Virtual Mentor
American Medical Association Journal of Ethics
March 2003, Volume 5, Number 3: 80-83.

CASE AND COMMENTARY
An Impaired Resident, Commentary 2
Commentary by DeWitt C. Baldwin, Jr, MD

Case
Steven and John are second-year residents in internal medicine at a major urban hospital. They have been friends since medical school and became closer while sharing long shifts during their intern year.

Over the past few weeks, John has not been himself. Steve thinks John has looked more sleep-deprived than the usual resident does, and that he might even appear tearful at times. John hasn't been joining the other residents for lunch and, when he does, Steve notices that he doesn't eat very much. Concerned, Steve realizes that John has been somewhat withdrawn for several months now. Previously, John, Steve, and Steve's wife Maria often went out to dinner or got together in the evenings, but John has declined the past few invitations. Steve has been passing off John's new behavior as the "winter blues" combined with the normal ups and downs of residency training. The R2s have been working as many hours as they did as interns,so Steve didn't make a big deal out of the fact that John didn't have time to hang out.

Last week, Steve saw the normally friendly and even-keeled John growl at a medical student and then yell at a nurse on the unit. Afterwards, he heard the nurses complain that John seemed distracted, hard to locate sometimes when they needed him, and had yelled at them about some missing lab results when it was he who had forgotten to order them in the first place. John had also been asking them for the correct dosages of commonly prescribed medications. In fact, John's behavior seemed so unpredictable and difficult of late that one nurse on the unit was asking for a transfer.

When Steve asked John whether everything was okay, John replied, "Yeah, fine. "When Steve pressed a little about John's mood, John became defensive. "What, I'm supposed to be cheerful, too? Just because I'm not here 15 minutes before everyone else, and I ask some questions before charging ahead with treatment, suddenly the attending is all, 'You'd better shape up, Dr. Masterson.' Whatever."

Steve began thinking John must be depressed, or at least that John should talk to someone about his dissatisfaction with how things were going. Since he had been ignoring his friends, Steve wondered how willing John would be to accept help. Steve even found himself worrying about John's patients.

On the other hand, Steve thought that he might be making too much of what was just a bad mood. And he worried about the potential harm he could do to John's career by mentioning the situation to the residency director. Steve had heard that state medical boards require psychiatrists to turnover records of doctors whom they saw as patients. He also thought about the negative image many in the hospital had of mental illness (or any weakness in general) among residents. He didn't want to paint John as deficient just because he had a bad week.

Finally, Steve brought up the topic with Chris, another resident, and a mutual friend of his and John's. Chris said, "Oh, man, I wouldn't touch that with a ten-foot pole."

"If he was drinking or doing drugs, would you do something?" Steve asked.

"Yeah, but there's a difference."

"What's the difference?" asked Steve. "He's actin' weird. He's making mistakes. You want to wait til someone gets hurt? What if John gets hurt?

"Yeah, but if you label him as a psych case, he'll never get a job. Hell, he may not get a license."

"And if he screws up and causes harm to somebody?"

Chris did not respond. Great. Steve was more confused than before.

Commentary 2
There are 4 basic questions here.

1. What is going on with John?
2. What is causing it?
3. How aberrant is it?
4. What can/should Steve (or others) do about it?

Is John behaving in an impaired manner? Of course he is! His friends and fellow residents, Steve and Chris, as well as the nurses and medical students have all noted and even commented on it. And it will probably not be long before his attendings become aware of it, if they are not already. Is it unusual? From what we are told, it seems to be unusual for him. He simply is not behaving the way he usually does both at work and away from work.

Is such impaired behavior unusual among sleep-deprived and overworked residents? Not at all! Over half of the PGY1 and PGY2 residents in a recent national survey reported that they had worked at least once during the past year while in an "impaired condition," ascribing it largely to sleep loss and overwork.1

Should we be concerned about his behavior? Absolutely! If he continues to do the things he is doing, the care of his patients is going to suffer and the chances of a medical mistake appear likely. Steve's concern for his friend and colleague is well founded. And even Chris knows that John is heading for trouble, but is fearful of the traditional "marine corps" mentality of medicine that admits of no "weakness or failure."

But is this all that's going on? No! He is also clinically depressed. In addition to showing some of the types of impaired behavior that many residents may show under conditions of sleep deprivation and stress, he also exhibits some classical symptoms of depression: social withdrawal, loss of appetite, mood disturbances, mental distraction, sleep loss, cognitive impairment, and emotional outbursts that are not typical of him.

Is this unusual? Again, not at all! Many studies have described the serious physical, psychological, and emotional consequences of prolonged sleep deprivation, fatigue, and stress during residency.[1] In one report, more than 30 percent of residents were found to be clinically depressed during their first post-graduate year.[2] In the past, many such residents simply "toughed it out" or self-medicated.

What should/can Steve (or others) do? Since the situation appears to be deteriorating and clinical depression is eminently treatable, it would seem to be a friendly and collegial act to assist John to get some relief from the symptoms that must surely be disturbing to him as well. Indeed, not reporting behavior of a colleague that could potentially result in harm to a patient is unethical, since it violates the fundamental fiduciary responsibility of physicians to their patients. Allowing John to continue to "screw up" clinically also is unfair to him as well as to his colleagues and patients.

While Chris may feel concerned about the possible negative professional consequences of getting help for John, most residency directors today have been sensitized to the effects of prolonged sleep deprivation and fatigue during residency, and confidential systems for referral and treatment are nearly always available without prejudice. Talking to a sympathetic and trusted faculty member, or to the program director, or even to the director of medical education in the hospital, is probably the best way to start the process if John cannot accept the fact of his impaired and potentially harmful behavior and seek help himself.

As far as stigmatizing John with a psychiatric diagnosis, his depression, while clinically real, seems fairly recent and largely situationally determined. As such, it can probably be treated as well by an experienced internist or generalist as by a psychiatrist. Since medication for depression may take a few weeks to become fully effective, a brief medical leave may be considered. However, recognition and acceptance of the problem, together with good medical treatment and collegial support, should make such a disruption unnecessary. As for Chris's concerns about how this could affect John's future licensure, since depression is frequently treated

by physicians other than psychiatrists and is such a common problem among residents, I believe there is little substance to his worries about John's having a psychiatric record that would be of concern to a State Medical Board.

References

1. Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med*. 2002;136(5):358-367.
2. Valko RJ, Clayton PJ. Depression in the internship year. *Dis Nervous Sys*. 1975;36(1):26-29.

DeWitt C. Baldwin, Jr, MD trained in pediatrics, psychiatry, and family medicine and has held professional rank at 9 medical schools, 2 of which he helped to start. He currently serves as scholar-in-residence at the Accreditation Council for Graduate Medical Education (ACGME), where he continues to research and write about the working and learning environment of medical students and residents.