The challenges of caring for a physician with a mental illness

Michael Esang, MBBCh, MPH, and Hasnain Afzal, MD

A physician's mental health is important for the delivery of quality health care to his/her patients. Early identification and treatment of physicians with mental illnesses is challenging because physicians may neglect their own mental health due to the associated stigma, time constraints, or uncertainty regarding where to seek help. Physicians often worry about whom to confide in and harbor a fear that others will doubt his/her competence after recovery.[1] Physicians have higher rates of suicide than the general population.[2] According to data from the National Violent Death Reporting System, a diagnosed mental illness or a job problem significantly contribute to suicide among physicians.[3] Additionally, physicians also have high rates of substance use and affective disorders.[1,4]

Here, we present the case of a physician we treated on an inpatient psychiatry unit who stirred profound emotions in us as trainees, and discuss how we managed this complicated scenario.

CASE REPORT

Dr. P, a 35-year-old male endocrinologist, was admitted to our inpatient psychiatry unit with a diagnosis of bipolar disorder, manic, severe, with psychotic features. Earlier that day, Dr. P had walked out of his private outpatient practice where he still had several appointments. After he had been missing for several hours, he was picked up by the police. Dr. P had 2 prior psychiatric admissions; the last one had occurred >10 years ago. A few weeks before this admission, he stopped taking lithium, while continuing escitalopram. He had not been keeping his appointments with his outpatient psychiatrist.

At admission, Dr. P had pressured speech, grandiose delusions, an expansive affect, and aggressive behavior. He was responding to internal stimuli with no insight into his illness. He was evasive when asked about hallucinations. Dr. P believed he was superior in intelligence and physical prowess to everyone in the emergency department (ED), and for that reason, the ED staff was persecuting him. His urine toxicology was negative.

On the inpatient unit, because Dr. P exhibited posturing, mutism, and negativism, catatonia associated with bipolar disorder was added to his diagnosis. For the first 2 days, his catatonia was managed with oral lorazepam, 2 mg twice daily. Dr. P was also observed giving medical advice to other patients on the unit, and was told to stop. Throughout his hospitalization, he dictated his own treatment and would frequently debate with his treatment team on the pharmacologic basis for treatment decisions, asserting his expertise as a physician and claiming to have a general clinical knowledge of the acute management of bipolar disorder.

Dr. P was eventually stabilized on oral lithium, 450 mg twice daily, and aripipra-

Michael Esang, MBBCh, MPH

Hasnain Afzal, MD

Dr. Esang is a PGY-4 Psychiatry Resident and Dr. Afzal is a PGY-2 Psychiatry Resident, Department of Psychiatry and Behavioral Sciences, Nassau University Medical Center, East Meadow, New York.

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zole, 10 mg/d. He also received oral clonazepam, as needed for acute agitation, which was eventually tapered and discontinued. He gradually responded to treatment, and demonstrated improved insight. The treatment team met with Dr. P's parents, who also were physicians, to discuss treatment goals, management considerations, and an aftercare plan. After spending 8 days in the hospital, Dr. P was discharged home to the care of his immediate family, and instructed to follow up with his outpatient psychiatrist. We do not know if he resumed clinical duties.

Managing an extremely knowledgeable patient

During his hospitalization, Dr. P frequently challenged our clinical knowledge; he would repeatedly remind us that he was a physician and that we were still trainees, which caused us to second-guess ourselves. Eventually, the attending physician on our team was able to impress upon Dr. P the clearly established roles of the treatment team and the patient. It was also important to maintain open communication channels with Dr. P and his family, and to address his anxiety by discussing the treatment plan in detail.[5]

Although his queries on medication pharmacodynamics and pharmacokinetics were daunting, we empathized with him, recognizing that his knowledge invariably contributed to his anxiety. We engaged with Dr. P and his parents and elaborated on the rationale behind treatment decisions. This earned his trust and tremendously facilitated his recovery.

We were also cautious about using benzodiazepines to treat Dr. P's catatonia because we were concerned that his knowledge could aid him in feigning symptoms to obtain these medications. Physicians have a high rate of prescription medication abuse, mainly opiates and benzodiazepines.[2] The abuse of prescription medications by physicians is related to several psychological and psychiatric factors, including anxiety, depression, stress at work, personality problems, loss of loved ones, and pain. While treating physician patients, treatment decisions that include the use of opiates and benzodiazepines should be carefully considered.[4]

A complicated scenario

Managing a physician patient can be a rewarding experience; however, there are several factors that can impact the experience, including:

- **The treating physicians' anxiety and countertransference/transference dynamics.** We repeatedly imagined ourselves in Dr. P's position and thought long and hard about how this scenario could happen to anyone in the medical profession; these thoughts induced significant anxiety in each of us. Further, interacting with Dr. P was reminiscent of our training under senior residents and attendings. Dr. P viewed us—his treatment team—as his trainees and challenged our clinical knowledge and actions.
- **The physician-patient's emotional responses,** which may include anxiety, despair, denial, and an inability to accept role reversal.

Our medical culture needs a paradigm shift. We need a model designed to encourage early self-disclosure and treatment-seeking among physicians with mental illness. This will reduce the stigma towards mental illness in our profession.

Clinical Point

We need a model designed to encourage early self-disclosure and treatment-seeking among physicians with mental illness

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