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Treating Medical Students and Physicians

Michael F. Myers, MD, and Leah J. Dickstein, MD

Dr. Myers is Clinical Professor, Department of Psychiatry, University of British Columbia School of Medicine, Vancouver, British Columbia.

Dr. Dickstein is Professor Emerita, Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Louisville, Kentucky.

Learning Objectives

Clinicians will understand the wisdom of embracing a biopsychosocial model when assessing and treating medical students and physicians, appreciate the unique roles of stigma and other confounding variables in diagnosis and treatment, utilize advocacy strategies on behalf of their patients, and identify key transference and countertransference dynamics.

Editor's Note

In this lesson, many of the concerns that we should be aware of in treating fellow professionals are discussed, whether medical students, residents, or practicing physicians. But there is another message here as well. We may be the physician-patients and no less subject to feeling stigmatized, anxious about being found out by colleagues, and fearful of what the diagnosis, treatment plans, and prognosis may be.

The authors give us very specific guidelines for managing the initial interview. As with any patient, we are expected to take a full and complete history and evaluation, including confirmation that a primary care physician is attending to any physical concerns. But when the patient is a medical student or doctor, special considerations come into play. For example, it's important to be welcoming, reassuring, compassionate, and respectful, realizing how difficult it may be for the health care professional to assume the role of patient and all that implies. At the same time, we must make it clear from the start that we are in charge of all aspects of treatment, and this includes prescribing medications. Confidentiality must be discussed in detail and clearly guaranteed, since the patient has undoubtedly overheard cases being discussed randomly in hospital elevators and dining rooms.

Mood disorders, alcohol and drug abuse, and anxiety disorders are among the most common conditions seen. One should never hesitate to explore suicide risk factors in detail and to be guided accordingly. And, since psychiatric illness and alcoholism and substance abuse can cause significant impairment in cognition, memory, and judgment, we should familiarize ourselves with state resources and reporting requirements.

There is a positive side to being treated for a psychiatric disorder: the physician can approach his or her own patients with more empathy and sharper diagnostic skills, and become more effective in recognizing and managing stress in his or her own professional and personal life. —*F.F.*

Introduction

We are often asked the question, "What's so different about medical students and physicians—aren't their illnesses the same as those of the general public?" The short answer is: "Yes—and no." The ailments of medical students and physicians fill the pages of the *Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition* (DSM-IV), but what gives these individuals their unique cast is the unique nature of their personal and family dynamics, the demands of medical study and practice, their characteristic defense mechanisms, their ambivalence about treatment, a tendency toward prescribing for themselves, and a high level of perceived stigma associated with psychiatric illness.[1]

The reader of this lesson will (1) understand the importance of using a biopsychosocial model when assessing and treating medical students and physicians—these individuals can be challenging and complex, and warrant a thorough general medical and psychiatric evaluation, diagnosis, dynamic formulation, and comprehensive treatment plan; (2) gain an appreciation of the pervasiveness of stigma in the house of medicine and how stigma affects morbidity and mortality in medical students and physicians;[2–5] (3) know how to utilize advocacy principles and strategies to help medical student- and physician-patients; and (4) recognize common transference and countertransference dynamics when treating these patients.[6] Unique facilitating and confounding variables come into play when both the patient and the therapist are medically trained.

Although the special concerns connected to diagnostic and treatment issues in medical students closely resemble those seen among physicians, there are some differences, so that each group warrants separate discussion.

Psychiatric Treatment Issues in Medical Students

THE INITIAL INTERVIEW:

Since the availability of mental health services for medical students and residents varies considerably—depending upon administrative attitudes and commitment, mandatory insurance coverage or lack thereof, and services covered—students' courage and knowledge to seek services vary considerably.

Assuming students have been made aware of the route to access mental health services, they may approach an administrator or faculty member directly and in a timely manner. **Of major importance is the need for students to be evaluated by a psychiatrist initially to ensure a complete assessment. Psychotherapy with another mental health professional may then be chosen or offered.**

A psychiatrist's school, faculty, or community professional reputation is often widespread, whether the psychiatrist practices as part of the faculty or in the community full time.

The first interview is crucial for obvious and indirect reasons. The student may have had to be excused from a rotation responsibility or a required pre-clinical session and may feel pressured to return quickly, while appearing emotionally in control and without visible tears. A supportive peer may have accompanied the student to the first session. A faculty or significant other may have called ahead to support the student's need for treatment.

