When your patient is a doctor

In a population of nearly 50,000 people (the number of doctors registered in Australia[1]) it would be remarkable if there were no crime, mental illness, addiction, physical illness or cause for concern about the competence of any member of that population. And yet, doctors always seem ill equipped to cope when a colleague becomes ill or needs help.

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Doctors are an at-risk population. They are more likely to be addicted to drugs, be alcoholic, suffer from burnout and depression and, tragically, commit suicide than the general population.[2,3] These statistics may reflect a fundamental problem with self-care: 'Illness doesn't belong to us. It belongs to them, the patients. Doctors need to be taught to be ill.'[4]

Doctors often find it difficult to access health care. Although most would agree that regular check ups with a focus on preventive health and promotion of a healthy lifestyle is good advice for their patients, most do not see that this advice applies to them.

Self-prescription and self-referral are common (Figure).[5] Fewer than 50% of doctors can identify their own general practitioner and of those who can, many are referring to their spouse or their practice partner.[6] We have to ask the question – if you can't bring yourself to see another doctor for a check up or a medical illness, how difficult will it be if you are depressed or have a drug or alcohol problem?

Even when a doctor takes the difficult step of seeing another doctor as a patient, the experience may not be a good one. There are all too many examples of the treating doctor being overwhelmed by the experience, taking short cuts, asking the doctor-patient to diagnose him or herself and recommend his or her own treatment or just simply talking about the latest crisis in the health system and patting the doctor on the back, saying 'you're alright, aren't you'.

Doctors who have been ill report concern that 'because of their medical status, they were not given adequate information, follow up or psychological support'.[4] In a study of the medical care of doctors, 26% had suffered from a medical

IN SUMMARY

- **Doctors are an at-risk population. They are more likely to be addicted to drugs, be alcoholic, suffer from burnout and depression and commit suicide.**
- **Junior medical officers, rural practitioners and those working in solo practice are at even greater risk.**
- **Fewer than 50% of doctors can identify their own general practitioner and of those who can, many are referring to their spouse or their practice partner.**
- **Inappropriate self-reatment can delay the diagnosis of serious illness, and rarely identifies psychological problems such as depression and addiction.**
- **Doctors contemplating the doctor–doctor consultation are often concerned about confidentiality, lack of confidence in the treating doctor, embarrassment and difficulties in knowing how to behave in the consultation.**

condition they would like to have discussed with another doctor but had not done so because they were a doctor.[7] In an unpublished survey of general practitioners, those contemplating consulting another doctor about their own health expressed concern about confidentiality, lack of confidence in the treating doctor, embarrassment and difficulties in knowing how to behave in the consultation. So clearly we need to become much better at looking after the needs of a very important group of patients – doctors.

Psychological disturbance

We acknowledge that there are certain groups of patients who are at more risk of psychological disturbance – for example, women in the postnatal period and adolescents. These groups of patients require special attention with regard to symptoms of stress and depression. With a suicide rate three times that of the population – and an increased incidence of alcoholism, cirrhosis and drug addiction – doctors fall into this category as well. It is important to structure the consultation in a way that allows enquiry into these areas.

There are groups of doctors who are statistically at even greater risk – junior medical officers, rural practitioners and those working in solo practice. These groups of doctors require special care.

Doctors commonly self-medicate and organise their own investigations and referrals. Clearly this is outside the bounds of an appropriate supportive consultation where the broader aspects of the illness are considered in context and where there is the objectivity of a skilled clinician. Inappropriate self treatment can delay the diagnosis of serious illness, and rarely identifies psychological problems such as depression and addiction.

The doctor–doctor consultation

Strategies for a successful consultation are summarised in the box on page 60. Perhaps the best starting point is to set the ground rules. The treating doctor should acknowledge that the patient is also a doctor but explain that they are going to manage the consultation as any other: 'I know you are a doctor, but I'm going to treat you as I would any other patient.' Many doctors are concerned about confidentiality, so it is helpful to reassure the doctor-patient that the consultation is completely confidential. Offering to keep a closed file can be helpful (i.e. the file is kept apart from the ususal filing system and can be accessed only with the treating doctor's permission).

Setting out the rules of the consultation in terms of a routine or usual consultation as for any patient can be helpful since it allows the treating doctor to conduct a structured consultation where enquiry into difficult areas such as alcohol and drug use is seen as routine. 'I'm just going to go through my usual routine.' Normalising behaviours can make disclosure easier: 'There are a lot of stressed doctors out there – how are you coping, juggling work and family?'

