Acute Illness in the Active Psychotherapist: A Review of Early Errors

10 Sep, 2008

Obsessive Ruminations #3

(Dr. Alan Karbelnig, who somehow slipped into his 50s and lost much decorum in the process, writes this regular column to provoke reaction from his SGVPA colleagues. Bolstered by Soren Kirkegaard's lament that "ours is a paltry age because it lacks passion," Alan strives to offer ideas to stimulate thought. Having been a member of SGVPA since 1988, Alan served as president in the early 1990s; he has chaired the SGVPA Ethics Committee for the last 14 years. He is a Training and Supervising psychoanalyst at the New Center for Psychoanalysis and the Newport Psychoanalytic Institute. He practices psychoanalytic psychotherapy and forensic psychology in South Pasadena.)

Having visited hell early this summer, I return to terra firma with many tales to tell. I could write of the incredible devotion and bravery of my wife and two daughters, of the blessings and curses of our health care system, of the real experience of post-traumatic stress disorder, or even of the incredible meals that we've been served here at my home thanks to the generosity of all of you SGVPA members. But I choose to fill this first Obsessive Rumination since my illness with a brief description of what occurred, and then a review of the clinical and ethical errors***[1]*** I made when I was suddenly hospitalized.

Before reading further, please imagine this scenario: You abruptly have about five pain-and-terror-filled minutes to close up your practice for six weeks or more. What would you do? Who would you call for help? How would you achieve this while maintaining patient confidentiality, preserving your therapeutic relationships, and attending to your own urgent needs? And more importantly, how could you avoid this problem in the first place?

Avoiding Denial and Disavowal

In retrospect, I believe I was ill as early as late April 2008, but was denying the intensity of my discomfort. I believe that I showed signs of endocarditis that early. Endocarditis is an inflammation of the heart resulting from a bacterial infection of the blood – in my case bacteria of oral origin, from flossing, or from biting my lip, or some such. I usually don't see a physician until I'm really symptomatic (a form of avoidance and disavowal from which I've now completely recovered). I delayed consulting my internist, Claire Tilem, MD, until 10 days into severely painful GI symptoms I had after attending a wedding in Jamaica. I assumed I had the "touristas." Dr. Tilem gently admonished me for waiting so long, and prescribed an antibiotic. I failed to tell her then that I was also having night sweats, and was generally not feeling quite right. Towards the end of May, I began experiencing excruciating back pain. I assumed I'd pulled a muscle during my usual weekend gardening. Muscle relaxants and physical therapy did not help, and my sense of feeling generally tired and worn-out gradually increased in intensity.

On Tuesday, June 10, 2008, I went for a spinal x-ray series and immediately afterwards, without an appointment, consulted Dr. Tilem again. This time I shared more of the symptoms with her. She ordered

more extensive blood tests. Within 24 hours, I received a rather frantic call from her indicating that my hemoglobin (red blood cell) count was dropping. That meant that I was likely bleeding internally, or worse. I first began to feel frightened then. Dr. Tilem called her friend, an infectious disease specialist, Kim Shriner, MD, and together they put together that the symptom-complex could indicate endocarditis. I first met with Dr. Shriner on Friday, June 13 when she ordered a blood culture test and an echo-cardiogram. I had my second appointment with Dr. Shriner on Tuesday, June 17, 2008, at 1pm.

Now we meet denial, disavowal, and even rationalization because I was convinced by the time I saw her that second time that she'd tell me I was fine. I had decided that the blood loss was likely from the two weeks of GI symptoms. I anticipated that Dr. Shriner would tell me I needed an intramuscular injection from an orthopedist to alleviate my back pain. I was so confident, in fact, that I had a whole afternoon scheduled in my own office starting at 1:45pm that same day. As soon as I sat down in her office, she said straight out that I had to cancel the imminent family trip that I'd planned for a year, that I needed to go into Huntington Hospital immediately, and that I could be helped but I was really sick with endocarditis. I'd never really had any serious illness, and have not been in the hospital since I was age 12 and had an appendectomy. I just couldn't believe it.

While I will not run to doctors with every little sniffle, I sure as hell will go running whenever I have anything more significant. I am still left wondering if I could have avoided open heart surgery had I sought more intensive medical evaluation in late April. Here's a quick version of the rest of the story: 20 hellish days in HMH, daily immersion in IV antibiotics, more than a week of heavy narcotics to reduce the unbelievable pain in the back (that was actually caused by a bacterial infection in two inter-vertebral discs), and then the real slammer: Open heart surgery to repair a small cardiac aneurism and to replace my aortic cardiac valve – both problems caused by the bacterial infection. By the time I was discharged I weighed 134 lbs, about what I did in middle school.

Patient Calls in Altered States

As professional psychologists, we have a responsibility to the persons who consult us. But we must always be balancing that with care for ourselves. I lost that balance, at least for the first few days. I was literally in tears from fear and back pain as I drove the two small blocks to Huntington from the MD's office. Nonetheless, I began speed dialing the numbers of the patients I had scheduled for that day. I don't remember some of these phone calls, likely due to the intense pain, which is worrisome. I learned later that I failed to complete a call with one woman who was to meet with me later that afternoon. I cut her off quickly because my wife was calling me, and I never returned her call. It wasn't until a week later that she learned more reassuring details of my condition. Luckily, my wife Amy had met me at the hospital's admitting department. By then, the pain was simply too great for me to function. I gave her some patient phone numbers, and also gave some to my psychological assistant, Matthew Cantrell, MA.

