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Abstract

Manic or hypomanic doctors tend to draw attention. From the gregarious physician sought by her colleagues for her enthusiasm and drive to the doctor who has impulsively purchased his fourth sports car by leveraging his home and office, the terms mania and hypomania imply a broad spectrum of personal and institutional problems. This chapter views the problem of manic behavior among physicians from multiple perspectives at various stages in a physician's career. Key points include thresholds for initial intervention, the impact of mania on a physician's personal development, understanding early versus late recovery, awareness of suicide risk, and the management of a return to work that respects the safety-sensitive nature of medical practice. Composite case vignettes are used and any resemblance to a specific person is not intended.

7.1 Epidemiology and Diagnosis

A recent graduate in internal medicine was identified because nurses reported smelling alcohol on his breath while he was working in the hospital. His Chief of Staff requested that he take a leave of absence to have this issue appropriately dealt with. In accordance with mandatory requirements, the Chief of Staff also made a report to the regulatory authority. The young man was assessed and found to have a significant problem with alcohol. Following discussions with his personal doctor and family, he agreed to attend and successfully completed a residential treatment program. After a few months of good recovery, he returned to work.

Six months later, further problems arose at work. He was described as behaving in an unprofessional manner within his team. His communication style was abrupt and sometimes irritable, and he responded inconsistently to calls from the ward. After a discussion with his Chief of Staff, he was again requested to provide accountability regarding his health status. The unspoken apprehension was that he was drinking again. The physician was understandably stressed by this additional interruption of his work, and the inconvenience to him as well as his colleagues, and he reluctantly agreed to get the requested information. He was now worried about the potential negative impact on his work record.

Evaluation of his recovery from an alcohol use disorder found no evidence of relapse, though the addiction specialist remarked that he was difficult and made inappropriate comments while interacting with members of his therapy group. Thus, he was assessed by a psychiatrist who diagnosed him with type 2 bipolar disorder after carefully reviewing his history and gathering collateral information from family members and the workplace. Ongoing treatment helped him to develop relapse prevention skills both for managing his mood fluctuations and maintaining sobriety. Once stable, he successfully returned to work with the support of his Chief of Staff and departmental chief. Looking back, he was surprised and disappointed that neither he nor anyone else had suspected a comorbid mood disorder.

Conditions with manic or hypomanic symptoms can be roughly divided into bipolar disorders (types I and II and subthreshold conditions) along with a

heterogeneous group of other medical-induced or substance-related conditions. Hypomania or mania related to substance intoxication or withdrawal is important, because it often points to a significant substance use disorder with a high risk of impairment.

Bipolar disorder, defined according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), is a descriptive diagnosis (American Psychiatric Association 2013). No consensus exists on whether it is more helpful to think about this family of conditions as a spectrum or as a group of discrete entities, each with preferred treatment strategies (Angst and Sellaro 2000; Phillips and Kupfer 2013). The DSM-5 subdivides people with bipolar disorder into bipolar I disorder (signifying a history of at least one manic episode), bipolar II disorder (signifying hypomanic and major depressive episodes), cyclothymia (chronic cycles of subthreshold symptoms), and symptom clusters attributable to medications, substances, or a medical condition. The terms, “rapid cycling” and “mixed features”, in DSM-5 are illness specifiers. Psychotic symptoms, when present in mania, are typically though not always mood congruent (Fountoulakis 2015).

Incidence and prevalence estimates for bipolar spectrum disorders in the United States range from 3 to 6%, reflecting heterogeneity in survey methods and sample populations (Angst et al. 2002; Judd and Akiskal 2003; Kessler et al. 2006). The 12-month and lifetime prevalences of bipolar I disorder in the United States are 0.6% and 1.0%, respectively (Merikangas et al. 2007). The lifetime prevalence for bipolar II disorder is 1.1% and for cyclothymic disorder it is between 0.4 and 1.0% (Merikangas et al. 2007; Merikangas and Lamers 2012).

There are no definitive studies regarding the prevalence of bipolar disorders among doctors; however, like many health conditions it is reasonable to consider a prevalence somewhat lower than the general population based on the assumption that medical training tends to select out people with more severe forms of disability (Goldberg 1980). That said, some physicians manage to channel subthreshold hypomanic symptoms into functional work activity. Moreover, several reports describe high rates of depressive symptoms (including suicidal ideation) among medical students and residents, and this group is likely at elevated risk for a future diagnosis of mood disorders, including bipolar disorder (Tyssen and Vaglum 2002; Center et al. 2003; Dyrbye et al. 2006; Myers and Gabbard 2008; Goldman et al. 2015). A recent systematic review and meta-analysis estimated rates of moderate depression in residents at 20.9–43.2% (Mata et al. 2015).

Among people diagnosed with bipolar disorder, recurrence is the rule. In the general population, the 1-year recurrence rate is approximately 37 and 58% after 2 years (typically a depressive episode) (Geddes and Miklowitz 2013; Fountoulakis 2015). Among bipolar patients followed in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) study, 48.5% had recurrence within 2 years with twice as many being depressive episodes (Perlis et al. 2006). Practicing physicians diagnosed with a recurrent mood disorder (50% bipolar I and II) who were enrolled in a Canadian professional workplace monitoring program had a 36% recurrence rate leading to work interruption at 2 years (Albuquerque et al. 2009).

Prior to the publication of DSM-5 in 2013, a history of at least one major depressive episode was required to diagnose both bipolar type I and II. Now, bipolar type I is diagnosed with the occurrence of one manic episode, and though a history of recurrent depression is common, it is not necessary.

A specialist organized her life around episodes of low energy. She would describe these periods as “running out of gas” and she would seclude herself and sleep for a week or so before coming back to work. The doctor went for years with this pattern and was good at finding ways to use the “downtime” as vacation or grant writing time. It was not until her “downtimes” started to be longer and darker with suicidal ideation that she sought help.

Because the syndrome waxes and wanes with symptom patterns often taking shape in adolescence, a valid diagnosis is often not reached for years (Phillips and Kupfer 2013). In one retrospective study of doctors with bipolar disorder, the average time between symptom onset and diagnosis was 10 years (Albuquerque et al. 2009). Physicians exhibiting irritability and problems at work need a careful workup so as not to miss the diagnosis. Doctors typically rationalize their behavior; “I have had a tough week of challenging cases and on-call;” “I am working towards my vacation and know I am a burning out.”

