Healing the Healer – A 10-Year Journey of Supporting a Medical Student with Bipolar Disorder

Abstract
Mental disorders are increasingly becoming a significant issue among medical students, consequent to rapid societal changes and increase in life stress. Yet, help seeking for mental health problems in medical students is universally poor. Attitudinal factors, stigma, and systemic barriers prevent early detection of such problems and often push students to self-harm and suicide. The fear of losing the capacity and license to practice often prevents students to come forward for treatment. Here, we discuss the various issues of a similar case from India and deliberate on the possible solutions to help such students in need.

Keywords: Balint, bipolar, doctors with depression, medical student, mental disorder

Introduction
The medical profession is a noble and privileged profession,[1] tasked with the honorable duty of mending the ailment in others. Yet, doctors and medical students often fall victim to the affliction of mental disorders, suffering silently without finding any help for themselves. The medical profession seems to be a real-world corollary of JRR Tolkien’s fictional hero Aragon, famous for his saying “I give hope to men, I keep none for myself.”[2] Studies through the ages consistently show that although physicians and medical students have better access to health care for physical illness, they often have more mental health morbidity and do not seek mental health treatment for various reasons, often resulting in loss of life.[3‑5] The major barriers to seeking help for mental illness seem to be primarily attitudinal.[6] Doctors are trained to see themselves as care providers and therefore often have difficulty in accepting the role of a care receiver. Neglecting one’s own needs leads to denial, rationalization, and minimization of symptoms. Being exposed to severe illness on a daily basis also raises the threshold of alarm in medical practitioners, thereby often missing the early symptoms of mental illness in themselves. Extended and stressful work hours, lack of time, need to prioritize work, and career over health result in delay in health seeking. Stigma and need for confidentiality take priority over necessity, and medical professionals are often at wits end to find services that can help them.[7] The final and perhaps the most important reason for doctors to hide mental disorders is the threat to profession and career.[8] Most Western countries with structured guidelines for medical licensure require all applicants to divulge any history of mental disorders. Such events are investigated by the licensing boards, and applicants often will be placed in supervised positions and can even be barred from medical practice. Even when the board clears the candidate, the record remains lifelong, and individuals often find difficulty in attaining positions in hospitals when competing with other doctors without mental illness records.[9,10]

In our country, where no policy guidelines are available from the medical council, and where reporting of mental conditions is not required for gaining practice license,[11] aspiring doctors feel forced to suppress their mental illness even more.

In this background, medical students with mental disorders represent a very vulnerable population.[12‑14] The burden of mental disorder itself exacts a huge toll at a critical juncture of their life. Additionally, at stake lies their whole life course and
career. In contrast to the Western world, where alternate career in health care is still possible, albeit with great difficulty, medical students in India are faced with the dark chasm of no real alternatives, other than to forgo the years of training and effort and start anew in some different career path. Faced with the financial burden of treatment, the monetary loss of investment of the family in supporting for medical education, and the expectations of the family on the student to become a successful career professional, even surviving mental disorders seems to be an uphill task. Added to the difficulty faced by students is the absence of student mental health support systems in medical colleges and lack of systems that protect vulnerable mental health students. While students with mental health problems are encouraged to take session breaks in the United Kingdom and UK General Medical Council provides guidelines protecting the career of such students, such facilities are lacking in India.[12] Inability to meet the minimum requisite yearly attendance, inability to complete course in time, and failing to pass examination with a specific number of years of joining, force students to leave course, rather than to receive treatment and achieve goals. Faced with such unsurmountable odds, medical students rarely seek treatment of their mental disorders early, although reports both from India and abroad suggest a high prevalence of mental disorders and substance use in medical students.[15‑17] Students who brave the stigma and manage to seek treatment for their mental illness, the struggle for life and redemption, can be both educative and uplifting. I share my experience of managing the mental illness in a medical student from my own institute, to highlight the trials, the plight, and the difficult questions faced by all medical students with mental disorders. With depression and mental disorders poised to be the most common noncommunicable disorder in the near future, I also highlight this case with the hope that it will sensitize readers to urge national and college authorities to form guidelines, not to penalize but to safeguard the vulnerabilities of our future generations of students who suffer from mental disorders.

