Quick Takes
A PODCAST BY PHYSICIANS FOR PHYSICIANS
HOSTED BY DR. DAVID GRATZER

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David Goldbloom on his retirement, on his career, on psychiatry

[Edited for grammar and clarity by CAMH]

[short musical intro]

David Gratzer: Welcome to *Quick Takes.* My name is Dr. David Gratzer. I'm a psychiatrist here at the Centre for Addiction and Mental Health. On this episode, we talk to Dr. David Goldbloom. Dr. Goldbloom is a senior medical advisor here at CAMH. He's a professor of psychiatry at the University of Toronto, former chair of the Mental Health Commission of Canada, former editor of the *Canadian Journal of Psychiatry*. He's also a bestselling author and a returning guest. And in a few days, he adds another title to that long list: retiree. Welcome, Dr. Goldbloom.

David Goldbloom: Thank you. Nice to be with you, David. And I'm very mindful that you have a parallel series running on innovation, whereas this episode is more about when dinosaurs roamed the earth.

David Gratzer: Well, that's a good segue into our first question, which is retirement. Are you sure?

David Goldbloom: Well, how can you ever be sure of anything? If you're waiting for a certainty, you're going to be waiting for Godot. So you have to make a decision. And, you know, the elimination of mandatory retirement ages, which was a very helpful yardstick for a lot of people, was a liberation for many people. But for others it placed them in another kind of quandary: when should I retire when nobody's telling me when to retire? And so that triggered a fair amount of thinking on my part about what would be the right time for me, not for everybody, but for me personally. And I had a kind of moment of epiphany, if you will, when I realised that absent a prescribed retirement age, my only options were too early, and too late when it came to retirement. And given that forced choice, my preference was very strongly in the 'too early' category, based on the old Broadway adage of always leave them wanting more. And frankly, when I thought about how I would want my colleagues to react, I thought better they should express surprise and disappointment than a sigh of relief.

David Gratzer: You've put much thought into this.

David Goldbloom: You know, I have and I think, like is the case for many people, this kind of thinking was accelerated by the pandemic. Accelerated in the context of spending lots of time working from home, without our home becoming a crime scene, and realising that I didn't need to be at the epicentre of the hospital, feeding off the energy of the hospital in a way that I had for most of my career.

David Gratzer: Yet you're still very busy, tremendously active actually, clinically seeing patients, making decisions, helping people.

David Goldbloom: Well, yeah. I know some people prefer to wind down and that's not in my temperament. So as the sands of time are quickly falling through the hourglass, in terms of my career, I decided, well, if I'm

going to retire in December, I want to do as much as I can before I stop. So, I'm doing a high volume of consultation while figuring out transitions for my ongoing patients, but I'm not slowing down until I actually stop.

David Gratzer: There are other people at your stage of career. There are people not at your stage of career. But we'll all eventually wonder, when should I retire? What advice would you give?

David Goldbloom: Well, I think it should be earlier than you had perhaps thought you would work until, in other words, the idea that, well, I'll keep working until my faculties start to fail ignores the idea that your skills may be getting past their best before date. Maybe you're not keeping up on literature as well as you should. And if you're starting to feel, I think in any way professionally stale, you've got to have either a plan to reinvent yourself professionally or move on because you don't want to do a disservice to patients. I think the other thing is if you have the privilege of working in a large organisation like you and I do, where there are incoming waves of young, talented people, you want to make sure that there's lots of room for them to thrive and you also realise you've become part of history. And one of the lessons I learned during the pandemic was when I would show up for my weekly shift vaccinating people in our vaccine clinic, I'd meet young doctors and introduced myself and they'd say, Oh, hi, what do you do here? And I'd say, well I'm a physician here in the assessment clinic. And they wonder, how long have you been here? What else have you done? And I realised I am, for this new group, understandably somebody who's not part of their milieu or their circle. And so you don't want to be hanging around as a ghost of yourself.

David Gratzer: Let's pivot. You've talked about the decision. What are your thoughts about the state of psychiatry today?

