

Clinical and Forensic Implications of Psychosis in Physicians

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Abstract

Over the last six decades, the mental health of physicians has received increasing interest, particularly regarding the occurrence of depression, anxiety, substance abuse, and burnout in physicians. Much less attention has been paid to the occurrence of psychosis in physicians. This study aimed to (1) conduct a narrative review of the literature on the occurrence of psychosis in physicians, seeking to clarify its prevalence, nature, and associated treatment issues and organizational handling; and (2) consider implications for clinicians and forensic evaluators of physicians experiencing psychosis. A search of electronic databases was conducted using relevant search terms, yielding 21 identified articles after review of titles, abstracts, full-text articles, and reference lists. Findings suggest that the occurrence of psychosis in physicians poses unique clinical (e.g., poor insight, antipsychotic side effects, countertransference/transference issues, forced medication) and forensic (e.g., emotional reactions to physician evaluatees, over-reliance on self-report) challenges. Developing a strong therapeutic alliance with the physician-patient is pivotal in addressing clinical challenges, while engaging in self-reflection with as-needed consultation and psychotherapeutic support can temper the forensic challenge of managing emotional reactions to physician evaluatees. Moreover, steadfastly adhering to professional guidelines such as those for psychiatric fitness for duty evaluations for physicians may help address the risk of over-reliance on physician evaluatee self-reports, which may include denial of symptoms for those experiencing psychosis.

Keywords: Psychosis; Physician; Psychiatric fitness for duty; Physician health programs; Forensic evaluation; Treatment issues

Introduction

The mental health of physicians has been a topic of interest for many decades, dating back to at least 1960, when, for example, Pearson MM, et al. [1] described mental health conditions among physicians treated in a private psychiatric practice over a 15-year period. Since then, increasing research has focused on this topic, with most studies examining the occurrence of depression, [2] anxiety, [3] substance abuse, [4] and burnout [5] in physicians. These conditions have been noted to occur at significant rates among both residents and practicing physicians [4,6].

Much less attention has been paid to the occurrence of psychosis in physicians. This could be due to psychotic symptoms occurring less frequently in physicians compared to other mental health (e.g., mood or anxiety) symptoms, similar to the relative commonality of these symptoms in the general population [7]. In addition, physicians may be more reluctant to disclose having experienced psychotic symptoms due to concern about stigma attached to such symptoms, fear of licensing ramifications, or lack of insight into having the symptoms [8].

While less common than mood and anxiety symptoms, the occurrence of psychotic symptoms in physicians can have important clinical and legal implications. For example, psychotic symptoms typically require treatment with antipsychotic medication, the side effects of which can impact an individual's alertness, with potential effects on the physician's practice [9]. As another example, because of the nature of psychosis, a physician may be unwilling to accept treatment for this condition due to poor insight, and may require involuntary psychiatric hospitalization, which, if resulting in court-ordered treatment, may require disclosure when applying for medical licensure or clinical privileges at various health care settings [10].

The limited literature on psychosis in physicians mainly comprises case reports detailing clinical presentation and career outcomes. For instance, Crammer [9] described three physicians who developed psychosis in medical school and experienced recurrent episodes. In the first case, a medical student developed grandiose and paranoid delusions, leading to hospitalization after failing final exams. Despite multiple relapses due to medication nonadherence, he stabilized on fluphenazine decanoate, completed his training, and practiced as a general practitioner for five years without incident. The second case involved psychotic depression triggered by a failed relationship. After

initial stabilization on chlorpromazine, the physician relapsed following medication discontinuation but improved with trifluoperazine plus nortriptyline, eventually functioning well as a hospitalist for 2 ½ years. The third physician became increasingly withdrawn and suspicious during his final year of medical school, requiring several hospitalizations for relapses related to noncompliance. His symptoms were controlled with fluphenazine decanoate, and after dose adjustment to reduce side effects, he completed his training without further issue.

More recently, Freedman JL, et al. [11] described a female medical school graduate who developed acute psychosis- characterized by paranoia, bizarre delusions, poor self-care, and disorganized thinking- under the stress of residency interviews and rejection. Despite repeated hospitalizations and nonadherence to ziprasidone, she began an internal medicine residency but could not complete her intern year due to relapse. After an 8-week hospitalization and partial hospital program, her symptoms improved with olanzapine, haloperidol, and cognitive behavioral therapy, though she experienced significant sedation and weight gain on olanzapine, which was later discontinued without symptom recurrence. With clinician support, she secured full-time work as a salesperson and hoped to eventually resume medical training.

While reports like these provide interesting examples of the clinical courses of some physicians who have experienced psychosis, to date there have been no attempts to summarize the literature regarding the prevalence, nature, treatment issues, and organizational/agency handling of physicians experiencing psychosis. Moreover, to our knowledge, there have been no published efforts to examine the unique forensic implications of physician evaluatees experiencing psychosis. Clarity in these issues would be helpful to mental health clinicians and forensic mental health evaluators [11,12].