7.1.1 Differential Diagnosis

When doing an evaluation, the value of collateral information cannot be overemphasized, because physician-patients with bipolar disorders may lack insight and/or minimize their symptoms. Roughly two-thirds of people eventually diagnosed with bipolar disorder are initially misdiagnosed with unipolar major depressive disorder (Phillips and Kupfer 2013). Delayed diagnosis has also been attributed to comorbidities like substance use disorder, attentional problems, and anxiety states. Further complicating the diagnosis, some medications, for example antidepressants, may intensify rather than relieve the frequency and intensity of symptoms, so that people with bipolar disorder may present to specialist care with treatment-resistant depression.

The differential diagnosis for hypomanic and manic states, summarized in Table 7.1, includes a number of psychiatric conditions, medications, and substances (American Psychiatric Association 2013).

The DSM-5 includes categories for substance- or medication-induced mania or hypomania (substance/medication-induced bipolar and related disorder) and mania attributed to a medical condition (bipolar and related disorder due to another medical condition). These categories require evidence of a substance or medication, either during intoxication or withdrawal, that directly precedes a manic or hypomanic episode. The diagnosis requires that the substance or medication has known links to causing these symptoms. The prevalence of substance-related mania is unknown; however, the lifetime prevalence of substance use disorders among physicians is 10–15%, similar to the general American population (Domino et al. 2005; Brewster et al. 2008). However, the lifetime prevalences of substance use disorders

Table 7.1 Differential diagnosis of manic and hypomanic states

Psychiatric disorders	Medical conditions	Prescribed medication effects/side effects	Nonprescribed medication effects/side effects/withdrawal
Bipolar disorders	Endocrine disorders (e.g., Cushing syndrome, hyperthyroidism)	Antidepressant-induced	Cocaine, crack
Cyclothymia	Epilepsy	Steroid-induced	PCP
Subthreshold conditions	Infectious diseases (e.g., syphilis, HIV)	Antibiotics (acyclovir, chloroquine, interferon, sulfonamides, etc.)	MDMA
MDD	Renal failure	Chemotherapeutics	Hallucinogens
Schizophrenia or schizoaffective disorder	Diabetes	Ketamine	Ketamine
Psychotic disorders (e.g., brief reactive psychosis, delusional disorder)	Autoimmune/inflammatory conditions (systemic lupus erythematosus, multiple sclerosis)	Medical marijuana where legal	Heroin
Anxiety disorders (GAD)	Space-occupying lesions (brain tumors)	Biologics	Alcohol intoxication
ADHD	Cardiovascular (stroke) → organic mood disorder	Stimulant	Stimulant–amphetamines
Borderline personality disorder	Delirium		Over the counter
Intoxicated states—alcohol		Dopamine	Medications, supplements
Withdrawal states—alcohol, sedative, antidepressants			
Severe anxiety states			
Early dementia (frontal lobe, Pick’s disease)			

ADHD attention-deficit/hyperactivity disorder; *GAD* generalized anxiety disorder; *MDD* major depressive disorder; *PCP* phencyclidine; *MDMA* methylenedioxyamphetamine

in patients with bipolar disorder, types I and II, in the general US population are 60% and 40%, respectively (Merikangas et al. 2007). It makes sense that a minority of doctors will present with psychosis during intoxication, withdrawal, or treatment of a substance use disorder (e.g., alcohol, cocaine, stimulants). This group is typically admitted to a hospital for acute stabilization. Little is known about the long-term prognosis of this small group of physicians.

7.2 Unique Aspects of Manic and Hypomanic States in Physicians

A family physician in her early 50s had received antidepressants on and off for 15 years for recurrent mild-to-moderate depressions. She never required time away from work and she had never been hospitalized. She was twice divorced with grown children from her first marriage. While on a trip to the United States she was noted to be acting unusually more energetic, more emotional than usual and not sleeping well. Her usual alcohol intake had increased to nearly a bottle of wine daily in the last couple of months. Her family expressed concern about her drinking but she laughed it off. In the United States there was an altercation in a restaurant, the police were called, and she was transferred from the police department to a hospital. She was admitted with a diagnosis of mania and treated with antipsychotic medications before being transferred back to Canada. This was her first episode of mania and of psychosis.

In retrospect it was possible to identify some periods of time when she was more energetic than usual, even obsessed with how her clinic should be run, which medical record system to use, and how to develop it, while having enough energy to take a dance class and remain actively involved with her extended family. People around her enjoyed working with her immensely and felt that she was a terrific doctor who cared deeply for her patients. They would later admit that sometimes they wondered who would arrive at work today: the “lovely doctor,” the “withdrawn doctor,” or the “irritable doctor”?

She had a family history of mood problems, alcohol problems, and one suicide. After a full workup she was diagnosed with bipolar disorder and started on lithium. She struggled with her new diagnosis and began to feel overwhelmingly guilty about all the trouble she had caused. She worried that the regulatory body would be notified and that she would no longer be allowed to practice medicine.

A month after discharge she returned to work with no overnight-call duties but otherwise managed her own workload. Two weeks later she was found unconscious at home after an overdose, leading to hospitalization. In the hospital, she began to divulge her anxieties and suicidal thinking. She was diagnosed with severe depression with mixed features and responded well to augmentation strategies added to the mood stabilizer.

On discharge, a structured aftercare program was recommended which included family involvement. She and her psychiatrist also worked to firm up their respective roles.

She agreed not to make decisions regarding medications and would continue to report her symptoms and worries. They agreed to use a daily mood monitoring chart and to include self-report mood scales into their work together. Four months later she negotiated a safe return to work with a good coworker friend and the clinic director. She let them both know her diagnosis of bipolar disorder, and confided what her early warning signs for relapse might look like. She asked them to please feel free to reach out to her and her treating psychiatrist or family doctor if they were concerned or heard about any concerns about her behavior.

