valorisation of lab investigation and consequent depreciation of anamnesis ("let the patient talk, listen to the patient");

On the other hand, inside Psychiatry:

- metaphysical conceptions, like Psychoanalysis, with abusive conclusions;
- an insufficient medical foundation of most psychiatrists, with a psychological predominance in their development;
- an excessive utilisation of social and political aspects and criteria disturbing its medical foundation; so much that in the 70s Psychiatry nearly lost its track when attacked by the anti-psychiatric movement (part of the anti-culture movement initiated in USA in the 60s).

Psychiatry has always been considered as Medicine's rejected son, being at the same time both the preferable scapegoat and an item for a garbage bin. There was a time when the position reached a crossroad: from one side, psychiatrists accusing their colleagues of constantly neglecting the psychological and existential aspects of the patient, and doctors from other specialties attacking the psychiatrists for very often losing themselves in subjective and unfounded interpretations, results of just a personal point of view.

For some time now, the main arena for confrontation, mutual understanding and collaboration is the General Hospital. The hospital's everyday life declares the requirements for the psychiatrist's presence. Therefore, is to the psychiatrist the main responsibility to contribute to the

harmony and effectiveness of this relationship, making it an essential part in the treatment of so many patients.

This lecture will focus on essential relation aspects of Psychiatry-Medicine, initially with a brief description of the development of Psychiatry as a medical specialty, and how Psychiatry met Medicine in the General Hospital.

Considering the history of western civilisation, Psychiatry as medical specialty was born very late, in the 19th century. Before (with the exception of part of the classical Greece) mental disturbs were manipulated by philosophers, sacerdotes, mystics, etc. The phenomena's interpretations were all metaphysical analysis or mystical divagations. A few obstacles for late medical evidence of Psychiatry:

- the difficulty in defining its object: what is a psychic event? or, who is the person psychological ill? No doubt, these questions remain not completely resolved;

- the precise specification of its methodology: how should the psychic event be investigated? how to have access to its essence or structure? how to recognise a man as psychologically ill?

- the frequent social denial and/or rejection of the concept mental illness and the mentally ill. Psychiatry became to be socially accepted when the risk of being mentally ill became a possibility for all in cities with a big population. One contributing factor is the non-personal social organisation of these cities. However, until nowadays psychiatric patients suffer from prejudices.

- the impact of the mental illness in man's reason. As there is a fear of death, there is a fear of madness. Men try to stay away from madness, and a way is to isolate the mad in psychiatric institutions, prisons, nursing homes, etc.

Pinel gave a major step for Psychiatry's credibility with the scientific community in 1793, locating specific institutions for patients with mental illness and initiating a systematic study of madness. After that period, the 19th century could be known as the Alienists' Century: doctors living in the same institutions where the patients were treated, having the opportunity to follow their everyday life and get close to their personal lives. The predominant philosophy of that time - the positivism, base of the scientific method - offered to Psychiatry the same naturalist method used in General Medicine. Psychiatric studies started to look for a corporal foundation for the mental symptoms (neuropathologist Griessinger, the neurologist Jackson, Kraepelin, Bonhoeffer, etc.). This tendency went so far that Kleist established detailed areas of the brain that would be directly responsible for the diseases ("localisation"). This field of research continues through various sorts of studies: biochemical, pharmacologic, genetic, immunologic, neuroendocrine, neuro-imaging, etc.

As reaction (by some) or as complementation (by others), Psychiatry evolves incorporating different perspectives, highlighting cultural and philosophical man's aspects (Dilthey, Nietzsche,

Husserl, Jaspers, Scheler, Binswanger, Minkowski, etc). If long ago the philosophers were the ones dealing with madness, then came psychiatrists with a philosophical approach.

The acquisition of knowledge in parallel with Medicine and many therapeutic techniques favor the entrance of several para-medical professionals in Psychiatry, leading to the “teams" composed by psychologists, nurses, social workers, occupational therapists, etc. In fact, many of these “psychiatric teams” developed a non-clinical activity, in reality a political strategy for the anti-psychiatric movement. During few years, again Psychiatry was under risk of losing its place in the medical field because of the predominance of these several parallel areas in the psychiatric practice, to the point that the psychologist, the social worker, etc, were frequently taking over, exclusively, the complex task of treating patients with mental illness.