The Case

I first met Amir (name changed) in March 2008 when I was a final-year psychiatry resident. One summer evening on duty, I got a call from my consultant, that a second-year MBBS student was behaving oddly in his hostel room and his friends were unable to bring him to emergency. Hence, armed with a syringe full of lorazepam 2 mg, and my nascent knowledge in psychiatry, I went to intervene. I found Amir in his hostel room, locked from the outside with at least twenty students and security guards crowding. As his friend opened the door and I entered, I was barraged by a rapid succession of authoritative questions on who I was and what business I had in entering his room. I saw a young man of around 20 years of age pacing rapidly in his room and speaking continuously in a loud voice. He was abusing his friends outside, threatening to teach them a lesson, as they did not know who he really was and how well connected he was. He looked disheveled and told me to leave as it was his life, and that he was fine. My instant diagnosis – “manic episode, provided substance abuse and organicity are ruled out.” I sat quietly for half an hour while he spoke on, holding my tongue and keeping a pleasant face. After a long time, he fell silent and asked me what I could do to disperse the crowd outside. I softly replied that people outside will probably never understand his perspective, and they will anyhow force him to the emergency for calming him. Further, it did not matter whether he was right or wrong, the crowd gets the last word, as is the nature of the world. The best way to make them go was perhaps to trust and accompany me to the ward on his own will, with his dignity intact, and to prove them all wrong. After a moment, he agreed, surprising even me, and I silently thanked my stars and my teachers who taught me to remain calm in front of patients with mania. Thus, I became the treating resident of an undergraduate student from my own institute.

A detailed inpatient workup, with corroborating information from Amir’s friends and father, revealed that he hailed from a Muslim nuclear family of upper socioeconomic status from Madhya Pradesh. His father was a surgeon and had a history of a depressive episode in the past and was on antidepressant medications. His mother was also a clinician without any past or family history of psychiatric disorders. His parents were well settled and had their own private nursing home. Amir was born of a normal delivery, cried at birth, and achieved developmental milestones normally. He had passed his 12th standard with 86% marks and secured a rank to get admission for MBBS at the All India Institute of Medical Sciences (AIIMS), Delhi. He was apparently maintaining all right for around 2 months back (January, 2008), when he started complaining of low mood and decreased interest in studies. He had started missing classes and would mostly remain in his room. He would also avoid his friends and would get irritable in their presence, complaining to his parents that his friends were disturbing rather than helping him. He decreased eating hostel food and would often stay awake at night and sleep or keep lying in his bed during the day. In February 2008, he had gone to his home, where he was shown to a psychiatrist, who made a diagnosis of depressive episode and prescribed him antidepressant (escitalopram) for his condition. Within 1 week of starting medication, he had become restless, irritable, and authoritative at home. He had demanded a new iPod and demanded to return to Delhi, as his parents were not understanding him. At the college, he has been found to be progressively become overactive and overtalkative, often discussing his idea to go abroad and spend time with Western women, as they understood the concepts of pleasure better than Indian women. His father reported that over the last few days, before admission,
he had become disinhibited and belligerent over phone, asking for more money and discussing with his father about his plans to visit a sex worker. Inpatient mental status examination (MSE) revealed increased psychomotor activity, increased speech rate and flow, an elated mood with elevated self-esteem, overplanning, and grandiose ideas with impaired judgment and with no insight into his illness. Further, past history revealed that he reported of feeling lonely after a short but tumultuous relationship with a female colleague in the 1st year of MBBS and in the past 1 year had multiple episodes of transient low mood lasting for days followed by sudden improvement and indulgence in spending and partying with friends. In view of the history and MSE, a diagnosis of bipolar affective disorder, with a current episode of mania, was considered. Amir was put on oral lithium and quetiapine tablets and recovered completely within a month. Being a MBBS student, he was suggested regular follow-up directly with the faculty of psychiatry and psychology for his affective problems and his difficulty in studies.

