"Doctoring" Doctors and Their Families

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Being selected to provide medical care to other physicians or their family members represents not only a gratifying professional recognition of competence by one's peers but also a challenge. Many personal and psychological factors may influence the medical care of physicians. Ill physicians may have difficulty with role reversal and "the VIP syndrome," while treating physicians may have to deal with their own anxiety and issues such as confidentiality, privacy, empathy, and intrusion by a physician-relative into the care of medical family members. Based on experience with more than 200 physician-patients and many adult family members of physicians, suggestions are offered for care of these patient groups.

THE OPPORTUNITY for a physician to give medical care to other physicians and their family members often is considered a privilege, for it represents a gratifying professional recognition of competence and humanity by one's peers. Although extra time and effort may be required, acting as a physician's physician usually is a very worthwhile experience.

A few articles have appeared about physicians and their families as patients3-4 (aside from personal reflections5-20 and reports dealing with psychiatric illness21-27 and substance abuse28-30), but rarely has there been a discussion about "doctoring" the doctor.21 While some physicians deal easily with medical problems of fellow physicians and their relatives, others may feel pressured, strained, and insecure. A few even actively avoid such encounters.

Unlike the special training given to the priest who has the unique role as the Pope's confessor,22 physicians learn to care for other physicians mainly from on-the-job training.2 Some have suggested that medical schools should teach physicians how to treat colleagues23,24 and that special clinics for physician-patients be set up.25 This approach has been tried in Norway, with "doctoring" the doctor.21 While some physicians deal easily with medical problems of fellow physicians and their relatives, others may feel pressured, strained, and insecure. A few even actively avoid such encounters.

My experiences with more than 200 physician-patients and a large number of adult family members of physicians during 43 years of practice, mainly as an academic neurologist, have led me to define several management approaches to this unique patient population. Before discussing them, some factors that may influence these encounters will be reviewed (Table).

PSYCHOLOGICAL BACKGROUND OF SOME PHYSICIAN-PATIENTS

Allegedly, "doctors make the worst patients."36,32 Anxiety greater than that found in nonmedical patients seems a primary cause. Most physicians remember "diseases" they developed in medical school as they uncritically applied signs and symptoms being studied to themselves.2 Later, when physicians develop actual illnesses, they may imagine the worst possible diagnosis or outcome and intense economic and social fears may compound the problem.26 Most neurologists have seen colleagues as patients whose occasional muscle twitches have been self-interpreted as amyotrophic lateral sclerosis. Often the physician-patient may attempt to downplay anxiety with an embarrassed statement about becoming a "crock." Anxiety may lead to considerable delay in seeking medical attention,27,28 usually by denial of symptoms or their meaning.1,5,6,39,40 The history may be influenced significantly by anxiety, with important portions omitted or minimized to avoid serious conclusions or actions by the consulted physician.30

Some physicians lead lives of considerable tension related to the stress of professional work and poor coping strategies. They may be driven by an unconscious need to feel omnipotent,41 suffer chronic fatigue,42,43 and have few diversions outside medicine. Physicians may flee into work to avoid personal problems, hold the delusion of being indispensable,21 fear loss of self-esteem when ill, and feel reluctant to place personal needs above the desire to satisfy demands from patients and colleagues.2,23,30 Many physicians rarely take sick leave and often work when they feel significantly unwell. These characteristics have been termed the "disease of being a doctor."41

Physicians are trained to value compulsiveness, but this trait may lead to doubts, guilt, or an exaggerated sense of responsibility that may become pathological.41 Some physicians seem almost phobic about asking for help for fear that this signals weakness.22,34

Drug and alcohol abuse, depression, marital instability, and suicide26,44-46 pose significant problems for physicians, and physical illness can heighten these tendencies. Physicians on probation because of substance abuse may be particularly at risk for suicide.47 as allegedly are psychiatrists, surgeons, ophthalmologists,44,45 and women physicians.48-51

Awareness of the possible influence of these psychological factors is extremely important, and if present they must be dealt with carefully.
Factors Among Physician-Patients That May Influence Their Care

- Anxiety
- Denial of illness
- Need to feel omnipotent or indispensable
- Chronic fatigue related to overwork
- Loss of self-esteem when ill
- Personal needs subordinate to practice demands
- Fear that illness equates to weakness
- Pathological compulsiveness
- Depression and substance abuse
- Poor choice of personal physician
- Inability to reverse roles to become a patient
- Fear of loss of confidentiality and privacy
- The VIP syndrome

CHOICE OF A PERSONAL PHYSICIAN

Although the selection of the best caregiver by a physician-patient might seem simple, making such a choice may be complex. Unlike most patients, physician-patients may select a physician known personally and often socially. While the choice ostensibly rests on the treating physician’s reputation for skill, fairness, compassion, and availability, subtle reasons may reflect personality factors and psychological issues.