The anti-psychiatric movement badly affected Psychiatry’s social and professional images. An illustrative event was the 1975 movie “One Flew Over the Cuckoo's Nest.” Consequently, many doctors viewed psychiatrists as incompetent to exercise Medicine, and for that reason have chosen Psychiatry to hide medical ignorance. One reason to understand this negative reaction towards Psychiatry: it is a specialty more inclined to have professionals saying “It’s my opinion..., I think..., I suppose..., It can be..., Maybe…” Psychiatry was again under severe scrutiny.

With the advancement of psychopharmacology from the beginning of the second half of the last century, Psychiatry was laureated with a new glamour: the mental diseases could be approached more precisely under a scientific point of view and the patients could receive some effective treatments, many times without the nightmare caused by an admission to a mental asylum. The heavy doors of the psychiatric hospital were opened by psychopharmacology. A mad man could be partially or totally cured, could be re-integrated to the family and society.

Psychiatry established a systematic methodology of research adjusted to its object (a mentally ill person). The diagnostic approach, following the principles of a medical diagnosis, was enriched by the philosophical vision, creating the idea that what has to be treated is a specific person with a disease (Anthropological Medicine). Then, the brain became the center of all attention, as well as any element that could affect this extraordinary complex organ (a multi-organ organ). The great development in all medical specialties and their particular technique of investigations (laboratory, imaging, etc.) contributed to the definite insertion of Psychiatry into Medicine. Psychiatrist could wear the white coat.

The General Hospital offered this space of collaboration between one specialty and all others, between psychiatrists and colleagues of all specialties.

Now our presentation takes other turn. Let’s leave aside the formidable technological progress in Medicine and consider - as psychiatrist - the modifications that this progress caused to the patients.

The big, intense and fast technological progress obliged Medicine to be divided into specialties. Along the way, we face too many specialties, and it seems there are more and more to come. If, until the middle of the 20th century, we used to consider doctors only as being clinicians and surgeons, nowadays we are not able to declare the name of all specialties with a bunch of fingers of numerous hands. The major problem is that this excessive subdivision of Medicine did not maintain, in theory and practice, the principles of "only one diagnosis" (as much as possible) and the person's unity. Surprisingly, historically known as the major example of humanistic person with remarkable cultural knowledge (base of vocational professional) and social status, the doctor became concentrated in the technical management of the patient, ignoring the concept of the person with an illness and the meaning of being ill. The patient was turned into pieces by the technological progress of Medicine. As consequence, a large distance was created between the doctor and the patient. The medico-patient relationship - the main aspect in medical practice - was deeply affected. Of course, not considering exceptions, this relationship is superficial, fast, lacking human feelings, understanding; it is just pragmatic. Let's treat the disease. As the person is not any more a subject to study (eminently via anamnesis), the patient is overloaded with laboratory investigations. Medicine is medicine of the sick organ, not Medicine of the person.

But non-psychiatrists are very aware of this crisis in Medicine. By not being conveniently prepared (lacking courses of Medical Psychology, Psychopathology, Psychiatry, Psychopharmacology, etc.), they need to request psychiatric intervention for their patients. Often, the need is much more due to a difficulty in dealing with psychological issues of the patient, his particular situation disturbing his professional or family life, for instance. Sometimes, the doctor has the sincerity to declare his non-psychological preparation to deal with - for example - a terminal patient and family. But, most of the time, an old or new mental disorder declares its life when in a hospital setting. In this case, the presence of a psychiatrist becomes a requirement to be fulfilled.

These are the concrete aspects of the relationship that appear through the medico (general)-psychiatrist relationship. This relationship has two levels:

- during the clinical relationship (the co-joint work between two specialists)
- during the pedagogical-psychological relationship, when the psychiatrist has an active role.

These two levels are inter-dependent, but it may occur that the first turns out to be dependent on the second.

