One of the few psychiatric residents who wasn't able to adapt to the Village culture was a man who came from a family with six generations of physicians in the Middle East. He had known he was going to be a doctor ever since he could remember and he knew how a doctor was expected to act. Unfortunately, the highly authoritarian model he knew did not fit into our recovery based culture. I was particularly appalled when he told me that he remembered how his father treated a woman who was brought to his office by her husband for hysterical paralysis. His father slapped her across the face and ordered her to stop it. And she did. Many of our members, especially the women, had trouble relating to his style and started refusing to see him. I had a revolt on my hands. Frustrated, I wrote down this list of instructions for changes he should try to make, but he ended up having to leave the Village. I was going to throw away this list, but the team leader said he thought it might be useful in the future, so here it is.

Medication Collaboration Strategies

(1998)

1) Treat members as though they were doctors or colleagues instead of just patients.

2) There is almost never only one "correct" medication regimen, so always give people choices.

3) When someone requests something, including a particular medication, try to accommodate them unless it's dangerous, harmful or unethical.

4) Never say, "Because I'm a doctor." Explain your underlying reasons instead. "Because I'm a doctor" is a way of emphasizing and exploiting the power you have over people, which is demeaning.

5) Never threaten to or stop seeing someone because you don't agree with their decisions or because of their behaviors. The decision to include or exclude someone from program membership is a team decision and not yours individually. Explain that to ongoing and prospective members. There are special strategies for dangerousness, personal abusiveness, program destructiveness, and sexual attraction.

6) Try to make medication visits as much like conversing with a friend as possible and limit clinical interrogation. Listen without an agenda for long periods of time. Discuss non-clinical items of mutual interest (like sports, politics, shopping, movies, etc.) Use personal disclosure freely. Try to make it fun and enjoyable to be with you.

7) Talk to members outside of medication visits as acquaintances or friends (in front of the office, at lunch, between visits, in the community, etc.)

8) Try to be flexible and accommodate members' desires (like meeting in private, or outside, or scheduling around their lives). We are here for their benefit. They aren't here to give us convenient and comfortable jobs. Their choices as customers are limited by their poverty and limits in public mental health services. Don't limit them further in your relationships.

9) Try to be appealing both to the members you're treating and others around you. Members should like you and want to talk with you. New members should be asking if they could talk with you, too. There is often an audience of people suspicious of psychiatrists that you should be engaging.

10) Attend at least one social activity in the building and one out of the building per month. Choose something you honestly like, regardless of the time it's scheduled, and flex the hours.

11) De-mystify and de-professionalize mental illness, medication, and psychiatrists as much as possible so members can comfortably include us in their lives for a long time. Sharing stories, experiences, and personal views is often more effective than academic education in this regard.

12) Try to work on their treatment goals rather than yours. This requires listening to their view of their lives and their illnesses.