One study found that only 35% of treating physicians chosen by 468 physician-patients for all illnesses, and only 55% for severe illnesses, could be considered high quality. The physician-patient allegedly weighed “the therapeutic rewards of choosing a highly competent physician against the social costs of requiring help from a superior source.” When the patient felt equal to the treating physician, they often established an inappropriate collegial relationship rather than a physician-patient association. When the chosen physician was “superior,” the ill physician was most likely treated as a patient, a role not always easily accepted and illustrated by a physician’s complaint: “Don’t treat me like a patient. Treat me like a doctor.” For some physician-patients, the loss of quality care seems less costly than loss of rank, authority, and autonomy.

Prior to choosing a treating physician, physician-patients may consult colleagues inappropriately in the corridor, may attempt to disguise the identity of the person inquired about, and may even obtain unlabeled or falsely labeled laboratory and radiological studies. The frequently conflicting information derived may increase fear.

Although the patient-physician relationship should be a collaborative one, at times there may be a conflict as to which physician is the “quarterback.” Physicians may find it difficult to reverse roles and give up control of their care. This may be magnified if the illness falls within the professional competence of the patient, such as a neurologist with a neurological disorder. A tug-of-war about diagnosis and treatment may cause significant problems for patient and physician.

ADDITIONAL PROBLEMS OF PHYSICIAN-PATIENTS

Many physicians have not had personal experience with serious illness. It may upset them to encounter the frequent annoyances of being a patient, such as delay in obtaining appointments, inconvenience and unpleasantness associated with some medical tests, surprise at expense, restrictions of managed care and insurance, and distress if treated as patients and not physicians.

Some treating physicians, perhaps to deal with their own anxiety, may limit meetings with physician-patients, may provide only brief and dogmatic explanations, and may assume incorrectly that physician-patients possess sufficient medical knowledge to fill in information gaps. This behavior offers little opportunity to develop an empathic relationship and unsatisfactory care may result.

Preservation of confidentiality and privacy, which most physicians know to be only relative, is a major issue for many physician-patients. Illness may adversely affect malpractice and other insurance coverage as well as hospital credentialing. In my experience, confidentiality issues are a major reason for delay by physicians in seeking personal medical attention, especially when psychiatric or cognitive illnesses are a concern.

Both physicians and their patients may act unconsciously as though physicians are not supposed to become ill. Self-treatment, sometimes inadequate or incorrect, is frequent and denial of disease is rampant, occasionally aided and abetted by colleagues and family.

Whether sought for or not, some physician-patients may fall victim to “the VIP syndrome.” Circumvention of administrative and medical regimens and difficulties nurses and other health care professionals have in dealing with the physician-patient, may lead to poor medical care and outcomes, confusion, and occasional hostility. Many physicians know little about hospital routines and procedures, and nurses may be embarrassed to discuss them. Nurses may become annoyed at a medical family’s expectations for greater than usual personal service. I have seen well-meaning colleagues turn the physician-patient’s hospital room into a private club, complete with alcoholic drinks.

These same colleagues may offer gratuitous diagnostic and therapeutic advice to the patient and second-guess the treating physician. The presumed VIP status of the patient, as well as serious illness that greatly troubles caregivers, may result in isolation, which in turn may precipitate a vicious cycle of increased demands and further staff withdrawal.

Professional courtesy for physician charges is somewhat less awkward an issue now for physician-patients and their relatives than it once was. The physician-patient may obtain some reimbursement by “insurance only” billing, but the lack of full payment for professional services occasionally may cause discomfort for both patient and physician.

MEDICAL CARE OF FAMILY MEMBERS OF PHYSICIANS

Many issues mentioned above are relevant when the patient is a medical family member. The physician-relative may consider illness of a family member a sign of weakness. The patient may not reveal substance or physical abuse and psychological problems for fear of embarrassing the physician-relative. A patient of mine, found to have a high drug level that had caused a perplexing variety of symptoms, vehemently denied drug use for a long time to protect her physician-husband.

Sometimes there may be intrusion by the physician-relative in the management of the medical problem. X-ray films and laboratory test results may be seen by the physician-relative within minutes of completion and the patient informed of the results without prior discussion of their significance with the treating physician. This intrusion can influence significantly the patient’s thinking and emotional state, especially if the results are abnormal. A physician-relative may persuade the patient to carry out only part or none of the recommendations made by the consultant, particularly when psychiatric consultation or treatment is recommended.

In teaching hospitals, physician’s children are more likely to see staff physicians and/or consultants in the emergency department than residents, thus bypassing the medical educa-
tion system. The same appears to be true in my experience for adult relatives of physicians. Convenience and economics often lead physicians to prescribe medications and do physical examinations for family members. In one study, 15% had acted as primary attending physician for family members in hospital, and 9% had operated on a relative. Thirty-three percent of physicians had observed inappropriate involvement by other physicians in the care of a family member, while 22% were made uncomfortable by acceding to inappropriate requests, such as avoidance of follow-up or continuation of care by the physician-relative.

Little has been written about the care of a physician’s wife and less about that of a physician’s husband. In both instances, medical care may be optimal while emotional care may be ignored. As do their husbands, physician’s wives have an increased risk of drug dependence and suicide. Hospital staff may feel as apprehensive in caring for a physician’s wife as for a physician-patient. Treatment by the physician-husband may compromise good care. I have found that sometimes it has been difficult for a physician’s wife to accept recommendations from a consultant when this differs from what her husband has told her.