7.2.1 Confidentiality

One of the most common anxieties among doctors and trainees going through a mental health crisis surrounds the confidentiality of their health information (Myers 1994; Gardner and Ogden 2004). Not only can physicians exhibiting unusual or bizarre behavior become targets of media attention, but they may also be involuntarily detained and treated at the same hospital where they work. This is especially a concern in rural or remote areas. Even if care is delivered away from their workplace, contact with colleagues will raise worries about how they are perceived and potential effects on their future career trajectory. One doctor referred to bipolar disorder as “a professional death sentence,” fearing that their expert judgement would always be perceived as impaired or somehow inferior. In the future, any strong expression of emotion might be medicalized as another “episode” of illness, undermining the self-confidence essential to functioning as an expert in a medical team.

Consider a physician with mania being picked up by the police during a Medical Committee meeting or medical conference. The police will need to transport the physician to the nearest emergency room for a psychiatric evaluation, and in many jurisdictions, police are mandated to report severe impairment to medical regulators. After heavy sedation, the physician awakens in the hospital not only with embarrassing and potentially traumatic memories of events leading to admission, but also to worries about regulatory requirements and accountability at work.

7.2.2 Self-Treatment

It has been documented that physicians tend to seek help later than the general population, often at the urging of family, friends, or colleagues (Myers and Gabbard 2008; Center et al. 2003; Gendel et al. 2012; Frank et al. 1998). It would not be unusual for a doctor, recently diagnosed with bipolar disorder, to disclose years of struggle (“white-knuckling”) and self-prescribing medications to try to manage his or her health in order to continue working. Self-treatment, as a tradition, has a long history in the profession of medicine, and while it is still common, it is generally not recommended except in urgent situations. Physicians are more likely than the general population to misuse prescription medications (Merlo et al. 2013; Knight et al. 2002; Hughes et al. 1992). This is in part due to the fact that many doctors do not have a primary care physician, and if they have one they often feel it necessary to filter the personal information they provide (Schneider et al. 2007; Stoudemire and Rhoads 1983; Center et al. 2003; Gross et al. 2000). Often the primary care physician is seen as a colleague and perhaps a friend. The doctor-patient may not want to burden their physician with mental health concerns, due to anxieties about regulatory intervention and a loss of standing in their colleague’s eyes. These anxieties can be magnified in rural practices, where personal and professional roles can be closely interwoven (Gendel et al. 2012). When a physician feels it is unsafe to disclose his or her mental health issues, for either personal or private reasons, he or she may choose to treat himself or herself.

7.2.3 Denial and the Problem of Objectivity

Any serious health issue can challenge the way a person thinks about themselves and imagines their futures (Martin 2007; Frank 2002). When a physician's judgment has been temporarily altered, their identity as a responsible, rational citizen will have been shaken. It is worth considering how that identity threat can play out not only for the physician experiencing impairment but also for the physician whose job it is to provide an objective medical assessment. The psychiatrist, Glen Gabbard, has written that ... "doubt, guilt feelings and an exaggerated sense of responsibility form a compulsive triad in the personality of the physician (Gabbard 1985)." A typical example might be a family doctor in solo practice, seeing patients daily and sometimes on Saturday, working evening hours to be available for patients. These same traits, when threatened, may lead doctors to strongly deny early signs of illness or disability (Myers 1994; Stoudemire and Rhoads 1983; Wallace et al. 2009; Gardner and Ogden 2004).

Among people dealing with substance use disorders, denial is a core tendency; doctors with addiction problems often deny that they use substances or are intoxicated until there is incontrovertible evidence. Taking what a doctor reports at face value when there is a plausible risk of a substance use problem is not optimal at best and potentially dangerous at worst (Domino et al. 2005; Brewster et al. 2008; DuPont et al. 2009).

Denial, when threatened by the formality of an emergency psychiatric assessment, can derail objectivity. Evaluators may downplay or ignore warning signals like rapid speech or implausible schemes. Instead, they may take grandiose claims uncritically, preferring to assuage their own discomfort with mental illness rather than viewing a colleague's problems through a medical lens. In many ways, this is understandable, given the stigma of mental illness, which has been described since the mid-1960s, notably in the work of the sociologist, Irving Goffman (1963). Difficulties seeing a colleague's behavior as a psychiatric illness can be amplified when the patient is known to the assessor as a supervisor or consultant. Yet failure to diagnose and treat an impaired physician can not only prolong the suffering of the individual and potentially endanger the public but may also represent a missed opportunity to fully assess that physician's suicide risk. The doctor with an untreated substance use disorder takes substances to deal with pain, fatigue, concentration problems, and low mood in an effort to continue to serve his or her patients.

The entangled problems of objectivity, denial, and overidentification with the physician-patient represent opportunities to modify medical education. Educators may wish to rehearse this type of clinical encounter during medical training. Some have argued that failing to address personal vulnerabilities, including mental health, is a recipe for perpetuating not only stigma against physicians who suffer from mental illness, but also a view that a physician's health is not as important as their patients' (Myers and Gabbard 2008; Myers 1994; Wallace et al. 2009; Abbey et al. 2011; Wallace 2010). Taken a step further it unwittingly

upholds the profession's difficulty seeing doctors as vulnerable, which in turn leads those who need help to manage their problems quietly, if not silently, and on their own (Gold et al. 2016). It is gratifying that across North America, programs to counter a culture of denial are gaining momentum; however, it is essential that discrimination within the profession continues to be addressed at all levels.

A number of doctors who have bipolar disorder have been courageous to share their stories at least in part so that someone else who is struggling with symptoms might feel less alone and less hopeless (Nielson 2016; Miles 1998; Ely 2016; Fiala 2004).

But stigma is not solely the domain of others. As professionals we need to be conscious of our own stigma-prone behaviours or the internalized stigma we may perpetuate (Dr. Manon Charbonneau) (Canada 2007).

7.2.4 Suicide

Bipolar disorder is associated with a high suicide rate, 15 times the general population (DSM-5). Likewise, physicians have a higher rate of suicide than the general population which makes careful assessment of doctors with bipolar disorder even more critical (Schernhammer and Colditz 2004; Myers 1994). Doctors who are manic and possibly psychotic may die as a result of judgment issues, although it is more likely that a doctor dies from accidental overdose or while in a depressed state. Any doctor who discloses thoughts of suicide must be taken seriously, especially if the doctor has recently experienced acute stressors such as a marital rupture, patient complaint, or regulatory investigation.

