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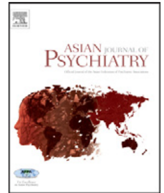

Treating a physician patient with psychosis

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ABSTRACT

The authors present a case of a psychotic female patient who is a former graduate of a locally prestigious medical school and has subsequently been diagnosed with schizophrenia. The patient entered treatment in an outpatient clinic following discharge from her 11th hospitalization. This hospitalization was initiated after the patient's physician friend had called the police and notified them that the patient was significantly disorganized to warrant further evaluation. Treatment was characterized by significant transference and counter-transference reactions amongst her clinicians – both treatment-promoting and treatment-interfering – based on her status as a physician. The problem of insight was a significant hurdle in the treatment of the patient as her medical knowledge of mental illness was substantially greater than her insight into her own mental illness.

Throughout treatment, a number of medical-legal and ethical issues arose. Initially, the question was raised as to the legality of the actions by the patient's friend—having made a clinical assessment without having a clinical role in the patient's care. As the patient's clinical status improved and she sought to re-enter the medical field as a resident, new medical legal issues surfaced. What were the roles of the patient's treaters in maintaining confidentiality and simultaneously ensuring the safety of patients that the psychotic physician might care for?

This case highlights the universality of psychiatric vulnerability. Insight in psychosis as well as the transference and counter-transference issues involved in caring for a psychotic physician are discussed. Additionally, a thorough medical-legal discussion addresses the various complexities of caring for a psychotic physician.

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1. Introduction

The following case – while based on a clinical experience of multiple authors – has been altered in certain details for the purposes of furthering the education of mental health professionals.

2. Case history

Ms. A is a 31-year-old Asian female and a graduate of a New England medical school with a history of severe non-affective psychotic illness who entered our care at a community mental health center after being referred from an inpatient psychiatric unit for continuing care following a three month hospitalization. Prior to her first psychotic break at age 26 as a 4th year medical student, she had no previous history of psychiatric care, substance abuse, or trauma. She is a single woman, born in her home country in Asia, and raised in America from the age of three. She reached all developmental milestones appropriately but had a chaotic upbringing notable for her parents' divorce at the age of 10 and her older sister's first psychotic break approximately four years afterwards. After these two events, Ms. A grew up with her mother in Alabama. She described this as an "academically-pressured environment" which she left subsequently to attend a local college before entering medical school. Patient had no significant substance abuse issues, medical problems, or other notable family history of psychiatric illness other than her sister's chronic psychotic illness which had been quite traumatic for the patient, specifically in regards to the sister's fall from grace as an aspiring lawyer.

The patient's first psychotic break was in the context of her father's arrival at her medical school residence with her older sister in the midst of one of the sister's psychotic decompensations. This was terrifying to the patient as the patient's father had sought her assistance in managing her sister's illness. Following this disturbing

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incident, Ms. A sought guidance from a medical school mentor in psychiatry who found Ms. A to be disorganized and recommended outpatient evaluation. This evaluation resulted in outpatient treatment with a failed trial of fluoxetine. Further decompensation ensued, leading to the patient's first hospitalization in which Ms. A was stabilized on an unknown dose of ziprasidone. Since her first psychotic break, she has been hospitalized 11 times due to inability to care for herself in the context of severe psychotic symptomatology (bizarre delusions, paranoia, poor hygiene and self-care) largely secondary to medication non-compliance (notably self-discontinuing ziprasidone for unclear reasons) stemming from poor insight into her psychotic illness ("I'm fine, sometimes I just get depressed"). While Ms. A did eventually graduate medical school and was able to begin residency in internal medicine, she was unable to finish the intern year due to the reemergence of her psychotic symptoms. Ms. A's disorganization was worrisome to her program director who mandated an involuntary medical leave of absence and outpatient treatment. When Ms. A attempted to return to work, her program director felt "uncomfortable" with this and she was "forced to return home to her mother." Of note, many of her hospitalizations over the past 5 years were in the context of academic and career-related stressors—specifically during the application and interviewing process for placement in residency programs and her subsequent rejection from these programs.

This most recent hospitalization began after the patient left her mother and returned to New England with the intention of reconnecting with friends and a former mentor from medical school. Soon after arriving, Ms. A sought out her mentor at her place of employment at a local hospital. When this mentor was found to be unavailable, Ms. A then called an old friend from medical school, hoping to stay at the friend's home for the night. The friend, a current resident physician, was immediately struck by Ms. A's disorganization and became quite concerned that Ms. A was in need of psychiatric care due to her inability to have a coherent conversation. Initially the friend suggested that they walk together to the emergency room for Ms. A to be seen by a psychiatrist. When Ms. A refused and ended their conversation, the friend felt "scared and helpless, not knowing exactly what to do." Ms.

