When a doctor becomes a patient, the unique expectations and behaviours in a disease: preliminary report

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ABSTRACT

Descriptions and interpretations of cases in which a doctor becomes a patient are rather marginal in the Polish and Western medical literature. Still, analysis of doctors' behaviours when they become patients themselves seems interesting. The available research results suggest that doctors find it difficult to adopt the role of a patient and very often delay the process of diagnosis and therapy. A substantial number of them treat themselves and have problems with following therapeutic advice. There are particular features which make doctors demanding or even tough when placed in the role of a patient. Doctors often select 'partners' in therapy among their colleagues, expect 'individual therapy' and 'special' treatment (a longer appointment, consultation after regular working hours etc.). The problem of 'doctors in sickness' has been addressed by professional organisations. The British General Medical Council suggests that due to potential risk for one's patients' and one's own health, an ill doctor should consult his/her highly qualified colleague and follow the advice. Moreover, he/she is advised to consult a GP who is not a member of their family in order to guarantee independent and objective medical care. Similar solutions have been adopted by medical organisations from other countries.

Key words: 'a doctor as a patient', disease

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INTRODUCTION

Available descriptions and analyses of the doctor-patient relationship stress the fact that particular elements of doctors' social role grant him/her a dominant position due to the fact that they are related to saving life and restoring good health. The uniqueness of tasks which a doctor is expected to perform in a reliable and effective way makes this job a profession of public trust, and, as a result, place it high in the hierarchy in terms of prestige. This, in turn, leads to considerably increased autonomy and more rights in comparison with other professions. All these job-specific features influence the doctor-patient interaction and make the social relationship between the two asymmetric. The doctor 'represents' authority, control and domination, may ignore patient's opinions 'for his own sake', and limit patient's autonomy in certain situations 'for the sake of the therapy'. Many patients are more or less aware of the fact that therapy is a kind of a forced situation in which giving up some of one's rights unforced is a price one has to pay for a chance of being cured [1,2].

Descriptions and interpretations of cases of a 'reversed relationship' in which a doctor becomes a patient are rather peripheral in the Polish and Western medical literature. Still, analysis of doctors' behaviours when they become patients themselves seems interesting. On the one hand, it should be taken for granted that an ill doctor should be subject to particular regulations, just like all the other patients. On the other hand, one cannot ignore the fact that as a patient, a doctor will always use his/her professional knowledge, experience, relationships and own position.

Knowledge about doctors' functioning in the role of a patient is gained from articles in medical magazines and journals, books, blog posts, diaries, memoirs and short narratives written by those who happened to see 'the other side of a therapy'. Being subject to therapy made doctors realize that they are no different to their patients (mortal, helpless and alone when in a disease), and that other doctors rarely understand it. Therefore, the literature listed above plays numerous roles: apparently it helps doctors interpret what they have experienced as patients, but also share their knowledge with their colleagues (education, urge to improve the quality of medical care).

An attempt to research doctors' behaviour when put in the role of patients was made in Poland as well. A questionnaire of 20 questions was published in *The Medical Bulletin of the Medical Chamber of Warmia and Mazury Region in Olsztyn* (*Biuletyn Lekarski Okręgowej Warmińsko - Mazurskiej Izby Lekarskiej w Olsztynie*), *Rok XXI, 2010* booklet, *issue no. 113*, pages 15-16. Readers were asked to complete the questionnaire and send it back. Although the bulletin was published online and the printed version was also sent to home addresses of over 3100 doctors, only 3 (!) completed questionnaires were received.

The aim of this work is to analyse selected publications concerning the functioning of a 'doctor as a patient' and written by authors from both Poland and other countries. The publications selected to discuss the problem include articles available in English databases as well as materials available in Polish.

The present state of research and an attempt to interpret it

It has been stressed that education, social status, perception, interpretation and assessment of symptoms are of particular importance in the process of becoming a patient [3]. Therefore, it can be assumed that the fact that doctors have professional knowledge changes their way of identifying and classifying disease symptoms (as either severe or mild), and, consequently, applying particular coping strategies.

Professional knowledge helps assess symptoms in a quicker and more reliable way, as well as decide on the type of help needed. The 'self-diagnosis' observed among doctors as early as during their studies, may lead to two wrong ways of thinking about one's disease. Firstly, it may trigger 'catastrophic thinking' in which a person has professional knowledge about symptoms of serious diseases and identifies one's own symptoms experienced with them. Secondly, it may lead to ignoring the symptoms observed and rejecting a potential disease [4,5]. Debasish Debnath points to the fact that the doctors-as-patients' perception of their own disease may be distorted by such elements as: fear, denying the disease, one's need to be omnipotent, lost self-confidence, fear of a disease understood as weakness, inability to take on the role of a patient [6].

