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REVIEW ARTICLE

# The physician's disease: The impact of medical knowledge on personal illness

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(RECEIVED July 31, 2006; ACCEPTED August 27, 2006)

## ABSTRACT

*Objective:* When physicians confront a personal illness of a serious nature, they may discover that the transition to the sick role is challenging, and the inability to relinquish their stethoscope may cause undo anxiety. The physician–patient relationship is intrinsically asymmetrical, and the role of the physician is to regulate the amount of information patients need in order to become educated about their illness and to make informed decisions about their treatment plan. This article explores the challenges in the physician–patient relationship when the patient is also a physician.

*Methods:* This article is a literature review of publications involving the unique challenges physician–patients experience when suffering from serious personal illness.

*Results:* The medical knowledge physician–patients harbor has the potential to complicate their ability to cope with difficult or terminal diagnoses. Paradoxically, knowledge about a condition may fuel anxiety instead of alleviating the fear associated with the unknown. Medical knowledge therefore may entail a certain loss of innocence, and physicians are often unable to revert to being “mere” patients. Furthermore, managing this anxiety in physician–patients may prove to be challenging to the treating physician.

*Significance of results:* From a medical perspective, physician–patients need to be addressed like any other patient. Psychologically, however, these patients are unique, and the specific challenges their education and experience bring into the consultation room needs to be explicitly addressed.

**KEYWORDS:** Lymphoma, Physician–patient relationship, Physician illness, Psycho-oncology, Cancer anxiety

After graduation from medical school 3 years ago, I understood empathy. I could give a textbook definition and I appreciated the positive role empathy played in the physician–patient relationship. I knew how to share a certain degree of understanding with patients. I knew how to respond to the statements distressed patients frequently say when confronted with difficult circumstances. I knew, also,

how not to respond to other frequently expressed concerns. Empathy, in my mind, was a simple balance between authentic compassion and choreographed acting. Our genuine concern for patients is augmented by stereotyped responses and gestures that patients expect when discussing difficult subjects.

My appreciation of empathy and its role in the physician–patient relationship changed dramatically last year after I was diagnosed with Hodgkin's lymphoma. Barriers in the patient-physician relationship with nonphysician patients should be transparent to both parties. Confidence and trust should

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not be apparent burdens in the relationship. Empathy should be a conditioned and unconscious response on behalf of the physician. This transparency quickly becomes opaque, however, when the physician enters into a physician–patient relationship with a colleague. The nature of the relationship subtly, yet profoundly, shifts. As a patient, I found that my own medical education and professional experience presented numerous obstacles to my own treatment and palpable strain in my personal ability to engage with my treating physicians. It may be helpful to consider my experiences in the context of past research and commentary related to physician–patients.

My initial symptoms manifested approximately 3 months prior to my formal diagnosis of Hodgkin's lymphoma. The fatigue, cough, and chest tightness progressively worsened, but I managed not to become alarmed, even after the emergence of a sentinel lymph node in my neck. My symptoms were consistent with an atypical pneumonia, an illness of the sort that thrives in the public psychiatric hospital where I worked at the time. I convinced myself that this was nothing of concern.

The possibility of lymphoma crossed my mind on occasion, but only as a fleeting, morbid speculation. The prevalence of lymphoma seemed too remote to be concerning. At a certain point, however, I gave in and became a patient. My expectation of a simple diagnosis and treatment regimen enabled me to cross this transition without hesitancy. This, however, is a difficult process for many physicians (Rabin et al., 1982; Bowes, 1984; Mullan, 1985; Mandell & Spiro, 1987; English, 1991; Aoun, 1992; Viner, 1994; Bone, 1996; Keoun, 1996; Kirsch, 1996; Spiro & Mandell, 1998; Horn, 1999; Silagy, 2001; Tierney & McKinley, 2002; Srivastava, 2006). Becoming a physician–patient requires a crossing of an daunting threshold and lying down on the exam table. Regardless of the presenting symptoms or illness at hand, it is often trying to relinquish the stethoscope, prescription pad, and aura of authority and submit to the new role of patient.

Multiple issues complicate the process of a physician assuming a new role as patient (Glass, 1975; Meissner & Wohlauer, 1978; Edelstein & Baider, 1982; Rosvold, 2002). As physicians, we should be the first to recognize the importance of preventive medicine and to practice what we preach. Our profession, however, erects internal barriers that often prevent its own members from obtaining adequate medical care (Scally, 1996). We operate in a privileged professional circle that compensates its members with social prestige and financial stability, but these rewards can prove costly. As physicians, we abjure personal frailty in order to project an air of

invulnerability and omnipotence (Bennet, 1997). The medical culture implicitly, if not explicitly, stigmatizes physicians who undermine the invincible façade by entering the world of the ill.

