



The Mentally Ill Physician: Issues in Assessment, Treatment and Advocacy

Michael F. Myers, MD, DLFAPA, DFCPA¹; Alison Freeland, BSc, MD, FRCP(C), FCPA²

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Introduction

One of the fundamental responsibilities of the medical profession is a commitment to self-care and peer support.² This includes imperatives to value personal health and wellness and to promote a training and practice culture that supports and responds effectively to colleagues in need; empowers physicians to seek help to improve their physical, mental and social well-being; and supports change to remove individual and systems-level barriers to physician health and wellness. Additionally, the importance of this on health care outcomes for patients has been clearly outlined in the Institute for Healthcare Improvement (IHI) Quadruple Aim to advance patient experience and optimize health system performance.³ IHI

has added the goal of improving the work life of health care professionals, including addressing burnout and increasing the joy of work, as key to improve patient outcomes.

In concert with these objectives, the Canadian Psychiatric Association (CPA) is committed to the compassionate and comprehensive care of physicians experiencing mental illness. This includes ensuring that the standards of confidentiality, illness recognition, early diagnosis, evidence-based treatment, and rehabilitation and recovery, which are essential for all good psychiatric care, are equally applied to physicians and nuanced to address their unique needs. Because of the clear relationship between physician wellness and competence to practise medicine, it is the position of the CPA that:

¹ Professor, Clinical Psychiatry, Immediate Past Vice-Chair, Education and Director of Training, SUNY Downstate Medical Center, Brooklyn, New York; Member, Advisory Board, Committee for Physician Health, Medical Society of the State of New York; Past-President, Canadian Psychiatric Association.

² Vice-President, Quality, Education and Patient Relations, Trillium Health Partners, Mississauga, Ontario; Associate Dean, Medical Education (Regional), Faculty of Medicine, University of Toronto; Associate Professor, Department of Psychiatry, University of Toronto, Toronto, Ontario.

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1. There must be an ongoing focus within the health care community to advance physician wellness and well-being overall.
2. Organizations that oversee physician training, practice, licensure and credentialing create processes to educate, support and advocate for physician mental health.
3. There is ongoing advocacy promoting fairness and balance between preserving physician autonomy and privacy, and restricting licensure where necessary, so that no harm befalls a physician's patients.
4. There are ongoing opportunities for research and education related to developing evidence-based approaches to the treatment of mentally ill physicians.

This position paper highlights a few current issues in physician mental health, related to wellness, prevention, diagnosis, stigma and comprehensiveness in treatment approaches, and provides a selection of relevant references for clinicians treating these patients. With increased awareness, advocacy efforts by individual clinicians and mental health agencies on behalf of Canada's physicians are more likely to succeed.

1) Physician Wellness

Finding a lack of conceptual clarity and uniformity in defining and measuring wellness in physicians, Brady et al⁴ have proposed the following: Physician wellness (well-being) is defined by quality of life, which includes the absence of ill-being and the presence of positive physical, mental, social, and integrated well-being experienced in connection with activities and environments that allow physicians to develop their full potentials across personal and work-life domains.

At the national level, the Canadian Medical Association (CMA) champions physician health and wellness across the physician life cycle through leadership and advocacy and through a lens of shared responsibility—from “individual” to “system”—with particular emphasis on system-level initiatives.⁵ The CMA lists a host of factors that can contribute to adverse well-being and illness in physicians: disruptive work environments, restricted autonomy, heavy workloads, long hours and fatigue, reduced work-life balance, financial strain, high expectations, stigma and influences within medical culture.⁵

The need for a public health approach to advancing and ensuring physician wellness has been clearly articulated.⁶

The domain of primary prevention examines the training and work environment. Secondary prevention identifies at risk individuals and early recognition of the same, and tertiary prevention delineates mental health treatment, both improving access to professionals and dedicated mental health treatment programs.

2) Physician Impairment

Physicians can be mentally ill and not occupationally impaired. Physicians have an ethical obligation to maintain the ability to perform patient care tasks in a safe manner and are deemed to be “impaired physicians” when unable to do so on the basis of physical and mental disorder or injury.⁷ Assessing whether or not a physician is impaired requires the treating physician to assess and diagnose illness and determine the impact of illness on competence to practise. Furthermore, legal and regulatory practices treat the distinction between impaired and unimpaired as binary, yet symptoms of illness and their impact on professional functioning exist on a spectrum.⁸ Behaviours that raise a red flag, such as neglect of practice or documentation, and unexplained changes in relationships with others, appearance, work schedule and work quality, can escalate to boundary violations, unethical or illegal actions, and medical errors.