7.2.5 Shifting Relationships with Colleagues

A clinician with a physician-patient takes on a dual role. Not only must they care for their patient but they are also implicated to some degree in occupational risk management, since medicine is a safety-sensitive profession. Physicians have multiple motivations to return to work, and treatment providers may find themselves pressured to certify a functional recovery, often too soon. While treating clinicians may have had some working and even collegial relationship with their patient, once they are in a treatment relationship, this role shift needs to be made clear. And when the doctor-patient is ready to return to the workplace, it is incumbent upon the treating physician to carefully assess the plan and ensure that the institutional ingredients for success are in place. This may include coaching the physician to prepare for workplace conversations and/or communicating directly with relevant leaders and colleagues after obtaining written informed consent. Doctors returning to work frequently feel both grateful and responsible for having been ill, for placing a burden on their colleagues, and for any impact they may have had on their patients. Early in the return-to-work process, physicians tend to

agree to workplace suggestions and requests rather than considering them carefully in the context of their ongoing recovery. This may include taking extra shifts, seeing difficult patients, and seeking out ways to “show” the team that they are making up for lost time (Myers and Gabbard 2008). Providing clear-stepped return-to-work plans for physicians is prudent, and there is a confluence of evidence that facilitated peer groups can add meaningfully to the recovery and return to work process (Sanchez et al. 2016). Treating clinicians are in a good position to educate their physician-patient, the family, and to some extent where possible the workplace.

7.2.6 Monitoring and Risk Management

A physician is impaired when he or she is unable to practice medicine with acceptable skill and safety as a result of a health problem, including a psychiatric illness or a substance use problem (Health 1973; Anfang et al. 2005). To ensure that physicians with health problems are not working while impaired, all states and provinces in North America have some form of physician monitoring program. For physicians identified by regulators with substance use disorders, treatment and monitoring have been associated with good recovery, with around 70% successfully returning to work (Lefebvre and Kaufmann 2017; Brewster et al. 2008; Domino et al. 2005). Of those returning to work and monitored for 5 or more years, 75–85% have maintained remission from their substance use disorder.

Similarly, physicians identified with mental health disorders enter monitoring agreements when there is a request for ongoing accountability regarding their health and stability. Few studies have reported on mental health conditions or comorbid conditions among physicians in monitoring programs. Knight and colleagues evaluated the Massachusetts physician health services program after it began to monitor doctors with mental health issues. While they did not provide a diagnostic breakdown of their group of 58 doctors, 74% completed the 2-year monitoring program successfully (Knight et al. 2007). Albuquerque and her colleagues looked at 50 doctors enrolled in the Ontario physician health program who had recurrent MDD or bipolar disorder, all of whom were stabilized and returned to work (Albuquerque et al. 2009). Of these, approximately 64% had completed 2 years without a clinical relapse.

A fulsome risk assessment is most relevant in the return-to-work process, where full sustained recovery is the goal. For the purposes of an occupational risk assessment, it is helpful to think in terms of three spheres; individual symptoms including severity, duration, and past history; functioning at home and in social (nonoccupational) circumstances; and finally workplace functioning (Lefebvre and Kaufmann 2017; Harrison 2008; Anfang et al. 2005).

7.3 Developmental Issues

7.3.1 Early Career

Meg was a 23-year-old who had moved from her rural home to the city to attend medical school. She found the adjustment difficult and in the first few months, she relied heavily on her family and friends back home. Once she had settled and made some friends in her class she felt much better. There were so many possibilities available to her, ranging from political advocacy groups and public health education to focused study groups. She was seen as energetic, enthusiastic, and up for anything and others wondered how she found the time to do it all. Meg's roommates worried that she was keeping them up late into the night. In the morning they would often find meals partly cooked, laundry left unfinished, and Meg seemingly oblivious to their concerns. The roommates, also in medical school, tried to refocus back to their own studies, which was easier to do as Meg started spending more time out of their home. She was rarely at school, and when she attended, she was animated and energetic. One day, Meg came to lectures dressed in flamboyant clothing and bright red lipstick with her eyebrows heavily penciled. She was speaking so quickly that students and staff could not follow. She was sneering and condescending to all who tried to calm her down stating that she alone had access to the answers. The undergraduate office was notified as well as the wellness liaison physician. Fortunately, Meg was in the building and the wellness doctor was able to guide her to the ER onsite where Meg was admitted.

Bipolar disorder often presents in late adolescence or early adulthood. It is conceivable that a medical student can enter training already diagnosed with a bipolar disorder; however, it is more typical for them to present with a history of depression. Often a diagnosis of bipolar disorder leads the student to consider whether the choice of medicine is still what they want and perhaps they might reconsider the viability of living a healthy life as a medical doctor. Is Meg's constitution able to manage the stress and strain of medical training and practice? Will a medical career be hazardous to her? The individual needs a safe place to explore these serious issues before making a decision to return. Most choose to return to medical training with some adjustments in their trajectory. For instance, a resident in a surgical program was diagnosed with bipolar disorder and he decided to switch residency programs with support from his family and academic advisor.

Often, learners will need to request some accommodations as a result of their condition, for example a period of reduced overnight-call duties. This can be a real challenge as this age group is developmentally concerned with peer identification and acceptance; being "different" is often not valued. With few exceptions most learners want to manage their health and do the work ("like everyone else"). This can be a challenge as medical students and residents often do rotations in sites far from home, increasing stress, making it more challenging to have normal feedback from friends and family, and being distant from their health care providers. Some learners will have to stay closer to home as a result of health issues, which increases

their fears and uncertainties as the stressful residency matching process and other career decisions unfold.