The psychiatrist must explain early on in the first session how this treatment will be conducted as well as issues of confidentiality, not only of records, but also verbal confidentiality. *This latter issue is appropriate because students continually hear and observe faculty sharing patient information in hallways,*

elevators, physicians' lounges, hospitals and clinics, and lunchrooms. Telling students that you understand their normal concerns about confidentiality will lessen some of their anxiety. Furthermore, stating that no one will know anything except if it ever becomes a matter of someone's safety, (ie, that of the student, a significant other, a peer, or a patient).

In discussing confidentiality issues during the first session, the psychiatrist must outline possible circumstances in which she or he must:

1. **Discuss future medical license questions the student-patient will be asked.**
2. **Discuss future health insurance application questions the student-patient may be asked.**
3. **Explain the student's choice or requirement, depending on the severity of the illness and ability to function currently, to report a need for a school medical leave or for a personal leave, or to explain an academic failure.**

Emergency contact information must also be explained, (ie, a backup call number, the physician's coverage system, and numbers to use). The psychiatrist should tell students that they will not automatically be dismissed from school on entering psychiatric treatment and that they may request a medical leave of absence. The psychiatrist can extend an offer to write a letter of support or attend a school committee meeting with a student, if desired.

OTHER FIRST-SESSION CONSIDERATIONS:

Other essential first session issues can be introduced by asking about a history of any psychological, physical, or sexual abuse, as victim and or perpetrator; legal experiences; sexual orientation; family history, (eg, adoption, parents' divorces, support or lack thereof, the student's roles in the family to date); and substance abuse. **Clearly, current and past symptoms must be elicited**—including depression, suicidal ideation—including plans, attempts, and what has and would keep them from committing suicide; whether the student was adopted and its repercussions; a 3-generation family history of all psychiatric and general medical disorders and successful or failed treatments; and current and past personal and family experiences of domestic or other violence and rape.

Common general medical conditions that can impact mood include thyroid, parathyroid, other endocrine disorders (such as diabetes); immune system disorders; rheumatoid arthritis; fibromyalgia; multiple sclerosis; Crohn's disease or irritable bowel syndrome; as well as urinary tract disorders; migraines or other types of headaches; spontaneous or elective abortions; infections (including HIV and STDs); cardiovascular disorders; body image;and eating disorders. Therefore, identification of a primary care physician, a complete physical exam and a set of studies to obtain must be included in the first session. This work-up should include a blood chemistry panel, urinalysis, and tests for thyroid stimulating hormone levels, HIV, pregnancy (if indicated), and a vitamin B12.

The Pedestal Effect

The "pedestal effect" can prevent students from self-perception of treatment needs. This term is used to describe the psychologically isolating experience of medical students. They are put on a pedestal by many who know them "as someone who is closer to God," all knowing, too busy to ever be bothered, never experiencing problems or in need of emotional support. This isolationist policy, unfortunately, can continue in perpetuity and can increase a student's belief that he or she cannot or should not reach out for personal support or professional help.

Further stereotypic pressure emanates from the "white knight syndrome," another of this author's coined terms. White knights are men—here medical students and residents—who feel they should not reveal normal emotional dependency needs when they are rejected in a relationship. ***So, instead of allowing normal reactive tears and depressive symptoms to show and then reach out to known and trusted others, the male student in a white jacket or long white coat appears stoic, like a historic knight in steel armor and helmet, displaying no visible emotions.***

As a stereotypic white knight, he is expected—and he expects—to lash out in anger, perhaps with additional interpersonal violence and substance abuse behaviors as a physical reaction to feelings of rejection. The following case report illustrates this point.

A senior male medical student reveals his wife left him and has filed for divorce because he is away for so many hours and days. He has purchased a gun to go after her, but with misgivings about such action, has sought psychiatric consultation. Fortunately, to date, no one has been hurt. After revealing these facts, he bursts into wracking tears, with his head down in his hands. Evaluation for possible needed hospitalization follows. The psychiatrist praises the student for this courage to reveal normal sadness and dependency needs in response to rejection and says that together, patient and psychiatrist will be able to work through the issues in therapy so long as the student controls his potential violent thoughts. The student readily agrees.

Attempting to be "superman" or "superwoman" for the medical student is dangerous and should be discussed during the first or second session, depending on presenting symptoms and personal history. Student-patients must understand and accept, perhaps for the first time in their lives, that no one can be all powerful and invulnerable to any and all personal pressures, academic challenges, and stressful situations.

Specific Disorders and Clinical Conditions

ANXIETY DISORDERS:

Anxiety disorders often surface for the first time when students are required to present on rounds or at a case conference. In an operating room, they may find themselves getting upset, perhaps having sudden and unexpected difficulty breathing and a racing pulse, but are unable to leave. The following case report illustrate this.