Psychiatrists with the requisite knowledge and experience⁸ may be asked to complete a fitness to practise or fitness for duty evaluation of a physician. These are independent assessments and cannot be performed by the treating psychiatrist or any psychiatrist who may be in a conflict of interest with the person. Guidelines and resource documents are available,^{9,10} to ensure that the evaluation is comprehensive, sensitive and fair.

3) Burnout

Although burnout is not listed as a diagnosis in DSM-5, it is mentioned in the 10th edition of the International Classification of Diseases.¹¹ Because of its high prevalence (approximately 50 per cent of physicians), it is an entity that may prompt a visit to a healthcare practitioner. It was first defined in the 1970s by Freudenberger¹² and encompasses the following three components: emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment in people who work in human services professions.¹³ It is more common when job stress is high and personal autonomy (or agency) is low. Burnout has been studied extensively in medical students, residents and physicians beyond their training years.¹⁴⁻¹⁶ Studies exploring gender differences in prevalence are inconclusive.¹⁷ Studies vary in which specialties have

higher rates except primary care, which is consistently high.¹⁷ Burnout has physiological, behavioural, psychological, spiritual and clinical components.¹⁸ It is rooted in the workplace and hence, unlike depression, is an occupational syndrome.

Burnout seems to carry less stigma than depression. Physicians are more likely to speak openly about experiencing burnout, whereas they rarely disclose that they are suffering from depression. However, like depression, burnout has significant fallout—increased self-reported error, work attrition and turnover, loss of empathy for patients, and reduced patient satisfaction and compliance with treatment.¹⁶ It has also been linked to suicide in some research.¹⁹

Burnout is believed to be distinct from depression,²⁰ but there is much overlap in symptoms and workplace behaviours. It is often comorbid with substance use disorders, anxiety disorders, posttraumatic stress disorder (PTSD) and relationship discord. Making the correct diagnosis (or diagnoses) is imperative because the treatments are different. There are numerous examples of physicians who erroneously concluded that they were burned out and quit their jobs or who were retrained in another specialty or retired from medicine completely only to find that they still felt unhappy, numb or fatigued because of an unrecognized mood disorder.

There does not seem to be current evidence that supports specific guidelines to treating burnout. Given its complex underpinnings and multiple contributing factors, clinicians take an individualized approach to treatment, which includes wellness counselling, psychoeducation, stress management strategies, cognitive behaviour therapy and monitoring for any emergent substance use disorders and mental illness. Prevention strategies, including teaching physician wellness as part of medical learner curricula and continuing professional development, are increasingly prevalent. More research will be required to determine the impact of these strategies on overall physician mental health.

4) Mood and Anxiety Disorders

Although separate clinical entities, depression and anxiety are common and often comorbid in physicians.²¹ During training, rates of depression increase substantially.^{22,23} The prevalence of depression or depressive symptoms in medical students was found to be 27.2 per cent in one meta-analysis study²⁴ and 28.8 per cent in a similar study of residents.²⁵ Early career physicians report higher rates of emotional exhaustion, depersonalization and burnout than their peers.¹⁴ A recent

survey by the CMA reported that one in three doctors screened positive for depression.²⁶ Research on anxiety disorders in physicians is less robust and complicated by different assessment tools, but at least one older study of medical students reports higher rates of trait anxiety and symptoms of anxiety when compared with the general population.²³

All physicians presenting with anxiety and/or depressive disorders require a thorough assessment, including use of symptom rating scales. Psychosocial contributing factors should be carefully explored. Attention should be paid to understanding some of the unique pressures faced by physicians, including specific health care systems issues that affect the physician's sense of personal autonomy in how to practise. Healthcare systems are increasingly directive around delivery of care, and changes in the perception and value of physicians' scope of practice are challenging factors to consider in their treatment and care.

