# An Interview with John P. Docherty, MD

John P. Docherty, MD, is Founder and Chairman of CNS and Chief Program Development Officer of Comprehensive Neuroscience, Inc., White Plains, New York, a clinical drug development and disease management company, as well as Adjunct Professor of Psychiatry at Joan and Sanford I. Weill Medical College, Cornell University, in White Plains, NY.

Dr. Docherty has held academic appointments at Yale, Harvard, Tufts, the Uniformed Services University of the Health Sciences, Professorships at UCLA and Cornell, along with Visiting Professorships at the University of Oslo and the University of Hawaii. Trained as a clinical research fellow at the National Institute of Mental Health (NIMH) Neuropsychopharmacology Branch, Dr. Docherty returned to the NIMH to become Chief of the Psychosocial Treatments Research Branch. In that capacity, he was responsible for the development, funding and oversight of all federally supported psychosocial treatment research in mental health nationwide. While there, he also oversaw the successful development and completion of the landmark National Collaborative Study in the Treatment of Depression, a study in which the methodologies for successful clinical trials in psychosocial treatment research were established as a standard for the field.

Dr. Docherty has received numerous honors and awards, including the Merck Recognition Award for Advances in Medical Quality Management, the Psychiatric Institute of America's Medical Director Leadership Award, the National Association of Private Psychiatric Hospital Presidential Award for Research, and the Yale-Seymour L. Lustman Award for Psychiatric Research. He is a Fellow of the American College of Psychiatrists and a distinguished lifetime fellow of the American Psychiatric Association. Dr. Docherty has authored over one hundred scientific publications and has had extensive personal experience in the design and conduct of clinical trials with central nervous system pharmaceuticals.

***CS:*** **What were key decision points in your career and how have these ultimately led you to your present position?**

**JD:** Oh my—this question takes me back. I would say that overall the decisions I have made have been guided by a single principle, which is, given my knowledge and skill and interests at the time, where could I best help and improve our ability to help those people suffering from mental illness.

How did it start? The first two influencing experiences were emotional and personal. I was seven or eight years old, and we had just gotten a television set. I was home alone watching it. There was a documentary on schizophrenia. This was about 1951, before the introduction of chlorpromazine. The show was coldly "clinical." It was largely a demonstration of the symptoms of schizophrenia. One of the patients was a seventeen year old girl with catatonic schizophrenia who was being used to demonstrate "waxy flexibility." She was mute and uncommunicative. I think, being a child myself, that I identified with her. I remember thinking, "This is a girl with a long life ahead of her and yet she won't be living. She will have years and years of isolation and suffering." I still vividly recall her to this day.

The second experience was in my family. When I was a teenager, my father, whom I very much loved and enjoyed and admired, developed a severe unipolar agitated depression. I saw in a deeply personal way the terrible pain that severe mental illness brings—to the patient and the family. Unfortunately, I also saw the prolongation of pain and the despair that impersonal and ineffective treatment brings. This experience led to my interest in research and the grounding of treatment in evidence rather than the sad but still too widespread provision of therapies sprung whole, like Athena, from the head of a self-appointed Zeus and pursued with religious fervor by zealous acolytes. For example, this experience led to my decision to accept the position of Chief of the Psychosocial Treatments Branch of the NIMH, a position from which I felt I could help forward the excellent work that was being done by people like Gerald Klerman, Tim Beck, Myrna Weissman, Lester Luborsky, Jerome Frank and others (including my mentor, Morrie Parloff, and wonderful colleagues, Irene Waskow and Tracie Shea) to develop a methodology to empirically test the efficacy and comparative efficacy of psychotherapies.

There is not sufficient space here, I am afraid, to mention all the wonderful colleagues who guided and continue

to guide and influence me. Each day I am influenced by my mentors (still), colleagues and students. This has been one of the great joys of my life in our field.

***CS:* What does your typical workday look like?**

**JD:** I do not have a typical workday. One of the things I like about my current job is the diversity of experiences. I am overseeing a company that provides for the clinical testing from Phase I–IV of new medications—including designing, conducting and reporting the results. As a consequence, we are close to the new science of our field. We also provide automated disease management services that now are used to help improve the population health of over ten million people. I also still see patients, conduct my own research, and teach and lecture. Everyday seems to bring something new and unexpected.

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***CS*: Do you still see patients?**

**JD:** Yes. Some are patients I have seen for a long time and are now quite stable. New patients tend to be people who are not doing well for one reason or another.

***CS:* Why did you choose a career in psychiatry?**

**JD:** I believe, as you can see from the first question, that it chose me.

***CS:* What did you learn early on in your career that has turned out to be important or helpful to you?**

**JD:** As I mentioned, the benefit of basing treatment on evidence (limited though it might be) and on a logical, systematic inference from that evidence—rather than "winging it" on the basis of my own great thoughts.