In 2008 and 2009, although his psychiatry and psychology follow-ups were managed by the respective consultants, he still maintained regular contact with me. He would drop by in the outpatient department (OPD) or will meet at the coffee shop (residents and students stay in the same campus) and would discuss about how he was doing in general. Me not being his treating clinician helped form a loose bond between us, where he could vent his frustration and despair without fear. He would often complain of the side effects of lithium in the form of excessive thirst and report of having significant difficulties in studies. He would blame the medications for his academic loss and question “what is the point of taking medicines if I am not myself?” “Why don’t you all trust me when I am saying that I will remain all right and I don’t need medicine anymore?”

In 2009, his medication was indeed changed from lithium to valproate, probably because of his increased water intake. I, by that time, had passed my MD and had joined back as a senior resident at the same institution. Despite now being in a different unit, Amir kept on coming to me in the OPD, asking for guidance on how to study as he had not given his second professional examinations after his episode in 2008. Although he maintained without any episode during this period, he would often complain of aimlessness in life, a feeling of dejection as his friends had all moved ahead in life, and a deep fear that his life was not going anywhere and he would never be a good doctor. He ultimately gave his second professional MBBS examination in December 2011 and passed, albeit with low marks. He became more aloof from his friends, and would be seen often aimlessly wandering in the campus or sitting in the coffee shop. His visits to the OPD and to me grew infrequent, and I too became busy with the changing career priorities of post-senior resident (SR)-ship position. In March 2012, Amir was admitted to the psychiatry department, with a suicidal attempt by consumption of multiple tablets of benzodiazepines. History revealed that he was increasingly having difficulty in studying. Thinking it to be a cognitive side effect of quetiapine, Amir started smoking cigarettes, which quickly increased to about a pack a day. To decrease his anxiety related to career and studies, he also started drinking alcohol and was consuming 40–60 ml of Indian-made foreign liquor every evening. He had also gained significant weight from 75 kg in 2009 to 120 kg in 2012. Finally, after not being able to study and after a failed relationship with another classmate, he attempted self-harm.

Amir’s father was called, and it was suggested that he stay with the student in the hostel. In addition, the department took proactive measures to inform and involve the registrar and the academic section to allow him to drop out for a semester to stay at home or to look for an alternative career. Other psychiatry residents who were students from the same institute formed a support group and would regularly take turns in teaching Amir for his next examination. As a SR, I took more personal interest in Amir’s career, and he and his father would often visit me in the OPD for discussions. Despite guided teaching, Amir kept on struggling with his studies and appeared only for the community medicine paper in the final professional examination in 2013. By that time, I had completed my senior residency and had joined AIIMS Jodhpur in my first faculty post. Although I did not have clinical contact with Amir for the whole year, his father would call me regularly and discuss his plans for his son. I patiently listened and marveled at the unfailing support he provided for his ward. I came to know that Amir had changed his therapist and was doing well. He had started dating using tinder and was socializing by joining new hobby classes such as photography. He was following a daily schedule as prescribed by his therapist, was exercising regularly, and had lost around 20 kg of body weight. His father had made plans for him to come and manage his hospital as Amir’s father and mother were both growing old.

In 2014, I joined back AIIMS Delhi as a faculty to the department of psychiatry, and within the first few months of my joining, Amir was readmitted under my unit suffering from his second episode of mania, this time with psychotic features. History showed that in 2014 Amir had gone back home after his father suffered a cardiac stroke. There he remained restless and depressed with his career and life. He had often complained to his father that his medications were making him dull and preventing him from studying and had finally stopped all medications suddenly around June 2018. He had come back to AIIMS in July 2014 and had been having symptoms of mania for the last 2 months. All through 2013 and 2014, he continued consuming alcohol in a harmful manner 2–3 times/week, often alone in his room, used cigarettes in a dependent manner, and occasionally used cannabis with friends. This time, during
the planned long admission, in addition to optimizing his medications, the ward team focused intensely on daily routine, activity scheduling, coping strategies, and social skills training. He was stabilized on 4 mg of risperidone along with 1.5 g of sodium valproate and was discharged after a period of 3 months when he was able to manage his daily schedule unsupervised.