I was started on Morphine within minutes of my admission, and that became another problem. Once the pain receded, I insisted on making as many patient calls, personally, as I could. The difficulties here should be obvious, but I want to add one point emphasized by Amy: You do not always feel mentally altered even though you are. I thought I was lucid a few days later when I was literally hallucinating. Somehow, over the course of the first few days of my hospitalization, all of my patients were advised of

my condition and its positive prognosis. But, in retrospect, this process was haphazard. I should have had a much better plan.

In Praise of Dr. Linda Bortell

Part of any plan is having someone close to you – a fellow professional – in whom you deeply trust. I knew Linda's professional accomplishments well – CPA Board Member, LACPA president, SGVPA president, etc, but did not personally experience the incredible extent and depth of Linda's competence until she was abruptly thrust into this helping role. I cannot possibly put words to my appreciation for Linda's efforts. Sometime early that first afternoon – maybe while I was still driving – I called her and advised her of the situation. She responded immediately, and amazingly. My only complaint: She did get somewhat nasty with me at times, but only when I really deserved it, like, for example, when I wanted to keep calling and rescheduling my patients even while on Morphine, Methodone, Dilaudid, and more. She'd get that demanding tone of voice, and then talk to my wife, and I'd be rendered powerless. A few days into the hospitalization, Amy actually wrenched my cell phone from me as I tried to send a text message to a patient, fomenting one of the only violent episodes of my life. I threw a water pitcher at her. How 21st century, huh?

Again, in the middle of Linda's own busy day, she started pursuing all the proper issues, in the correct order, and so much more. I never gave her my voice mail code, but she was, of course, completely on track nonetheless. She began covering for me; several fairly needy patients began consulting her. She pinch-hit for some supervision of psychological assistants. She cooked me several amazing meals and was one of the SGVPA members responsible for spoiling me with so much food. She visited me many times. She took daily notes of her interventions regarding my practice, and gave them to me to review later, when I could think. Linda Bortell is one amazing human being and professional psychologist.

The Limits of Panicky Voice Mail Greetings

At some point – I no longer remember when – I recorded an outgoing voice mail message saying something like: "This is Dr. K, I'll be away due to a medical emergency causing me to be absent from my office the rest of July. I will not be returning messages. If this is urgent, please call Dr. B, etc." Within 24 hours, Linda called me on my cell and told me, in my doped-up state, that my message was "scaring the shit out of your patients." That's an exact quote. I listened to it and found that it scared me to listen to that message! I wrote out a script and had my youngest daughter Natalie help me to record it. She was cracking up because I couldn't follow the script. I kept improvising sections, part out of creativity (I think) and part out of intoxication from the pain medications. If this ever happens to you, please let a colleague or even a family member or friend record your message. Let them script it as well, particularly if you are really ill, on major narcotics, or any other such nasty combination.

Make Sure to have a Clear Record of Your Patients and How to Reach Them

It was actually only a few days ago that Amy recounted Linda, Matt and her efforts to figure out my schedule so they could call people and cancel upcoming appointments. I use "Therapist Helper" software, and all of this information is recorded there, but I have no way to access that when away from my office. I keep my schedule on my cell phone, but all patient names are unidentifiable, i.e. Jill E on Fridays at 2pm – nicely HIPAA-esq. I also still use a Daytimer to track appointments, particularly because there are

always changes of some form every week. Amy tried to read these entries, but could hardly make out any names. I vaguely remember listing out the appointments in the ensuing week or two. Linda put a note in the waiting room advising the persons there that I was on medical leave through July. Luckily, only three or four people showed up during the entire time so the various means of contacting them worked fairly well. Matt, Amy, and Linda were eventually able to contact all of my active patients by telephone, but even this took several days, and again was somewhat sloppy in form.

The Risks of Written Communication

Sometime by the end of the first week, I wrote a letter advising all of those in my practice of my medical leave. I put much thought into it – or so I believed – and mostly wanted to get as much information onto one page as I could. I included the names of the two primary MDs taking care of me, the main conditions, and the fact that the prognosis was so positive. Being a psychoanalyst, I am well aware of the controversy surrounding such a degree of self-disclosure. More conservative therapists might have just indicated that they were away due to a family emergency. That is not my style. But as Linda and several others pointed out to me, I was also really not in good enough shape to write that letter. It contained more information (like the names of the doctors) and too many details of the three illnesses that I had (endocarditis, diskitis, and cardiac damage requiring surgical repair). You, like me, like offering help: That's what we've molded our careers around. Sometimes you have to know when you need it yourself, and how to surrender yourself to it.

Enough for Now

Writing this has served many purposes: Sharing my experience, seeking to be helpful, and perhaps venting some of my considerable residual anxiety, hopefully without projecting excessive fear into you! I hate to end on such a cliché note, but only the usual aphorisms come to mind: This is a precious life so make sure your work is only part of it; since our work involves such an immense degree of responsibility, please make preparations for what you should of course hope will never happen to you. That includes not only plans, but a close connection with someone who can step in and help, quickly and professionally. And finally, remember that I felt, like you almost certainly feel, that "this will never happen to me." I am looking forward to the return of that shield of denial, but can assure you that I will have a new plan in place when it does.

NOTE:

1. Since this article is certain to be presented to me by opposing counsel next time I'm involved in a forensic case, let me note from the onset that none of these errors would rise to the level of an extreme departure from the standard of care nor would they even remotely form the basis for a malpractice lawsuit. I do not believe I was ever truly negligent nor do I have any indication that those that consult me were actually harmed by these "errors."