This paper has two aims: (1) To conduct a narrative review of the scientific literature on the occurrence of psychosis in physicians, seeking to clarify the prevalence, nature, and associated treatment issues and organizational handling of this phenomenon; and (2) to consider clinical and forensic implications of physicians experiencing psychosis. Of note, this paper is a narrative review supplemented by information based on the author's clinical and forensic experience, rather than a systematic or scoping review. A narrative review format was chosen because of the limited literature on the topic of psychosis in physicians, portending the need for a broad overview of this topic with expert interpretation, rather than the strict approach of a systematic or scoping review, which might exclude valuable information.

Methods

A search of the electronic databases PubMed, Ovid MEDLINE, PsycINFO, and Embase, from database inception to present, was conducted on February 4, 2025, using the search terms, "psychosis," "psychotic symptoms," "hallucinations," "delusions," "disorganization," "physician," "doctor," and "resident." The initial search revealed 20,553 citations. After review of titles and abstracts and removal of duplicates, 27 citations remained. After review of full-text articles, 16 citations remained (11 were excluded for not relating to the topic of psychosis in physicians). An additional 5 articles were identified from review of reference lists, resulting in 21 articles reviewed that were relevant to the occurrence of psychosis in physicians.

Inclusion criteria for this review consisted of the following: published in English, pertained to the topic of psychosis in physicians (or at least included physicians experiencing psychotic symptoms as

part of the data analyzed in the study), and peer-reviewed. Citations not meeting all of the above criteria were excluded from review.

For purposes of this review, "psychosis" was defined as a mental state characterized by a loss of touch with reality as evidenced by hallucinations and/or delusions, or grossly disorganized thinking and/or behavior, that may result from a primary psychiatric illness, substance use, a medical condition, or other cause. "Physician" was defined as an individual who has completed medical training and has earned a medical degree, including residents and practicing physicians. Citations were assessed for inclusion in this review until saturation was reached, i.e., additional data did not lead to any new emergent themes.

Results

Twenty-one articles were identified in this review [1,7-9,11-27]. These fell into four categories: treatment focused, epidemiology focused, organizational/agency focused, and personal/patient focused, as presented in table 1.

Treatment Focused Articles on Psychosis in Physicians

Twelve such publications were identified [1,8,9,11-15,17,19-21]. Of these, five specifically focused on the occurrence of psychosis in physicians, [9,11,12,21,26] while the other seven examined the treatment of physicians with a range of mental health conditions, including psychosis [1,8,13-15,17,19]. Common themes highlighted in the treatment of physicians with psychosis included the following:

1. Countertransference issues. For example, the treating physician may see the psychotic physician as a "warped mirror of oneself," [11] leading the treater to question whether this condition could happen to them, fueling minimization of the physician-patient's pathology [11,12,19,21]. Alternatively, the treater may view the physician-patient as having "VIP" status by way of possessing a medical degree and therefore not subject to the same rules as other patients, leading to splitting and frustration of unit staff and isolation of the physician-patient [11,19]. As a third example, resident treaters working with psychotic physician-patients may experience reminiscence of interacting with past senior residents and attendings due to the physician-patient questioning their knowledge and experience and treating them as trainees instead of as treaters [12].
2. Transference issues, in which the psychotic physician-patient prefers to see themselves not as a patient, but as a "peer" who is separate from the other patients on the unit and is interacting with "peer" treaters (manifested, for example, by calling treaters by their first names and by describing proposed treatments in intellectual, general terms without insight into the fact that such treatments are being recommended for their own mental health condition) [11,12,19,21].
3. Insight issues, in which the physician-patient experiencing psychosis shows lack of awareness of having this condition, misattribution of psychotic experiences or symptoms, lack of appreciation of the need for treatment (resulting in frequent requests for early discharge from inpatient psychiatric settings), and failure to comply with treatment (particularly following discharge from inpatient settings) [1,8,11,13,15,21].
4. Delays in seeking care, in which physicians experiencing psychosis (like those struggling with other mental conditions) may put off attempting to obtain professional help due to the aforementioned lack of insight, concerns about associated stigma, time constraints, uncertainty about where to seek help, and ineffective (and harmful) attempts to self-treat with alcohol or other substances [8,12,15].

Table 1: Published articles on the occurrence of psychosis in physicians.