A male junior medical student, 6 feet 3 inches tall and a former star athlete, arrives in the psychiatrist's office on the arm of a male classmate, insisting that he must withdraw from school because of an OR panic experience. His response to questions about anxiety disorders in his biologic family is negative. He is asked to call his parents and ask for a three-generation family history of psychiatric problems, primarily anxiety. Returning the following day, he reveals in surprise that his older sister and father are in treatment for anxiety disorders; his sister also has social phobia, and his father has OCD. He had no prior knowledge of this history. A complete general medical and laboratory evaluation by his primary care physician proves to be normal. He is willing to try an SSRI and, within a week, he reports in surprise that he can handle the OR, looks forward to being a primary care physician, and will always ask his patients about family history from now on.

A CASE OF BULIMIA:

A woman medical student asks for an appointment and in the first few minutes apologizes for taking the psychiatrist's valuable time. Academically, she is third in her class, but she feels she doesn't have the time as a second-year to continue binging and purging as she had since the first year of high school. Her parents never noticed. Instead, they teased her about simply spending so much time looking at herself in the bathroom mirror. Her weight was and is normal. In college, her roommate starved herself, but the two never talked about their eating behaviors. No health professional ever asked her if she had symptoms or signs of an eating disorder during routine checkups. When questioned now, she revealed that her father and his younger sister both had problems

with alcohol, and her mother had recently filed for divorce from her father. Neither her father nor her aunt had ever been in treatment. The student's younger sister has shown PTSD [posttraumatic stress disorder] symptoms in the last 3 years without treatment. The patient thinks her father may have sexually abused her sister during one of his episodes of alcohol abuse, but no discussion of it ever took place.

A CASE OF OBSESSIVE COMPULSIVE DISORDER WITH SUBSTANCE ABUSE:

A woman junior medical student seeks consultation. She admits to feeling overwhelmed academically for the first time in her life. As the oldest child, she was always academically first or second in her high school and college classes. Her parents are both professionals; her mother is a cardiologist, her father an attorney. They are very proud of their daughter's accomplishments. She doesn't feel that she has enough time to copy all her notes into her laptop computer, so she drinks 2 liters of caffeinated soda each evening and ends up not being able to sleep. To remedy this, she has recently begun using marijuana, which was obtained from a classmate. Now she doesn't feel as motivated to study and stay at the top of her class. She senses her heart racing when she goes to bed, and feels helpless and trapped, unsure whether to continue her studies and become a physician or not. The psychiatrist asks further questions about earlier schooling and personal behaviors, and summarizes the situation for the student by identifying her obsessive compulsive disorder and substance abuse symptoms, and outlining a treatment plan which includes a checkup by her primary care doctor.

MOOD DISORDERS AND THE RISK OF SUICIDE:

The incidence of mood disorders, particularly major depression and dysthymia, has been reported to be somewhat higher among medical professionals than in the general population. One of the first diagnoses you should consider when assessing students, residents, and other physicians is depression and, of course, the frequently associated risk of suicide.

Unfortunately, the suicidal medical student is an all too common occurrence. This predicament often ends in tragedy, because the student may not seek treatment and those around him do not act, despite noticing changed and alarming behaviors. The following case report is illustrative.

A male medical student with a prior psychiatric history of major depressive disorder does not seek treatment when symptoms return and is unable to pass all his subjects by the end of the year. **He does not order medical instruments, as do his classmates, and eventually seeks treatment with his former psychiatrist. A classmate, noticing his visibly disturbed attitude, contacts his family, but to no avail. At the end of the academic year, the student drinks a large amount of alcohol and uses a gun to kill himself.**

Risk factors for student suicides include those evident in all potential victims, with the additional stresses of perceived family attitudes, self-imposed pressure, first-time anxiety disorder, academic failure, and substance abuse. Social withdrawal, denial of any academic or social problems, and a "final straw," (eg, a failing grade or shame associated with the realization of an inappropriate career choice)**, may also incite a suicide attempt.**[2]

During the assessment, humor or inappropriate informality should be guarded against. The student must be asked about the possession of any lethal means, (ie, a gun, pills, injectables, etc)**. The student must be informed of the procedure the psychiatrist will follow. If the psychiatrist becomes seriously concerned, contact may be made with university public safety or local police, the student may be**

hospitalized via a voluntary admission, an involuntary 72-hour hold order, or the issuance of a mental inquest warrant. At the end of the first session, a respectful handshake to represent understanding and agreement to all these therapy issues can be very useful and supportive.

Another case report illustrates the importance of a detailed inquiry into suicidal intent and means and of sustained follow-up treatment.