An unusual way of perceiving and living with an incurable disease has been presented in interviews with professor Religa [7,8]. Once diagnosed with a lung cancer, Religa was aware of both what it may lead to and the fact that he knows nothing about oncology. Given that, he did not browse through textbooks or look for medicines or therapies abroad that would make a miracle, but trusted his doctor and began the therapy. He accepted his disease and regarded it as 'nothing special'. After each phase of the therapy he tried 'to recover as soon as possible and not lose the momentum' i.e. he worked, realized his passions and claimed: 'the disease is as if next to me, not in me. It is there only because I need to fight it'. The down-to-earth and active attitude together with neglecting the disease result from the realistic perception of himself and the world around, as well as from the conviction that 'we

all need to die at some point, there are no exceptions' [8].

The proper course of the diagnosis may be disturbed when the doctor-patient questions the physician's competence. A patient who uses medical jargon may be misleading and make some key questions remain unasked during an appointment. However, there are physicians who resist this pressure and treat the doctor-patient in the same way as a layman-patient would be treated [6].

The seriousness of the problem is stressed by a handbook published in 2008 entitled '*The Physician as Patient: A Clinical Handbook for Mental Health Professionals*'. Its aim is to help others 'understand doctors in sickness', who are referred to by the authors of the handbook as 'a horde of people who are often misunderstood and treated inadequately' [9].

The problem of 'doctors in sickness' has been addressed by professional organisations [10]. The British General Medical Council provides an online guidebook entitled 'Good practices in medicine' which suggests that due to potential risk for one's patients' and one's own health, an ill doctor should consult his/her highly qualified colleague and follow the advice. Moreover, he/she is advised to consult a GP who is not a member of their family in order to guarantee independent and objective medical care. Similar solutions have been adopted by medical organisations from other countries.

It becomes interesting to know what doctors-patients suffer from most often. Results of population-based studies point to the fact that doctors are less likely than others to come down with cancer or cardiovascular diseases [11,12]. Although they live longer than others [13], the risk of becoming addicted to alcohol or other psychoactive substances (opioids, benzodiazepines) [13-15], suffering from depression or dying in a suicidal attempt is higher than among other people. The difference is moderate among men and significant among women [16-19]. Furthermore, higher suicide rates among physicians have been observed for quite some time now [20]. Job-related stressors are mentioned as potential reasons for this situation: long working-hours and sleep disorders, which lower the work quality and lead to burnout, as well as going on sick leave less often than other professionals [13]. The term 'impaired physician' (meaning the one who is unable to perform his professional or family duties due to mental disorders or alcohol or drug addiction) has already been introduced into literature [19].

Perceiving the role of a patient, a person's behaviour when in sickness and his/her willingness to consult medical institutions are also influenced by how important health is in one's own hierarchy of values. Health, along with other instrumental values related to it i.e. ability, independence or physical attractiveness, is a variable which considerably modifies one's behaviours as a patient.

A research conducted in Australia shows that physicians find it really difficult to take on the role of a patient and are more willing to work despite the symptoms suffered [21]. Diagnosis and therapy is often delayed by professionals who experience serious medical problems since they are convinced that 'as physicians, they are privileged (and feel a sense of causality and often authority)' [22].

'Pamiętniki lekarzy' ('Memoirs of physicians') published in 2004 offer a story of a female doctor who was discharged from a hospital upon her request and said that ' it feels strange to be on the other side of the bed. I have never thought that it is so difficult to trust someone. Fear of the unknown is stronger that common sense' [23]. Difficulty in accepting the role of a patient may also result from the fact that a physician-patient is worried about his/her privacy and that the disease itself may influence his/her professional career [24].

The doctor-patient's attitude to the physicians who are taking care of him/her is influenced by a number of conditions, and may be positive (more effective communication, partner-ship, following doctors' advice conscientiously) or negative (questioning competence, distrust, conflicts). There are certain features which make a sick doctor a demanding patient or even a 'tough' one [25]. The fact that a doctor belongs to medical staff and has formal and informal relationships with other physicians may have a considerable influence on one's choice of the therapist and willingness to cooperate with him/her. When possible, a layman chooses his/her physician based on previous contact or as a result of negotiations with other laymen. A doctor chooses from among his/her colleagues [26] or after negotiations with people from the medical environment. Domeyer-Klenske and Rosenbaum point to the fact that doctors who are looking for a physician whom they will entrust with their health, expect special treatment from their fellow-doctors [27]. This has been confirmed in analyses by Krall, who even uses the term 'VIP syndrome' with reference to doctors who expect 'individual therapy' and 'special' treatment (a longer appointment, consultation after regular working hours etc.) [4].

'Pamiętniki lekarzy' ('Memoirs of physicians') published in 1939 is one of the oldest sources which offer a physician's account of his/her being ill. One can read extensive memories of Z. Karasiówna, a doctor who was treated in a privileged way when she was a patient. She was instantly directed to a regional hospital, while her colleagues paid more attention to her than to other patients. She stayed in a hospital for a few weeks and in that time the therapists consulted diagnostic and therapeutic procedures with her. Much to her surprise, even as a patient, she could not stop being an active doctor' [28].