Author(s)/ Year	Perspective	Participants	Study Aim	Setting	Study Design	Findings
Pearson MM, et al. (1960) [1]	Treatment	66 physicians (mostly male, 20-60+ yrs)	Describe illnesses in physicians over 15 yrs	Private outpatient psychiatry; ⅓ needed inpatient (U.S.)	Retrospective descriptive	• 23% psychosis dx (affective 17%, schizophrenia 3%). • Delayed treatment from physician resistance and neglect by family, colleagues. • Most achieved symptom remission.
Duffy JC, et al. (1964) [8]	Treatment	93 physicians (gender unspecified, 28-86 yrs)	Describe psychiatric illnesses among physicians over 10 yrs	Inpatient psychiatry (general hospital in U.S.)	Retrospective descriptive	• 33% psychosis (most affective). • Denial, AMA discharge common. • Stress from medical practice, family duties, own emotional vulnerabilities main cause; colleagues hesitated to intervene.
A'Brook MF, et al. (1967) [13]	Treatment	93 physicians (gender unspecified, 28-86 yrs)	Describe psychiatric illnesses among physicians over 10 yrs	Outpatient and inpatient psychiatric settings in Great Britain/U.K.	Retrospective descriptive	• Reluctance to accept illness/need for tx, premature discharge common. • 28% affective psychosis, 8% schizophrenia. • More effective screening and intervention for medical students and ↓resident work hours advised.
Small IF, et al. (1969) [14]	Treatment	40 physicians (95% male, mean age 42)	Describe problems of physicians before/after admission	Inpatient psych facility; follow-ups with pt/family conducted	Retrospective chart review	• 53% schizophrenia, 15% affective psychosis • In 25% of cases, issues could have been detected and treated earlier as students • Most returned to practice; decisions managed informally
Vincent MO, et al. (1969) [15]	Treatment	93 physicians (94% male, 28-80 yrs)	Describe psychiatric morbidity among physicians	Private psychiatric hospital (Canada)	Retrospective descriptive	• 53% schizophrenia, 15% affective psychosis • In 25% of cases, issues could have been detected and treated earlier as students • Most returned to practice; decisions managed informally
Franklin RA (1977) [17]	Treatment	100 physicians (age, gender unspecified)	Describe psychiatric illnesses among physicians	Private psychiatric hospital in York, England	Retrospective descriptive	• 2% schizophrenia, 40% affective psychosis, 8% organic psychosis • 20% alcoholism, 10% other drugs • Psychosis due to schizophrenia lower in physicians than controls (14%)
Crammer JL (1978) [9]	Treatment	100 physicians (age, gender unspecified)	Describe physicians experiencing psychosis during training	Inpatient and outpatient psychiatric settings in England	Case Report	• Regular, adequate, long-term antipsychotic tx, early discharge from hospital, timely return to work, frequent follow-up, and kind, invested physicians led to successful practice return • Return should be trialed safely and not presumed impossible due to past psychosis
Meissner WW, et al. (1978) [19]	Treatment	N/A (2 physician case examples)	Describe conflicts when physicians receive inpatient psychiatric tx	N/A	Opinion article	• Identity struggles/narcissistic trauma from role reversal • Unit/staff tension possible from externalization of these conflicts • Open, empathic communication allowing airing of inner conflicts can reduce countertransference and countertherapeutic responses to physician-pt

Waynik M (1985) [20]	Treatment	1 Indian male physician	To illustrate paranoia in cultural context	Outpatient psychiatric clinic in U.S.	Case report	- Suspicious about poisoning and witchcraft by wife represent common beliefs in Indian culture - Persecutory ideas consistent with cultural status as youngest child (higher status granted to eldest) - Understanding norms improves care/alliance
a'Brook M (1990) [21]	Treatment	N/A (2 physician case examples)	Describe issues in inpatient psychiatric tx of physicians	N/A	Opinion article	- Denial by all involved (physician-pt, relatives, colleagues, psychiatrist); psychosis threatens omnipotent self-image - Encourage complete tx course; avoid overinvolvement, treat as educated layperson
Freedman JL, et al. (2012) [11]	Treatment	N/A (2 physician case examples)	Describe issues in inpatient tx of psychotic physicians	Inpatient psychiatric unit (location unspecified)	Opinion article	- Countertransference, transference, lack of insight frequent. - Therapeutic alliance helps (e.g., by identifying areas of shared concern, such as difficulty thinking clearly, even if pt disagrees with dx)
Esang M, et al. (2019) [12]	Treatment	35 year-old male endocrinologist	Describe issues in inpatient tx of physician with manic psychosis	Teaching hospital psychiatric unit (location unspecified)	Case report	- Anxiety, denial, difficulty with role reversal in pt - Countertransference, transference issues between residents and physician-pt - By thoroughly reviewing tx options and keeping open communication, team eventually earned pt's trust, which facilitated recovery
Murray RM (1974) [16]	Epidemiologic	378 physicians (age range, gender unspecified)	Summarize nature and impacts of psychiatric illness in physicians	N/A	Narrative review	- Affective psychosis: 14-28%; organic psychosis: 5-9%; schizophrenia 5-9% - Stress of medical practice may be main factor - Sick physicians find it hard to accept pt role, while psychiatrists often treat as "special pts" with overly optimistic prognosis
Murray RM (1977) [18]	Epidemiologic	110 male physicians (25+ yrs)	Compare admission/discharge rates for physicians vs controls	Scottish mental hospitals and psychiatric units	Registry-based analysis	- Higher admission and discharge rates for affective psychosis for physicians than controls; could be due to unique stress of medical practice - Physicians more likely than non-physicians to be referred by self or family; may reflect physician reluctance to diagnose psychosis in peers
Betts WC (1996) [22]	Epidemiologic	103 physicians in NCPHP (age, gender unspecified)	Describe psychiatric/ SUD and return-to-work rates	Mixed inpatient, outpatient, and residential	Retrospective descriptive	- Schizophrenia 3%, bipolar 21%, dual dx 30% of physicians with a psychiatric dx. - None with schizophrenia returned to work. 64% of those with psychiatric dx alone returned to work successfully.