The prevalence of bipolar illness in physicians compared with the general population is unclear. Similar to the age of presentation in the general population, bipolar I disorder can present with a manic episode in a medical student or resident, usually resulting in delay in completion of training. A later diagnosis of bipolar I or II illness in a physician with a history of major depressive disorder is also seen clinically and may be challenging to differentiate from a medically induced or substance-related mood disorder or a separate comorbid diagnosis of substance use disorder. Once diagnosed, recurrence of mania is common, with one study showing a 36 per cent recurrence rate in bipolar physicians enrolled in a Canadian professional workplace monitoring program.²⁷

5) Substance Use Disorders

Physicians' rates of substance use disorders are approximately 15 per cent compared with 13 per cent in the general public.²⁸ Physicians are more apt to misuse prescription drugs than nonphysicians, usually via self-medicating after prescribing for themselves.²⁹ Although alcohol remains the most common drug of abuse in physicians, overuse of other drugs (both proprietary and illicit) varies with age, stage of training or beyond, accessibility and branch of medicine. Because of the long length of problem drinking or drug use before a diagnosis is made, the pattern may begin in medical school or residency, when trainees treat their stress, burnout, anxiety or depression with alcohol or illicit or prescribed drugs. Classically, they rationalize their use as a societal norm or simply as a means of coping with a challenging period in their professional evolution as a physician.

Despite trainees' education and knowledge about the genetic and psychological underpinnings of familial substance use disorders, many cannot grasp their own vulnerability and ignore early warning signs.

Medication-assisted treatment of alcohol use disorder (AUD) is now evidence-based practice. Patients with AUD whose goal is to reduce alcohol consumption or achieve abstinence should be offered an anticraving agent such as naltrexone or acamprosate. Although there is no research focused on outcomes with use of these medications specific to physician patients, their benefit to the general population overall has been established, and therefore, their use in treating the physician patient should be considered.

Similar to the general population, substance use disorders frequently co-occur with mental illnesses, and careful assessment to ensure concurrent disorders are detected and treated is essential.

6) PTSD

PTSD is not only more commonly diagnosed today than in the past, but there are more publications in the physician health literature as well.³⁰⁻³⁴ It is believed that physicians have been subject to trauma for decades, but it has been unrecognized and even unaccepted as legitimate, with a societal assumption that health care professionals are trained to be impervious to all the physical and psychological assaults that occur in clinical work.³⁵ There is now a better understanding of the impact of exposure to trauma in health care professionals. Trauma surgeons, burn surgeons, emergency medicine physicians, critical care specialists and psychiatrists are particularly prone, but really no branch of medicine is immune, particularly with vicarious (so-called second victim) trauma.³⁶ Additionally, medical students^{37,38} and residents³⁹ can be traumatized not just by the clinical work they engage in but also by their teachers.⁴⁰ PTSD can be comorbid with symptomatic alcohol and other drug overuse in physicians and is often overlooked while physicians struggle with recovery and addressed only once treatment is well underway or abstinence is achieved.⁴¹

Like the general population, physicians can be traumatized by nonclinical stressors that arise in their personal life.^{32,33} Unresolved childhood and adolescent abuse (physical, sexual, bullying) can be reactivated in the adult physician, either through non-clinically related trauma or through workplace experiences. Ensuring a detailed trauma history is taken will improve understanding of the issues contributing to a presentation of PTSD and consequently optimize a treatment plan for

addressing it. Despite more advanced understanding of adult traumas including sexual harassment, assault and domestic violence, and increased exposure to these concepts as part of medical training curricula, it often remains difficult for both female and male physicians to disclose that they have been or are being victimized because of the sense of shame and low self-worth associated with these events.

7) Mild Cognitive Impairment

The issue of cognitive decline in aging physicians requires careful consideration. The presence of mild cognitive impairment can impair the practising physician's ability to accept that they may no longer be able to practise safely, and as such, recognition of this concern by colleagues and regulatory bodies is essential to ensure the appropriate assessments are done that will protect both patients and the physician.⁴² Expert screening, assessment, planning, remediation and follow-up are necessary to determine if and how the physician with mild cognitive impairment can continue to practise in a time-limited way, potentially with some limits placed on scope of practice.⁴³

8) Disruptive Physician Behaviour

With professionalism and collegiality now being articulated as necessary competencies for every practising physician, disruptive behaviour in physicians is gaining increasing attention. Processes around identification and reporting of these behaviours are now a mainstay in most regulatory bodies, for example, the College of Physicians and Surgeons of Ontario.⁴⁴

Any physician with a pattern of disruptive behaviour warrants a comprehensive assessment to ensure a fulsome understanding of any contributing mental illness or substance use disorder, as these physician-patients may too quickly be labelled as having a "difficult personality," with illnesses requiring treatment being overlooked. Reynolds⁴⁵ has called for caution about labelling doctors, especially if the disruptive behaviour is situational and not pervasive, deep-seated, or resistant to change.