> ***A male student acknowledged ongoing thoughts of suicide and promised he would not act on them.*** **However, he also revealed possession of his grandfather's shotgun and a box of shells he had inherited 4 years earlier. He had grown up hunting and fishing with this grandfather, his father, and two uncles. One month after first expressing suicidal ideation to his psychiatrist, he called to say he had dropped the box of shells into the lake near his parents' home and had hung the empty gun on the wall in his living room as a peaceful memorial to his beloved and gentle grandfather. In the months and years following, while in therapy, he continued to slowly gain self-esteem, was compliant with his antidepressant, and turned to the arts with paintbrush and canvas to express emotions; he became a respected community board-certified physician, married his college sweetheart, and helped raise their three children. He proudly and humbly gave one of his early paintings to the psychiatrist for their office wall where other students' art of all types was exhibited.**

Dysfunctional Social Interactions

Another unique, first-time issue may be the experience as a racial, ethnic, or religious minority in an otherwise homogenous community. Real or perceived lack of the social skills necessary to integrate oneself into the majority in informal and formal situations such as social events, may cause social anxiety symptoms.

Encouraging minority medical students to reach out to others of similar background, locally and nationally, via various medical student organizations can be a means of providing a major support and add to personal growth that may also be addressed through ongoing psychotherapy.

Peer isolation can also occur for the first time for medical students who have always spent a great deal of time in isolated study and been successful thereby, but now find themselves failing exams. An assessment may reveal a diagnosis of adult attention deficit disorder. If diagnosed correctly and treated appropriately, the outcome is usually favorable; not only do they become academically proficient again, but often for the first time social interactions improve markedly.

Common Transference and Countertransference Issues

The fact that a treating psychiatrist is a faculty member is not a reason to avoid treating students. This author (LD) has treated more than 800 medical students and several hundred residents while teaching and supervising them before or following treatment. However, countertransference issues too often arise because of unresolved issues for the therapist at this stage of his or her career, along with pressure caused by a limitation in the number of treatment sessions imposed by school or personal insurance policies or fiscal support. ***Being impressed by a student's academic success and making a statement like, You're fine, simply a bit anxious," or "You wouldn't hurt yourself or anyone else, would you?" is a potentially serious mistake. Omitting questions about suicide ideation, history, plans, methods currently available, gun or medication access, hopelessness, or plans to drive into a tree is completely unacceptable. To follow a superficial interview with a pat on the shoulder or an inappropriate comment such as "You're a medical student; keep a stiff upper lip and you'll be fine" is an unprofessional practice and in some instances can prove deadly.***

Furthermore, boundary violations involving socializing, including sexual harassment, and/or sexual rela-

tionships, are illegal. Socialization is very inappropriate, and accepting, much less asking for gifts is prohibited.

Toward Becoming A More Empathic Physician

As a rule, physicians who are healthy former psychiatric patients are less likely to harbor the still prevalent stigma associated with psychiatric patients and the medical specialty of psychiatry itself. Thus, in their everyday practice, psychiatrists can save more lives and help more of their patients enjoy healthier and happier lives.[1]

Special Issues in the Psychiatric Treatment of Physicians

PREEXISTING RELATIONSHIPS:

Many of the points discussed with regard to the treatment of medical students and residents apply equally, and sometimes more so, to the treatment of physicians. There are a number of important differences, however. You, the psychiatrist, are also a physician, and this must influence, to some degree, how you regard your physician-patient and how your patient regards you. Your first task is to establish a rapport and in doing so to be welcoming, respectful, and compassionate. However, you must also comfortably take charge of the situation. Your words and manner can serve to allay anxiety and give your patient a good deal of relief from the anxiousness that most physicians feel during the initial visit.

You must consider carefully any preexisting relationship you may have had with your new patient. Is this your first contact, or have you met or worked together at an earlier time? The latter is not unusual, given that many physicians like to "check out" those to whom they entrust their personal troubles and are likely to choose someone from the medical community to which they belong, unless, of course, they experience such a strong stigma that they seek help as far away from home base as possible. You may have been residents together or in the same class in medical school. Perhaps you are members of the same golf club, have served on committees together, or have referred patients to each other. Maybe you even treat a member of the physician's family, or your doctor-patient takes care of a member of yours. Whatever the relationship may have been, be certain to note it and begin to appreciate this new context of the individual becoming your patient and you becoming his or her psychiatrist. You must start to shift your mental set and establish a whole new set of boundaries. Remember that your previous relationship will never be the same.

