Contemporary Themes

Psychosis in young doctors

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Summary and conclusions

Three young men who had serious psychotic illnesses as final-year medical students, with damaging recurrences later in two, have subsequently succeeded as clinical practitioners. One has so far completed five healthy years, the others two years each, since treatment with phenothiazines and support.

Introduction

A doctor, like anyone else, may suffer from any form of personality disorder or mental illness. When such a breakdown becomes known fears often arise that he may harm his patients or bring discredit on the profession. If he recovers it is often thought that the stress of medical practice may be enough to precipitate further mental breakdowns, and he is therefore advised or even forced to leave medicine altogether and find some other occupation. A medical training, however, is long and costly, and the clinical experience of even a young practitioner represents a community asset. It is therefore wasteful of society's resources as well as hard on the individual with a heartfelt commitment to medicine to exclude all doctors from further practice if they suffer a breakdown, unless exclusion is shown to be essential.

Most reports on psychiatric illness in doctors refer to alcoholism or drug dependence in the middle-aged. Manic-depressive and schizophrenic illnesses in the young, however, present very different problems, not least because some conditions are fully controllable with psychotropic drugs. In such cases it is wiser and kinder to judge each individual in terms of what he can do than to rely on generalisations about stress or on psychodynamic hypotheses. Three young men, who all broke down in their final year as medical students and had one or more subsequent breakdowns, illustrate this point.

Case histories

CASE 1

This man had done well at school, and was described as conscientious, serious, and outgoing. In his last year at medical school he began to have rapid swings of mood with extraordinary perceptions and thought he heard voices saying "No," "Perhaps"; he became domineering, suspicious, and anxious, and believed himself highly gifted. He failed his final examinations and had to be admitted to psychiatric hospital.

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He was treated with perphenazine and was discharged after two months much improved, but he continued taking the drug. He failed his finals again but passed them on the third try and started a six-month residency. He married. He had often complained that phenothiazines made him drowsy, and he had stopped taking them. Towards the end of his house job he became ill again and was advised to give up clinical medicine, which he did. He took a laboratory job, but despite outpatient treatment he became increasingly grandiose, irritable, and overactive. He suddenly vanished abroad and returned, and was admitted to psychiatric hospital under order three years after his first admission.

He was treated with chlorpromazine and seven sessions of electric convulsion therapy, and after two months was discharged fully recovered. He returned to his laboratory job and then suddenly obtained a post as house physician at a hospital, which appointed him before learning his history. He continued to take chlorpromazine, however, and did well enough to be promoted after six months to a further one-year job. Towards the end of this time he stopped his drugs. Very soon he started to quarrel with nursing staff, to suspect his wife of infidelity, and to believe that he was being poisoned. He was quickly readmitted to hospital, 18 months after his second admission.

His symptoms rapidly remitted with chlorpromazine, and his treatment was converted to fluphenazine decanoate, 25 mg by injection fortnightly. He resumed his hospital work, re-establishing good relations with the staff. Within a few weeks, however, his wife left him for good, taking the children with her. He became very depressed, inactive, suicidal, and was again readmitted. After two weeks' treatment he had largely recovered and was discharged, but his hospital refused to have him back.

Through a stroke of luck and kindness he was taken on as an assistant in general practice. He has now completed five years in this practice without breakdown, becoming a partner with his own list. Recently he had a period of heavy strain at work when in addition to caring for the practice of an independent GP who went on holiday, he had to cover for his partner, who suddenly fell ill. Despite this and earlier emotional divorce proceedings, he has remained well. He continues always on fluphenazine decanoate, now reduced to 12·5 mg every three weeks, which he can adjust himself if he recognises the early signs (restlessness, unusual thoughts) of breakdown reappearing.

Comment—Review of his history of breakdowns and treatments suggests that a phenothiazine, if used in adequate dosage, would prevent further relapse, since after four hospital admissions in four years he has enjoyed five clear years while taking fluphenazine regularly despite strains in work and marriage. He had a severe depression about two months after starting this drug but he continued taking it, and there has been no recurrence.