After the admission of 2014, I was surprised to see a definite change in Amir, akin to the waking of the insight. Compared to his admission in 2008, when he would be oppositional and would rephrase his condition as a temporary state, Amir in 2014 not only accepted his diagnosis, but seemed to internalize it both cognitively and emotionally. After discharge, he would be regular in follow-up, would take medications by himself responsibly, and would take active participation in his future plans. He would be troubled by his cognitive difficulties and sexual side effects with risperidone but would himself reiterate the need for treatment. He quit smoking completely in 2015, left cannabis, and limited his alcohol intake to parties with friends. Faced with the real possibility of him not being able to complete his MBBS, in 2015, he joined a social media marketing startup as a content writer for 3 months. Those 3 months of not being a doctor affected Amir deeply. Although he was competent as a content writer, he would be dysphoric and irritable and would often complain that years of his life spent preparing and studying to become a doctor has gone waste. Unable to accept his failure in completing his MBBS course, he left the job and came back to study in 2015 and completed his MBBS final professional examination. He was allowed to give his final examinations under special circumstances after intervention from the department of psychiatry. He completed his internship and was conferred his medical degree of MBBS in June 2017. Amir subsequently completed his 1-year rotating house job at AIIMS in 2018. He reported that he felt better when he was with patients and could find some purpose and hope for life. In the early 2019, after being free of any mood episode for 4 years, and with a degree under his belt, he decided to attempt the MD entrance examinations of the country. He tries to adhere to a daily routine, goes to the gym regularly, and comes for OPD follow-up often. His father reports that he is aware of relapsing to substance use and therefore makes his cousin brother stay with him in his apartment. His problems with studying and difficulty in concentration continue, and he still feels distressed about his career and his inability to make long-lasting relationship, but the completion of his medical degree has provided him with some modicum of hope. He is aware that he might not be able to do clinical practice in future although he chooses to remain hopeful.

Discussion

Amir’s future still remains uncertain, but knowing Amir through the years has made me aware of the issues that medical students with mental disorders face. In addition, managing Amir in my various capacities, from a trainee to a faculty, has made me appreciate the complexities of managing such cases. As I have learned and grown clinically over the years, I now understand certain issues which I was unaware as a student myself. Amir’s case is by no means unique or even challenging diagnostically, and we all, in the course of our practice, come across such Amirs regularly. Yet, when asked the simple question – “Should he be allowed to continue to become a medical professional?” we are unable to provide any confident answer.

Early detection and treatment

With increasing life stress and rapid change in the society, medical students are progressively suffering more from mental disorders. Work stress, long hours, and delay in achieving life goals in comparison to other professions, make young doctors-in-making vulnerable to mental disorders. The decaying trust of patients on doctors, workplace violence, and the fall of the respect of the profession in the eyes of the society make medical students easily disillusioned and increase the chance of burnout, depression, and substance use. Systems at institutional level need to be created catering to the mental health needs of students, preventing burnout to progress to depression and suicide. The GMC (UK) guidelines for managing mental health issues in medial trainees call for early detection and treatment along with reintegration into the course. At AIIMS, New Delhi, creation of such a student welfare center has seen definite success in promoting the awareness of mental health issues in students and in the early detection of mental disorders. Psychiatric screening of all students at entry also helps us detect vulnerable students and allow us to help them without subjecting them to any discrimination. A major barrier to early detection of mental health issues in students stems from the student’s need to maintain confidentiality. Therefore, setting up student counseling center at student premises (gym/library), rather than in the hospital, might help frightened students to come out and seek help. In addition, creating a network of mental health professional whom the students can contact and who are outside the institute might help students seek help.

Pharmacotherapy as a cornerstone of treatment

Focus of management of mental disorders varies from country to country. However, in resource-constrained and resource-skewed situation like India, where psychotherapists and psychiatric social workers are scarce, pharmacotherapy still remains the cornerstone of management. Students often request primarily psychotherapy and counseling and reject the need for medication. It remains the responsibility and the prerogative of the treating clinician to decide the course and components of management based on scientific evidence and established guidelines, rather than
on the behest of the student. Deviation of guideline-based treatment, minimization of dose or duration of medication, and overprotective prescriptions, because the patient is also a doctor, harm the patient more in the long term. In addition, doctors and (by extension) medical students make poor patients, with respect to adherence to treatment and OPD follow-ups. Therapeutic contact helps in maintaining medical adherence and therefore structured follow-up appointments should be adhered to.

