Dr. Olders

LETTERS TO THE EDITOR

ROYAL COLLEGE POLICIES QUESTIONED

Dear Sir:

I read with interest the short communication on the problems which the Ontario government is now having in recruiting psychiatrists (1). The authors suggest that the 1986 changes in licensing regulations and the policies of the Royal College of Physicians and Surgeons may have been specifically designed to reduce the number of graduates of foreign medical schools practising in Canada. However, there may be other reasons why the Ontario government is having increasing difficulty in recruiting psychiatrists. In my experience the Royal College is much less efficient in processing applications for Board certification than its American counterpart. As a result, I am now seriously reconsidering whether or not it makes sense to return to Canada. If the Royal College is able to discourage a Canadian with a record of defending the Canadian medical system (2), imagine the effect it must have on foreign graduates with no particular allegiance to Canada.

Policies which prevent foreign graduates from practising in Canada hurt Canadians not only because they decrease the number of psychiatrists available to treat patients, but also because they diminish the diversity of training of practising physicians. While often not stated, there is a tendency to assume that physicians who are trained abroad are less well trained than Canadian physicians. I know of no evidence to support this assumption. The United States has benefited enormously from its policy of actively recruiting foreign graduates (including Canadians). In addition, there does not seem to have been any deleterious effect on the quality of psychiatric care resulting from the American policy of encouraging but not requiring Board certification for physicians to practise as specialists.

If Canada hopes to continue to attract physicians and keep the physicians it now has, it will have to become more competitive with the United States. Making the application process for Board certification more difficult or time consuming will not improve the quality of medical care. In fact, if it decreases the number of physicians who decide to come to Canada or drives well trained physicians to the United States, where the application process is more stream-lined and efficient, the Royal College Board certification policies are likely to worsen Canadian medical care.

In one of its form letters to physicians applying for Board certification the Royal College writes: "Canada has one of the most favourable physician-population ratios in the world." Perhaps the Royal College should reevaluate its policies while it can still make this claim.

References

1. Draper R, Galbraith D, Frost B. Physician recruitment in Ontario provincial psychiatric hospitals. Can J Psychiatry 1989; 34(8): 800-803.
2. Fedoroff JP. Controlling health expenditures: the Canadian reality. N Engl J Med 1989; 321: 549.

J. Paul Federoff, M.D.
Baltimore, Maryland

DR. DRAPER REPLIES

Dear Sir:

I would like to note that our paper recorded as fact that progressive changes in licensing and certification regulations from 1986 on had severely restricted the numbers of graduates of foreign medical schools able to enter practice in Ontario. The paper did make a point that control of numbers should be an administrative function, totally separate from considerations of professional standards, but it did not suggest that the changes in license and certification requirements had been *specifically* designed to reduce numbers.

R.J. Draper, M.D.
Brockville, Ontario

NEGATIVE SYMPTOMS IN SCHIZOPHRENIA

Dear Sir:

In their report on negative symptoms in chronic non schizophrenic patients (1), Drs. de Bosset and Shaul demonstrate that negative symptoms are not specific to schizophrenia. We would like to comment on the clinical importance of this fact. In our work with chronic psychotic patients in day treatment and outpatient clinic settings, we also observe "secondary" negative symptoms in patients who experience parkinsonian side effects of antipsychotic medications. If these "secondary" negative symptoms are not recognized as side effects of the medication, this may blur the clinical picture sufficiently that such patients are misdiagnosed as suffering from chronic schizophrenia.

We have seen several patients who were misdiagnosed as schizophrenic following an initial psychotic break. We should not forget the power of the written word (or the uncertainty of our diagnostic schemes). Our experience has been that once a diagnosis is written on a chart, it is regarded as truth regardless of the reality. When the clinician then senses a "praecox feeling" from the patient and fails to recognize that this may be due to the medication, there is an added reluctance to reconsider the diagnosis. Such patients can then be committed to a lifetime of incorrect medical management which exposes them to unnecessary risks, such as tardive dyskinesia.

The wisdom of a thorough chart review and reassessment should not be forgotten. With all our patients, we reduce the antipsychotic slowly in an attempt to determine the minimum therapeutic dose. One of the many benefits of this approach is that this also reduces the "secondary" negative symptoms and can permit the underlying pathology to become more clearly visible. This has allowed us to rediagnose some patients who have carried the label of schizophrenic for many years. It is particularly gratifying when affective symptoms emerge or a chart review leads us to change the diagnosis, and treatments such as lithium carbonate, antidepressants or carbamazepine result in more appropriate and better control of the illness.

Reference

1. de Bosset F, Shaul S. Negative symptoms in chronic non-schizophrenic patients. Can J Psychiatry 1989; 34(8): 807-809.

Virginia Duff, M.D.
Henry Olders, M.D.
Montreal, Quebec

Verso →

DR. DE BOSSET REPLIES

Dear Sir:

The observations made by Dr. Duff and Dr. Olders once more confirm that negative symptoms are non specific and are very common in chronic psychiatric illness. "Secondary" negative symptoms may be more frequent than "primary" negative symptoms. The "secondary" or treatable negative symptoms are not secondary only to side effects of neuroleptics. Other factors such as psychotic symptoms, an under simulating environment and dysphoric affect are also frequent causes of the manifestations, which at one point were seen primarily as belonging to schizophrenic symptomatology.