CASE 2

Academically very successful, this man was rather introverted and solitary. At the start of his last year at medical school, during an unsuccessful love affair, he became increasingly depressed and had to be admitted briefly to hospital, where after a seeming failure of imipramine he was treated with phenothiazines and made a slow recovery, being able to pass an important examination soon afterwards. He resumed his studies, gave up his chlorpromazine, and about eight weeks later, within three months of his final examinations, suddenly relapsed, becoming extremely inactive and silent, feeling dead inside, and hearing voices "not like voices in your ear but two separate thoughts debating in my head."

He was treated with trifluoperazine, up to 45 mg daily, and after six weeks was discharged, improved, and returned to medical school, although he was unable to do much mental work. His spontaneity and concentration returned only slowly but he passed his final examination. He had a holiday, by which time he could read a novel with pleasure, and then took two jobs as locum house surgeon for five weeks, both successfully accomplished. He began taking nortriptyline, 25 mg three times a day, in addition to trifluoperazine reduced to 10 mg daily, and his energy, concentration, and confidence improved further. He applied for a post at his old hospital but was rejected on grounds of mental illness. He managed to obtain a post at a peripheral hospital. Six months later he obtained a better post, and after this a third one. He became engaged to be married two-and-a-half years after his last admission.

Comment—Despite two severe breakdowns just before his finals, he was encouraged to sit the examination. He has been able to work effectively in the hospital service for over two years since qualifying, with every prospect of continuing well, thanks to chemotherapy and careful follow-up in the first twelve months.

CASE 3

A foreign graduate from a well-to-do medical family with a pronounced history of psychosis and suicide, this man was academically able. A sociable boy, with many interests, he unexpectedly failed his finals at medical school. He eventually qualified, and did some hospital work thanks to his father, but was unemployed part of the time and at age 29 was in hospital for eight weeks with depression, receiving ECT and phenothiazines.

Shortly after discharge he went to the USA and studied for the ECFMG examination, which he failed twice. After about a year he was put on the boat home from New York in an apathetic and anorexic state, and then had a second period (of four months) in hospital having drug treatment. On discharge he came to England and obtained a hospital post. For a few months he appeared normal, but then colleagues noticed him to be odd, withdrawn, suspicious, talking to himself, and doing less and less, until he stayed almost continuously in his room. Despite protests from the staff, the hospital authorities allowed him to stay out his time. He then came to London and stayed almost continuously in a room, eating little, speaking to no one, going out only at night. His speech was vague and he drifted from topic to topic on quasi-philosophical matters, and he hoarded candles, bottles, coins, etc, believing he was doing research on them. After about six months a relative arrived in England to rescue him and take him to a doctor.

On admission to hospital he was slow and withdrawn and sometimes smiled or shook his head unexpectedly, and his ideas were imprecise and bizarre. He was treated first with trifluoperazine, 30 mg daily, and then with fluphenazine decanoate injections, 25 mg weekly, and benzhexol, 12 mg daily, to control cramps and restlessness.

After two and a half months, through the kindness of two consultants, he started hospital work, first as clinical assistant, then as locum, and after four weeks of this he was discharged; but he continued to attend as an outpatient, at first once a week, later once a month. Through an agency he obtained further locum posts. He complained of difficulty in walking and writing, daytime drowsiness, lack of interest in things, and inability to concentrate, and his chiefs gave very poor reports of his work. The fluphenazine was reduced to 12·5 mg fortnightly and the benzhexol raised to 15 mg daily, his stiffness and drowsiness went, and he became more outgoing and able to learn, as reported by another consultant for whom he worked as a locum resident and who resolved to help him. After a further three months his fluphenazine was reduced to 12·5 mg monthly, his benzhexol reduced in step, and he later discontinued the benzhexol altogether on his own initiative. He became cheerful and more confident, began to read medicine, and after further locum posts obtained a senior house officer's post one year after leaving hospital. He took a membership course and sat the first part of the examination, and then obtained a second one-year residency in a different hospital.