Betts WC (1996) [22]	Epidemiologic	335 residents (64% female, mean age 31 yrs); 20 yrs data	Describe profiles of resident physicians admitted to mental health program	Specialized mental health service (inpatient and outpatient) in Spain	Retrospective observational	• Psychotic disorders in 2% residents • Adjustment, mood, substance use, anxiety disorders most common • Residency programs should teach how to identify and cope with mental distress, foster help seeking, and offer free, accessible, confidential, and reliable mental health programs
Paquin V, et al. (2025) [27]	Epidemiologic	502 medical residents (66% female, mean age 28 yrs)	Estimate prevalence of PLEs among resident physicians	University residency programs (Quebec, Canada)	Cross-sectional survey	• 50% reported PLEs, but 1.3% met CAPE criteria for psychotic disorder • PLEs linked to minority status, possibly reflecting experience of discrimination among these residents
Breen KJ, et al. (1998) [23]	Agency/organizational	82 physicians in impairment program (84% male, age unspecified)	Describe psychiatric/ SUD rates, impairment board process	Mixed inpatient, outpatient, and residential (Australia)	Retrospective descriptive	• 42% psychiatric illness (% psychosis unspecified) • Refusal of assessment triggers formal hearing • Mandatory reporting when condition may seriously impair practice or pose risk to public • Those with convincing demeanor when formally assessed may experience prolonged psychosis
Farmer JF (2002) [24]	Agency/organizational	Junior physicians (3 case examples)	Describe return-to-work issues	Unspecified (Queensland)	Retrospective descriptive	• Career change may be best outcome • Families need support • Empowering pt in process (e.g., timetable of return to work) helps outcomes
Wilhelm KA, et al. (2004) [25]	Agency/organizational	Medical students, physicians in impairment program (age/gender unspecified)	Describe return-to-work issues	Unspecified (New South Wales)	Retrospective descriptive	• Psychosis can occur in medical students (given age of onset of schizophrenia) and can disrupt cognitive processing and interpersonal relationships, which may hinder successful career/training • Alternative careers advised when needed
Fox K (2018) [26]	Personal/lived experience	1 female GP trainee	Describe experience of psychosis as GP trainee	Outpatient and inpatient (UK)	Opinion article	• Dx/tx of psychosis delayed by stigma (among family, friends, and psychiatry team). • Reluctance of physicians (including MHPs) to diagnose psychosis in other physicians. • Mental health risks in stressful work systems.

Many studies noted that one key factor that may help address the treatment issues of countertransference, transference, and lack of insight in psychotic physicians is development of a strong therapeutic alliance [11,12,19,20,21]. These studies noted that such an alliance may allow better collaboration between treaters and physician-patients in the informed consent process for medications (e.g., by using the physician-patient's knowledge of medications as a strength in thoughtfully arriving at agreed-on treatments for their psychosis) [11,12] and may facilitate identification of areas of common concern (e.g., not being able to think clearly) even when physician-patients are unaccepting of a psychosis diagnosis, which can pave the way for accepting medication treatment [11]. Waynik M [20] further advised

that treaters consider cultural norms when making diagnostic and treatment decisions in physicians presenting with psychotic symptoms, to enable better understanding of their presenting picture, enhance the working alliance, and increase the likelihood of a successful outcome.

Epidemiology of Psychosis in Physicians

Five studies focused on the epidemiology of mental health conditions, including psychosis, among physicians [7,16,18,22,27]. These studies reported rates of psychosis among physicians ranging from 1.3% [27] to 28% [16], although the sample sources, sample sizes, and context for the psychosis reported were highly variable. For example, Paquin V, et al. [27] surveyed 502 medical residents enrolled in

four residency programs in Quebec, Canada, and found that 1.3% met screening cutoff criteria for “psychotic disorder” on the Community Assessment of Psychic Experiences (CAPE) [28]. Braquehais MD, et al. [7] examined 335 residents admitted to a specialized mental health program (with inpatient and outpatient components) in Spain and found that 2.1% were diagnosed with schizophrenia and other psychotic disorders (similar to 2.5% of consultant physician controls also in the program). Betts WC [22] studied 103 physicians with a psychiatric diagnosis partaking in the North Carolina Physicians’ Health Program (with a mixture of outpatient, inpatient, and residential treatment) and found that 2.9% had a schizophrenia diagnosis (while 21.4% had bipolar disorder). Murray RM [16] conducted a narrative review of three studies involving a total of 378 physicians in the United States, England, and Canada receiving a mix of inpatient and outpatient psychiatric treatment and noted that affective psychoses were reported in 14% to 28%, organic psychoses in 5% to 9%, and schizophrenia in 5% to 9%.