The ability of physicians to seek treatment is complicated by the relationship between our profession and our individual senses of identity. Our vocation encourages us to blur the boundaries of personal and professional identity such that the latter may colonize the former (Spiro & Mandell, 1998; Fromme & Billings, 2003). Because of this entanglement, when physicians fear a direct threat to their professional identity, they may face a crisis of self-worth. Physicians may, therefore, be driven to deny illness and to continue practicing medicine as long as possible, regardless of circumstance (The doctor as patient, 1972; Spiro et al., 1978; Scally, 1996).

We physicians often delude ourselves into believing we are immune to the illnesses we treat (Gold, 1972; Marzuk, 1987). Whether this is a result of selecting narcissistic students as medical student candidates or the consequence of a grueling medical education is unclear. Although medical school selection committees attempt to select perfectionistic and conscientious applicants, evidence suggests these traits are defenses against subconscious anxieties of passivity and self-doubt (Vaillant et al., 1972). Medical school and residency appear to augment baseline senses of omnipotence, invulnerability, and detachment, which further encourage physicians to deny medical illness (Ellard, 1974; Scally, 1996).

Even once the need for medical care is acknowledged, where does a physician seek medical help? The obvious first choice is self-management. Although several regulatory ethics committees discourage self-medication, this practice is widely used as a means to avoid the stigma of becoming a patient and the inconvenience of scheduling an appointment (American Medical Association, 1993; British Medical Association, 2004). Self-management, however, obscures objectivity and denies the ill physician the opportunity of undergoing the natural self-bereavement process and adopting the “sick role,” which is occasionally a necessary process for alleviating anxiety (Allibone et al., 1981; Allibone, 1990).

Another common means of obtaining care is through “curbside” consults among colleagues cornered in the hallways of hospitals and clinics. Often, this type of care is favored, not simply to avoid the bureaucratic jungle of the health care system, but as a means to avoid the stigma of illness. These favors, however, almost universally result in poor outcomes due to incomplete evalu-

ations or the ease of avoiding difficult subjects (Pullen et al., 1995).

If a decision to seek care through the traditional route is accepted, with whom should a physician schedule an appointment? The process is often compared to the selection of the Pope's confessor (Osmond & Siegler, 1977). Many considerations must be accounted for when choosing a personal physician. A personal friend and colleague may be empathic, but nonobjective. This may potentially result in an overly enmeshed relationship without clear boundaries. The reverse may be true for a nonacquaintance. Objective, nonempathic physicians may distance themselves from the relationship and leave the physician–patient without needed emotional support (Fromme & Billings, 2003).

Although many physician–patients regard clinical competence as the primary factor when choosing personal physicians, studies suggest very few physicians choose optimal treating physicians (Bynder, 1967). These often include younger, less experienced physicians outside the academic setting. This may, in part, be secondary to an unconscious need to maintain control in the relationship. In contrast, narcissistic physician–patients may expect to be managed by prominent research physicians or department chairs. But although administrative physicians may carry a prominent name or title, they may not necessarily be current on the medical literature and they may lack necessary procedural skills. In both circumstances, the physician–patient may be trying to indirectly manage their own care.

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Throughout my entire ordeal I made no mistake greater than not allowing myself to be simply another patient. Having access to medical records and diagnostic results enables physician–patients to peruse their own medical information. Our medical system operates for a purpose, and one of those is to allow difficult diagnosis to be made in comfort. The temptation to circumvent this system may become overpowering. I overstepped my role as a patient and found myself in difficult waters. Instead of waiting for my previously scheduled follow-up appointment with my physician, I decided to view my own CT results.

I walked into the radiology reading room alone. The attending radiologist was discussing a film with an eagerly attentive resident sitting beside him. Quietly walking up behind them, I overheard someone say "It would be difficult to biopsy without hitting the aorta." The mass on the film was clearly evident, even to a psychiatrist. The radiologist then

turned over his shoulder and asked if there was a film I needed to discuss. Before I had the opportunity to speak, I noticed that the film on the board was mine. The radiologist noted my name on my badge, assessed the awkwardness of the situation and then asked me to sit down. He was probably trying to recollect the last time he actually had to give bad news to a patient.

