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Optimising the treatment of doctors with mental illness

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Introduction

There exists a common view that doctors are 'difficult patients' and some psychiatrists experience anxiety when faced with the prospect of treating another doctor. We believe that doctors' health can be optimised at an individual level. Here, we outline strategies to optimise the psychiatric treatment of doctor-patients garnered from our clinical experience.

The mental health of doctors

Most doctors are fit and extremely resilient. However, medical professionals as a group are at higher risk of poor mental health. The prevalence of depression or depressive symptoms in doctors-in-training is 29% (Mata et al., 2015). The risk factors for poor mental health in doctors include frequent exposure to traumatic events beyond normal human experience, lack of recognition of illness in themselves and others and the lack of consistently available services to support doctor health and wellbeing.

Doctors who present for treatment are a relatively self-motivated and compliant group. Once in treatment, most doctors with mental illness make good recoveries. An audit of outcomes of case management at the Victorian Doctors Health Program found that four in five doctor-patients had good recovery at 5 years (K Jenkins 2018, personal communication, 10 July).

Understanding the unique needs of the doctor-patient

Personality factors and temperament can negatively impact on how doctors cope with the stressors of their work and also impact on their engagement with health care professionals when unwell. Features of perfectionism and obsessionalism, which are advantageous during medical training, can lead to self-reproachment when a doctor becomes unwell (Myers and Gabbard, 2008).

Often these characteristics are imbued in doctors during their training. Doctors work in a medical culture characterised by implicit or explicit demands for impeccable professionalism with limited room for vulnerability (Stanton and Randal, 2016). The culture emphasises stoicism and sacrifice with many doctors shaped to abjure personal fragility and adopt a persona of omnipotence and detachment. There is an embedded belief around the dichotomy of doctor and patient, an 'us versus them' paradigm famously epitomised in Samuel Shem's (2010) Laws of the House of God that 'the patient is the one with the disease'.

Doctors can hold a view that they are invulnerable to mental illness or are not permitted to be sick. They can have difficulty with relinquishing their professional role and adopting the role of a patient and may not seek help through usual channels. Quite often doctors affected by mental illness mask their distress and do not disclose their mental illness. When doctors do seek help, they may minimise or rationalise symptoms to avoid appearing 'weak' and also to suppress preconscious and unconscious fears of being ill.

Understanding the barriers to good psychiatric care

The most commonly identified barriers to doctor-patients seeking care are lack of time and confidentiality concerns. Long work hours and on-call arrangements can make regular medical appointments difficult to attend. Partly due to this, self-treatment among doctors is endemic and normalised. Many doctors self-treat in pursuit of expediency. In a study of US psychiatrists, 43% would consider self-medication or would self-medicate if afflicted with mild to moderate depression, and 16% had treated themselves for depression in the past (Balon, 2007). This is likely due to fear of a permanent record and stigma. In

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Australia, concerns about mandatory reporting have resulted in some individuals eschewing care for fear of being reported to the regulatory authority.

Stigma about mental illness is ubiquitous and pernicious within medical culture. Mental illness is perceived by some doctors as a sign of weakness, and doctors with a history of mental illness are perceived as less competent by some peers. There also exists stigma against psychiatry within the medical profession, thus some doctors may experience additional stigma around having to see a psychiatrist.

Optimising the care of the mentally ill doctor-patient

Before the consultation

Doctors with psychiatric illnesses often present late, so efforts should be made to prioritise and expedite their assessment. 'Corridor consultations' are marred by lack of role clarity, insufficient assessment, and inadequate documentation and should be avoided. Instead, the doctor-patient should be encouraged to make an appointment and supported in doing so.

Psychiatrists who treat doctor-patients may feel nervous or even intimidated when treating a fellow doctor. The reasons for this include a desire to impress, insecurity about knowledge or skills and feeling vulnerable to criticism by the wider medical community should an adverse outcome occur.

Doctor-patients want a doctor who can be flexible and understanding with regard to the working timetable of a busy doctor and the difficulty of fitting in appointments around working hours. They also prefer a doctor who can appreciate the sense of shame that some doctor-patients live with and their fears about medico-legal implications. If a psychiatrist is concerned about their ability to manage a fellow doctor, they should consider a referral to a psychiatrist experienced in doctors' health.

During the consultation

Like consultations with all patients, a doctor-patient requires a thorough biopsychosocial assessment and formulation. Given the tendency of doctor-patients to 'put their best foot forward', they may omit some aspects of symptoms, functioning, habits or past history. This 'selective disclosure' may be a symptom of their own denial but may be an attempt to consciously or unconsciously avoid an unwanted diagnosis. The treating psychiatrist should request old medical records and obtain collateral information from friends and family.

There should be early recognition that many doctors desire to be 'good patients' who may minimise their difficulties and distress. In some, this desire to be a compliant patient may result in reluctance to voice disagreement with treatment plans and lead to disengagement from the therapeutic relationship (Stanton and Randal, 2016). Early acknowledgement of challenges that arise and regularly checking in with the doctor-patient about their experience during the consultation can prevent premature disengagement.

Psychoeducation should be tailored to the doctor-patient's needs. Too much medical jargon can be confusing and distancing or lead to a pseudo-academic discussion of the doctor-patient's symptoms as though they were being experienced by a third party. However, using exclusively lay language may be insulting. The psychiatrist should avoid excessive deference in order to 'spare' doctor-patients from embarrassing aspects of the psychiatric assessment.

Shared decision making is important but it should be recognised there can be a tendency to give other doctors special care. Treating doctors must be aware of the potential for identification with the doctor-patient. Going that 'extra mile' may be appreciated but has the potential to lead to boundary crossings.

Follow-up

Follow-up should be arranged with timing and frequency determined by clinical need. Ensuring that the patient has a general practitioner (GP) who can address comorbid physical health problems is essential.

Supervision is a sine qua non for optimal psychiatric care. Peer support is recommended for all psychiatrists treating doctor-patients to ensure the provision of optimal treatment and to promote self-care. To protect confidentiality, consultation with peers who do not practice in the same location is always best.

Conclusion

To be a doctor's doctor is both an accolade and a challenge. Doctor-patients face unique barriers and have some distinctive needs, and it is important that psychiatrists are aware of these. That being said, doctor-patients are no different from any other patient in that they require compassion, understanding and expertise from their psychiatrist.

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