Those who have their first manic episode while in training may incorporate other colleagues and staff into their fantastical beliefs. It can be a challenge for medical schools and residency programs to effectively help the individual experiencing mania, since they often lack insight and feel perfectly in control. *If an emergency assessment is initiated from medical school, like Meg in the example, the student will in effect have revealed aspects about her health, out of her control, which can have a ripple effect through her class and school. The administration may want to debrief, once the medical student is safely in care, to assist any fellow students or staff who might be distressed from the experiences and to discuss strategies to limit stigma against the affected student. As Meg begins to stabilize she will face a tough reality as she remembers how she behaved while psychotic and recalibrates her identity to a new diagnosis, placing her in an exquisitely fragile state.* It is helpful for universities to have a dedicated person (often from a wellness office) to contact the afflicted learner and help manage the flow of information. The small efforts of reaching out and caring are experienced by people going through disabling illness as exceptionally important. Too often people, institutions, and systems get caught up in risk management and miss the human suffering at hand.

Illnesses such as substance use and mood disorders have an insidious effect on learning. Some residents will remark on the relief of having been “caught” and that they knew it was impacting all aspects of their life even if they were still capable of passing exams while severely depressed or high on cocaine, for example. Once in recovery, they frequently immerse themselves in learning the materials they missed. Medical training programs are challenged to ensure that students and residents have met standardized learning goals if they have needed extended time off for treatment.

An initial return to an educational setting is less about work and more about managing all the potentially stressful encounters, some well meaning and others perhaps less so. Often early-career physicians will seek workplaces that value mentoring junior staff, which provides an additional safety net for them as they return to work and build their confidence. While stigma and discrimination are problematic at all stages of a medical career, for medical students, residents, and early-career doctors, anxieties often center around failing to achieve a chosen career and life path. Central to this stage is anxiety about the impact of a mental health diagnosis, including a substance use disorder, on relationships.

7.3.2 Mid-Career

The mid-career is a time where most doctors are at their prime in professional confidence, knowledge, and clinical skill. It is a time when many doctors find that they are enjoying the richness of their practice and academic interests and have equally rich lives outside of medicine, often with family experiences and time to invest into hobbies. From an Eriksonian point of view the mid-career doctor is engaged in generativity and building or creating something that possibly is life-defining. Having

a manic episode abruptly halts work and leaves the doctor in a place where the path ahead is no longer as clear; the existential crisis has an impact on career trajectory and relationships. Many in these moments find that the challenge runs deep to the core of their identity as a physician. Consider the research scientist who has a psychotic/manic episode related to substance use. Effective treatment takes time, learning to live a better life in recovery, which means practicing skills before this doctor can effectively return to the workplace. Consider another example of a physician who has a recurrent mood disorder that has become increasingly prone to relapses. Here the challenges are different, having to accept that the illness is likely chronic and unstable, and one cannot depend on the powers of medicine to completely heal one's own body. In essence it is akin to slowing down before the person had planned (well before in all likelihood). This can lead to financial issues and more for affected families.

A missed diagnosis, especially bipolar II, is common in mid-career individuals. *John is an energetic, keen specialist who aspired to be a field leader. Despite his ambition, he was perceived by colleagues as chronically incapable of working effectively in groups. He was seen to take over and often antagonized others who weren't onside with him. People around him had polarized opinions; they either loved him or they resented him. Then John was arrested for shoplifting, which required disclosure to his regulatory body. His legal counsel suggested an expert psychiatric opinion, which led to a diagnosis of bipolar disorder type II with hypomanic episodes. Considering his behavior and emotions from the perspective of a mood disorder was a revelation for John, and he began to have more insight into his behavioral problems over time. But the wear and tear on his medical department and colleagues had eroded their good will and, in the end, John decided to find new employment. His treating clinicians had much to deal with; John had to come to terms with his diagnosis, its impact over time, and his need for new skills and behaviors as well as to deal with regrets (shared by his treatment team) that the diagnosis had not been made earlier.*

Having to reduce work hours can raise concerns about the fairness of work distribution and underlying prejudices toward people who have experienced mental health disabilities. Some workplaces would like all colleagues to contribute equally, "We have always done it this way, we all agreed to this principle and we are not going to change." What is unsaid is that we are not going to change for this doctor, in this moment, because of his problems; but this response also typifies an entrenched workplace culture that stigmatizes mental illness. There is no blanket solution for this, and each request for permanent accommodation will raise its own specific challenges. A physician with a substance use problem who had denied the issue (often repeatedly lying to colleagues) has an opportunity to rebuild trust following successful rehabilitation; colleagues are often happy to provide support such as clinical coverage when the doctor needs to give a urine sample for monitoring or attend an AA meeting. The culture of a workplace or a medical department is highly influenced by its leadership and it is important that physician leaders appreciate the complexity of these situations. In some cases, it is helpful for the whole team to hear from the returning physician, who has the opportunity then of perhaps apologizing

and asserting his commitment to the joint work of medical care, while inviting people to let him know when they are unhappy or concerned. Similarly, leadership needs to be perceived as making decisions based on the facts from all sides, communicating that neither discrimination against the returning physician nor impairment in the workplace will be tolerated.

7.3.3 Late Career

An increasing number of physicians are moving into the category of late career, and medical associations across North America are making a priority of supporting this population. As the Australian psychiatrist Carmelle Peisah puts it, “[I]n the absence of an objective ideal, successful ageing can, and should be, person-specific and individually defined, specific to one’s bio-psycho-social and occupational circumstances, and importantly, reserves. There can be no one-size-fits-all solution” (Peisah 2016). Specific issues range from finances to novel ways to help senior physicians remain engaged through teaching and mentorship. Physicians can and do continue to work into their 70s and some well into their 80s. Regulators differ across North America on when and what screening interventions are needed based on age (see Chap. 9). Williams and Flanders (2016) argue that while health issues may increase with aging, performance decrements are more related to health than age. Nevertheless, when questions about mental health arise in this group, regulators understandably and often request, in addition to reviewing the doctor’s practice, formal cognitive evaluation for fitness with neurocognitive testing and often forensic psychiatric assessment (Moutier et al. 2013). Because a history of manic symptoms in a late-career physician is almost always a recurrent problem, new-onset behavioral changes raise questions of substance use or a comorbid medical problem, especially early dementia, which can present with symptoms resembling hypomania (Table 7.1). This in turn raises important questions of patient safety and mandatory retirement.