Upon receiving the definitive pathologic diagnosis after surgical biopsy, I spent an excessive amount of time reading about the prognosis of Hodgkin's and the treatment options. My personal anxiety began to materialize on two fronts: fear of the disease and fear of the treatment. The thought of having cancer is terrifying. The prognosis is immaterial; survival rates are meaningless. The 5-year survival rate could have been over 99% and it would not have affected my personal outlook on the situation. Furthermore, regardless of the potential lethality of the diagnosis, survivability requires chemotherapy. Chemotherapy is a treatment that may potentially invoke a greater amount of suffering than dying from the disease itself. The thought of not undergoing treatment never crossed my mind, but I knew healing would be a challenge.

Our job, as physicians, involves regulating the asymmetrical nature of knowledge within the patient-physician relationship (Parsons, 1975). We do not necessarily tell patients everything about their condition. We tell them the information they strictly need regarding their prognosis and treatment options in order to make informed decisions. This is not a method of deception, but a means to comfort patients when managing difficult illnesses and serious conditions. The emotional well-being of our patients is foremost when discussing these issues and occasionally excessive information may, in fact, fuel anxiety.

A physician–patient, in contrast with a "mere" patient, may expect his or her medical knowledge and wisdom to make the process of coping with serious illnesses easier. Fear is partially a reaction to the unknown and the unknowable. Knowledge about one's illness and about the details of the treatment regimen theoretically should alleviate anxiety. Access to information, however, does not necessarily make dealing with a medical condition easier. The contrary may actually be true; excessive medical knowledge and wisdom may be counterproductive and anxiety provoking (Cockerham et al., 1980; Lipsett, 1975). This may be the case even for those who routinely manage such information on the treating side of the clinical relationship. Like a branding iron, it matters which end one is holding.

Physicians are often highly educated about their illness and have unprecedented access to medical

information regarding pathophysiology, prognosis, and treatment options. When physicians become patients, they often see their condition through a highly distorted lens. Medical literature and education often focus on the management of difficult and treatment refractory cases and complications. Physicians, consequently, are able to grasp the potential terrible significance of a given diagnosis faster than nonphysician patients (Fromme & Billings, 2003; Schneck, 1998). This likely exacerbates the documented problem of serious death anxiety among physicians relative to nonphysician patients (Kane & Hogan, 1985; Hamama-Raz et al., 2000). All of this may distort the medical care of physician-patients; while often too slow to see the initial need for care, they paradoxically end up pursuing unnecessary interventions (Bunker & Brown, 1974).

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Strangely, I rarely discussed details of my diagnosis or issues about my specific treatment plan with my treating physicians, for everyone presumed I educated myself about Hodgkin's lymphoma. An uncomfortable amount of decision making was subsequently placed in my hands, as it was assumed that I was more than capable of steering my own ship. The truth is that I possessed much data about lymphoma, but little knowledge—there is a difference. It was difficult to extrapolate information from idiosyncratic studies and apply it to my specific circumstance. Opinions regarding treatment plans vary greatly. Are four cycles of chemotherapy adequate or should we be cautious and undergo six? How much radiation is absolutely necessary? How much treatment can my body tolerate? These answers cannot necessarily be found in the literature.

Often, physicians believe physician-patients *want* to maintain control of their care and determine their own course of action, yet this may not be universally true. In the context of life-threatening illness, physician-patients often want their treating physicians to make decisions for them (Ende et al., 1990). Was it fair to make me decide how much chemotherapy and radiation I wanted? I neither asked for nor wanted that burden. If my cancer recurred in the future, I would be responsible for choosing the wrong course of treatment. No cancer patients should suffer the crushing guilt associated with the belief that they determined their fate or are responsible for their disease recurrence.

Treating physicians may feel personal anxieties when they manage the medical care of colleague physicians, particularly when difficult or terminal diagnoses are involved. This may be felt as pres-

sure to adhere to a higher clinical standard or as concern that one's competence is under close scrutiny. These anxieties may be alleviated in one of two ways: through an overly thorough set of studies or through quick evaluation and rapid referrals (White & Lindt, 1963). Neither process is desirable. A tedious evaluation may result in a missed opportunity for intervention if time is a critical factor. Rapid referrals may result in poor evaluations and feelings of estrangement and rejection.

A second significant source of anxiety for the treating physician rests in the development of empathy. This is a challenge because managing physician-patients often forces treating physicians to confront their own mortality (Fromme & Billings, 2003). Determining a balance between overinvolvement and objective detachment is often more challenging when the patient is a physician colleague. Although a balance is ideal, physicians who manage other physician-patients often do drift toward detachment (Philips, 1983). Frequently, this results in the "You really should" syndrome, where the treating physician removes himself from the relationship and defers management and monitoring of the illness to the patient (Philips, 1983). Such self-distancing may also result in a failure to elicit sensitive information in the history and avoidance of unpleasant tests or exams.

