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When the Patients Puts YOU in Check:
Navigating the Grey Area of Mental Illness in Healthcare

Mental health has become one of the leading causes of disability in the United States. It is estimated that 1 in 4 Americans had a mental health disorder in the past year, most commonly anxiety or depression.[i] Now, during the COVID-19 pandemic, our mental health has been tested even more. Mental illness has been shown to be closely linked to conditions like hypertension, diabetes, cancer, and other chronic diseases.[ii] Although optometrists treat and manage solely ocular conditions, we must take into consideration the patient as a whole person.

In my first month of residency, a 53-year-old white male was added to our medical eye clinic as an "urgent care" complaining of eye pain and irritation. His previous records showed multiple visits with our Dry Eye Clinic dating back to January 2019, and his medical history included prior antidepressant use, recurrent skin lesions on his face and neck, and high blood pressure. Immediately after we walked back to the exam room, he rustled through his backpack and pulled an assortment of things from his bag, including a thick notepad and Ziploc bag filled with miscellaneous eye sprays and over-the-counter artificial tears, all previously unsuccessful at relieving his symptoms. His first question was to ask my name, to which he wrote and drew a dark line underneath before taking attentive notes throughout the exam.

I asked questions regarding his pain, the duration, context, positive symptoms, negative symptoms, etc. He proceeded to pull out the items from his Ziploc bag one by one and explained when and how he'd been using all of these drops, eyelid sprays, and warm compresses with little improvement in symptoms. He was extremely anxious and uncomfortable throughout the whole case history. His incoming acuities were 20/20 in both eyes. Upon examination, his eyes were white, quiet, had no corneal fluorescein staining, and had adequate meibomian gland expression on palpation with just a few capped glands. The non-mydriatic 90D examination was unremarkable. His Schirmer test results were 3mm OU, suggesting aqueous-deficient dry eye, which has never been documented previously. After discussing my findings with him, I dispensed a 30-day sample supply of Restasis, told him to continue his current dry eye regimen, and we could follow up in 1 month.

Two weeks later, while I was on-call, he called our emergency line and I immediately recognized the name. He reported "severe eye pain" that had been keeping him up for the past three nights. The only things that helped were Melatonin and Ativan, but even then, he only slept for about 30 minutes the night before. He seemed extremely distressed on the phone and said that he was almost ready to "check himself into a mental health facility". While I was on the phone, I asked myself many questions, wondering if I had accidentally missed something serious during his initial exam. What could possibly cause such severe eye pain that the patient is unable to sleep through the night? But after further questioning, it really just seemed like his eyes were dry. He denied any photophobia, decrease in vision, or eye redness. He just described it as extreme grittiness and dryness that had been causing him extreme distress. After reassuring him that it was not an ocular emergency, I encouraged him to get a good night's rest and we could meet the next morning.

He arrived with his notepad and Ziploc bag in hand. Once again, his incoming acuities were 20/20 in both eyes, his eyes were white and quiet, his corneas were clear, and his posterior segment was unremarkable. At this point, I felt like I'd exhausted all my options. I knew he wanted an answer, but I couldn't attribute any ocular signs to his severe symptoms. After lengthy discussion and constant reassurance that his eyes are healthy, I suggested that instead of exploring the idea that the dryness was the reason for lack of sleep, that he should contact his primary care physician to consider medication for insomnia or anxiety. That conversation did not go well. He called me dismissive and pointed out that I was downplaying his symptoms. He called me out on *exactly* what I was thinking in my head: that his eyes were not dry at all, but instead that he had some obsessive-compulsive tendencies, or that underlying anxiety, stress, or depression could be the cause for his insomnia. I felt terrible about these assumptions.

Mental illness-related stigma in healthcare has been proven to create barriers to access and care to many patients. Patients with mental illness commonly report feeling "devalued, dismissed, and dehumanized" by health professionals.[iii] On the contrary, health care providers have rated patients with mental illness to be "demanding, manipulative, and less deserving of care".[iv] Studies show that people with serious mental illnesses experience a higher rate of health conditions and die on average 15-30 years younger than other people their age.[v] Patients with mental illness are *less likely* to be referred for specialty testing (i.e. hospitalization,

mammography, cardiac catheterization) and significantly *less likely* to be admitted to the hospital compared with people with no mental illness.[vi]

Studies have also shown that health care providers are guilty of having "implicit biases", being the "unconscious collection of stereotypes and attitudes that we develop toward certain groups of people, which can affect our patient relationships and care decisions."[vii] For example, one study demonstrated physicians were less certain of the diagnosis of coronary heart disease for middle-aged women, who were then twice as likely to receive a mental health diagnosis than their male counterparts.[viii] Another study took a survey of medical residents' attitudes towards patients with and without a label of "psychiatric illness" and their willingness to treat this person. Residents who were told their patient had a "psychiatric illness" were less likely to want to treat the individual and be involved with them in various ways.[ix] While characteristics such as age, gender, race, and prior medical history are necessary to paint a patient's history, they should not alter the kind of care a patient receives.

"Diagnostic overshadowing" is a process by which physical symptoms are misattributed to mental illness.[x] I found myself participating in this concept, assuming that my patient's symptoms were less than what they could be and that his mental health was the main contributor to his insomnia. Although it is often unintentional, discrimination remains a major hurdle to quality care, treatment, and recovery. Not only in cases of mental illness, but discrimination against others from different race, ethnicity, religion, sexuality, socioeconomic class, or other identifying factors. I started to take a step back and asked myself how I could be failing my patient and displaying my implicit bias against mental health.

I felt that I owed something to my patient, so I researched other potential causes for my patient's ocular condition. I began reading case-study articles, discussing with my mentors, and asking ophthalmologists for their opinions on this case. My attending printed out a paper published in 2017 by Dieckmann et al. studying patients with "neuropathic corneal pain". The condition exactly mimics the signs and symptoms of my patient, a pain that is out-of-proportion to a patient's signs. After reading more about this condition, I regretted brushing off my patient's ailments as symptoms of anxiety. I felt guilty about it. I still do.

He came back to the office for another follow-up appointment, signs and symptoms unchanged. This time, I had a different attitude. I excitedly presented him with some new possible causes for his symptoms and explained that there could be an alternative solution to his

pain. I proposed the Proctor Group Foundation, an interdisciplinary team of ophthalmologists that are specialized in investigating rare, atypical ocular diseases. He was ecstatic at the idea: it validated his feelings, and he finally felt a sense of hope and direction. He shared his past frustrations with doctors that were unable to give him answers to his questions, and instead cycled him through temporary symptom relief and a refusal to investigate further. This was the first time in years that he felt listened to.

It takes mental effort to unlearn the implicit bias, to make it a habit, to build discipline, and to be more inclusive. Many of us will go through continuing education, diversity and inclusion training, sexual harassment training, and more, but are we putting in the mental effort to consciously dismiss stereotypes and eliminate preconceived assumptions about others? As doctors, it is our duty to deliver impartial care to all and we should be aware of any negative associations that are linked to a particular group. We must ask ourselves these questions when you find yourself in these gray areas: "Am I taking any shortcuts? Jumping to any conclusions? Have I done the research to familiarize myself with this specific group of people?" No one of us can solve this problem, but all of us can be part of the solution with conscious and active mental effort.

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