Some physicians will use health issues as a signal to slow down or stop work. *One surgeon with a bipolar disorder that had become more difficult to stabilize decided to take the necessary time off to get well, and during this time away, made the decision to retire. A year later, after enjoying his time in retirement, the doctor decided to return to work part-time as a surgical assistant, a role that allowed him to remain part of a medical team, use his skills, and transition into planned retirement several years later.*

7.4 Assessment and Treatment

After a diagnostic assessment, the treatment of mania and hypomania is typically divided into an acute stabilization phase and a maintenance phase where optimizing health and addressing any persisting symptoms occur; the latter includes education

around relapse management skills. Most doctors will want to return to work as soon as possible, yet the ingredients for a successful return to work need to be in place first. Merely achieving symptom-free status is not enough. For physicians and others returning to safety-sensitive work, it is especially important to lay the institutional groundwork for communication about signs and symptoms of early relapse. This will require developing a shared language between key people (treatment providers, perhaps an identified person in the workplace) and the individual physician as he or she recovers.

7.4.1 Assessment

Evaluation requires careful psychiatric and physical assessments. A detailed clinical history should identify times of irritability, lability of mood, impulsivity, compulsivity, insomnia or a reduced need for sleep, relationship issues (outside and inside work), professional complaints, and a detailed substance use history. The latter should include an exhaustive list of prescription as well as nonprescription medications, over-the-counter medication, and use of pharmaceutical sample products. Every assessment should include a urine toxicology screen and confirmation test. A thorough evaluation includes a detailed background history including developmental history (including a life mood chart) and may be enhanced with the use of screening tools such as the 13-item Mood Disorders Questionnaire (self-assessment) (Hirschfeld 2005). Collateral information from family, friends, and colleagues is essential; however there are limitations since others may not be aware of self-administered medications, either prescription or nonprescription drugs; and some family members may minimize symptoms to protect the physician's work and income. Laboratory tests can help rule out mania due to medical issues (Table 7.1). If this is a first episode of manic symptoms, the workup may extend to imaging and other investigations. One algorithm for assessing and treating physicians with symptoms of mania comes from the Canadian Network for Mood and Anxiety Treatments (CANMET) (Yatham et al. 2013).

By definition a doctor who is manic is impaired and cannot work. The hypomanic physician is more of a challenge for the evaluating clinician and having a multidisciplinary team is helpful. When evaluating any physician, it is important to consider a history of job instability. This includes reports from regulators in all relevant jurisdictions. Is the physician currently working? If not, how long has the person been off work and how many times might there have been workplace interruptions? Have there been any issues raised about the physician's health or wellness by anyone (family, friends, workplace colleagues, hospital administration)? Are there any accountability issues, for example, complaints? A hospital's chief of staff or department head may be helpful in this regard. Is the doctor's regulatory body aware of any health issue? Current information about concerns in the workplace or increased accountability may be very useful in helping guide decisions about whether an interruption of work would be prudent while treatment ensues. Table 7.2 describes the practical intersection between typical symptoms of mania and hypomania and risks specific to the assessment and management of practicing physicians (DSM-5).

Table 7.2 Presentation of manic and hypomanic symptoms among physicians

	Mania	Hypomania
Appearance	Prone to excesses (jewelry, makeup) Severe states—dishevelled, inappropriate (to temperature) or even unclothed <i>At this stage may need emergent help</i>	Often unchanged <i>Making it difficult to notice in the workplace</i>
Behavior	Can be cheerful. Typically, over-excited and marked disinhibition <i>Can present as requiring urgent care.</i> <i>At other times can upset people, with complaints and increased negative views.</i>	Increased sociability Some disinhibition <i>Unless disinhibition is excessive (typically if combined with substances) these qualities are enjoyed and appreciated in the workplace. If overdone can start to engender negative views</i>
Speech	Pressured speech and possibly flight of ideas <i>Usually quite a change from baseline. People will try to reason and the doctor-patient will try to explain but often thinking is not clear or is becoming psychotic. Typically, a shock to the workplace. Need for urgent care.</i>	Typically, talkative <i>Might be challenging to be around when not able to slow down, though most doctors can refocus at times of need</i>
Mood	Usually elated, euphoric but can be irritable or quick to anger <i>This will quickly be identified as problematic in the workplace by staff, colleagues, and patients</i>	Mild elevation of mood, can fluctuate with irritability. <i>Elevated mood is generally not seen as abnormal. Irritability or fluctuating moods can be seen as a problem</i>
Sleep	Reduced need for sleep and no fatigue <i>Together with other issues regarding judgment, these doctor-patients can be seen to be working at all hours</i>	Reduced need for sleep, good energy <i>Can be very productive which can be encouraged, unless irritability or disinhibition impacts judgment</i>
Activity	Marked increase in goal directed activities and increased energy <i>Initially can be seen as extremely productive, but quickly the difficulties in managing so many goals and commitments starts to show, or judgement issues become prominent</i>	Increase in goal-directed activities and increased energy <i>Typically encouraged and appreciated because the person takes on a lot of work and does it well. Fraying at the edges with irritability/impulsivity.</i>

(continued)

Table 7.2 (continued)

	Mania	Hypomania
Judgement	Risk-taking behaviors, sexual indiscretions, and other behaviors with high potential for harmful consequences <i>Usually frankly impaired in the workplace</i>	Risk-taking behaviors, sexual indiscretions, and other behaviors with a potential for negative consequences. <i>Problematic e-mails sent at all hours, rambling, upset.</i> <i>Problematic behaviors in meetings.</i> <i>Often seen as disruptive and engenders ill will in the workplace</i>
Insight	Fluctuating to nil <i>This is important as without some external action this person will continue to be manic with all the risks associated</i>	Preserved at times but not full insight <i>Often a doctor can control symptoms when given feedback for a time. Because the doctor typically feels good and/or is productive, this is not considered to be a problem by the doctor and coworkers, unless problems emerge in other domains</i>
Psychotic symptoms	Grandiosity with delusions is common. <i>Usually quite obvious and most recognize this as an emergent situation</i>	Typically, not present Grandiose flavor does not rise to level of psychosis <i>If grandiosity is present it can rub people in the workplace the wrong way, garnering ill will. May interfere with job promotions or advancement</i>

7.4.2 Phase 1: Acute Stabilization

Safety, including awareness and assessment of elevated suicide risk, is priority one, and this may include involuntary hospitalization. The highest risk is in depressed and mixed phases. Additional red flags include the experience of acute financial strain, litigation stress, marital breakdown, and a history of accidental overdose in addictive disorders (Center et al. 2003; Schernhammer and Colditz 2004; Hawton et al. 2001; Lindeman et al. 1996; Gagne et al. 2011).