Comment—After several breakdowns, culminating in about nine months' continuous illness, he has with treatment been able to take up hospital practice and make progress as never before, having remained well now for two years, with every prospect of continuing so.

Discussion

These three young men all broke down with serious psychotic illness before their final examinations and had two or more distinct attacks before successful treatment and rehabilitation. Their psychiatric illnesses were such that they rather quickly withdrew from ward work and their defection was noted by medical and nursing colleagues who compensated for this. The successful outcome depended on adequate, regular, and long-continued administration of a phenothiazine, early discharge, and return to work as soon as possible (despite incomplete remission of illness or the presence of drug side effects), careful and frequent follow-up over 12 months, and the kindness of individual physicians who were prepared to help them when official bodies turned against them.

The follow-up period was important in several ways. The drug regimen had to be modified cautiously to ensure suppression of all psychotic disabilities with a minimum of handicapping side effects. The patients had to be indoctrinated with the protective value of chemotherapy for them, and given guidance on how to judge it and control it for themselves. They needed to be reassured that full recovery was slow and needed patience, but given confidence that it would come in time. Their shattered self-confidence had to be restored by encouragement and acceptance and by opportunities for discussing personal affairs—a somewhat paternal befriending. Contact was at first weekly, then monthly, and finally quarterly, sometimes by telephone.

Several errors need to be avoided in treating such cases. Nearly everyone who suffers a psychosis is harmless, and the young doctor with a breakdown is usually not working in professional isolation but is observed by colleagues. There should be positive evidence of his potential dangerousness to patients instead of an automatic assumption of his unsuitability for clinical medicine. In judging him and his work before and after breakdown the standard to be applied is not that of the best, but simply the minimum that is accepted from his healthy peers. Why should a doctor who has had a mental breakdown be expected to do better than one who has not? Thirdly, much nonsense is talked about the "stress" of clinical practice. It is unwise simply on the basis of psychodynamic hypotheses to decide that anyone needs protection from everyday life, and the proper test is to let him try it and see. Nor is it always necessary to provide intensive analytical therapy. There may be some individuals vulnerable to particular stresses and needing specialist psychotherapy, but these three doctors have done reasonably well in medicine and in life since their breakdowns without protection from either stress or analysis.

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ONE HUNDRED YEARS AGO A number of wholesale grocers, who were found to have supplied Hanwell Asylum with "cocoa" consisting of 25 per cent of added starch, 32 per cent of sugar, and 3 per cent of red earth, justified themselves on the ground that the contract price was only £2 per cwt, while it is well known that genuine cocoa sells at the rate of £7 per cwt; and that it could not, therefore, have been in the minds of the committee that they were going to be supplied with genuine cocoa. This is, of course, not a valid defence; but it is undoubtedly the fact that the committees of many workhouses, hospitals, etc, are in the habit of giving out contracts for necessary articles of daily diet at prices which preclude the possibility of the old people, sick people, and children under their care being supplied with genuine and unadulterated food. It has been conclusively shown, by series of analyses published by Mr Wanklyn for the Government, that the workhouse milk generally is skimmed and watered; and our own published investigations show the same state of things to prevail largely at hospitals. To this, and as partly explaining it, we may add that we are informed that vendors of pure milk on the largest scale, such as the Aylesbury Dairy Company, habitually decline to send in contracts for such institutions, as the prices offered are such that it is not possible that pure milk should be supplied. The kind of economy which encourages and accepts spurious, deteriorated, and impoverished articles of food for the carefully limited dietary of public institutions, in order to effect an apparent saving, is most honoured in the breach. Some improvement has been effected in many of the principal metropolitan hospitals since we have repeatedly called attention to the subject; but there is still much room for further improvement. (*British Medical Journal*, 1878.)