PERSPECTIVE

More Than a Feeling

Jennifer B. Plotkin, MD[1,2]

[1]VA Greater Los Angeles Healthcare System, Los Angeles, CA, USA; [2]Department of Medicine, David Geffen School of Medicine at University of California, Los Angeles, CA, USA

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She was driving when the familiar feeling hit her: crushing chest pain, dizziness, sweating, a certainty that she was going to die. The last time she felt this way, it was a panic attack. The time before, a heart attack. She drove straight to our emergency department to answer the question: was it her heart or her brain?

So began the classic chest pain workup. The overnight intern weaved the story and the data. The electrocardiogram held steady. Blood draw after blood draw showed no signs of a damaged heart. She was symptom-free by morning. We concluded that it was her brain and not her heart. We could finish her discharge paperwork and send her home within the hour.

I scanned her medication list over the shoulder of my junior resident. As a third year medical student, not many medications caught my eye, but this one did: "Venlafaxine: 37.5 mg." Now, I started to sweat in anticipation. I knew I was going to have to say something. I rehearsed in my head, turning over my words, scrutinizing my testimony for any admission of guilt. I didn't want to let on that I knew more than I should.

> "I saw that she's on the minimum starting dose of venlafaxine," I said, carefully, "I think it's basically a placebo at that dose. Should we consider increasing the dose before she leaves?"
> "That's an outpatient problem," replied my attending, without missing a beat. "Her primary care doctor can handle it."

Not her heart, not our problem, he seemed to say.

The team moved on. I couldn't.

For me, 37.5 mg of venlafaxine only made me fidget. It wasn't until I hit 112.5 mg that I started to feel better. Today, I find myself on 150 mg, a boost that became necessary in the aftermath of the COVID-19 pandemic.

I was one of the lucky ones struggling with mental illness. I was sick, but not sick enough to feel hopeless. I knew I would get better. My death wishes remained passive. I had strong social support. I was able to continue school. My father is a psychiatrist, and I grew up in a home where mental illnesses were spoken of with the same weight as any other illness. I knew the scary thoughts in my head were symptoms. A broken bone creates throbbing pain; my broken brain created psychological pain.

Most importantly, I had the right diagnosis and the right medication.

I had a disease. I had symptoms of a disease. It was treated, and it was treated seriously, like any other potentially lethal illness. Over months, I started to feel less and less like a prisoner in my own mind.

I often imagine a similar patient care scenario with an entirely different outcome. If she had come in with burning chest pain, the diagnostic question heartburn or heart attack, this woman would not have left the hospital without medication to control her acid reflux. Because she had a psychiatric diagnosis, she left undertreated. We did not give her the medication she needed to treat her chest pain, despite it requiring an overnight hospitalization.

And she's not the only one. Many doctors prescribe their patients antidepressants without increasing the dose enough to see an effect, as much as 46% in the outpatient setting.[1] Now here we were, part of the problem in the inpatient setting.

I've seen physicians misunderstand major depressive disorder as a natural emotional response to a difficult situation. "Well of course this patient is depressed," they say, "I would be too if I was in his situation." When a person's brain tells them that they are less than, makes them feel at fault for challenging circumstances beyond their control, and urges them to take their own life, it is anything but natural; it is pathologic. And it needs treatment.

The toll of unchecked mental illness is perhaps clearest with suicide. Suicide was the 11th leading cause of death in the United States in 2018-2021, claiming over 48,000 lives.[2] And the death rate from suicide is only increasing, nearly yearly from 1999 to 2018.[3] This is despite depression being a highly treatable illness with numerous effective therapies. We are doing worse, not better, in the fight against mental illness.

We need to do better, and we can. We can start by recognizing and reexamining our own stigma. Brave voices from within our healthcare community are sharing their stories and doing just that.[4–7] We read their stories, we put

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ourselves in their shoes, and we imagine- or, for many of us, we remember- what it's like to suffer from mental illness. And hopefully, we apply that empathy and understanding when our patients come to us for help.

A sick mind is just as dangerous as a sick heart. Mental illnesses are medical illnesses. We, as providers, should treat them as such.

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Corresponding Author: *Jennifer B. Plotkin, MD; , VA Greater Los Angeles Healthcare System, Los Angeles, CA, USA (e-mail: Jennifer.plotkin@va.gov jplotkin@mednet.ucla.edu).*

Data Availability *The referenced data are public domain via the Centers for Disease Control (CDC). Information can be accessed through the Wonder database at https://wonder.cdc.gov/controller/saved/D158/D321F126 and is referenced in Hedegaard et al.*[3]

Declarations

Conflict of Interest *The author has no conflicts of interest.*

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