EMPATHIC REASSURANCE:

Empathy **for your patient will be enhanced by your appreciating the range of emotions that most physicians feel when consulting a psychiatrist.** Some are more than a bit terrified of your diagnostic impression and treatment plan. Some harbor fear of losing control, good judgment, sanity, and autonomy. **Most come to us with stigma—feelings of shame, embarrassment, and anticipated criticism. Most feel guilty**—for being ill, for letting others down. **Many struggle with despondency, feeling distressed over being sick or manifesting symptoms of a mood disorder. Many come with "the doctor's character armor"—a cool and controlled demeanor, the use of medical jargon, and the use of the impersonal third person in conversation** (eg, "there has been no anorexia or weight loss" instead of "I haven't lost my appetite or any weight"). Intellectualization may represent the physician's protective use of adaptive denial carried over from the medical workplace. **It might be helpful for the psychiatrist to ask, *"How is this for you . . . talking to me, opening up like this?"* or to make reassuring statements like *"You're doing fine . . . it's ok."***

HISTORY TAKING:

Allow time during your first and subsequent interviews to conduct a thorough history, dynamic assessment, mental status examination (as appropriate to the symptomatology and your differential diagnosis), **and dynamic assessment.** *Watch for the articulate physician-historian, who gives a polished presentation and omits important details, or the overly obsessive physician, who gives inordinate detail but avoids painful subjects.* Be rigorous—do not assume that physician-patients will volunteer the details that

are important to you. When treating other psychiatrists, be as thorough, careful, caring, and unassuming as you would with any non–physician-patient. Their fears of mental illness and insanity may be very great, primitive even. ***Do not expect insight as a given***. Remember that you are the treating physician; be respectful, but always allow your physician-patient to be the patient.

FAMILY AND INTERPERSONAL RELATIONSHIPS:

Marital difficulties are only too common in the lives of physicians. And they are not immune to having family members with psychiatric difficulties in members of their family. In evaluating your patient's interpersonal relationships, try to determine whether the people around your patient are truly loving and supportive or demanding, rejecting, or critical. Are there conflicts that center directly on his or her work as a physician? What is known about the family's genetic background? Explore your patient's relationships with colleagues, patients, and friends. If appropriate and indicated, ask to interview the patient's spouse or partner, to gain further insights and to offer helpful psychoeducation.

From the beginning of treatment, it is wise to indicate the potential value of making yourself available to the patient's family as circumstances warrant. Such contact may later prove to be invaluable. Enlist family members as your allies in the care of your physician-patient. Information that they provide may not only help you develop your diagnostic and treatment plan but may also be life saving should your patient become suicidal or homicidal. You can also help them by explaining your patient's symptoms and introducing them to reading materials and sources of community support. **When loved ones are physicians themselves, perhaps even psychiatrists, remember to approach them as concerned and often worried relatives, not as colleagues.** You may have to watch for role blurring and undermining of your treatment plan by family members. Be assertive and open up lines of communication if you sense that misunderstandings are occurring. Always think in terms of family systems and be aware that spouses and children are sometimes symptomatic themselves. They may need to be assessed independently and treated. This can be challenging, and may call for diplomacy and finesse on your part.

BOUNDARIES:

Pay close attention to your boundaries. **In fact, your assessment of your patient may tell you a lot about his or her boundaries with patients, and this may influence the transference.** Always avoid any conflict-of-interest situations, (eg, treating someone whom you are currently teaching and evaluating or who is an employer or employee). The following case report illustrates this point.

> **One of us (MFM) had been treating Dr. A for a number of years for bipolar illness. His condition was stable; he was compliant with his medications and was being monitored only at 6-month intervals. In addition to private practice, Dr. A was the director and CEO of a private company that put on medical conferences. MFM received a letter from the patient inviting him to speak at a conference that his company was hosting. A handsome honorarium was offered. When MFM contacted the patient to decline and explained this decision as a conflict of interest, the patient was surprised. In a quickly arranged visit, Dr. A was able to identify and talk about a range of feelings toward MFM—some anger, mild disappointment and hurt, and embarrassment for his initial failure to understand.**

Formulating a Diagnosis and Plan of Treatment

Leave time toward the end of the first visit for summing up and to offer tentative diagnostic impressions and treatment options. Invite questions. Most physician-patients appreciate explanations that they can understand. Watch your use of jargon. Avoid talking down—or up—to physician-patients. Be reassuring, clear, and as prognostically upbeat as you can be.

Remember that the person opposite you is a human being who just happens to be a physician. If medication is necessary, explain that you will prescribe it. Take over any self-prescriptions. With complicated physician-patients, always consider second opinions and the use of other medical specialists and subspecialists in mood disorders, forensic psychiatry, neuropsychiatry, eating disorders, and the like.