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My treatment regimen involved four cycles of AVBD followed by radiation therapy. I understand some patients complete their treatment without significant complications or adverse effects. I was not as fortunate. The first treatment was tolerable, but predictably each treatment became more difficult. The nausea soon became routine. When the intravenous fluids were opened into my veins, I could smell the PVC from the newly opened IV lines. That is when the vomiting began.

During every treatment, other patients constantly infringed upon me, asking numerous questions regarding my circumstance, as I was the youngest patient in the clinic by several decades. I continued to see every chemotherapy patient in the clinic as hospital patients, not fellow cancer survivors. Personal questions regarding my own medical history appeared to be gross boundary infractions. I wanted out of the suite. I wanted to receive my treatments in isolation. As a physician, do I not have the right to special treatment? Must I sit and listen to the narrative of every patient in the clinic while poison is pumped into my veins?

Because of a physician's education and position, physician-patients often believe they are somehow

privileged and entitled. They frequently succumb to the “VIP Syndrome,” a process characterized either by the physician–patient’s demand that he or she be treated in a superior manner relative to nonphysician patients or by the treating physician’s insistence that his or her patient is somehow special and privileged (Weintraub, 1964). These attitudes and demands, however, often result in more frequent and serious complications during the course of evaluation and treatment for many diagnoses. Furthermore, excessive demands or complaints by either the treating physician or the physician–patient may result in conflicts with the health care staff.

Part of this demand for privilege may result from difficulties physician–patients experience in establishing trust with the health care system (Stoudemire & Rhoads, 1983). Physician–patients are acutely aware of the numerous pitfalls in the health care system. Mistakes frequently occur and occasionally result in poor outcomes. Because of these truisms, physician–patients may find themselves overly cautious about their care. Requests for verification and intrusions into routine care may be interpreted as entitlement.

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Anxiety is more complex than one would guess by simply reading the criteria from the *Diagnostic and Statistical Manual*, the so-called *Bible* of the psychiatric profession. Numerous individual criteria and checklists belittle the complexity of anxiety and the unique circumstances each individual confronts in his or her daily life. A diagnosis of “anxiety disorder not otherwise specified” does little to capture the phenomenology of my personal experiences. My treatment regimen is now complete and I approach the 1-year anniversary of my diagnosis.

My experiences over the past year, however, may or may not be over. Statistically, I am “cured”—or in long-term remission—depending on whether one believes cancer can be cured. Although every rogue cancer cell may be annihilated, the psychological echo may resonate for decades. Recurrence remains an ever-present phantom—a sword of Damocles constantly swinging above.

Much of my current anxiety is a manifestation of my personal medical knowledge. I understand the dreadful significance of a relapse: more challenging treatment regimens and a subsequent chiseling at my survival rate. Even the reassurance of complete remission will not necessarily curtail my anxieties. I realize that I will likely suffer complications from my treatment regimen years down the road. I can only hope they will not jeopardize my life.

Medical knowledge entails a certain loss of innocence, and physicians are unable to revert to being “mere” patients. Physician–patients are incapable of experiencing the role of the traditional patient, as information may undermine confidence. My current posttreatment cough is not simply a nuisance. Although it cannot be satisfactorily explained, I understand its possible devastating significance. Concerns and questions are never resolved, simply replaced with new trepidation. For the physician–patient, there may never be an end to this anxiety.

I learned more about being an empathetic physician in 6 months of chemotherapy and radiation therapy than in 6 years of prior formal training. Empathy requires a great deal more than memorizing stereotyped responses and honing acting skills. Patients, specifically physician–patients, may have the capacity to peer through the façade and expose an empty corner in the relationship. Fighting a serious medical illness is challenging unto itself. Fighting to establish a relationship with a treating physician wastes resources that may be employed for more productive means.

Physician–patients are unique in this respect. From a medical perspective, they need to be addressed like any other patient. Patient outcomes may be affected by attempting to give privileged treatment to physician–patients. Psychologically, however, these patients are unique, and the specific challenges their education and experience bring into the consultation room need to be explicitly addressed. Developing rapport and empathy will likely necessitate additional effort. This effort, however, may have lasting effects that will help physician–patients cope with a potentially devastating diagnosis.

## ACKNOWLEDGMENTS

I would personally like to thank Neil Scheurich, M.D., John Neill, M.D., and Robert Kraus, M.D., for intellectual and editorial assistance.

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