Dr. W related her experience during her recent hospitalization, which included a discharge and quick readmission due to a serious suicide attempt. She recalls not feeling so bad while in the hospital. When the staff suggested a weekend pass, she was agreeable and in the end they chose to discharge her from the hospital instead. It was left to Dr. W to make a follow-up appointment with her psychiatrist which, at the time, she felt was quite reasonable. Once discharged however, she noticed very quickly how challenging life was; she was expected by her family to take up some of her typical duties; and she inevitably started worrying about work, couldn't sleep, and was agitated most of the day. The suicidal thoughts intruded with force. Her husband came home from work unexpectedly and found her in the car planning to end her life.

This scenario illustrates how physicians may not appreciate their level of disability in the early recovery phase. The capacity to compartmentalize and rationalize is

a strength that in this case led a treatment team to see a stronger recovery than their patient had achieved.

Whenever possible, family should be part of the process of care, which can extend to providing information to help with the management of professional responsibilities. Physicians have a duty to ensure that they have mechanisms to take care of their office, have coverage for patients, and notify hospital chiefs so that no patient is unduly affected by their sudden absence. For instance, in a family practice, a voice message would need to be left at the clinic notifying patients of their doctor's absence. Most regulatory bodies detail the requirements under such circumstances and typically it is family or a trusted colleague who assists. Financial competence should be considered in all cases of manic behavior.

The acute stabilization of hypomania and mania is primarily one of pharmacological intervention, to help decrease and control agitation, aggression, and impulsivity. This is a stressful time for the doctor-patient and often quite challenging for family. If possible, having the person in a quiet location with diminished stimulation can be helpful.

Treatment guidelines recommend mood stabilizers or atypical antipsychotic medications for the management of acute mania. Selection is informed by a patient's past response, preferences, and need for sedation. Medication interactions also need to be taken into consideration (Hirschfeld 2005; Yatham et al. 2013; Goodwin and Psychopharmacology 2009; Geddes and Miklowitz 2013).

Generally, a good response with adequate dosing and therapeutic blood levels occurs within 10–14 days of treatment. Should severe symptoms not resolve, guidelines recommend adding another mood stabilizer or antipsychotic medication (or changing the antipsychotic medication if already prescribed). Treatment-resistant illnesses will require more specialized interventions.

Depressive disorders are addressed more fully in Chap. 6. Bipolar depression will be mentioned here, because it is very common in the bipolar spectrum conditions and relapses over time are more likely to be depressive in nature. A diagnosis of bipolar depression is made when a person with bipolar disorder meets criteria for MDD (DSM-5). Bipolar depression is generally more resistant to treatment than unipolar depression or mania (Geddes and Miklowitz 2013). Despite concerns about inducing hypomania or mania, antidepressants are often used cautiously in an attempt to alleviate suffering; however, care should be taken to ensure that this is done in conjunction with mood stabilizers or atypical antipsychotic medication. Some antidepressants, such as tricyclics and venlafaxine, are generally not used because of a higher potential to induce hypomania or mania (Yatham et al. 2013; Fountoulakis 2015). Clinicians should assess for mixed symptoms (the presence of both manic and depressive symptoms) and rapid cycling between mania or hypomania and depression. If either is present, the pharmacologic treatment would not include antidepressant medications alone. Unlike treatment of unipolar depression, which includes an extended treatment phase, guidelines recommend limiting long-term antidepressant exposure in people diagnosed with bipolar disorder to 6–8 weeks following resolution of depressive symptoms (Yatham et al. 2013).

7.4.3 Phase II: Maintenance

The term “maintenance” is deceptive. It is often taken to mean little more than compliance with medications for a period of over 6 months (Yatham et al. 2013). However, in the context of a physician’s recovery and return to professional life, maintenance is best considered as a new way of life involving increased self-awareness and an ability to appreciate the difference between normal and pathological states within oneself well before they may pose a danger to others. It implies an ability to incorporate a diagnosis of mental illness into a “prediagnosis” identity, and this process usually requires some form of structured psychotherapy, individual and/or group. Some physician monitoring programs offer peer support groups to facilitate the healing process. It is useful to consider therapeutic goals of the treatment and monitoring of physician-patients with bipolar disorders and concurrent disorders. The box below provides some practical endpoints (Geddes and Miklowitz 2013; Cunningham 2010).

7.4.3.1 Early Maintenance Phase

On discharging a physician from the hospital, psychiatrists are often asked to provide their opinion regarding the patient’s trajectory to return to work. In cases of mania and hypomania it is important that stabilization is considered separately from return-to-work planning. As mentioned earlier, the vast majority of doctors want to return as soon as possible and sometimes do, to their detriment. For this reason, a lag (sometimes months) between when the physician recovers symptomatically and when they return to work is advisable. It is probably wise for inpatient staff to discharge the physician-patient to the care of the outpatient treating team or clinician without recommendations on a return to work. At any stage the treating clinicians may be required to update a regulator and workplace. They may consider referral to a physician health program for specific guidance (Anfang et al. 2005; Harrison 2008). In general, physicians should not be managing their own return to work.

Early in the maintenance stage, the goals are to optimize the physician’s health and to address chronic or subthreshold symptoms and comorbidities. Nonpharmacological interventions such as psychotherapy, group therapy, family support, and education as well as stress management training all play a key role in moving the physician-patient towards stability and wellness.

As no medication is free of adverse effects, one of the important components in the maintenance phase is reviewing the rationale for the medications prescribed, any changes that are to be considered, and a blueprint for the near future. All patients struggle with finding a rhythm to work with medications and doctors are no different. That said, regulatory expectations are an added motivator for physicians to accept ongoing interventions. For those individuals whose mania has been related to substance use, an addiction medicine assessment is necessary to review the diagnoses, consider the need for treatment, and emphasize the goals of abstinence, acceptance, and relapse management skills specific to substance use disorders (Lefebvre and Kaufmann 2017; McLellan et al. 2008; DuPont et al. 2009).