**SUGGESTIONS FOR CARE OF DOCTORS AND THEIR FAMILIES**

The following guidelines, derived from my experience, have been very helpful when treating this special patient group.

1. **Do not accept such patients if you are likely to feel an excessive degree of anxiety from the responsibility for their care.**

   You may feel somewhat greater concern than is usual with nonmedically related patients, since your professional competence may be scrutinized more closely. Unless this can be tolerated, tension may lead to indecisive actions.

2. **Perform the history and physical examination as thoroughly as for any other patient.**

   This is an effective way of establishing trust and confidence while dissipating patient anxiety. Do not avoid asking personal questions and, when appropriate, do not omit intimate parts of the examination, such as breast, rectal, or pelvic, because of embarrassment. Such omissions may preclude adequate diagnosis and management. One should take the history directly from the patient to avoid having the physician-relative edit it.

3. **Deal openly with the patient’s anxiety and allay it as soon as possible.**

   Recognize that the ill physician is as sick and frightened as any other patient. It can be difficult for the treating physician to deal with individuals who sometimes dislike being treated as patients while at other times complain that they are being treated as professionals. Ask for and consider the patient’s self-diagnoses seriously. Many physicians tend to make incorrect self-diagnoses with absolute certainty, particularly in fields other than their own.

4. **Clarify the patient-physician relationship as early as possible.**

   Assure the patient that he or she will be treated most appropriately as a patient and not as a physician or a physician’s relative and with the same degree of confidentiality and access to communication as any other patient. At times, this may be a problem when a physician’s spouse asks you not to tell something to the mate. Emphasize that you will provide information as quickly as it becomes available, that you will discuss it completely, and that if questions, concerns, or complaints arise you want to hear about them promptly. This clarification seems especially necessary when dealing with physicians’ spouses, who often express the view that their feelings and ideas are given short shrift. Try to empower the physician-patient with the same degree of decision-making authority and autonomy as one would with any other patient.

5. **Avoid overly close identification due to empathy or sympathy.**

   Such feelings, while understandable, can inhibit diagnostic testing and therapy. Negotiation over testing is a hazard that may lead to too many or too few studies. Modifying routines to save the patient time, trouble, and money may result in poor medical care. Nonstandard practice may be a major contributor to the common belief that when physicians or their family members are treated, things are more likely to go wrong than with nonmedical patients. Discourage the physician-patient from self-ordering studies or ordering them for relatives. The therapeutic results may be compromised if both the treating physician and the physician-patient cannot complete the needed role reversal.

6. **Discuss the diagnostic and/or treatment plan in detail to diminish anxiety.**

   Do not take for granted that the physician-patient knows much about the medical problem, particularly if it is outside his or her practice area. Discuss medications in detail without the assumption that the patient knows dosages, effects, and adverse effects.

7. **Leave plenty of time for a clear discussion of your opinions and recommendations.**

   Citing lists and giving statistics while leaving it up to the physician-patient to discern your point of view is unlikely to be reassuring. Offer the opportunity to obtain a second opinion early to emphasize patient autonomy. Guard against overly intellectualized discussions with the physician-relative when reviewing results and plans with family members. Sending a summary note or even a copy of the full note to such patients may help avoid confusion.

8. **As much as possible, speak directly to the patient who is a medical relative without the intermediation of the physician-relative.**

   Spend some time alone with this patient to discuss personal material. Emphasize that no information without the patient’s permission will be given to the physician-relative, who should never be told anything more or different from that which has already been discussed with the patient. Having this conversation with both parties present is desirable.

9. **Discuss issues of privacy, confidentiality, payment, insurance, and credentialing early.**

   Physicians and family members know that medical personnel frequently gossip about patients. Assuring patients honestly that this will not happen is an important part of the therapeutic relationship. Discuss with physician-patients the fact that medical records are only relatively confidential. If privacy cannot be managed satisfactorily locally, referral to an out-of-town physician may be the best solution.

10. **Professional courtesy should mean more than just a financial arrangement.**

    Your staff should make every effort to give clear instructions, appropriately speedy appointments, and rapid response to inquiries, as should happen for all patients. Discussions with...
nurses and other caregivers about roles and potential difficulties when the patient is hospitalized often will prevent many problems. Avoidance of “the VIP syndrome” is paramount. Awareness that patienthood is often the antithesis of doctorhood,11 and that some physicians view sickness as a sign of weakness, should encourage the treating physician to be supportive, protective of the dignity and independence of the patient, and always hopeful even in bad times.10 Do not be surprised if you are the target of occasional harsh words from the physician-patient or relative if things are not going well and defuse such anger patiently and honestly.

CONCLUSION

To be known as a “doctor’s doctor” is also an accolade and a challenge. I hope that the comments and suggestions made herein will foster a better understanding of this relationship and lead to an enhancement of medical care for physicians and their families.

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References

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