Jefferson Faculty

Rajnish Mago, MD

Building a Better Toolkit to Manage Mood Disorders

Some trainees in Jefferson's Department of Psychiatry and Human Behavior call them "Magoisms" — the tenets around which associate professor Rajnish Mago, MD, encourages them to shape their practice. "Always aim for your patient to get 100 percent better," one he echoes often, stands out as particularly ambitious.

"We should not be satisfied with a patient's improvement as being 'good enough,'" says Mago, director of the Mood Disorders Program, which covers both depressive and bipolar disorders. "We must use a broad range of interventions, not just a prescription, and always try to have patients improve 100 percent, even though we know this is not always possible."

While people with mood disorders often receive medication and psychotherapy from separate clinicians, Mago prides himself on his expertise in both areas. He is as much a researcher as a clinician and has conducted important studies into the adverse effects of antidepressants, previously neglected territory.

"A typical recommended minimum duration for an antidepressant is eight to 12 months, but within three months more than half of patients quit, mostly because of side effects. We must find ways to manage these. It's like with cancer and chemotherapy — the medication can be life-changing, and you can't stop it just because of side effects."

With a grant from a private, donor-funded foundation, Mago completed the first-ever study of antidepressant use and excessive sweating, a problem experienced by up to 14 percent of people taking antidepressants. He demonstrated an effective treatment for the sweating, enabling patients to continue treatment without the distressing side effect.

The same foundation awarded him a second grant with which he developed computer software to systematically assess medications' side effects. Patients answer questions before and after starting a medication, and the software uses an algorithm to determine whether various symptoms may be related to treatment.

Mago recently shared his views on his work and the practice of psychiatry.

What are some of the major issues in your field today?

Two problems are occurring simultaneously: underdiagnosis and overdiagnosis. More than two-thirds of people with bipolar disorder are initially misdiagnosed, which is a big problem because they get don't get the right treatment.

But then anyone who is sad is said to have 'depression' — not to *be* depressed, but to *have* depression, as if a virus got into them. We need to distinguish between being depressed about a specific situation and having a clinical depressive disorder, because overdiagnosis leads to inappropriate prescription of medication. These days, you can't throw a stone without hitting someone who's on antidepressants, and a lot of the prescribing is unscientific. Feeling sad doesn't necessarily mean you have a chemical imbalance.

What are you currently studying?

I am always working with the pharmaceutical industry to develop new medications, and I am currently examining whether a new antidepressant reduces sexual dysfunction, one of the most problematic reactions to antidepressants.

I am also looking at the relationship between genetics and side effects. A battery of genetic tests has become readily available in recent years, and I got a grant from one of the test manufacturers to study people who have unusually frequent side effects to see if genetic differences can explain that.

What is your teaching philosophy?

I break down the widely accepted dichotomy of clinician versus researcher. Many researchers don't see patients in the clinic, and many clinicians don't do research, don't read research and cannot interpret research. Students shouldn't think they have to be one or the other. I have a passion for teaching evidence-based medicine, for showing students how to interpret scientific literature so that they can apply research to their clinical work.

What advice would you give students pursuing psychiatry today?

I'd tell them to be prepared for good and bad. This is an exciting time for psychiatry because we're seeing a lot of progress in basic neuroscience and hoping that new treatments will come out of it; we are poised for a growth spurt. On the other hand, most students are interested in clinical work, and this is a challenging time for clinical psychiatrists. Payments have decreased, and many doctors have to see more patients in less time than ever before. Students must be aware of the challenges they will face.

Photo by Sabina Pierce

What do you consider your greatest contributions to your field?

I am proud of my research because it has directly helped many patients. For example, since my study on antidepressants and excessive sweating, many doctors have told me they are identifying and treating this problem, which they never did before.

I am also proud of my mission to raise awareness of adult attention deficit hyperactivity disorder. I have seen a lot of so-called treatment-resistant patients, and over time I realized many of them weren't getting better because the underlying problem was actually ADHD, and their depression was a consequence of struggling in life due to that. Since I've shared this discovery with my colleagues, many of them have identified patients with ADHD and treated them successfully.

Where do you see your field heading in the future?

New medications are constantly being developed, so I see progress toward better treatments. We also need to focus on technology. Medical science has been slow to take up the Internet. Health information is one of the most important things people seek online, yet physicians don't tell their patients what websites to use, which is dangerous because the Internet is full of misinformation. I'd like to see an increase in the use of new technologies to disseminate accurate information and counter the fiction that is out there.

I also hope to see clinicians finding ways to spend more time with their patients, which our healthcare system currently discourages. Some psychiatrists only spend 15 minutes with each patient — they can't even remember their patients' names. But there is no shortcut to good psychiatry. The clinical history that a physician takes is the gold standard for accurate diagnosis.

— Karen L. Brooks