Dr. Steven A. Rasmussen: From Brown Alum to Department Chair

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PROVIDENCE – Dr. Steven A. Rasmussen, the newly appointed chair of the Department of Psychiatry and Human Behavior at The Warren Alpert Medical School of Brown University, recently reflected on his more than three decades at Brown.

In an interview with the *Rhode Island Medical Journal* at his office on the Butler Hospital campus he recalled his early years in the 1970s as an undergraduate, when the "new" curriculum was new, and Stanley M. Aronson, MD, was dean of the fledgling medical program.

Q. You are a '74 Brown alum, and a '77 graduate of Brown's medical program. What was it like to be a student in those years and during the formative era of the medical school under Dean Aronson?

A. Back then, before the 8-year Program in Liberal Medical Education was formed, it was a seven-year program and students received a master's in medical science and an MD. I was working on my master's thesis as an undergraduate and was able to take advantage of the best Brown had to offer, when the 'new' curriculum was still new. The emphasis was on working to determine your own path. Some of the best professors I had were from the English department. An interest in psychiatry, poetry and literature often go together. You learn about human life through reading novels and poetry. Michael Harper in the English Department was a formative influence for me in terms of my own personal development.

Stan embodied the medical program's principles – to train physicians in providing excellence in care guided by humanistic values.

Q. Did you have an early professional mentor who was key to the path you have followed in your career?

A. I did my residency at Yale. At the time there were many leading figures in academic psychiatry teaching there. George Heninger was a mentor to just about all of us. Once, somehow, we got on the topic of fate and Moby Dick and we argued about whether Ahab was a villain or hero. He always took the outrageous position about things to make you think and react to a position that was contrary to the way you thought. He was a very original thinker; he had a metaphor for everything.

In addition, he was a truly outstanding scientist, devoted to figuring out ways to relieve human suffering. He had a tireless motivation to help people suffering with mental illness.

Q. As chair of psychiatry at Lifespan, Brown, and Care New England, you have to be a bridge builder. How do you build collaborations across separate entities?

A. Working for separate organizations is like working for Coke and Pepsi. Each system has its mission and definition of what it wants to become. But when you look carefully at the healthcare systems and Brown, their missions are not that disparate. You look for areas where the visions coincide. When you put together collaborations, you can achieve something greater that a single system couldn't do it on its own and that can really benefit health in Rhode Island in general.

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I think the job that I have is more to say that we really have an opportunity to pull all the healthcare systems and Brown together in certain arenas where it's going to pay to work together and develop best practices across the systems.

Q. You are a pioneer in developing the use of gamma knife surgery to treat obsessive-compulsive disorder and deep brain stimulation to treat

depression. What treatments and/or technological advances do you hope to see in these areas?

A. The hope is to develop a new range of noninvasive neuromodulatory devices. Right now we are looking at the effects of transcranial magnetic stimulation, with both transcranial direct current stimulation (TDCS), and transcranial alternating current stimulation (TACS), at the Providence VA through a $1 million (renewable each year) center grant for five years.

What we are trying to do is develop ways to influence rhythms in brain structures that are thought to be involved in the pathogenesis of pain, depression, and other psychiatric disorders, using OCD, where the neurocircuitry is better understood, as a window.

The hope is that we are going to be able to use the great basic science infrastructure at Brown to help bioengineer new generation of devices to be able to treat some of these conditions.

Q. Do you anticipate that Butler Hospital will be developing its own imaging and biochemistry laboratories for the detection of biochemical or structural changes underlying the neurodegenerative disorders associated with dementia?

A. At Butler, one of the clinical groups is involved in the early testing of drugs for neurodegenerative disorders that is recognized nationally as one of the best in the country. The three focus areas we've prioritized are neurodevelopmental diseases, neurorestoration and neurodegeneration. It's hard to know if additional facilities would be developed at Butler or in a collaborative type of consortium. In order for us to be a national leader we need to work together with Brown, CNE and Lifespan to develop a critical mass.

Q. Should there be a major component of neurology based at Butler, for the outpatient care of such disorders as multiple sclerosis?

A. There is a real intersection between the compassionate and behavioral health side of dealing with people who have these neurodegenerative disorders and the scientific side, working on advances that might affect the course of the disease. In the interim there is a tremendous crush in how we are going to manage neurodegenerative diseases in this country. We are getting better at people living longer and longer; as a result more and more people are going to have these neurodegenerative diseases for which there is no known cure. There's a very important role in trying to bring together neurology and psychiatry to optimize treatment and help patients maintain and restore function to as great a degree as possible.

Q. In your 36 years as a physician, what is the biggest change you've seen in the practice of medicine?

A. Business has taken over medicine. And it has had major effects on the ways physicians practice. The necessity of having to do things quickly and efficiently has had, I think, a negative impact on the way that physicians have traditionally been seen as healers. We don't have the time to spend to get into people's lives in the way we used to. The vast majority of psychiatric practice is no longer psychotherapy; it's prescribing medications for the major psychiatric illnesses.

Most doctors didn't go into medicine to make money. They wanted to help people. The whole notion of how do you make a profit is contrary to the way most doctors think. ❖