David Goldbloom: Well, look, I'm very mindful that all of us are kind of grains of sand against the large beach. That is the history of our profession. And I was saying before we started to record this that I'm nearly finished reading Andrew Skull's new book, *Desperate Remedies*, which is a history of 20th century psychiatry, with a decided emphasis on the warts and the things that we got wrong, which is indeed the history of any area of medicine. My late father always cited the statement that today's dogma is tomorrow's malpractice, and that's true of psychiatry as much as any other specialty. But I'm not an entirely gloomy or nihilistic person, either by temperament or based on what I've witnessed over the last 40 years. And I think our profession is in better shape than it was when I started. Attracting lots of talented and smart and passionate and committed people to work in it, like in bigger numbers than ever before. And so I think that the human factor in terms of who chooses psychiatry is kind of critical. I've seen a significant shift among younger psychiatrists towards a sense of care for and responsibility for the needs of people with severe and persistent mental illness. A return to hospital-based work with the most severely ill, emergency room work, with that population. You know, the areas where progress has been more incremental would be in the area of therapeutics. And that's a frustration, which is to say that we have good treatments for all the major disorders, treatments whose success rates are comparable to many of the treatments across medicine broadly. But when you spend time with patients, what you also know is they're not good enough. And if you use the yardstick of what you would want if this patient was your brother or sister, then they're really not good enough. And they're not enough of a paradigm shift from what we had available in the 1960s and 1970s. They are tweaks, they are refinements, they are improvements, but they're not paradigm shifts.

David Gratzer: Are you optimistic about the future?

David Goldbloom: Well, what's my other option? I would say, yes, of course I'm optimistic about the future, because I think that the acceleration in the quality and sophistication and reach of research to try to come up with new paradigms, new approaches is so much better than it was 20 years ago, 40 years ago. Now, I'm also mindful that 100 years from now, people will look at our research that we're doing currently and say, can you believe how primitive they were? Right? But that's the beauty of retrospection. I take it from the point of view of looking back 40 years to where we are now and see huge improvements. And of course, the other area

which you and I live and breathe every day is the greater public awareness around mental illness, the greater public acceptance around mental illness. The fact that in our recent provincial election campaign, the three parties were competing with each other to see who would have a more comprehensive platform around mental illness. That is unfathomable as an idea 20 years ago. So, in that sense, I think we're much better positioned than we were. But we also need to be humble. We're dealing with the single most complex organ in the human body about which we know the least relative to other organs. We're making tremendous progress, but it is a daunting prospect and I quote that I've said repeatedly from… I forget who now originally said it, that "if the brain were so simple we could understand it, then we would be so simple that we couldn't." And I think that's still true. But the yardstick of progress is long.

David Gratzer: You touch on stigma and there's more conversations in the union halls and boardrooms and, of course, in political campaigns. There's also more philanthropy. You gave an interview a few years ago when Matt Galloway was still with Metro Morning, and you talked about donations to CAMH and you've had a big role in fundraising here and you talked about the McCain building. What are your thoughts on that and how fundraising has changed over time?

David Goldbloom: Well, I am old enough to recall when at our Queen Street site there was no name on any building. And in fact the four principal buildings for patient care were brilliantly called Unit One, Unit Two, Unit Three and Unit Four in a burst of creativity by the provincial government. And not only were they called simply by numbers, the numbers were not in any kind of order for wayfinding. They were numbered by the order in which they were built, which helped the provincial government track the flow of goods and services by building number. And now you and I work on a campus at CAMH, 27 acres of downtown Toronto, where every building bears the name of philanthropic supporters mainly of an individual or family rather than a corporate level, with the exception of the Bell Gateway Building. All of these are named for families who made the courageous step to say, I'm going to be publicly affiliated with this and support this. And it has a hugely, I think, permissive effect for other people. And we've been inordinately successful as an organisation in raising many hundreds of millions of dollars now for a cause that was once thought to be unsupportable by philanthropy.

David Gratzer: There's been major progress, stigma has faded, but stigma still exists. Is there a certain amount of stigma that will always exist? In one of your books, you talk about a childhood friend who you happened upon in the inpatient unit. He was a patient and you comment that 'they are us.' Is that something that inevitably lends itself to some element of stigma?

