Leadership in Psychiatry: Interview with Dr. David Goldbloom

Interview conducted by Flora Nasri, 4th Year Undergraduate Student, Neuroscience Specialist Program

Dr. David S. Goldbloom is a professor of psychiatry at the University of Toronto. In addition to his clinical practice as a psychiatrist, he serves as Chair of the Mental Health Commission of Canada and as Senior Medical Advisor in Education and Public Affairs at Centre for Addiction and Mental Health. Dr. Goldbloom received his bachelor's degree in government from Harvard University. After obtaining his M.A. in Physiological Sciences from the University of Oxford, where he was a Rhodes Scholar, he trained in medicine and psychiatry at McGill University.

UTMJ: Can you tell us about your academic background and about what led you to choose a profession in psychiatry?

DG: My undergraduate degree was in Government; it was not in the sciences. I was fortunate enough to go to Harvard; and there, many of the people who were planning on becoming doctors were not studying science. There was more of a liberal arts tradition. Plus, I come from a long line of doctors and my father told me before I went off to university, "if you are even thinking of becoming a doctor, don't study science as an undergraduate; it's your last chance to learn about the world." So I took that advice very seriously. I studied a range of things from music to literature to politics but also I did some science. And then I was lucky enough to get a Rhodes scholarship, so I spent two years at Oxford. And there I did do physiological sciences for two years. So by the time I arrived at McGill University for medical school in 1977 I knew at least a little bit of science, although nothing like the science I learnt in the first two years of medical school, which was hundreds of hours of anatomy, histology, and other things that I never needed to know again in my career. I went into medicine not knowing what area of medicine I was going to end up in, and I actually enjoyed lots of things, from pediatrics to surgery to emergency work. But when I did my first rotation in psychiatry there was something about the field, the issues, and the people that really turned my crank. And as I've advised many medical students over the years who have come to seek advice about picking a specialty - it is not that I was trying to push them into psychiatry - but I give them my three simple rules for picking a specialty once you go into medicine. Those three rules are: you like it, it likes you, and you think you could be good at it.

UTMJ: Other than your clinical practice what are some of your other roles that are related to mental health?

DG: I still see patients most days, so I do a lot of clinical work as well as supervising residents in psychiatry. But outside of the hospital walls I would say my work related to mental health falls into three areas. Number one is public education. So I do a lot of work speaking to all kinds of groups across the country: they could be oil and gas pipefitters; they could be Bay street wealth managers; they could be parents at a school or students themselves. It does not matter. There is a lot of work to be done to undo some of the mythology, the stigma, the discrimination; so I do a lot of that in terms of public speaking. The second thing that I do on behalf of CAMH is a lot of fundraising because in order to build the kind of new hospital that CAMH is we need money to put up the buildings. So I have been involved with that, which is not simply asking people for money; it is also about convincing them of the importance of the cause. And the third thing that I do outside the role of the hospital is as chair of the Mental Health Commission of Canada.

UTMJ: How does Canada compare to other countries with regard to mental health policies?

DG: Well, first of all, when it comes to spending, Canada spends less as a percentage of total health care spending than other countries. We spend about 7% of our health care dollars on mental health care. But the costs of mental illness are significantly more than that. It is one of the reasons the Mental Health Strategy for Canada that was released in 2012 by the Mental Health Commission calls for the funding to increase from 7% of health funding to 9% over the course of 10 years. We underspend, we have significant waiting times for services, and we have highly variable access to services. This is not to say there are not good things happening in mental health care in Canada; there are excellent examples from coast to coast. But we need to be doing much, much more in the context of the significant burden mental illness represents for individuals and families.

UTMJ: You were one of the major contributors to Canada's first mental health strategy, which was released in May, 2012. Can you tell us more about the strategy and its outcomes so far?

DG: First of all, it would be an exaggeration to say that I was a major contributor. Much as I appreciate the compliment, I have to say it is not true. And that is because we had a group of people who were drafting the strategy. We had a group of experts from across the country who were having major contributions to the strategy, and then we also held public consultation with literally thousands of Canadians, in person and online who also had input into the strategy. The strategy in its 2012 version consists of a series of strategic directions for mental health care with very specific priorities laid out as subcategories. And frankly because the Mental Health Commission of Canada does not control the resources, the success or failure of implementation of the strategy will be decided ultimately by the people who do control the resources - the provinces and territories - when it comes to health care. And I think we will not be able to measure that impact for several years.

UTMJ: There is some concern about overdiagnosis of mental illness. What are your thoughts on this issue?

DG: There is always the risk of overdiagnosis. There is always the risk of pathologizing things that are variants of what is normal. That being said, we also know from good research evidence that many cases, for instance of depression, are missed in clinical practice, particularly in primary care. So that lots of people go untreated and undiagnosed while at the same time there may be other people who are overdiagnosed and receiving treatments that they do not need to have. This is a problem throughout medicine. I mean, as we widen the boundaries of diagnosis, as we talk about people who are prehypertensive, or people whose PSA level is a little bit elevated, or somebody whose lipids are starting to look high, we have all kinds of screening and intervention approaches which always carry the risk of (a) mislabelling what is normal as abnormal and (b) triggering treatment which has side effects. So I do not think psychiatry is actually unique in this regard, but what makes psychiatry unique is that we have no laboratory tests that allow us to provide objective confirmation of a diagnosis. Instead, we are obliged to rely on symptom patterns and clinical histories. Now, as a bedside clinician, I happen to think taking a careful history from someone is an important diagnostic and therapeutic act, much more so than ordering a blood test.

UTMJ: Why does the stigma surrounding mental health issues still persist? What do you think can be done to reduce the stigma?

DG: There are many reasons why the stigma around mental illness persists; one of them I think is that nothing is more threatening to our sense of personal identity, of who we are, than mental illness. If you break your leg, you are still you. If your mind is broken, are you still you, in your own eyes and in the eyes of other people? So that is why I think it represents such a significant threat. One of the ways that we deal with threats like that is we either avoid them or we trivialize them, which is one of the reasons, I think, it's still in our twenty-first century politically correct society somehow acceptable to make fun of people with mental illness in ways that we would never do for physical illness.

UTMJ: What advice do you have for medical students who are interested in pursuing a path in the mental health field?

DG: I think there is always the danger in specializing too early. I encourage people, much as my father said to me, "If you want to be a doctor, do not study science. Learn about the rest of the world." I would say if you want to be a psychiatrist, in medical school, learn about the rest of medicine. Understand this unique privilege that you have been given to be a physician in modern society and the expectations that go with it, which is that you are not simply a doctor of the mind as a psychiatrist; you are a doctor. And understand, through the unique opportunity you get as a medical student, the full range of people's experience of illness, be it physical or mental.