Thus, the reported prevalence of psychosis among physicians varies depending on whether affective psychoses (such as psychotic depression or mania) or primary psychotic disorders (such as schizophrenia) are being reported, whether the sample source consists of physicians under psychiatric treatment versus a general population of physicians, and the year of the study (with more recent studies reporting lower rates of psychosis among physicians).

Of note, one study, a registry-based epidemiologic analysis of Scottish mental hospitals and psychiatric units, [18] found that first admission and total discharge rates for affective psychosis were significantly higher among physicians than social class-matched non-physicians, which the authors posited could be due to the unique stress associated with medical practice. That study also found that physicians were more likely to have been referred by themselves or by sources other than other physicians, suggesting that physicians may be more reluctant to diagnose mental health conditions in their peers.

Organizational/Agency Perspectives

Three studies fell into this category [23-25]. Two of these studies noted that medical boards may actively encourage and facilitate alternate careers for physicians when the personal and institutional cost of juggling a medical career with serious illness becomes untenable for both the physician and organization [24,25]. However, one study also noted that recovery for physicians with psychosis is possible with proper treatment and personal and professional support, and that empowering a vulnerable return-to-work candidate to control their own timetable (with input from treating health professionals) increases the chance of a successful return [24].

While not included in this category due to being ultimately deemed treatment-focused, three other studies provided perspectives on length-of-hospitalization and return-to-work issues for physicians experiencing psychosis [9,15,21]. Crammer JL [9] described three physicians who experienced psychotic episodes during medical training and found successful outcomes depended on long-term antipsychotic treatment, early discharge, timely return to work (despite ongoing symptoms or side effects), regular follow-up, and supportive colleagues. He argued that physicians should not be automatically deemed unfit for clinical work after psychosis unless there is evidence of risk to patients, and that the ability to return to practice should be tested rather than assumed impossible. In contrast, a’Brook M [21] recommended that psychotic physician-patients remain hospitalized and in outpatient treatment until fully recovered, noting good treatment response and favorable outcomes with adherence. He

illustrated this with two cases of physicians who, with emphasis on staying the full inpatient course and on post-discharge adherence, recovered uneventfully from psychosis and returned to practice. Supporting a’Brook, Vincent MO, et al. [15] noted that physicians often seek only short-term mental health treatment, limiting adequate care.

It should be noted that other authors have noted that depending on the agency, the focus regarding impaired physicians may vary. For example, state boards are typically concerned with the physician’s capacity to practice medicine, possible disciplinary action, and other issues in the name of public/patient safety, whereas physician health programs emphasize illness and rehabilitation [29].

Personal Perspectives

One article [30] fell into this category, an opinion piece authored by a general practice resident describing her experience with psychosis and depression in the setting of work pressures. This author described having long been told by family, friends, and a psychiatry team that she was not experiencing psychosis, and only receiving the treatment she needed after making a suicide attempt. Based on her experience, she pointed out the possible reluctance of physicians (including mental health professionals) to diagnose psychosis in other physicians, delaying needed care for physicians with psychosis. She also highlighted the mental health risks (including psychosis) associated with working in high-pressure work environments and systems.

Discussion

The findings of this review largely parallel those from studies of physicians with other mental health issues or substance use disorders, namely, that (1) delays in care-seeking by physician-patients or referring for care by peer physicians are common due to denial or hesitance on the part of physician-patients and peers, respectively [1,8,16,18,21]; (2) treatment of physician-patients is fraught with countertransference, transference, and insight issues that can often be addressed by developing a strong therapeutic alliance [11,12,16,19,21]; and (3) with proper treatment and adherence to treatment, some physicians can reasonably recover and return to practice [1,9,12,14,21], while others may need to seek alternate careers due to the severity of their illness hampering their ability to meet the demands of the medical profession [11]. This similarity in findings is noteworthy in that psychosis occurs less commonly than other mental health issues and substance abuse in physicians and has therefore received less published attention, yet presents unique clinical and forensic challenges, as described below.

Psychosis in physicians presents unique clinical challenges in that (1) impaired insight commonly accompanies psychotic symptoms, particularly in individuals with schizophrenia, making engagement in treatment difficult [30]; (2) antipsychotic medications, currently the most evidence-based treatment for psychotic symptoms, can cause side effects that may affect a physician’s alertness and fluidity of thinking and movement on the job [9,12]; and (3) unlike other mental health symptoms or substance abuse, psychotic symptoms can be forcibly treated with medication if necessary under a court order, further threatening the physician-patient’s sense of personal and professional identity already challenged by the role reversal inherent in becoming a psychiatric patient [19]. As above, cultivation of a strong therapeutic alliance (including validating the physician-patient’s knowledge base in, for example, pharmacokinetics of medications while clearly delineating the roles of the treatment team and patient and elaborating on the rationale behind treatment decisions) appears to be pivotal in navigating these issues with physicians experiencing psychosis [12].

