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Case Presentation

“Mr. R” is a 20-year-old man with severe schizophrenia who initially presented, accompanied by his parents, for medication management at the outpatient clinic of an academic medical center (“the Center”) after discharge from an inpatient facility at the Center. Mr. R was interviewed separately from his parents, during which he denied having any mental illness. His chief interest in attending the appointment was “so you can explain to me what my medication does.” He could explain neither his recent psychiatric hospitalization nor his parents’ concern for his well-being.

Mr. R’s illness developed when he was 17 years old. In trials of four antipsychotics, he had either not responded to the medication or been unable to tolerate it. A trial of clozapine had been considered but was never initiated because of concerns about neutropenia while the patient was being treated with olanzapine. The patient’s family reported that he had at least 10 hospitalizations, mainly related to medication nonadherence, before he established care at the Center. During his first hospitalization at the Center, Mr. R was started on treatment with a long-acting injectable antipsychotic.

Mr. R reported getting along well with his parents and his several younger siblings. He had graduated from a competitive high school and, according to his mother, won a prestigious scholarship to attend college. He was active in both athletic and artistic endeavors.

Mental Status Examination

Mr. R is a thin, energetic-appearing young man. He was casually dressed in a bright green and yellow T-shirt and white jeans and wore a metallic necklace. His thought process varied from overly abstract to overly concrete. The patient was suspicious about the resident’s intentions in prescribing medication but denied ideas of reference and auditory or visual hallucinations. His affect was blunted, and he denied suicidal ideation. However, he responded in bizarre ways to some questions. For example, when asked about peer relationships, he said, “It’s just trailer trash to me.” He also expressed a desire to convert to another religion and undergo circumcision.

Course

At Mr. R’s intake appointment, his mother explicitly acknowledged his diagnosis of schizophrenia and was particularly troubled by his delusions and disorganization of thought. Hence, she agreed that treating him with antipsychotic medication was necessary. She brought him to subsequent outpatient visits at the Center, which included injections of the depot antipsychotic. She engaged actively in discussion with the treating resident and the attending psychiatrist about the management of her son’s illness and seemed pleased with his care.

Much to the treatment team’s surprise, within a week of Mr. R’s first outpatient appointment, Mrs. R had begun posting disparaging comments on various web sites about the quality of her son’s care, specifically naming the treating resident. The comments described the treating resident as well as other members of the treatment team in derogatory terms. In addition, Mrs. R made comments that were vehemently antipsychiatry, including a statement that psychiatrists collude with pharmaceutical companies to generate profit rather than treat illness. She posted multiple comments in the days following certain clinic visits; the comments could be found easily by anyone who did a Google search using the treating resident’s name. The comments initially appeared on both a personal blog and a highly popular web site, later cropping up also on web sites that serve as general forums for consumer dissatisfaction and on news outlets as user-generated content.

When the resident learned of these comments, he was surprised by the contrast between the dissatisfaction they conveyed and the agreeable, collaborative attitude Mrs. R had presented in person. The resident could easily imagine how her feelings might complicate or even hinder Mr. R’s treatment, leading the resident to feel annoyed and disappointed in the mother’s inability to express her disagreement directly and constructively. In addition, he perceived an implicit personal attack in her comments’ negative content and hostile tone. He felt this criticism was undeserved. Unsure of how best to address the situation, or whether he should address it at all, the resident notified the attending psychiatrist. Their deliberations expanded to include other clinic attendings, the outpatient clinic chief, the medical director of the psychiatric institution, and representatives from the Center’s legal and risk management departments.

Two main concerns arose from the ensuing dialogue. Foremost was the potential for the mother’s online comments to undermine Mr. R’s care. For example, awareness of his mother’s comments could exacerbate Mr. R’s paranoia, leading to a disruption in his trusting relationship with the resident and a possible interference with his adherence to treatment. Moreover, the tone of the mother’s comments suggested a fundamental disagreement with the treatment team’s approach to her son’s care, one that could potentially lead to an impasse. In the absence of a satisfactory working relationship with Mr. R’s mother, the team would need to consider discharging him with a referral to another provider. Were they to do so, however, apart from feeling disappointed...
at not being able to continue providing Mr. R’s care, the
team would risk appearing either to be punishing him
for his mother’s actions or abandoning him for no clear
reason. Either interpretation might fuel the paranoid
perceptions he had regarding mental health care pro-
viders.

The second concern was that the mother’s comments
could damage the reputation of the treating resident.
The resident initially did not think to be worried about
his reputation, since he felt confident that he was well
regarded by those who knew him and had observed his
work with patients. Once this concern was raised, how-
ever, the resident thought of the potential impact the
mother’s public comments might have if he sought em-
ployment or further training outside his current institu-
tion. Given the fact that there is only limited public com-
mentary concerning residents, a few negative Internet
postings might adversely affect the opinions of poten-
tial patients, peers, or employers. Hence, the situation
presented a quandary regarding how to respond to the
comments posted online by Mr. R’s mother while trying
to avoid both potential harm to the patient and poten-
tial harm to the resident.

After deliberation, the team concluded that the best
course of action was to address the mother’s concerns
directly in a neutral, inquiring manner. To continue
treatment without mentioning the postings, the team
believed, would ignore an opportunity to explore a clear
signal of trouble in the patient-resident relationship. Ac-
cordingly, the resident invited Mr. R’s mother—as well as
his father, who previously had not interacted with the
treatment team—to meet with the attending psychia-
trist and him to attempt to develop mutually acceptable
treatment goals and methods.