Special Clinical Concerns

MOOD DISORDERS:

The incidence of mood disorders among physicians seems to be increasing. With the exception of studies on residents (now dated) showing depression in up to one third of trainees, we lack empirical data.[7] We need more studies on the biological determinants of mood disorders in physicians, particularly family-of-origin, workplace, and ethnocultural factors in depression. As in the general population, **mood disorders are more common in women physicians. However, substance abuse and dependency are more common in men physicians, many of whom have unrecognized and untreated depression coexisting or camouflaged by chemical dependency.** Physicians with refractory depression who are not responding to conventional biopsychosocial treatment should be referred to a mood disorders specialist at the nearest academic medical center for consultation.

SUICIDE RISKS:

As with medical students and residents, the suicide rate among physicians appears to be higher than in the general population. When assessing your physician-patient for suicide risk, watch for denial and subterfuge. Watch for what isn't said, the patient's style, and indirect clues suggesting despair, isolation, agitation, impulsivity, and a means of committing suicide. **Most physicians know the consequences of candor, namely that they may be hospitalized** (perhaps involuntarily) **and reported to their licensing board. Watch out for indications of an imminent risk[8] or a suicidal crisis,[9] as you would with any other patient. Don't sacrifice thoroughness and good judgment because your patient is a physician. Ask about stockpiled medications at home**—tricyclic antidepressants, lithium, insulin, potassium chloride, barbiturates, fentanyl, and the like. And don't forget to ask about firearms and means of hanging.

SUBSTANCE ABUSE:

To our knowledge, the rates of alcoholism and other drug use among physicians are not decreasing, despite 2 decades of research and teaching medical students and residents about this risk. Therefore, **you must assess your physician-patients carefully for high levels of social drinking; the use of street drugs, such as cannabis, cocaine, and ecstasy, comorbid use of alcohol and other drugs, use of samples from the office, and self-prescribing. Be rigorous—denial and minimization of use are very common among physicians.[10]** *You may require collateral information from loved ones. Remember that a significant percentage of medical students and physicians have first-degree relatives with substance abuse or dependency. Also, they do not always appreciate empirical research on the genetics of alcoholism.[11]*

Safeguarding Confidentiality

Safeguard confidentiality always, and be prepared to answer your physician-patient's questions about this subject. Their inquiries may be very specific and penetrating, honing in on such issues as your own professional habits and mental health, what you do and do not discuss at home, the professionalism of your secretary, third-party payers, note-taking, security of records, whether your medical records are computerized, who has access to them, on-call coverage, pharmacy networks, databases, publication of clinical details, your communication with other physician caretakers about the case, and so forth. The following case illustrates this point.

> **As Dr. B, an emergency physician, was going out the door at the conclusion of her first visit, she turned and said to her psychiatrist: "You're not bipolar, are you?" She immediately flushed, apologized, and backpedaled. She said, "I think I know why I blurted out that question. I stopped treatment with the psychiatrist I was seeing during my residency because of a terrible thing.**

One night when I was on call in the ER where I was training, my psychiatrist was brought into the psychiatric emergency room in a manic state. I didn't assess or treat him, of course. But when he saw me attending to other patients in the area, he began telling the staff and other patients that I was his patient and what my problems were. I was mortified."

Transference and Countertransference Issues

Pay keen attention to the myriad transference and countertransference dynamics that develop when psychiatrists treat other physicians: issues about control and power, intimidation, collusion, role blurring, eroticism, boundary transgression, fees, professional courtesy, and alignments and clashes with respect to gender, sexual orientation, race, ethnicity, and faith. The following case report illustrates this point.

Dr. C, a male psychiatrist, was a patient of Dr. D, also male. Dr. C was very obsessive and pedantic. In one visit, he went on and on about Freudian and Jungian principles in a very detached manner. The therapist felt annoyed and intimidated by his patient's scholarly knowledge base and he stated, "You seem to be using a lot of intellectualization today—are you avoiding anything?" To which Dr. C responded, "That's an interesting interpretation," and sat quietly staring. Dr. D felt even more irritated. Then Dr. C said, "I've been feeling the same way about you, actually. You used to be much warmer toward me. Have I done something wrong? I feel like I've disappointed you in some way, that I'm not being a 'good patient.' It's not easy being your patient; I feel very small." This led to a breakthrough of an impasse of the previous few sessions.

Obstacles to Treatment

STIGMA:

Stigma is a major obstacle to care when physicians become ill. There is a terrible sense of shame, infamy, and painful isolation that accompanies mental illness in physicians. Stigma enhances and prolongs morbidity; combined with guilt, it delays and stops the physician from reaching out for help. **Stigma kills—witness the number of physicians who die by suicide each year who received no treatment or inadequate treatment.** It is a malignant, circuitous, and very dangerous process.