Farideh de Bosset, M.D.
Toronto, Ontario

IN FREUD'S DEFENCE

Dear Sir:

Dr. Julien Bigras (1) joins the ranks of those contemporary authors (2-4) who accuse Freud of trying to deny and suppress the fact that father-daughter incest occurs. This is a disservice to Freud and runs the risk of obscuring the value of the theory of infantile sexuality in the public mind and in clinical work.

By moving from the seduction theory to infantile sexuality, Freud is not trying to deny sexual abuse but is calling for a distinction to be made between the child who is actually being sexually abused by her father and the majority of children who have *fantasies* of sexuality towards, or seduction by, the opposite sex parent as part of their normal psychosexual development. To say that all children have incestual fantasies is not to try to deny actual incestual violation. Admittedly, Freud has been known to minimize the role of the father in sexual abuse, claiming that "the seducers turn out as a rule to have been older children" (5). He did not discover the full extent of father-daughter incest; he did discover infantile sexuality. Not discovering is different from denying.

We do not need to throw out infantile sexuality and portray Freud as a patriarchal denier of incest to further the cause of fully exposing incestual abuse to public awareness. I do not know if Dr. Bigras intends to do this. But, by contributing to the perpetuation of this misleading trend of accusing Freud, he participates in maligning a great pioneer whose discoveries have been distorted, abused and misunderstood more often than they have been wrong.

References

1. Bigras J. Father-daughter incest: 25 years of experience of psychoanalysis with the victims. Can J Psychiatry 1989; 34(8) 804-806.
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3. Herman J. Father-daughter incest. Cambridge MA: Harvard University Press, 1981.
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5. Freud S. An autobiographical study (1924). In: Gay P, ed. The Freud reader. New York: W.W. Norton and Company, 1989.

H. Taynen, M.D.
Burlington, Ontario

INTERACTION OF FLUOXETINE AND SELEGILINE

Dear Sir:

Fluoxetine (Prozac) and selegiline (Deprenyl) are two new medications which have only recently been introduced on the North American market. There is limited experience using these two medications in combination, and we would like to describe two patients for whom there may have been an interaction between these two drugs.

The first patient is a 46 year old woman, with moderately severe, left-sided Parkinson's disease, who was maintained on levodopa (Prolopa) 15/12.5 q two hours and bromocriptine 10 mg tid. She was also taking amitriptyline 50 mg hs for a depression, which over the years had been considered to be an atypical depression. She had taken selegiline for a month in the fall of 1989, but discontinued it because of a lack of perceived benefit.

In January of 1990, because of anticholinergic side-effects, the amitriptyline was discontinued and fluoxetine 20 mg qam initiated. Selegiline was restarted about ten days later. Initially, the patient felt much better. However the next month, her behaviour became increasingly hyperactive, over communicative, elated and creative. Her actions and judgement appeared grossly impaired, and both clinicians thought her to be manic. Both the selegiline and fluoxetine were discontinued, and the patient slowly improved over the next two months. Review of her past history revealed that she had never had a manic episode previously and had always been considered to have a atypical depression. However, she had become expansive on one occasion, during childbirth after receiving analgesics.

Fluoxetine has previously been reported to cause mania (1,2) although usually at higher doses than 20 mg od, and manic symptoms in this case resolved quickly with discontinuation of fluoxetine. Selegiline is metabolized to l-amphetamine and l-methamphetamine, and may cause agitation in some patients. In one case, selegiline alone was reported to cause manic behaviour (3). Thus, the severe, prolonged mania seen in this patient may have been due to the concomitant use of selegiline and fluoxetine.

The second patient, a 56 year old woman with moderate Parkinson's disease, had selegiline 5 mg qam added to her previous regime of bromocriptine (Parlodel) 5 mg tid and levodopa-carbidopa (Sinemet) 100/25, eight tablets per day in January of 1990. She was also on amitriptyline, for depression which was discontinued in March of 1990 because of urinary hesitancy. The patient was started on fluoxetine 20 mg qam.

Several days after starting the fluoxetine, the patient started to develop episodes, during which she would shiver and break out in a cold sweat. The episodes would start in mid-afternoon and last for several hours. On these occasions, she would feel very clammy and her hands would be cold. She was seen in the office for assessment one month later. At that time, it was noted that she was very diaphoretic. Her hands were severely vasoconstricted, and the fingers were blue and mottled. Her blood pressure was 200/120. It remained elevated throughout the office visit.

Previously, the patient had had transient elevations of blood pressure, which were usually induced by stress, but she did not feel under stress on this occasion. The selegiline and fluoxetine were both discontinued, and she recovered within the next few days. Her blood pressure returned to normal (120/90). She did not have any further diaphoretic episodes. She has since restarted the fluoxetine with no side-effects.

This patient developed a very unusual reaction, which has not been reported previously with either selegiline or fluoxetine. As she was able to tolerate both medications independently, it would appear to be specifically due to this combination.