The clinical challenges noted above when treating psychotic physicians, including countertransference, poor insight, and reluctance to disclose, pave the way for forensic complications in working with these individuals, as both clinical and forensic contexts involve interactions between a treater/evaluator and the physician with psychosis. For example, forensic evaluators may be asked to perform psychiatric fitness-for-duty evaluations on physicians experiencing psychosis. Similar to clinical work, countertransference issues may arise during such evaluations, with the potential to introduce bias into the assessment, both during interactions with physician evaluatees and when formulating and communicating assessment findings [31]. Thus, for example, a forensic evaluator may over identify with a physician evaluatee experiencing psychosis by virtue of their shared education and training and inadvertently collude with the physician in minimizing the evaluatee's pathology, leading to a recommendation of "fit for duty" that may not be appropriate. Alternatively, a resident forensic evaluator may struggle with emotional reactions to a psychotic physician evaluatee whose frequent questioning of the resident's knowledge and competence may remind the resident of experiences with past senior residents or attendings, leading to feeling intimidated by the evaluatee's difficult personality and inserting bias into the assessment and fitness opinion.

In addition to countertransference/transference issues, because most physician evaluatees highly value their work and will thus commonly attempt to deny, mitigate, or hide their work impairment from others, forensic evaluators may over-rely on physician evaluatees' self-report of their symptoms, functioning, and basis of their referral for forensic evaluation (with frequent denial on the part of physician evaluatees of symptoms or functional impairment and externalization of reasons for being referred, e.g., "My supervisors have it in for me") [32]. This over-reliance on physician self-report is not necessarily based on evaluator over identification with the physician evaluatee, but may stem from presumed reliability of the physician's statements based on such responses being delivered in a calm, intellectualized manner combined with the physician having a history of admirable academic and/or clinical accomplishments. Previous literature on the quality of forensic psychiatric evaluations has suggested that the work of evaluators – particularly those not forensically trained – is deficient in data sources, extrapolation of the data, and inclusion of detailed support for expert opinions in the evaluation report [33,34].

Goldenson J, et al. [31] recommend that self-reflection, including acknowledging one's emotional reactions to forensic evaluatees, sometimes with the aid of consultation and psychotherapeutic support, may help to reduce bias and enhance the quality of forensic mental health assessment. Other authors [29,32,35] recommend forensic evaluators closely adhere to professional guidelines on conducting fitness for duty evaluations of physicians, such as the American Psychiatric Association Guideline for Psychiatric Fitness for Duty Evaluations of Physicians [35].

These guidelines outline a number of specific steps that forensic evaluators should take in addition to direct interview of the physician evaluatee to inform their fitness-for-duty assessments, including obtaining collateral input from family members, reviewing relevant documents of the event(s) leading to the fitness-for-duty referral, speaking with colleagues or supervisors, and considering psychological and neuropsychological testing where appropriate [35,36].

Within psychological testing, the Minnesota Multiphasic Personality Inventory-Second Edition (MMPI-2) [37] and Personality Assessment Inventory (PAI) [38] can offer information on personality

function, adult psychopathology, and the evaluatee's approach to the assessment (e.g., tendency to under-report symptoms) to complement data obtained from direct interview of the physician, and projective testing such as the Rorschach Inkblot Test can be useful in assessing questions of underlying psychosis [29,39]. Neuropsychological testing may provide more detailed assessment of impaired cognition or abnormal behavior suggesting possible frontal lobe impairment [29]. Of note, during initial fitness-for-duty evaluations of late-career physicians, cognitive screening tools such as the Montreal Cognitive Assessment (MoCA) [40] and the MicroCog Assessment of Cognitive Functioning [41]-the latter being normed on physicians and less prone to practice effects (thus having stronger content validity)-may be useful in determining if more comprehensive neuropsychological testing is indicated [42].

State physician health programs, established in nearly all U.S. states over the last 50 years, are designed to preserve the licensure status of and help physicians impaired by substance use or mental health issues, while protecting the health and safety of the public [43]. Referral to such programs can come from multiple sources, such as the involved physician, family members, colleagues, medical staff leaders, peer review bodies, or licensing boards, with the latter three entities often informed by psychiatric fitness-for-duty consultative evaluations. These programs have been shown to significantly help physicians stay licensed and in practice [43]. Thus, physicians experiencing psychosis theoretically have access to programs that can provide confidential, high-quality, and high-accountability treatment and monitoring, affording a pathway to preserving their medical careers, though outcomes may vary as noted above, and in the author's experience many physician health programs primarily address substance use disorders and non-psychosis-related mental health conditions.

Case Vignettes

The following illustrative case vignettes are not based on any single patient or evaluatee but feature common themes encountered in the author's work either clinically treating or forensically evaluating physicians experiencing psychosis. No identifiable clinical details are used in these vignettes.

