



CPA POSITION PAPER

Treatment of the Mentally Ill Physician

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Introduction

A physician may act as a colleague, consulting expert, or treating physician to another physician who is mentally ill. This paper acknowledges that the physician, like any other member of our society, is susceptible to mental illness. It outlines aspects of treatment and provides certain recommendations; the paper focuses on the role of the clinician as treating physician.

The Canadian Psychiatric Association (CPA) is committed to the humane and comprehensive care of mentally ill physicians. This includes recognition of illness, early diagnosis, confidential state-of-the-art treatment, return to work when the physician is well, advocacy, overcoming stigma, and research. Because of the close link between mental illness and competence to practise good medicine, the position of the CPA is to work closely with provincial medical licencing colleges and medical associations to educate, to promote mutual understanding, and to seek fairness (in both preserving physician autonomy and restricting licensure) so that no harm befalls a physician's patients.

Since the first position paper on the mentally ill physician was published in 1984 (1), there have been major advancements in our understanding and care of medical colleagues who suffer from psychiatric illness. Data on incidence (2,3), demographics of today's physicians (4-6),

stressors (7,8), nosology (Myers and Dickstein, unpublished), intervention (9-11), and outcome studies (12) have sharpened our diagnostic accuracy and broadened our treatment approaches. Given the multiple stressors in physicians' lives (13), the increased number of medical licence investigations and lawsuits (14,15), a consumer-driven climate of public accountability for professional behaviour and safety (16,17), and a tone of demoralization among many physicians (18), an updated CPA position paper on the mentally ill physician is timely.

Definition

Physician impairment is the inability to practise medicine with reasonable skill and safety because of physical or mental illness, including (but not limited to) aging-related complications, alcoholism, and chemical drug dependence (19). Physicians can be mentally ill and not occupationally impaired. In other words, their depression, eating disorder, alcoholism, or obsessive-compulsive disorder has not progressed to the point that it affects their medical judgement, competence, safety, or manner. Assessing for impairment is one of the essential aspects of a thorough diagnostic assessment of any symptomatic physician, both at the time of initial contact and throughout the treatment period. When the psychiatrist diagnoses impairment, or strongly suspects it, he or she must ensure that the physician stops practising medicine.

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Unrecognized and untreated physician impairment is both egregious and heartbreaking in its potential for harm (20). The patients of impaired physicians may receive care that is substandard, demeaning, outdated, psychologically traumatic, or medically dangerous, that is, care, or lack of care, which can kill them. Medical students and residents taught by impaired physicians may be poorly supervised, may be harassed and abused (21–23), and may become poor teacher role models themselves. Many families of impaired physicians suffer from neglect, bewilderment, shame, and despondency (24). Impaired physicians themselves suffer from loss of work satisfaction, unhappiness, absenteeism, secondary psychiatric and medical complications, decline in professional stature, loss of career progression, complaints to their provincial colleges of physicians and surgeons, and humiliation. Premature deaths of impaired physicians may result from underdiagnosis, inadequate treatment, medical complications, and suicide.

Alcohol and Other Drug Impairment in Physicians

Estimates of impairment among practising physicians in Canada and the United States report ranges from 7% to 10% and 10% to 12% (25,26). Of these, 75% are believed to be dependent on alcohol and/or other drugs. Addiction medicine specialists are the experts in Canada in recognizing, diagnosing, treating, and teaching about chemical dependency in physicians. In addition, all of the provinces have impaired-physician committees (or their equivalent) with expertise in investigation of reports by concerned individuals (staff, colleagues, family members), assessment, intervention, detoxification, residential treatment resources, 12-step programs, caduceus groups, random urine monitoring, and addiction counselling. These committees also work closely with provincial college authorities regarding licensure.

All physicians with alcohol and drug impairment should have a thorough psychiatric assessment. General psychiatrists who treat physicians impaired by alcohol or drug abuse should use sufficient peer and expert support and advice to provide optimal assessment and treatment.