Stigma may be present in both our patients and in us. It is a societal introject and may be reinforced when psychiatry is defamed in medical school, by embarrassing faculty role models, by a childhood or family history of psychiatric illness, and by rugged individualism in doctors. Further, the profession of medicine is not always caring toward or forgiving of its members with mental illness. Minority physicians and international medical graduates may have even higher levels of felt and perceived stigma when they become ill.

What about stigma among psychiatrists? Much like internalized homophobia, overcoming stigma in ourselves is a lifelong challenge. Even though we are trained in psychiatry and toil daily caring for patients, we may not have fully purged ourselves of stereotypic, false, and mean-spirited notions about mental illness and its sufferers. We may hold ourselves, and our medical colleagues, to an impossible standard of health and function.

RESISTANCE TO ACCEPTING THE ROLE OF PATIENT:

There are other obstacles to care. Many physicians resist accepting the patient role. Why? Becoming a physician may represent counterphobic behavior. For them, it is terrifying to be sick and very hard to relinquish control. It is easier to be in the "doctor" role. Further, it is alarming to have some knowledge, perhaps misguided and inaccurate, about the illness, its treatment, its prognosis, and those who treat it. All of us use adaptive denial in our daily work in order to provide objective and prudent care. Denial

becomes pathological when we cannot see that we are using it to ward off unacceptable and frightening symptoms or behaviors in ourselves. The following case report illustrates this.

> **Dr. E, a cardiologist, always came to his sessions wearing his white lab coat and a stethoscope draped around his neck. Well into the fourth visit, his psychiatrist said, "I notice that you always wear your white coat and stethoscope here—you can take them off and relax, if you like?" To which Dr. E replied curtly, "When I'm ready. In fact, I was just sitting here thinking that I would like to check your pulse and examine your heart. That would be much easier for me than having to talk about this bloody divorce."**

THE CONTEXT OF TREATMENT:

Another obstacle to care, and one that can affect adherence to treatment, is the context in which it takes place. When a physician becomes ill, potential barriers to the recognition of illness and attempts at reaching out may be identified through responses to the following questions: How severe or impairing is the illness? How embarrassing is the illness (it may be easier to talk about depression than bulimia)? What is the physician's age and gender. What are the physician's personality traits, attitudes, and behaviors? How complicated is the treatment? Are there drug side effects? Does lithium (Eskalith) need monitoring? How frequent are the psychotherapy appointments? How supportive or nonsupportive are the patient's coworkers (if they even know about it), family members, and friends? How available, accepting, nonjudgmental, and experienced are the physician's caretakers?

Physicians Who Treat Themselves

Why do so many physicians treat themselves? Some are very independent and self-reliant, and don't like to bother, depend on, or open themselves up to other physicians. Some trust their own medical judgment more than that of medical colleagues. Some are ashamed, and if they suspect that they're depressed, will start themselves on an antidepressant. Once they improve and feel less ashamed and guilty, they may turn their care over to their primary care physician or a psychiatrist. **At that point, your responsibility is very clear—that you are now the treating physician and that you will supervise and monitor treatment.** However, be patient and understanding. It can take years for physician-patients to really accept a mood disorder and its tendency to be recurrent. Thus, they may idiosyncratically revise, stop, and restart medications without consulting you. Consider the following illustration.

> **Dr. F, a family physician, began his first visit with this: "I am so relieved to be here. I concluded about a month ago that I was depressed. So what did I do? I acted like a typical doctor and dipped into my sample cupboard. I started myself on antidepressant A. After 10 days, I was no better, so I stopped it and tried antidepressant B. But then my insomnia got worse, so I stopped it and tried antidepressant C. It didn't seem to be working after a week, so I doubled it. But then the pharmaceutical rep came in with this brand new antidepressant, so I stopped what I was on and started it. That was 5 days ago. I don't like it, I feel agitated, and I'm having sweats. I'm so confused—I don't know if it's the drug, or my illness getting worse, or a virus that I've picked up. I really need your help to sort this out."**

PHYSICIANS FROM RURAL AREAS:

Physicians who live and practice in small or rural communities are more prone to self-care. Acceptable resources may be some distance away. However, you can be very effective after an initial face-to-face consultation. You can provide some follow-up by tele-

phone or e-mail between visits. Telepsychiatry is advancing rapidly and should prove very helpful in treating physicians at a distance. Because some physicians personally know or treat their local pharmacist(s) and laboratory personnel, they may prefer to have their prescriptions filled and blood work completed somewhere else, usually in the community in which you practice.