Case 1: Insight and Alliance

Dr. N, a 26-year-old first-year resident, was admitted to a psychiatric unit after a peer found him barricaded at home, expressing fears of surveillance and missing work for two days. On admission, Dr. N was pleasant and attributed his behavior to lack of sleep, requesting immediate discharge and denying symptoms. However, records showed prior agitation, disorganized thinking, and paranoia in the ER, which improved with olanzapine; labs were unremarkable. His program director reported months of increasing distractibility, disorganization, and talking to himself at work. Family could not be reached for collateral input. When tactfully informed that available information suggested concerns about his functioning in the last few months, Dr. N initially became angry and accused the inpatient psychiatric resident of colluding with others to illegally confine him. The next day, after receiving a dose of olanzapine for agitation overnight, he was more willing to hear the team's input, though still irate and guarded. The resident discussed her impression that Dr. N was experiencing challenges with clarity of thinking that may reflect a psychosis of unclear etiology, and that the team wished to help him improve this clarity of thinking to facilitate his safe and successful return to work. Dr. N gradually resonated with his thinking being less clear, reviewed antipsychotic options, and expressed concern about side effects. The resident reviewed detailed information about

medication options (including pharmacokinetics and common side effects), and a collaborative decision was made to start aripiprazole. After five days at 15 milligrams daily, Dr. N's symptoms improved, and he was discharged to a partial hospitalization program, with a four-week leave from work recommended to support his transition to outpatient care.

Case 2: Denial and Substance Use

Dr. H, a 33-year-old faculty member, was referred for a psychiatric fitness-for-duty evaluation due to repeated absences from clinic and lack of responsiveness. She was pleasant but anxious during the interview and reported increased depression and anxiety over the last few months after her father's death, along with occasional auditory hallucinations she attributed to stress. Cognitive screening (using the MoCA) revealed impaired concentration and memory. She denied acute safety concerns. She was recommended unfit for duty, accepted an outpatient mental health referral, and was given two weeks off work. At follow-up, Dr. H reported improvement in mood and

anxiety on escitalopram and readiness to return to work; however, she appeared fatigued with bloodshot eyes, which she attributed to recent sleep loss due to traveling out of state to handle her father's estate matters. With her consent, collateral information was obtained from her mother, which revealed recent erratic behavior, poor self-care, and paranoia (e.g., believing that objects in the home had been moved to intimidate her). Urine drug testing was positive for methamphetamine, cannabinoids, and alcohol. Initially denying use, Dr. H eventually admitted to escalating substance use under stress, and agreed to self-report to the physician health program.

Case 3: Systemic Context

Dr. G, a 45-year-old new faculty member, was referred for a psychiatric fitness-for-duty evaluation by his department due to reports of rapid and distractible speech when confronted about his higher-than-peers rate of procedural complications. He described feeling unwelcome in his department since joining 6 months earlier, relocating to expand an innovative medical procedure that he had pioneered at