A spent the night on the streets and contacted a second friend the following morning for unclear reasons. This second friend was also concerned for Ms. A's safety due to her disorganized speech and subsequently called the aforementioned resident physician who happened to be a mutual friend. At this point, the resident physician was frightened enough that she called 9–1–1, informing the police she was placing the patient on a Section 12 due to concerns that Ms. A was "psychotic."

The patient was located through Ms. A's two friends and brought to the emergency room by police. Upon evaluation by the consulting psychiatrist, Ms. A refused to engage in a full diagnostic interview and was found to be paranoid, disorganized and intermittently agitated. Ms. A was sent to an inpatient psychiatric unit for further diagnostic evaluation. Ms. A refused psychopharmacological management, and involuntary commitment and inpatient Rogers guardianship were obtained. During this time, her eventual medication regimen was olanzapine 15mg PO BID and haloperidol 15mg PO BID, both of which were started to treat her psychotic symptoms and increased to these doses over the course of eight weeks. After three months of treatment at this facility, she was transferred to a local community mental health center for outpatient continuing care in a Cognitive Behavioral Therapy (CBT) Partial Program.

Upon meeting the patient at the community health center, she was found to be quite paranoid and disorganized with a bizarre delusional complex that included thoughts that she was being "targeted for looking Middle-Eastern and being a terrorist." Initially the patient showed poor insight and loathed to discuss her treatment ("I'm fine, there is nothing wrong whatsoever, this is just a doctor's scheme to make money"). Over the course of a month that consisted of daily group and individual therapy sessions with a cognitive-behavioral approach, a therapeutic alliance developed. Ms. A became willing to engage in longer sessions where her previous history and current situation were explored in depth. She became gradually more involved in therapy and treatment planning and discussed her psychotic illness which she aptly called "my depression that sometimes makes it so that I can't put my thoughts into words."

At this point, Ms. A indicated that she was very concerned with some of the side-effects she was experiencing from treatment with antipsychotic medications, specifically daytime sedation and weight gain of approximately 30 pounds in three months of treatment with olanzapine and haloperidol. Therefore olanzapine was gradually tapered per patient preference and to minimize polypharmacy, and Ms. A remained on haloperidol monotherapy. There was no significant worsening of psychotic symptoms at this point and after approximately eight weeks in the Partial Program, the patient was determined to "graduate." With great personal initiative and support from her clinicians, she applied for a full-time job as a salesperson at an environmental engineering company. She was hired by a local company and is currently living at a shelter and receiving outpatient psychiatric care at the hospital to which she initially presented. Her current psychopharmacology regimen consists of haloperidol at 10mg PO QAM and 15mg PO QHS. Ms. A remains on these medications with the understanding that they help to prevent further hospitalizations and yet maintains the conviction that she will not require antipsychotic medications in the future.

By the time of discharge, Ms. A had forgiven her friend who called the police and placed her on Section 12, Ms. A having recognized that she "needed more help than just a place to stay at the time." The two of them have been in contact and meet for lunch on a regular basis. While the patient is very proud of her partial recovery, employment, and progress in obtaining more permanent housing, she remains saddened by her current lack of involvement in the medical profession. Ms. A hopes to resume medical training in a surgical subspecialty and has scheduled future meetings with program directors in the field to discuss restarting the application process.

3. Case discussion

While many patients enter treatment at the aforementioned community health center, this particular patient stands out in the minds of the authors. Most senior psychiatrists have had the experience of treating other professionals who work in the medical field, but this was the first time the author was the primary clinician for a psychotic patient that might have otherwise been a professional peer. This was a fascinating issue in terms of transference and counter-transference with both the patient and her treaters constantly aware of these dynamics. Ms. A was notably frustrated throughout much of her treatment due to her view that she was more connected to her treaters than with her fellow patients, stating "I'm not a crack-addict or a crazy homeless person, I'm a doctor." This was further evidenced as she deliberately called her treating physicians by their first names (as opposed to 'Dr. Crow' and 'Dr. Freedman'). This was difficult for her treaters and an attempt to engage the patient through validation of her strengths was most helpful in overcoming some of these aforementioned transference issues. This was specifically useful in discussing the patient's psychopharmacological regimen as the patient was able to engage in thorough risk-and-benefit analyses addressing the possible pros and cons of treatment with

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