Often medications that were most helpful and tolerated in the acute treatment phase are continued into the maintenance phase. There is limited high-quality research on the optimal duration for maintenance, and this should be considered on a case-by-case basis (Yatham et al. 2013). Factors like the number of past episodes in addition to their severity and duration will inform decisions around long-term maintenance medication. In many cases, multi-year or lifetime maintenance drug therapy will be recommended. Two retrospective cohort studies of physicians found that a comorbid psychiatric diagnosis increased the risk of relapse (Albuquerque et al. 2009; Domino et al. 2005). One retrospective cohort study of physicians monitored for bipolar disorder and recurrent unipolar disorder showed a relapse rate (severe enough to require time off work) of 32% at 2 years (Albuquerque et al. 2009). For physicians who are technical specialists such as surgeons and interventionists, medication effects on coordination, balance, reaction time, and tremor are all relevant considerations.

Lithium is the best studied medication in the maintenance phase of bipolar disorder since the 1950s (Alda 2015). There is some evidence that compliance with lithium is associated with reduced suicide rates in people diagnosed with bipolar disorder (Alda 2015; Geddes and Miklowitz 2013; Ahrens and Müller-Oerlinghausen 2001). Lithium's narrow therapeutic window means that it is necessary to monitor blood levels, as well as kidney and thyroid functioning. Lithium is associated with approximately a 10% rate of hypothyroidism (Yatham et al. 2013). Other maintenance medications include carbamazepine, divalproex sodium, lamotrigine, and atypical antipsychotics.

There has been considerable research interest around subtle cognitive dysfunction among people diagnosed with bipolar disorder (learning, processing, attention, memory, working memory) (Cardenas et al. 2016; Fountoulakis 2015). While this research has not yet translated into practical guidance, treating clinicians should be especially sensitive to the experiences of physician-patients around concentration, focus, and ability to retain information. At times further neurocognitive assessment may be useful in assessing global and specific function. Approaches to supporting and reviewing a physician's performance as well as their health and well-being upon returning to the workplace should be considered. Any perceived difficulties might lead to problem-solving strategies that could be potentially shared with the physician's support network. Finally, sleep problems may contribute to cognitive dysfunction as well as increase the risk for suicide and relapse.

7.4.3.2 Late Maintenance Phase

Once symptoms have resolved adequately, there is evidence that psychotherapy can help strengthen recovery and reduce the risk of relapse. Studies have shown that cognitive behavioral therapies (CBT), interpersonal therapy (IPT) and social rhythm therapy (IPSRT), family therapy, and group psychoeducation can help (Geddes and Miklowitz 2013; Yatham et al. 2013; Parikh et al. 2012). Health care professionals with comorbid substance use disorders often access Caduceus groups and mutual support groups (AA, NA) (Knight et al. 2007; Brewster et al. 2008; Sanchez et al. 2016). The process of formal monitoring offers additional structure, support, and

accountability that doctors find helpful in managing priorities as they move forward with a return to work (DuPont et al. 2009; Albuquerque et al. 2009; Lefebvre and Kaufmann 2017; Anfang et al. 2005).

Clinicians have an opportunity to advocate for their patient. An occupational plan is essential to coordinating clinicians and administrators. Practical questions about limiting overnight-call duties and a graduated return to work will arise and need to be negotiated. To the extent possible, accommodations at work should be made to support a regular sleep schedule. The occupational plan is helped greatly by information from the workplace. Doctors planning to return to work typically sit down with their department head and discuss any concerns they have, including institutional accountability, which may include permission to receive progress notes from treating clinicians or formal monitoring programs. Hospitals and other workplaces often have their own risk management programs in place that layer onto professional regulation. Occupational plans increase the confidence of all involved by providing some indication of good health, compliance with treatment, and suitable work performance.

Goals for Psychotherapeutic Interventions for Physicians (Bipolar Disorders and Substance Use Disorders)

Bipolar Disorder

- Education to understand the chronic nature of this illness that will require life-long attention and management of vulnerabilities
- Learning early signs and symptoms of relapse or recurrence
- Processing to accept the illness and its impact on life and work
- Importance of compliance and not directing one's health care
- Improving relationships at home, with friends and colleagues
- Learning stress management skills, effective communication skills
- Developing and nurturing health behaviors (sleep, eating, relaxation, exercise)
- Developing ways of managing risk to self and risk in the workplace
- Developing a network of trusted people who will provide feedback
- Reducing or stopping alcohol use and abstaining from any non-prescribed controlled substances

Substance Use Disorder

- Robust understanding of addictions as a chronic illness requiring life-long attention
- Understanding a "total abstinence" approach to recovery
- Facilitation to mutual support community-based recovery groups
- Facilitation to peer support and treatment groups for health professionals
- Learning fundamental relapse prevention skills
- Adoption of balanced, healthy lifestyle choices
- Stabilization of any appropriate pharmacotherapy

7.5 Key Points

1. Doctors are not immune to mental health and substance use disorders. Training at all stages of a physician career is essential to aid colleagues in knowing where to turn for help and the importance of managing their health.
2. Stigma and discrimination are important barriers to physicians getting care. Education, peer support, and confidential services are essential. Frank and open stories of doctors talking about their health issues have transformative power.
3. Bipolar disorder is difficult to diagnosis and can be misdiagnosed without careful assessment. The use of collateral information and workplace information is crucial.
4. Suicide is an elevated risk in this population and clear processes must exist to assist the suicidal physician as well as the colleague or friend who is trying to help the physician.
5. Recurrence is the rule in conditions that cause hypomanic and manic symptoms. In hypomanic and manic states, the doctor is often highly vulnerable and may have little understanding that they are ill. It is important that treatment professionals consider long-term treatment and monitoring of their physician-patients with these conditions.
6. Careful management of return-to-work planning involves the workplace and the treatment team. Physician-patients should not be engineering their return to work on their own.
7. With treatment and monitoring of diagnosed health conditions doctors can achieve stability and safely return to the workplace.

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