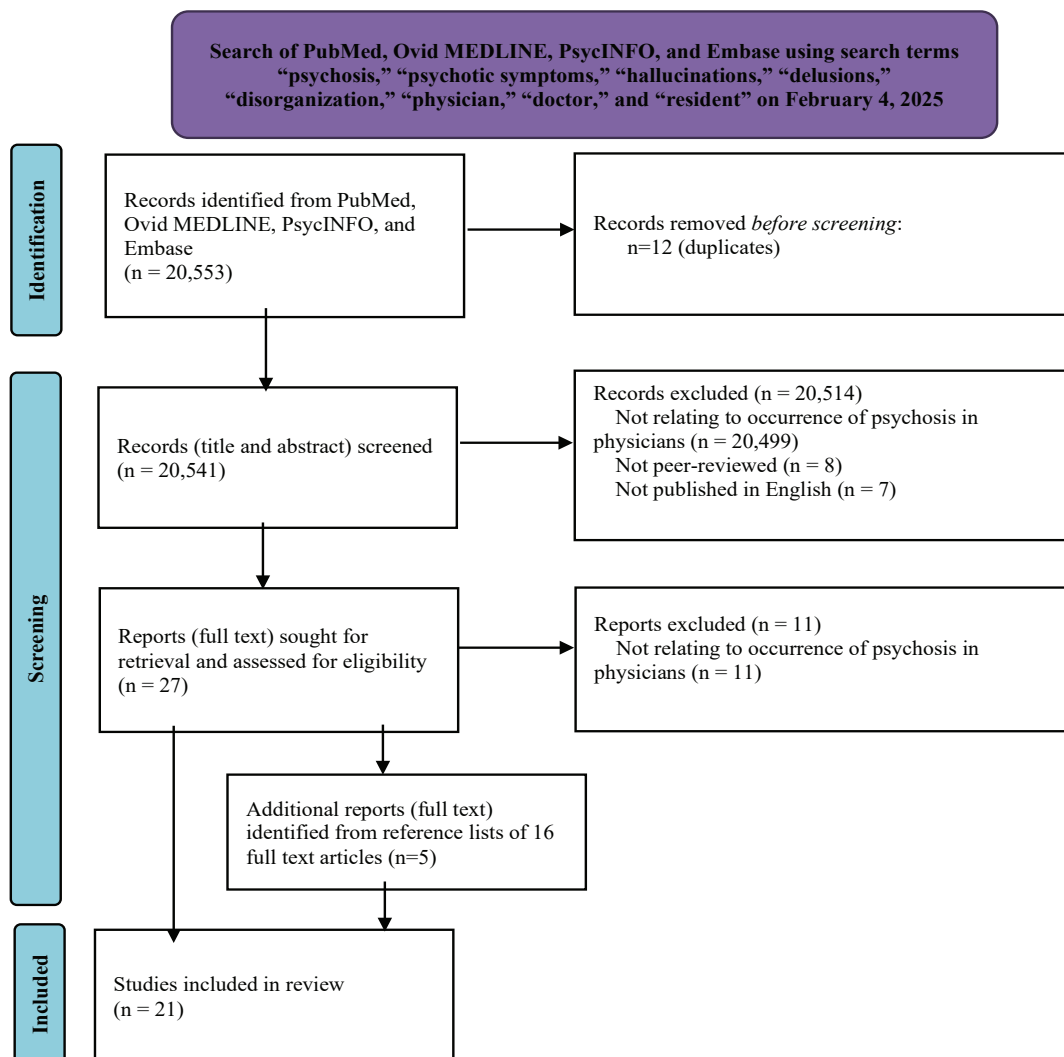


Figure1: PRISMA flowchart for bibliometric analysis of mental practice.

his previous institution. He clarified that he is one of 4 physicians in the U.S. who perform this complex (but life-saving) procedure that none of his peers will perform due to its high risk nature. On interview, he was calm, coherent, and well-groomed, reporting increased anxiety and distress related to workplace tensions (from both an unsupportive work environment and a peer review dragging out for many months) but otherwise noting no psychiatric or substance use problems. Urine drug screen was negative. Cognitive testing showed mild concentration issues; neuropsychological evaluation found minor challenges with complex information processing, but no significant deficits. He was recommended fit for duty, with recommendations for improved departmental communication. Two months later, he was again referred for fitness-for-duty evaluation amid ongoing concerns about communication and a policy violation involving improper computer use. At that time Dr. G reported staying up for many days straight, hearing voices, and inappropriately accessing colleagues' records to send invitations to an educational event he designed to be "the conference of the century." He expressed confusion about his actions in retrospect, and his drug screen remained negative. He agreed to self-refer to the state's physician health program for assessment and treatment of likely stress-induced manic and psychotic symptoms. Evaluator recommendations – in addition to deeming Dr. G currently unfit for duty – included addressing departmental culture, ensuring timely peer review processes, and providing unbiased faculty mentorship to better support Dr. G's integration.

These vignettes illustrate common issues encountered in working with physicians experiencing psychosis, including impaired insight and concern about medication side effects (Case 1), delay in seeking help for symptoms and denial or minimization even when help is available (Case 2), and the important but often overlooked role of unsupportive (and at times antagonistic) work environments (Case 3). All three vignettes also highlight the prudence of seeking collateral information during clinical and forensic assessments.

Limitations of this review include the limited number of studies in the literature focusing on the occurrence of psychosis in physicians; [Figure 1] while this review included such studies, it also featured studies generally addressing mental health conditions in physicians for which psychosis was not the primary focus. Also, the large variety of study designs, settings, populations, geographic locations, sample sizes, and publication dates in this review make it difficult to draw firm conclusions regarding the prevalence, nature, associated treatment and organizational issues, course, and prognosis of physicians experiencing psychosis. Finally, the aforementioned forensic implications of psychosis in physicians are based on the limited clinical and forensic literature to date, with few recent studies identified on forensic mental health assessment of physician evaluatees. Future research should examine forensic mental health evaluators' experience assessing physician evaluatees to identify any cognitive and emotional sources of bias, ascertain the extent to which evaluators adhere to published guidelines on evaluating psychiatric fitness for duty in physicians, and develop strategies to address any gaps in adherence, including updated guidelines for conducting such evaluations.

Conclusion

The occurrence of psychosis in physicians, while less common and less studied compared to other mental health conditions in this population, presents with treatment and organizational issues similar to those encountered when physicians experience other mental health conditions, as well as unique clinical and forensic challenges. Ultimately, the findings of this review suggest that some physicians

experiencing psychosis can recover if given proper treatment and support (which includes anticipating and effectively navigating their unique clinical challenges), while others may need to seek alternate careers due to illness severity. Moving forward, from a policy standpoint, more explicit addressing of psychosis in physician health programs (for example, via connection of physicians - where appropriate - to early psychosis intervention services) may bolster available support and facilitate improved occupational and social outcomes for these individuals. From an educational standpoint, evaluator training on bias management, reflective practice, and guideline-informed approaches should be prioritized to improve the quality of forensic psychiatric assessments of these individuals. Such policy and educational interventions would go a long way toward making less daunting the clinical and forensic implications of psychosis in physicians.

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Data Availability

No datasets were generated or analyzed during the current study.

Competing Interests

The author reports that there are no competing interests to declare.

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