***CS:* What advice would you give to residents who are considering a career in academic psychiatry today?**

**JD:** I am finding it hard to give residents much advice these days, since most of them seem smarter than I am and seem to have simply absorbed so many things that I struggled to learn. I think if I were to proffer advice, it would simply be to say this:

> Remember that you are doctors first, fundamentally and always. For the patient this is most basically represented in the therapeutic alliance. What all of us, as patients, want to know is that our doctors: 1) care about us as people, 2) understand the nature of our problems, and 3) can do something that will be helpful to us. When all is said and done, your job is simply to alleviate the suffering of your patient and return her or him to health. Also, unlike Las Vegas, what happens in the brain does not stay in the brain. It ramifies through the entirety of the patient's physical and social well-being. Do not get trapped by the fragmentation of healthcare that has been produced by an already outmoded system of "specialty" care that we have developed to handle the wonderful growth in knowledge that has derived from science-based medicine.

I also would and do share my enthusiasm for residents' decisions to become psychiatrists at what I believe is an historic inflection point in the history of the field. One of the rewards of my current position, and its involvement with new drug development, is that it provides a window far into the future. The unprecedented advances in medical technology and scientific methodology and discovery have provided us with an opportunity to transform our ability to treat mental illness, and we are only at the threshold of this new era.

***CS:* What has been the greatest disappointment in your career?**

**JD:** The greatest disappointment is the disastrous limitation due to managed care on our ability to provide adequate inpatient treatment, and the unaccountable waste associated with the thoughtless review of outpatient treatment. Untold suffering and unnecessary cost have been associated with the mindless limitation on inpatient care—a limitation completely at odds with evidenced-based medicine, and common sense, for that matter.

***CS:* What has been the greatest joy in your career?**

**JD:** Several years ago I had developed a respiratory illness that manifested in MRI changes consistent with bronchial carcinoma. I could have either an invasive biopsy or wait three months and repeat the MRI. It would either have progressed or not, and early diagnosis would not have a material effect on a lethal illness. I chose to wait and repeat—but during those three months, of course, I had to face the real prospect of imminent death. Surprisingly (to me), I felt calm and at ease due to one major thing—I felt that I had had a worthwhile life and that, in turn, was due not to honors and awards or material success, but to thinking of all the specific people I had helped as a psychiatrist. For me, this profession and that opportunity have been a gift and a joy.

***CS:*** **How do we truly measure quality in psychiatric care?**

**JD:** Not to be too pedantic (just a thought, but is it possible to be pedantic ever without being too pedantic?) but I have rather pompously expounded on this issue in my article "A Comprehensive System for Value Accounting in Psychiatry." The simple update I would make to that article is that I now believe that we should measure quality of outcome by a quantitative approximation of the concept we are calling "recovery." In the not too distant future I hope and now expect that we will measure it by approximation of true cure.

Butler S, Docherty JP. A comprehensive system for value accounting in psychiatry. J Behav Health Serv Res 1996;23(4):479-491.

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***CS:*** **What do you think are the major opportunities for psychiatry over, say, the next ten years?**

**JD:** I see five opportunities:

First, our progressive, detailed understanding of the relationship between serious mental illness and metabolic and cardiovascular disease, and the effects of our drugs on these multisystem illnesses, have provided a basis for integrated medical-psychiatric care. The knowledge that our schizophrenic patients are dying twenty years earlier than average, and dying disproportionately and predominantly of cardiovascular disease, requires that we, as psychiatrists and the systems we run, be adequately prepared to deliver comprehensive and integrated care.

Second, sufficient knowledge has now been generated to raise the bar of what we, as a profession, and the public should expect us to seek to achieve as the outcome of care. We now have sufficient knowledge to be seeking not just reduction of symptoms (Response), but remission of all symptom manifestation. The STAR-D project suggests that the systematic application of current knowledge could increase remission in depressed patients twofold—from one-third to two-thirds. The individual, economic and public health impact of such an improvement is enormous.

The third, fourth and fifth opportunities all derive from the stunning advance in knowledge in basic biology, especially genomics, molecular biology and cell signaling, systems biology and neurobiology:

The third opportunity is the ability to increasingly understand the relationship between the external environment in its broadest sense, including current context, and current and early life experience and biological expression. Recent work showing the ability of the environment to alter the gene expressing corticotropin-releasing factor (CRF) is an excellent example of our ability to bridge the "mind-body" dichotomy and develop more precise and effective psychosocial treatment.

The fourth opportunity is in many ways the most exciting. This new knowledge has provided the opportunity to develop drugs directed at completely novel biological targets and levels of neuropsychiatric illness. There are literally thousands of new compounds in development. Next to oncology, central nervous system (CNS) drug development is the most robust area of pharmacology. It is truly, I believe, a new world filled with new promise.

Fifth, this opportunity emerges from the other four. I believe that if—and it is a very big IF—we can properly educate the public about the four opportunities I have noted, and the knowledge underlying them, we can do a great deal to eliminate stigma and its toxic manifestations in social approbation, intolerance and misunderstanding, and a discriminatory and self-defeating healthcare benefit system.