David Goldbloom: Yeah. I'm not so pollyannish to think that we will entirely eliminate stigma. Now it is probably a little easier to eliminate the discrimination that flows from stigma, but those sort of very core beliefs on a set of illnesses that profoundly disrupt or have the potential to disrupt those elements of our being that are integral to our individuality, our moods, our thoughts, our behaviours are very, very different than a broken leg. And so I think it's probably too much to hope for that people would not personalise, in themselves or in other people, the profound disruptions to those components of who we are. That mental illness can sometimes engender.

David Gratzer: You talk about treatments and progress, though there remains ongoing problems. Why are treatments like antidepressants so controversial, or in some quarters so controversial? In recent months, Moncrieff has released yet another paper. She's built a career, as you know, as a professor of psychiatry, writing basically the same paper over and over again, questioning antidepressants, how they work and so on. Why does this capture so much attention in this day and age as opposed to metformin, also a medication we don't exactly know how it works, which is without any controversy? Is that just lingering stigma? Is that just resentment about the field's history? What are your thoughts?

David Goldbloom: Yeah, I think it's probably a combination of things rather than a single cause. You know, some of the criticism comes about from the narrowness of the gap between placebo response and drug

response in antidepressant trials. The fact that there is a significant placebo response, interestingly, is taken as an invalidation of human suffering. And that, to me, that's what I distill out of the critique. That when people see a placebo response rate in depression studies of 30% they actually, without maybe articulating it, say well, just how real is this problem anyway if 30% of people will get better with placebo? Which to me demonstrates a tremendous ignorance of the power of placebo in all forms of human suffering, including broken bones and, you know, torn viscera, whatever you want to describe. And I remember one of my teachers at McGill when I was a resident said, very wisely, that the power, the role of research in clinical trials is to minimize the role of placebo through a variety of techniques. And he said and the role of clinical practice is to maximize the role of placebo. So I think it builds on people's suspicions that those things that aren't, quote, real, unquote, like depression because you can't isolate it on an imaging study or in a blood test. The treatments therefore also become highly suspect. And the awful thing about that is the blind eye that it turns to human suffering.

David Gratzer: You've trained many residents and medical students over the years. You've won pretty much every major teaching award in the department and at the hospital. What advice might you give to learners and younger colleagues?

David Goldbloom: So first of all, in terms of practice and this may sound a little trite, it would be to see as many patients as you can because the exposure to a wide variety of people and wide variety of journeys is both humbling and profoundly educational. And it's also enriching, right? I happen to be the kind of person who enjoys connecting with people, be they colleagues, students, patients or friends. That's I'm just, I think affiliate of by nature. So for me, that's been one of the most rewarding aspects. I would advise young colleagues to keep reading. And the danger is that you just stop reading after you've got your shingle. And the explosion in our professional literature means that you require aggregating sites or filters or thoughtful editors to help guide you in your reading. But trying to stay current and stay stimulated is important. The third thing would be that if you happen to be one of those people who works in a large organisation do not be shy about consulting with your colleagues on cases where you feel stymied or perplexed. Right? It is not a sign of weakness or stupidity to ask a colleague either above you or below you, in terms of seniority, for help. And it should be happening, I think, much more in our hospital than it actually does. We don't seek second opinions as often as we should, and there's no way on earth we can be right all the time.

David Gratzer: That last piece of advice is particularly relevant for some of our colleagues at CAMH, a big centre where there are so many opportunities for second opinion, yet there's always hesitation. Is that part of the culture of medicine itself?

David Goldbloom: I think it's part of the culture of psychiatry that we are among the most secretive of medical professionals. You know if you're a surgeon it's called an operating theatre for a reason. Right? There's an audience frequently. There may be a group of people huddled around the person who's the subject of the operation and a gallery of observers at times. We work very, very secretively, and we rarely show our work, even in our teaching. Those of us who are teachers all too often will observe our students and residents interviewing but won't let them watch us work. What are we hiding? And so I'm all in favour of more exposure, more questioning, more collegiality. And it floats everybody's boats.

David Gratzer: You have done many things in your career, certainly worked in direct patient care, but you've held different positions in this hospital and in other organizations. What might you say was something you did that was different that you really enjoyed?