The successful treatment of a disruptive physician is rooted in a systemic understanding of the forces contributing to the behaviours, including any mental illness, and to their amelioration.⁴⁶

9) The Suicidal Physician

It is estimated that 300 to 400 physicians die by suicide each year in the United States. Rates in Canada have not

been systematically measured. Male physicians have rates slightly higher than men in general, and female physicians' rates are three to four times higher compared with other women.^{47,48} Of people who die by suicide, 85 to 90 per cent have been living with a mental illness. This applies to physicians as well, but in one qualitative interview study of families whose physician family member died by suicide, approximately 10 to 15 per cent of the decedents received no treatment at all.⁴⁹

It is recommended that treating clinicians be wary of making exceptions or treating the physician differently than other patients who present with suicidal thoughts. There is often increased reticence to involuntarily admit a colleague against their will to a hospital setting for their safety, which may increase the risk of suicide. For physician patients in this situation, it is additionally important to directly address any concerns that they may have regarding the possible impact on licensure and ability to practise.

10) Physician Health Programs

Clinicians may receive a referral to assess and/or treat a physician with mental illness and/or addictions from a provincial physician health program. These programs are designed specifically to address the needs of physicians where illness or addiction has affected their professional life, causing issues with colleagues, supervisors, or patients and families. With the cooperation of the affected physician, the physician health program will develop a treatment plan, which it oversees and monitors in the form of a contract with the physician. This contract, which may be in place for several years, may require urine monitoring or other assays, attendance at Alcoholics Anonymous or Narcotics Anonymous or other peer support activities, regular ongoing psychiatric care and treatment as appropriate, and worksite monitoring often involving hospital physician leadership and human resource departments. Psychiatrists and other clinicians who agree to participate in this type of treatment contract should ensure their involvement is clearly outlined and any obligations to report progress are well understood. Long-term outcomes of physicians being monitored by physician health programs continue to be very good.^{50,51}

11) Stigma

Internalized or felt stigma is common in physicians who feel self-conscious about having a mental illness, and it can manifest itself in many ways in the treatment relationship. First, physicians who feel ashamed of having a mental illness will be inhibited and less forthcoming and

may be embarrassed to disclose key pieces of their personal and family history that they perceive as shameful. Additionally, fear of mandatory reporting to licensing bodies and the impact that may have on their clinical practice can result in minimization of symptoms. As a result, the treating clinician may not get a true picture of the illness complexity and severity. Second, even well-intentioned physician-patients may be less treatment adherent because of busy clinical schedules and concern for loss of income for those patients who have to take time away from fee-for-service work. Third, patients may be at risk of concluding their treatment prematurely, given pressures of clinical work and a wish to feel well again. A variant of this issue are physician-patients with temporary absence from work, who present their symptoms as more improved than they really are in order to get a clean bill of health and return to work as quickly as possible. Finally, increased awareness of self-initiation of medications to start treatment is needed, as it is common and likely underreported.⁵²

There is some indication that stigma is slowly being addressed within the medical profession. There are now many powerful first-person accounts of mental illness written by medical students, residents, and physicians and available in both medical and lay publications.⁵³⁻⁶² These narratives have led the way for more open conversation about mental illness in medical professionals and are helping address the sense of isolation and suffering that some experience and hopefully encouraging others to reach out for help.

Conclusion

The well-being of Canada's physicians is a national imperative that concerns everyone. The CPA remains committed to advancing the mental health of physicians and supporting education and research to develop physician-specific best practices to treat mental illness and substance use disorders. It is hoped that the guidance and recommendations offered here will go some distance in reducing the morbidity—and mortality—in today's physicians.

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