The attending psychiatrist led the family meeting. He
emphasized to the parents the importance of working
collaboratively with the team to help Mr. R, and he re-
viewed the treatment plan, which included completing
the trial of the long-acting antipsychotic agent and then
considering treatment with clozapine. The parents ex-
pressed no disagreement. The attending then raised the
team’s concerns about the mother’s Internet postings
and expressed the team’s desire to hear directly about
her dissatisfaction. Mrs. R rejected the suggestion that
her comments were critical; in her view, they were state-
ments of fact and could not reasonably be perceived
as offensive. She also expressed disbelief that her com-
ments could undermine the efforts or injure the feelings
of experienced mental health professionals. The attend-
ing psychiatrist then offered to refer Mr. R to another
provider if she were to continue to express her dissatis-
faction publicly in such stark terms. In response, she
became enraged. She interpreted the offer to refer Mr.
R as an attempt to coerce her to refrain from posting on
the Internet. Within minutes she stormed out, bringing
the meeting to an abrupt end. Mr. R’s father said nothing
and left with her.

In the aftermath of the meeting, the resident noticed
other reactions to the situation within himself. He felt
some degree of resentment toward Mrs. R because she
rejected an attempt to engage in open, rational dialogue,
which had been offered by a respected senior attending
psychiatrist in as compassionate a manner as possible.
More than resentment, though, the resident felt sadness
for Mrs. R, as he had the impression that she had some
psychopathology herself—possibly cluster A personal-
ity traits in light of her son’s diagnosis. The resident felt
disappointment that although the mother needed treat-
ment as much as her son did, she was unlikely to receive
it because of the rigidity of her views and her lack of
openness to dialogue with the clinicians at the Center.

Arrangements were made to transfer Mr. R’s care to a
psychiatrist at another institution.

Discussion

When I was asked to consult on this case, I felt a good
deal of empathy for the resident. Here he was, delivering
good psychiatric care to a young man with severe illness,
but receiving criticism rather than appreciation from the
family. I recognized that there is now a public exposure in-
herent in psychiatric practice that can be daunting even
to experienced clinicians but may be especially painful to
vulnerable residents who are striving to become compe-
tent psychiatrists. Those of us involved in training hope to
protect our residents from the most difficult clinical situ-
ations, but there is little we can do to foresee these kinds
of developments.

The cyberspace revolution in the past two decades has
presented a new set of problems for psychiatric practice
(1). This clinical example illustrates some of the complex
challenges that psychiatric residents and faculty in an
academic medical center are encountering in the Internet
era. Both clinical and ethical/legal challenges are raised
by this case, but there is little in the way of consensual policy
within or across institutions on how to respond to such
challenges. To a large extent, academic centers are im-
provising as these situations arise. In this case, a veritable
ad hoc committee, including the medical director of the
institution, the director of outpatient services, assorted
attendings, and a legal/risk management team, was as-
sembled to brainstorm about the optimal response to the
dilemmas presented by Mr. R’s mother’s postings on the
web.

Two decades ago, Mrs. R’s negative feelings would most
likely have remained hidden from view. Mrs. R would not
have had access to web sites that were in the public do-
main, so her criticisms of the resident and treatment team
would not have come to the attention of those who treated
her son. She would have been cooperative and polite with
the resident at the Center, and her negative feelings about
the clinicians would have been voiced out of their earshot,
outside the facility.

But today we live in a different era. The advent of the
web has allowed for the dissemination of useful psycho-
educational information on diagnosis and treatment and
participation in support group discussions that transcend
geographical location, socioeconomic categories, and
educational background. However, these same sites have
become public forums used by both patients and families
to ventilate about the treatments they are receiving and
the clinicians who are administering those treatments.

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CLINICAL CASE CONFERENCE
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have had positive experiences in treatment to come to their defense with positive postings. Some clinicians have been tempted to ask other patients to provide a countervailing opinion. Other clinicians have even posted vehement defenses of their own skills and professionalism by posting under a pseudonym. Some criticisms, of course, are well warranted. We can all see the potential for these sites to do a public service by warning potential patients to stay clear of a professional who is providing inept treatment. On the other hand, we all know of patients who are outraged when a physician sets entirely appropriate limits on a patient who is seeking controlled substances, for example, or special treatment that is unreasonable, from the physician (1).

The resident treating Mr. R was concerned about the effect these postings about him might have on his future employment and his applications for further training. It has become routine in some places for potential employers or those working on admission committees in educational settings to do Internet searches on applicants. Unfortunately, those who are considering hiring a potential employee or accepting an applicant have no way of determining the truth of what they read on the web. Similarly, prospective patients frequently Google the professionals they are planning to call for treatment to investigate their reputations. Material that turns up on a search, often unknown to the prospective clinician, may prevent a patient from calling that clinician.

What can we do as a profession in the face of these challenges? The proliferation of Facebook, Internet forums, Twitter, blogs, and chat rooms is a juggernaut that cannot be stopped. We must live with these new intrusions into our professional lives and develop creative solutions. Institutions can develop policies so that ad hoc groups do not have to be assembled whenever delicate situations with potential liability arise. Psychiatrists and other mental health professionals can do periodic Internet searches of themselves to keep abreast of any personal or professional information about them that may have implications for their reputation. In some cases, web site administrators may be contacted who will remove what is posted. Those who use social networking sites like Facebook should probably use all available privacy settings so that personal information about them is not available to the public. The education of psychiatric residents and other mental health professionals should include discussions of common challenges that occur in the Internet era so that clinicians have some preparation for dealing with them when they emerge. Finally, guidelines regarding how to continue the treatment and how to respond to the attacks should be developed. Academic psychiatry has a long tradition of establishing protocols to deal constructively with difficult events in the trainee’s life, such as patient suicide or assault. Similar forms of support and assistance can be brought to bear to assist with challenges stemming from the Internet.

References