David Goldbloom: Well, look, like most people, I went to medical school around the idea of being a doctor and seeing patients, and that's always been foundational for me. It's how I started and it's clearly how I am ending my career. But the stuff that came in the middle was kind of unanticipated. And how often do you get to be part of a team that's creating a new psychiatric hospital with a different ethos of care? So the building years of CAMH starting from 1998 to 2003, were exhilarating and frankly, we were flying by the seat of our

pants. We had no manual on how to do this, and that made it a ton of fun. Did we make mistakes? Of course we made mistakes, but it was a huge learning curve for me. And I would guess that the second sort of unanticipated notable event was the opportunity I had to be part of the founding and ultimately the leadership of the Mental Health Commission of Canada, which took me into realms that I had never previously encountered, in political circles in the public eye, and that was a lot of fun as well. So I really encourage people, and I encourage junior residents and junior staff, to think about beyond the confines of their clinical or academic or research work, are there ways that you can get involved as a psychiatrist and make a contribution outside those spheres? Whether it's sitting on the board of a community agency or teaching in unusual settings or committing to do public education through the media or other ways. Those are the things I would encourage people to put their toe in the water with those activities.

David Gratzer: What about working in a vaccine clinic during a once in a century pandemic?

David Goldbloom: Okay that was a total blast! Right? And certainly a relief from the confines of home and probably the only year in my career where once a week, 12 people an hour would say thank you and mean it because everybody was so grateful for vaccination. And for those of us in psychiatry, which is not a hands-on specialty, that returned to that kind of elemental physical contact with patients with actually puncturing the skin to inject a vaccine and a fragment of a second of discomfort, followed by a sense of relief. What a trip. It was great!

David Gratzer: Writing in Toronto Life about some of the patients that you had worked with in the vaccine clinic days: "I have never seen so many tattoos. People with them are pretty chill about a quick and tiny needle. Some young muscle-bound people have a hard time allowing their upper arms to fully relax or flinch reflexively with such power that I'm afraid the needle will get stuck. It hasn't happened yet. I also never met so many people with needle phobia, some of whom have gone to other clinics already and left without their shot because they're overwhelmed by anxiety."

David Goldbloom: And look, I think our ability to reduce anxiety in people, which, again, to quote my late father, was the first mission of all physicians in all specialties, is the reduction of anxiety in our patients. But you had that opportunity frequently with adults and with children, especially little children in the vaccine clinic, in a momentary encounter you know, this isn't the 50-minute hour. This is a three-minute encounter with someone where you still can feel a therapeutic connection and feel like you've done something good for that person and reduced their anxiety. So if we get another pandemic, I would encourage everybody to sign up to work in a vaccination clinic.

David Gratzer: Sagely advice for the next pandemic.

David Gratzer: Dr. Goldbloom, as you know, it is a podcast tradition here at *Quick Takes* that we do a rapid-fire minute. Shall we put a minute on the clock?

David Goldbloom: I'm sweating bullets but go ahead.

David Gratzer: You've done fine the three times we've done this before. I think it'll be okay!

David Goldbloom: I feel like I'm back on *Reach for the Top*.

David Gratzer: One minute on the clock. Here we go. Dr. Goldbloom biggest wish for retirement?

David Goldbloom: Good health.

David Gratzer: Dr. Goldbloom biggest wish for the profession after retirement?

David Goldbloom: More progress on therapeutics and better understanding of how the brain works.

David Gratzer: Dr. Goldbloom thinking through your career. Biggest highlight?

David Goldbloom: Biggest highlight. You know, honestly, I would say probably the opportunity to work at CAMH.

David Gratzer: Are you going to write a new book?

David Goldbloom: I'm thinking about it.

David Gratzer: What are you thinking about in terms of a topic?

David Goldbloom: Well, I don't think I have anything left to say about psychiatry that I haven't said in the two previous books. So I'll have to think of a new angle, a new area to explore. So I haven't settled on it.

David Gratzer: And at the buzzer, a mistake you made somewhere in your career that others might learn from.

David Goldbloom: Excessive confidence in what I was doing. Right? And that is the folly of youth, perhaps. And maybe it's a necessary rocket fuel for continuing to work hard but being excessively confident that what I was doing was right and the truth.

David Gratzer: Dr. Goldbloom we're at the end of the minute and at the end of the interview, just a moment to thank you again for joining us today. And thank you again for everything you've done for people like me over the years in terms of supervision and mentorship and, of course, friendship.

David Goldbloom: It's been a privilege.

[Outro]

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