An interesting 'medical history' was written by Godziński, a gynaecologist from Warsaw who suffered in a serious car accident. As a result, he had to have a long-lasting therapy and rehabilitation. The author offers a day-by-day account of each phase of the therapy, from having his life saved on the first day, through other phases to rehabilitation. As a patient, the doctor kept reminding others what his job and social status are, expected better treatment and privileges, and did not perceive it as inappropriate. Such an approach was supposed to serve as an 'insurance policy' of a kind and protect him from inconveniences and iatrogenic errors. It was important for him to be treated as a partner in the therapeutic process, so he had expectations regarding the nurses and other staff. As a result, he received extra medicines, had his therapy fast forwarded and forced the staff to have extra examination [29].

'Being an ordinary patient' is an account written by a young doctor who had a serious car accident in 2007. The author described in detail and commented on his stay in different wards. He also pointed to the dysfunctions of medical institutions and staff in the so-called 'golden hour', i.e. in the time which is crucial in cases of serious injuries or traumas. As far as diagnosis is concerned, he described the staff's negligence and commented that had it not been for his knowledge and determination, the physicians would not have diagnosed the range of injuries he had suffered as soon as they have. Being a doctor-patient, he inspired and controlled medical procedures in the course of his therapy and was aware of the fact that this may lead to a conflict with the hospital staff. Interestingly, dr Skrzypczak, who is the author of this account, read Godziński's memoir while staying in the hospital and observed that 'the hospital rituals' have not changed much since 1960s [30].

Medical knowledge and practice make one more aware of the barriers and limitations of medicine, which, in turn, causes scepticism and unwillingness to follow advice of other physicians [26]. Over 90% of American physicians take medicines which they have prescribed for themselves (mostly antibiotics, anti-allergic drugs, contraceptives and sedatives), and many do not use public health care services [4]. Results obtained in Great Britain were similar. According to this research, a vast majority of British doctors treat themselves, and this is more frequent among GPs than among specialists [26], especially if it concerns mental problems [21], HIV infection or sexually transmitted infection [4]. Doctors indicate that they feel more confused in case of socially stigmatised diseases [21].

Given that, the results of meta-analysis of 26 studies concerning doctors' use of medical services come as no surprise. Many of those who have their dedicated GP still consult their partner, relative or friend who is a doctor. When doctors are unable to offer themselves reliable diagnosis (33-90% of doctors try doing it), they are more willing to consult their colleagues informally, on the corridor, than to follow the formal procedures [26]. During the research, doctors also listed a number of barriers to accessing healthcare services according to the three types of sources they may have: patient-doctor, healthcare provider, the healthcare system.

As part of a research conducted in Canada in 2012, a semi-structured interview was used to ask GPs about their relationships with physicians-patients. The top three challenges they mentioned included: 1. Keeping a clear boundary between a friendly relationship and the doctor-patient one, 2. Avoiding answering particular questions and providing particular information about health knowledge and behaviours, 3. Controlling the degree to which a doctor-patient may have access to test results and comments from other doctors. Given these challenges, doctors typically adopt one of the three strategies: 1. Ignoring the fact that the patient is a doctor, 2. Acknowledging the fact that the patient is a doctor and negotiating the medical care to be provided, 3. Allowing the patient to take over the control of the therapy [27].

The situation of retired doctors is quite specific. Seniors who completed the survey pointed to the following problems they faced in the course of the therapy: inability to obtain medical examinations and consultations referrals in a short period of time, charging for healthcare services, long queues for shortage medical procedures. One of the comments provided in the questionnaire was: 'Everyone's attitude changes when you go on a pension. (…) Doctors do not need an elderly and ill physician who sacrificed his/her own health to others' well-being and who is now a burden. Another respondent wrote: 'When I left my job, the head of the healthcare centre I worked at said: In the current system, we don't need an ill doctor.' What the doctor mentioned as most troublesome in this case was taking away his right to issue prescriptions for himself and his family [31].

CONCLUSIONS

1. Analysis of the literature suggests that physicians may and do experience various difficulties with becoming a patient and functioning as a patient.
2. Doctors tend to have a distorted image of their own disease. They often perform autodiagnosis, autotherapy and ignore physician's advice.
3. When choosing a doctor, they focus on their relationship with the person and expect special treatment.
4. The situation of physicians who treat doctors-patients is particularly difficult, from the diagnosis, through agreeing on the cooperation,

to therapy. As a result, doctors-patients are often misunderstood and treated inappropriately.
5. Since there is scarce amount of research on the functioning of doctors as patients available, the research team we have created aims to conduct some.

Conflicts of interest

None declared

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