To better understand what could happen in these two levels, we will have a quick look at the Medicine and Psychiatry fundamentals (see table below), and the academic formation of both the medico in general and the psychiatrist in particular.

As a science, Medicine takes the study of the human body (structure, function, development) as its main goal. The body itself is a natural thing able to be observed, manipulated and submitted to

experiments according to the classical Claude Bernard model. Certainly, Psychopathology (the psychiatric science) also considers the human body as an object of study, but only when the mental symptoms are directly caused by objective alterations in parts or functions of this same body (like a confusional state caused by an elevated urea). However, even in this case, the psychopathological consideration does not restrict itself to the dysfunctional body; this alteration and its mental symptom are taken as an expression of the whole dimension of a specific person. Therefore, Psychiatry has as its goal the human being mentally ill. The traditional dichotomised and partial Medicine vision is opposed to Psychiatry's holistic apprehension: not only an ill body, not only an ill soul, but the ill person.

To consider the object of study as the body or the person determines respectively specific methodologies. Medicine aims to find relationship between a cause and its effect, following the rules of the explicative-causal method, a naturalist approach: to a certain phenomenon corresponds a cause, in a direct relationship. (We are not going - for the summary of this presentation - to go further in the development and improvements of this method; we should by now just visualise the simple idea of this relationship.)

With a person, we search for connections of significant events to achieve an understanding: it is a historical approach. The specific person is to be considered according to a peculiar situation that he experiences in a unique mode. Saying that, it is not possible to apply the explicative-causal method and compare and then explain. It is necessary to try to understand the specific situation of a specific ill person.

While seems to be enough for a clinician to discover the element causing an infection and prescribe the related antibiotic (a simple example) and return a patient's health, more than this activity, the psychiatrist looks forward to the understanding of what is experienced by the patient: a profound sadness for the loss of a dear family member; a paralysing anxiety when facing a problematic vital situation (Ca); feelings of humiliation for being neglected, rejected by people that are important for this person; the sense of impotence and frustration for having an amputated leg; etc.

As we see, excluding the medical psychological approach, and being restricted to the laws and theories essential to Medicine, it would submit the ill person - inappropriately - to the rigorous system of cause-effect, leaving aside the historical-vital perspective.

In Medicine we face objective phenomena and/or objectionable phenomena (signs), and it is possible to register these alterations in many sort of devices, through simple or sophisticated techniques: blood pressure monitor, angiography, Pet scan, etc. Sometimes it is also possible to establish a correlation between the intensity of a symptom and the seriousness of the disease (quantitative evaluation). Objective symptomatology allows a clear (not always) perception of the

process and its communication from doctor to doctor in a correct and simple mode. Symptomatology, data and diagnosis may be shared for several doctors. It means that the objective symptoms usually contain in themselves a truth participated by all.

It has to be said that in Psychiatry objective phenomena are also taken into consideration, but as elements that may represent just a direct expression of an ill body or an expression of the soul through the body.

In Psychiatry, apart of the objective signs, such as attitude, posture, how the patient is dressed, talks, gesticulates, papers he had written, etc., and pathologic somatic manifestations, the inner experiences need to be made objective through the patient himself (descriptions from own consciousness, because they are peculiar to this patient) and through the psychiatrist's consciousness. The knowledge of the symptoms cannot be made by a simple comparison with the symptoms presented by another patient, or a well-defined model. The psychopathological symptoms are submitted to the doctor's illuminative consciousness; therefore -it is important to note- they are limited to the capability of perception and understanding of this specific doctor.

Psychiatry possesses other characteristics in relation to treatment. While in Medicine, usually the patient remains in a passive attitude during therapy (like in a surgery), in Psychiatry the treatment requires the patient's conscious active and continuous participation. The patient needs to develop a concomitant work of real value. Commitment, compliance and the patient's consciousness are basic elements to the proper development of a psychotherapeutic technique. If the patient does not want, the doctor only can do little (we are not considering here the situations where the patient is completely disturbed).