An unknown number of physicians suffer from a dual diagnosis (or comorbidity) such as chemical dependency plus major depression, bipolar illness, panic disorder, or obsessive–compulsive disorder (27). Illnesses like these require proper treatment, treatment that may be difficult psychopharmacologically because of the addictive

disorder (28). Unless the psychiatrist and the addiction specialist work together in a collaborative and mutually respectful manner, the physician-patient's treatment will fail.

The expertise of general psychiatrists can be invaluable in other ways with chemically impaired physicians: providing psychotherapy to physicians with associated unresolved childhood traumas and conflicts; treating marital discord with couples therapy (29,30); respecting the “family disease” model of addiction and providing (or recommending) family therapy; acting as a support or advocate for chemically impaired trainees in medical school or residency programs; acting as a liaison in the work place for physicians by providing consultation to hospital administrators, clinic managers, program directors, and licencing bodies; and “putting out fires” to make our colleagues' lives easier by combatting stigma, promoting inservice rounds on impairment, providing reassurance, and safeguarding privacy and confidentiality.

Nonorganic Psychiatric Impairment in Physicians

Physicians are not immune from the range of psychiatric illnesses that afflict humankind. Some of the more common of these illnesses are mood disorders (major depressive disorder, dysthymic disorder, and bipolar disorder), panic disorder, obsessive–compulsive disorder, posttraumatic stress disorder, eating disorders, adjustment disorders, personality disorders, and some DSM-IV “V” codes (“other conditions that may be a focus of clinical attention,” such as partner relational problem, occupational problem, or academic problem). Any of these disorders may be intense or protracted enough to render the physician unfit to practise medicine.

Although the actual incidence of depression in physicians is unknown, we know from several studies that one-fourth to one-third of residents become clinically depressed at some point in their training (31,32). Depression is more common in women (33), including women physicians. Studies of the general population reveal that depression is increasing. An unknown number of physicians are self-medicating with antidepressants.

A thorough biopsychosocial assessment is critical in fully understanding depression in physicians and informing treatment. Because of the stigma attached to depression, many physicians will delay or avoid reaching out for help (34). They feel flawed, inadequate, unworthy,

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and ashamed. Some will not realize that they are depressed or will underestimate how unwell they feel. Some will conceal suicidal ideas and plans because they fear hospitalization and temporary loss of their medical licence. It is sometimes for this reason that physicians self-prescribe, and once they are feeling a bit better, consult their family physician or a psychiatrist for ongoing treatment.

Delayed treatment is not without its hazards. Some physicians will have been symptomatic for weeks, months, or years. They may be malnourished, sleep-deprived, despairing, and delusional. They will need immediate and sometimes aggressive treatment. Some will have been suicidal a long time and will have stockpiled pharmaceutical samples at home. Depressed anesthetists, intensivists, and other physicians with ready access to intravenous drugs and equipment are at serious risk. They must be assessed very carefully for suicidal thinking and a plan. Because some physicians are so ill and feel so worthless, guilty, and frightened when they telephone for help, they must be seen very quickly, usually the same day.

Organic Psychiatric Impairment in Physicians

Any illness that affects the central nervous system and results in cognitive, mood, memory, or behavioural changes will impair a physician's judgement. Some examples are impairment caused by alcohol or other drugs (both formulary medications and street drugs), organicity associated with attempted suicide like drug overdoses and carbon monoxide poisoning, metabolic impairment and delirious states due to a range of medical illnesses, and the dementias associated with Alzheimer's disease, vascular disorders, Parkinson's disease, head trauma, and HIV infection (35).

Aging physicians who might be dementing and who practise in isolation and solely in an office setting without hospital privileges can pose a problem. Forgetfulness, errors, tardiness, procedural slips, poor medical record keeping, mood swings, and inappropriate speech and behaviour (including boundary crossing) may go undetected unless a complaint is lodged. The larger provincial colleges of physicians and surgeons now have peer-review procedures to assess the practices of physicians over a certain age (36).