THE IMPAIRED PHYSICIAN:

Physician impairment is the inability to practice medicine with reasonable skill and safety because of illness. Physicians can be quite ill yet not be impaired. Hence, you must carefully monitor the physicians you treat in terms of their medical judgment and safety at work. **The most common impairing conditions are alcohol and substance abuse and dependence, nonorganic psychiatric conditions** (eg, major depression, bipolar illness, eating disorders) **and organic psychiatric illnesses. Any illness that affects the central nervous system and results in cognitive, mood, memory, or behavioral changes will impair a physician's judgment.**[12] Aging physicians who may be developing dementia and who practice in isolation, solely in an office setting and without hospital privileges, can fall through the cracks. Forgetfulness, errors, procedural slips, poor medical record keeping, mood swings, and inappropriate speech and behavior (including boundary crossing) may go undetected unless a complaint is lodged to the licensing board by a patient or unless office peer-review procedures are in place. In fact, some referrals to you may come from your state physician support program.

Your assessment should include a thorough history and physical examination (usually completed by the primary care physician), mental status examination, collateral information, neurological consultation, diagnostic tests, and neuropsychological studies. Your patient may need involuntary treatment and pharmacotherapy. Your approach should be sensitive, caring, and explanatory regarding your objective: to protect both your patient and his or her patients.

WORKING WITH DISABILITY INSURERS:

Most psychiatrists today feel taxed by the demands of insurers for medical information on their disabled patients. When your disabled patient is a physician, this can become even more complex because of your patient's concerns about his or her confidentiality, rights to privacy, and having patients on disability themselves. You must work with the insurance company as collaboratively as possible and in a timely manner, or your patient's benefits will be delayed. **Keep your patient in the loop at all times.** Make certain that your patient understands what is being requested by the company and the limits, if any, of their signed consent. **Protect confidentiality and release only essential information.** Answer all questions to the best of your ability, and don't respond to questions for which you are not qualified to answer. **Do not release a copy of your patient's medical file unless directed by your patient and/or his attorney.** If your patient is to submit to an independent medical evaluation, he or she may appreciate any guidance that you can provide.

WORKING WITH STATE PHYSICIAN SUPPORT PROGRAMS AND LICENSING BOARDS:

Be clear about your contract with your patient and make sure that you have consent before speaking to anyone. However, if your patient is impaired, has no insight, and refuses to voluntarily withdraw from medical practice, you have no recourse but to report the situation tot he appropriate authority. You should become familiar with the terms of reference of your state physician support program and their relationship with the licensing board. Physician support programs and licensing boards vary in their mission, reporting statutes, understanding of psychiatric illness, approach, rigidity, and oversight. With complicated physician-patients, eg, doctors with dual diagnoses and/or those with charges against them, it is in the best interests of your patient to work cooperatively with others involved in their care, especially addiction medicine and forensic specialists.

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Questions Based On This Lesson

To earn CME credits, answer the following questions on your quiz response form.

64. Which of the following statements is correct?

A. The "white knight syndrome" is the author's way of describing a unique resilience possessed by medical students that enhances their ability to deal with stress.

B. Because the patient is a medical student or physician, any inquiry about suicidal issues must be approached hesitantly and, if possible, postponed until late in treatment so as not to offend his/her professional sensibility.

C. Physicians should not be treated by psychiatrists who are on the same hospital staff.

D. From the onset, the psychiatrist should make clear how treatment will be conducted, as well as issues of confidentiality.

65. In treating medical students or physicians:

A. Always maintain a cool, distant stance, avoiding the appearance of being at all welcoming, friendly, respectful, or compassionate.

B. Since many physicians are familiar with psychopharmacological agents and often self-medicate before seeking treatment, it's best to let them continue to choose their own medications and write their own prescriptions.

C. Do not assume the patient will have a significant degree of insight and recognize that they could be quite fearful of the diagnosis you may make or the treatment regimen you may outline.

D. To insure privacy, avoid any contact with family members, even if requested to do so by the patient.

66. Which of the following statements is *not* correct?

A. While the stigma still associated with psychiatric illness is commonly felt by physicians and can serve as an obstacle to their seeking treatment, one can safely assume that psychiatrists themselves are completely free of such attitudes.

B. Fear of loss of control in the role of patient and a "little bit of knowledge" about psychiatric illness, treatment, and outlook combine to make physicians particularly fearful of seeking help.

C. The most common impairing conditions in physicians are alcohol and substance abuse and dependence, and nonorganic and organic psychiatric illnesses.

D. If a physician-patient is seriously impaired, has no insight, and refuses to voluntarily withdraw from medical practice, you may have no recourse but to report it to the proper authorities.

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