**Boundary violation and role confusion**

A clinician treating a medical student must also be mindful of his/her other roles in the students’ life and must take necessary precautions to prevent role confusion. The problem becomes more manifest in case of postgraduate students where the clinician might also be the examiner, the case in charge, the thesis guide, or the administrative head of the students’ department. Students might be defensive, guarded, or may outright and avoid discussing sensitive issues in these situations. In such cases, referring the student to a neutral second clinician in the same or in other institute might help the student discuss his/her problems more openly and comfortably. Similarly, the boundaries of doctor–patient relationship should not be violated even when the patient is also a doctor. Some amount of time and place flexibility might be required considering the duty hours and the nature of the course, but unstructured follow-up visits in hostels, cafes, or over lunch breaks dilute the gravity of the condition and rob the student the opportunity to ask serious questions. Overly protecting a student in clinical and academic work because he is also a patient under one’s care, erodes the self-confidence of the student and disrupts the teamwork of the unit. In such situations, transfer of the student to a different unit might be beneficial to all parties.

**Psychotherapy and mentorship**

Established clinical guidelines should be followed when psychotherapeutic management is prescribed. Cognitive strategies for depression, dialectical behavior therapy for borderline personalities, and various behavioral therapies for obsessive-compulsive disorder are well established. General supportive therapy, and psycho-education, often forms the cornerstone of the initial psychotherapeutic process for most disorders. The advice needs of a doctor–patient, especially a medical student, however, are far more wide ranging than illness-related issues. The student is often looking for advice related to career decisions and life choices, and the therapist must therefore also provide mentorship related to studies, career, and life goals in general. If the treating clinician feels incapable of provide mentorship, due to time constraints or some other issues, appointing a separate mentor for such students, who has experience in dealing such issues, might be highly effective in the career growth of such students.

**Assessment of capacity to practice**

Medical licensing authorities all across the globe strive to achieve the fine balance between protecting the safety of the patients and upholding the individual right of the doctors. Increasingly, licensing authorities have become aware of the fact that too stringent licensing requirement are detrimental for the doctors in need of mental health treatment. In the past few years, the US medical board, the UK medical council, and the Canadian licensing board have come up with declaration to separate mental illness from being equated with the loss of capacity to practice.[18,19] Mental illnesses are now viewed as treatable conditions, and with proper management and adequate adherence, clinicians might not suffer from any impairment preventing them from practicing their profession. With medical supervision, even relapses and exacerbations can be detected early enough to allow doctors to return to practice after an adequate period of leave. For conditions that impair the capacity of practice, as in partially resolved symptoms, supervised or nonclinical positions can be provided as a valid alternative. Similarly, while advising students with mental disorders about future course of studies, assessment needs to be done for each individual, keeping in mind the nature and course of the illness and the individual prognostic factors of the case. Mental disorders do not necessarily preclude the chance of successful clinical practice of any branch, and the purpose of any treatment should be empowerment rather than restrictive.

**Need for national policy framework and institute guidelines**

Finally, there is a need for addressing mental health in medical students and doctors through national policy framework. Without such national directives, the plight of the broken healer will always remain unheard, and doctors will keep suffering silently. The GMC (UK) guidelines are particularly insightful with regard to protecting the future of the medical student with mental disorders. The guidelines suggest extended career breaks and spread-out coursework for students. Even for students who cannot complete the course due to mental disorders, the GMS suggests provision of a diploma or a course certificate commensurate with the knowledge and skill level of the student to help him/her progress in his/her career. At institute level, formation of an academic board to deal with such unfortunate students and to provide them with some benefits due to their temporary disability might help them complete their course. Further, uniform guidelines for the assessment of practice capacity in students with mental disorders will prevent arbitrary discrimination against such candidates. A uniform capacity guideline will also go a long way in communicating with students with mental disorders and in guiding them to clinical, nonclinical, or nonmedical career path early in the course of training.
Conclusion

Students like Amir are all too common in our surrounding, and unfortunately, most of them fade to obscurity under the burden of mental illness. While the absence of strict laws for reporting mental disorders in medical students may work out in favor of some suffering students, one should be warned that arbitrary discrimination thrives in lawlessness. Developing systems for mental health of medical doctors and students might therefore be the need of the hour in these troubled times.

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