Physicians suspected of organic impairment must have an intensive psychiatric assessment and a very careful mental status examination. Collateral information is piv-

otal. A consultation by a neurologist (with appropriate diagnostic tests) and neuropsychologist (with psychometric testing) should be done. Because higher-functioning physicians may feel threatened or humiliated by cognitive testing, they must be approached with sensitivity and given an explanation that the purpose is thoroughness—to prevent any possible inadvertent harm to the physician's patients or assault to the physician's professional integrity (like complaints to the provincial college, breaches of standards, or lawsuits). A physician whose organic mental illness includes paranoid delusions will need to be treated like any other patient, that is, with neuroleptics and possible involuntary commitment to hospital.

Physicians Who Are HIV-Infected

HIV-infected individuals must be treated with compassion and due respect to rights, privacy, and confidentiality (37). Because of the physician's professional obligation to do no harm, guidelines are needed in the event that physicians cannot perform professional duties because of HIV disease. Clinical evidence indicates that HIV infection is not spread by casual contact. All physicians who have a bloodborne communicable disease that may pose a risk to patients must 1) consult an appropriate colleague for continuing care and 2) consult a designated expert panel regarding the need for any alteration in the scope of practice, modification of practice techniques, and/or other precautions which are appropriate to protect the public from risk of harm through the continuing clinical practice of the affected doctor (38).

Regarding clinical competency, restriction of clinical privileges on the basis of HIV infection alone is clearly unwarranted. There must be evidence of impairment. Action against an otherwise qualified individual in licencing, hospital privileges, or admission to medical training programs on the basis of HIV status is discriminatory.

The treatment of physicians with HIV/AIDS is no different than that of the general population. The CPA currently has several helpful resources: 1) a videotape, "Learning to Care: An Introduction to HIV Psychiatry," which describes the pharmacological and psychotherapeutic management of patients with anxiety disorders, adjustment disorders, mood disorders, delusional disorders, delirium, dementia, and bereavement; 2) a position statement on HIV disease and AIDS (39); 3) a training manual, *HIV & Psychiatry: A Training and Resource Manual* (40); and 4) the *Consultant/Mentor Directory*:

HIV Disease and Psychiatry (41), which lists the names of psychiatrists throughout the country who are available to their psychiatrist colleagues for help with their patients, including physicians with HIV/AIDS.

Recommendations

1) Any physician with a possible psychiatric illness should receive an assessment quickly, ideally by a psychiatrist who is not a colleague or friend (guidelines paper of the British Columbia Physician Support Program, unpublished). In small communities, this will not always be possible; immediate or urgent care should be delivered by local physicians, and an "arm's length" assessment (and perhaps ongoing care) by a psychiatrist in a nearby community should then be obtained.

2) Psychiatrists must appreciate the unique features of assessing and treating physicians. Mentally ill physicians tend to deny, minimize, and rationalize their symptoms and actions. Mentally ill psychiatrists may feel like impostors, not fit to be practising medicine. Shame and guilt also often distort the picture. Reluctance by the patient to permit (or by the treating psychiatrist to obtain) collateral information from the family or other health professionals may compromise treatment. Both the physician-patient and the treating psychiatrist may inadvertently collude, causing underdiagnosis and inadequate treatment.

3) An empathic and comprehensive biopsychosocial assessment should highlight the following: previous history of psychiatric disorder, whether treated or not; family history of psychiatric illness; detailed medical history, including whether the patient has a family physician whom he or she formally attends (as opposed to curbside consultation or telephone referrals to specialists); complete alcohol and other drug history; questions about suicide and homicide; assessment of functioning at work, at home, and in the community; and questions about professional and ethical behaviour with patients.