The treating doctor should be alert to signs of underlying problems and not be afraid to enquire into these areas (see the box on page 000). Gastritis and stomach complaints, hypertension, hyper-

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Figure. Self treatment is common among doctors and fewer than half of doctors have their own GP.

Strategies for a successful consultation

- Reassure the doctor-patient that the consultation is completely confidential.
- Acknowledge that the patient is also a doctor but explain that you are going to manage the consultation as you would any other patient.
- Conduct a structured consultation – this will make enquiry into difficult areas such as alcohol and drug use be seen as routine.
- Normalise behaviours to make disclosure easier. For example, ask the doctor-patient 'There are a lot of stressed doctors out there – how are you coping, juggling work and family?'
- Conducting a physical examination gives the doctor-patient permission to be a patient, which is a very important step in the process. It also reassures him or her that the doctor is being thorough and not taking shortcuts.
- The doctor-patient knows about all the possible complications and rarities and will often need special reassurance to address his or her fears.
- Doctor-patients will often need permission to come back for review and ask questions.
- The doctor-patient should not be required to organise his or her own investigations or prescriptions or decide on the timing of follow up.
- The issue of payment is a matter of personal choice for each practitioner; however, nonpayment or reduced payment may be seen to devalue the service.

lipidaemia, gout, missing work, marriage and relationship problems, accidents and financial problems all could be associated with stress or alcohol and substance abuse.

The physical examination

All patients need to have a sense of confidence in their treating doctor. Having the confidence to carry out an appropriate physical examination without embarrassment is an important skill, particularly in the doctor–doctor consultation. This is usually reassuring to doctor-patients, who may have been trying to come up with a diagnosis by various means themselves. Conducting a physical examination gives the doctor-patient permission to be a patient, which is a very important step in the process. It also reassures the doctor-patient that the doctor is being thorough and not taking short cuts.

Pointers to underlying problems

The following can all be signs of an underlying psychological problem, and should prompt questions about stress, depression, alcohol and substance abuse.

- Gastritis and stomach complaints
- Hypertension
- Hyperlipidaemia
- Gout
- Missing work
- Marriage and relationship problems
- Accidents
- Financial problems

Fears and follow up

Many doctors have a fear of looking inadequate if they have not correctly diagnosed their own illness, or even worse that there may be nothing wrong with them at all. This is the opposite of the usual dynamic working in a consultation, where the patient is relieved to find that nothing is wrong.

The doctor-patient knows about all the possible complications and rarities and will often need special reassurance to address his or her fears. It is important, as in any consultation, to find out what the patient is concerned about and to discuss this. Doctors as patients will often need permission to come back for review and ask questions.

The investigation and management of the illness will require the involvement of the doctor-patient, who perhaps more than any other patient needs to understand and agree to participate in the ongoing care. However, doctor-patients should not be required to organise their own investigations or prescriptions or decide on the timing of follow up.

To bill or not to bill

The vexed question as to whether to bill a patient who is a doctor is one that requires exploration. In the end it is a decision for the individual practitioner to make. However, nonpayment or reduced payment for a professional service may be seen to devalue that service. Also, doctor-patients may feel more acutely that they are wasting the time of the treating doctor, that they should hurry, organise part of the treatment themselves to decrease the burden and should not request follow up or additional appointments. Clearly this increases rather than decreases the difficulty of the consultation for doctor-patients.

The impaired doctor

Doctors becomes impaired if they suffer from any physical or mental illness which detrimentally affects, or is likely to detrimentally affect, their capacity to work safely. A doctor may be unwell without being impaired – impairment is specifically related to patient or public safety. This impairment may take the form of drug or alcohol addiction or physical or mental illness. The important factor for the treating doctor is to recognise the risk to patient safety.

The role of the State and Territory medical boards in these cases is not a punitive one, but a constructive one aimed at setting safe limits of practice,

putting in place strategies to manage the problem and assisting that practitioner to return to safe practice as soon as possible. The statutory requirement to report impairment varies among States and Territories, but is underpinned by the recognition that reporting and engagement of the practitioner in a program monitored by the medical board will be the safest option for that practitioner and the public. Self-reporting is, of course, the most desirable situation.

Conclusion

There is no doubt that doctors should pay more attention to their own health. Equally important is that when a doctor does seek professional care from another doctor, the care is of the highest quality and that the doctor is made to feel comfortable in the role of patient. Doctors need to become better patients but we also need to recognise the difficulty of taking that role. MT

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