On the other hand, the techniques utilised by other specialties generally are concrete (surgical amputation, kidney transplant, hysterectomy, chemo, insulin therapy, etc.), and the results are also objectively registered. Psychiatry relies much on psychotherapy, an essential subjective technique, although supported by methods and theories well founded. In Psychiatry, the technique has to be appropriate for each case. It is not possible to have in Psychiatry a kind of a Bilroth II for a personality disorder. Therefore, the results should also be considered under the patient's perspective. This criteria reaches the point where the concept of normality in Psychiatry has to be very different from the one used in all other specialties. In this last case, normal is to be the same as the others, or as the model. In Psychiatry, normal would be the person that is distinct from others through a composed mature personality.

While the therapeutic result evaluation is primordially quantitative in Medicine (performance of some organs like heart, lung, liver, pancreas, etc.), Psychiatry gives importance to qualitative features like adequate attitude towards life, inner satisfaction, reasonably harmonic relationships, a well-composed life-project, etc.

Not much is mentioned about the Art component in the formation of doctors. The emphasis is on a scientific-tech education. Doctors are instructed to be objective, quick, pragmatic, turning to neglect cultural and philosophical preparations. In many schools, Medical psychology is not even part of the curriculum and Psychiatry is very poorly offered. As consequence, the restricted knowledge doctors have about Psychiatry and psychiatric patients cause them to have a more social or behavioural perspective of a mentally ill person than a medical one: a mental patient is the person that is agitated, disturbed, that disturbs, is inconvenient, extravagant, etc. It is a fact that many times a psychopathological symptom, like a mood disorder, is caused by a pre-diabetes, and the organic condition may be missing from the doctor's consideration: the patient is just depressed, therefore needs a psychiatrist. On the other side, psychiatrists forgetting their medical formation, gradually move away from clinical thinking; many times they do not search for a pathology behind a psychological symptom; they lose themselves in the illusion of psychological theories of poor value, or in the easy seduction of finding interpretation for everything, as if an explanation -even false- could lead to a proper solution.

To conclude, a few words are offered concerning the medical attitude facing the patient and the kind of relationship established. Contrasting to the important development in Medical Psychology, the relevance given to the doctor’s personality preparation aiming a good practice, there is a significant decline in the value given to the medico-patient relationship. Restrained by numerous difficulties (overload, time, money, etc.), doctors maintain a superficial and practical relationship with patients (“Balint six-minute consultation”), no time for evaluating important aspects of the patient, like personality and the significance of being ill for this person. These practical aspects invite the doctor to call the psychiatrist, with the expectation that it is up to this specialist to understand the patient’s personality and situation, and possibly give information concerning treatment and its implications to life after. When a radical surgery (Ca, kidney transplant), a consumptive disease, etc., are implicated, the multiplication of doctors may lead to a split in the medico-patient relationship, a split between body-soul, a split reflected in the anxiety of a patient lost between doctors and the uncertain future.

Medicine-Psychiatry gains importance when we look at the practical needs happening in the medico-patient relationship. In a world of a materialistic view, devoted to consume, propagating a philosophy that everything is disposable, a kind of de-humanisation is pervasive in most human relations. The medical field suffers -maybe more than any other area- this de-characterisation of the person. The talented Medical Anthropology of the middle of the last century -remaining until now in a little corner- may have a singular opportunity to reflourish in the General Hospital, where generalists, and specialists including psychiatrists, could bring together the totality of the ill person.

The unity and the whole of an ill human being are possible when Medicine is also Art and enriched with elements of a Psychiatric approach.

Because Psychiatry is Medicine. Because Medicine includes Psychiatry.

	Medicine	Psychiatry
Object of study	body (material)	person (unity material-spiritual)
Metodology	explicative-causal	predominantly understanding (historical)
Symptomatology	objective and/or objectable	objective and/or objectable but predominantly subjective
Vision of the problem	focus on, localised, partial	holistic
Disease intelligibility	the disease itself	the meaning of being ill
Treatment	direct action	direct action plus dialog
Evaluation criteria	quantitative	predominantly qualitative
Concept of normal	the same as others	different from others (particularity given by personality and history)

* Adapted extract of a Lecture given at the Department of Psychiatry and Medical Psychology, Faculty of Medicine Santa Casa of São Paulo, 1980.

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