4) Treating psychiatrists must never let their judgement be affected by the patient's being a physician. In other words, if the patient is very ill and warrants hospitalization (voluntarily or under certification) or residential treatment for chemical dependency, then he or she must be admitted. Historically, too many physicians have worsened and have harmed themselves (including committing suicide) or others while they were in need of protection. The provincial college of physicians and surgeons must be notified under

the statutes of the Medical Practitioners' Act. To safeguard privacy, treating psychiatrists should hospitalize physicians away from their home hospital, if possible. Inservice education of nursing and associated staff about treating hospitalized physicians will diminish anxiety and acting out and should ensure care that is sensitive yet firm.

5) If the physician has behavioural problems of a legal, sexual, or ethical nature, consideration should be given to bringing in an appropriately specialized practitioner, such as a forensic psychiatrist or ethicist. A more comprehensive, specialized, multidisciplinary treatment plan, beyond the expertise of the generalist psychiatrist, may also be indicated.

6) The rehabilitation of physicians requires that treating psychiatrists develop expertise in knowing when to place their patients on complete disability, partial disability, and no disability. It is therapeutic for physicians to be working, but not if they are still ill or if they have returned to a job that puts them at risk for relapse. Coddling or less-than-aggressive treatment is not good either, however: patients will lose confidence in their ability to return to practising medicine, even with continuing medical education and skills enhancement. Further, the treating psychiatrist must also recognize that some physicians will suffer from a factitious disorder or even malingering if they are drug seeking, facing criminal charges, or looking for financial compensation. Obtaining a second opinion from another psychiatrist or a rehabilitation counsellor will often be of help in such cases.

7) The treating psychiatrist must urge the physician-patient to obtain a family physician as soon as possible. Understanding that this is no easy task for physicians, psychiatrists must be prepared to help the patient find a family physician whom he or she trusts and respects and who is comfortable having physicians as patients.

8) Addressing confidentiality is an important issue in the treatment of physicians. These individuals will have witnessed breaches of privacy since they were medical students. Treating psychiatrists must be prepared for a host of questions related to what is and what is not being recorded on the file, who has access to it, whether all files are under lock and key, whether the psychiatrist has family members (who know the patient or his or her family) working in the office or doing the billing, what is being recorded on reports to insurance companies (under no circumstances should the psychiatrist photocopy a

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patient's clinical file and send it to the insurance company), what is on computer and what is not, whether a report is being sent to the referring physician (if the physician is not self-referred), and what the treating psychiatrist's relationship to the provincial college is. Psychiatrists must guard against being in a conflict-of-interest situation, for example, treating someone who is under their supervision, assessing an employee for psychiatric disorder, or treating both the complainant and the defendant in doctor-patient boundary crossing (42). Physicians who consult psychiatrists on their own and who have no problems with their provincial college have a different relationship with the psychiatrist than those who have college involvement. The latter relationship is embedded in a disciplinary context, and the psychiatrist has a higher duty to the public than in the former relationship (43). Further, the treating psychiatrist is expected to give assistance to the college, providing diagnostic information, progress reports, appraisals of posttherapy stability, and opinion regarding ongoing monitoring.

9) All provinces should have psychiatrists who serve on, or consult to, their physician well-being committees. This will not only promote intercollegial respectfulness with addictionologists but also ensure that mentally ill physicians receive prompt and comprehensive care either through consultation or referral to someone in their community. This outreach must extend to the families of symptomatic physicians. Too often families of psychiatrically ill physicians feel left out, confused, and frightened.

10) Peer-support groups for psychiatrists who treat physicians should be established at a provincial level. The work is highly specialized, is always evolving, and can be intense and complicated (for example, when physician-patients "split" the therapeutic team, are litigious, or commit suicide).

11) The CPA is committed to supporting, through its various councils and sections and its annual scientific meeting and publications, research on the mentally ill physician. There should be no discrimination by provincial colleges of physicians and surgeons (that is, licensing authorities), hospitals, medical schools, or other institutions that employ physicians against those who have a mental rather than physical illness but are not impaired.

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