

Expertise or Experience

A lecture held in a psychiatric hospital on Sept. 20, 1983

I will keep my story fairly general in order to clarify what kind of experiences you can have as a psychiatrist who has been working in psychiatry for some 25 years. In that period I have experienced the entire development of psychopharmacology.

When I started my work, we were in a revolutionary period, because psychiatry's status, and the work in psychiatric hospitals, was enormously changed by the use of psychoactive drugs.

Initially we had high expectations from them. I worked in an institution for a few years, and afterwards I went into private practice, but you remain confronted with what goes on in psychiatric hospitals when your own patients have to be hospitalized or when they are released.

And all that time, 25 years long, you wonder: when I prescribe medicines, what am I doing, and am I doing it right? Or: what has the other done, and did he do it right?

To know what you are doing, you need expertise. Big question: how much expertise do the experts have now? Because you're dependent on them when you have to take psychoactive drugs.

In the course of those years I was immensely shocked by my own lack of expertise in the area of psychoactive drugs. Am I such a bad psychiatrist? Yes, perhaps. But when you try to determine what you're doing, you discover that the available knowledge simply does not fit daily practice in relationships with people who seek help from psychiatry.

Why was my expertise so lacking?

An example. For 25 years I prescribed an increasing series of benzodiazepines (librium, valium, mogadon, dalmadorm, seresta, temesta, etc.) in my practice. Of course I read books about them. Of course I prescribed them thoroughly convinced that I was benefiting my patients.

When on a certain day you discover that for 21 years the facts were right under your nose, and you let a great deal simply slip past by your eyes unnoticed, then the scales fall from your eyes.

My eyes opened when the side-effects of a newly introduced sleeping tablet, Halcion, were discovered.

I collected thousands of disease histories with Halcion, each more dramatic than the other. A lot has been written in opposition to these discoveries. It was said, "Well, what does that psychiatrist mean? He's talking about psychiatric patients, and of course the effects on them are different than on non-psychiatric patients."

I was not able to dispel that criticism. A great many people were referred to me during that period who would never have fallen into the hands of a psychiatrist were it not that for some reason or other they were prescribed Halcion. These people became so ill, that I actually never heard so much tragedy from people in psychiatry as in that period.

When you discover that it's caused by Halcion, one of the newest benzodiazepines (and I won't now go into why Halcion does it) then in the ensuing years you take a look at the other benzodiazepines as well.

How shocked I was to discover that I myself for years prescribed temesta, seresta, mogadon, etc, and didn't realize that those patients in my care slowly degenerated into a sort of apathy, general misery, of which I kept thinking that it was because those people were lacking in enthusiasm for life.

Since then I have assisted a large number of my own patients, but also those of other practices, in stopping the benzodiazepines, but then I discovered to my shock that it is almost impossible when someone has been using benzodiazepines for years, to wean him away from them. Furthermore I noticed that when you use benzodiazepines for a few years, and then not for a while, you are not yet well.

Every pharmacologist will tell you, stop a medicine, and the half-life will be X hours times two and after that the drug is gone from your body. So within 24 hours, a week at most, you're rid of it, and it no longer effects you.

Forget it! That is not true. I cannot explain it. If you ask a psychopharmacologist, he'll tell you: that's impossible. At most he can say: I don't understand it, but I will pay attention to it.

You get the situation that highly educated people who for many years wrote highly educated articles about psychoactive drugs simply won't listen to the experiences of a practicing physician.

Of course that listening is hampered by the fact that they speak a totally different language with mice and rats than I speak with my patients.

So who has expertise? My expertise was scant, and the expertise of psychopharmacologists is highly limited, much more than they themselves admit.

Halcion convinced me: the most expertise is had by the patient.

But: just as I as a practicing psychiatrist speak a language with the psychopharmacologist that is not his language, which prevents him from listening to me, so I in turn am an expert towards my client, and he tells me experiences in a way that does not fit into my vocabulary.

So I have to discard my usual terminology; and when I discard it, and I also am willing to spend a great deal of time on what the person is telling me about his experiences, listening to them – I have developed the habit of writing everything down literally – I discover that all those people are telling me the same thing.

It turns out that with the terminology available to me I am missing a great deal that clients do have. So I have discovered that the best expert on the effects and side-effects of medicines is the client himself.

But for that, you have to be willing to spend an unheard of amount of time on registering what people say they have perceived.

Not every claimed perception is an actual perception, but when you compare the perceptions that different people relate, you discover that you can classify them and that you have to wonder whether there is a connection to the amount of drugs prescribed, the duration of the use of the drugs, or a combination.

My experience is that on average when patients return to me from psychiatric hospitals, I am shocked by the high doses as well as the combinations of drugs.

In the Netherlands, and we are here even in a blessed country as far as that goes, it occurs that people have a combination of neuroleptics and a combination of benzodiazepines!

And then the government Bureau for Drug Side-effects writes in a bulletin to all physicians in the country, in October, 1982, that benzodiazepines should never be prescribed as sleeping pills for more than three weeks, don't laugh; that benzodiazepines as anxiolytics should never be prescribed more than four months, don't laugh; and that benzodiazepines should never be prescribed in combination at all, or you have to be very careful.

Then I think I am reading the Duckville Gazette, because in actual practice it's all very different.

Besides, my colleagues regularly inform me that they consider such guidelines by the Bureau for Drug Side-effects nonsense.

So we're right in the middle of the problem.

Why do physicians disregard such, in my opinion quite dependable, information from the government?

The reason is that physicians are constantly influenced by advertising campaigns by pharmaceutical manufacturers whose products cost a lot of money to get to market, and who have every interest in keeping them there and increasing sales.

It is of course ludicrous that when in a certain province the use of sleeping pills declines, not everybody involved shouts "hurray!", because there must be something good going on in that province which improves people's sleep.

No, instead, drug representatives are dispatched to that province to make sure that their share is purchased.

We are in fact the victims of an extraordinary game of powers into which we have little insight. What determines prescription behavior?

I would like to advocate first of all that everybody who uses medicines is lent a willing ear by his physician and by nursing staff as to what has changed inside of him, and what he thinks has been changed by the drugs, or by combinations of drugs. It is of supreme importance that that is properly documented.

Furthermore, it should always carefully be attempted with a patient to reach the lowest possible dose.

And that will result in the client's feeling better. I cannot doubt that at all.

In addition I wish to advocate that thorough information is provided to physicians by bodies that have no business interest, with the stipulation that only the practicing physician who is provided thorough psychopharmacological information, and who takes the time to carefully weigh what kind of information he is receiving from the person with the highest expertise: the client, only that physician is capable of prescribing medicines properly.

I wish to close with one thing.

If tomorrow you pose the choice to me to abolish everything we have as to medicines in psychiatry, you will not find me a proponent.

Unfortunately, we cannot do without psychiatric drugs.

The only thing I have tried to say is that physicians must be extremely cautious in applying the drugs that are available in psychiatry.

That people have the right to tell what the drugs do and don't do to them.

And the worries that seize them when there are side-effects.

But I would not want to sacrifice the drugs that are established in psychiatry.

I wish to advocate great caution, I wish to emphasize that again, so that you won't think I oppose it all. That is not true.

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