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pif Psychiatry Interest Forum

A doctor's first concern is the patient. When this is one and the same person, the mandate is paradoxically weaker and there are numerous intrinsic and extrinsic challenges obstructing access to a standard and acceptable level of healthcare. Although medicine is recognised as one of the most stressful occupations, with an estimated twenty-five per cent rate of psychological morbidity, doctors do not always access or receive the level of care they provide (Garelick 2012). The medical profession has decades of a documented culture of denying their own health issues and they are even referred to as 'hazardous heroes' (Kay et al 2004; Rosvold and Bjertness 2001). This essay will explore the challenges of walking through the avenues of illness, both physical and mental, from the doctor-patient's perspective.

Before a doctor contemplates opening the consulting practitioner's door, he must adopt the identity of a patient. The duty of care and the social expectations of a medical practitioner often become internalised, making removal of oneself from one's label difficult. Seeking help places doctors in a submissive rather than their usual assertive and controlling role and makes them dependent on another professional. Moreover, doctors may be reluctant to admit to ill-health, given their duty to prevent and treat it. A study of general practitioners suggested that doctors feel the need to portray an image of perfect health to patients and colleagues (Thompson et al 2001, cited in Adhsead). Adshead (2005) argues that a helpful challenge for the health of the healthcare profession is to develop a therapeutic identity that does not require doctors to be constantly 'perfectly pure, perfectly good and perfectly healthy'.

The help-seeking behaviour, or lack thereof, of doctors is a further challenge. In a survey by Pullen et al (1995) of randomly selected GPs from the medical register, twenty six per cent reported feeling inhibited consulting another doctor. Physicians may treat themselves or seek advice from colleagues instead of routinely using the health care services (Røvik 2009). Perceiving the need for treatment for mental health problems, in particular, does not always translate into help-seeking. Røvik (2009) found in his ten-year longitudinal study of Norwegian medical students and early career physicians that thirty-four per cent reported being in need of treatment for mental health problems but only sixty-four per cent of this group had actually sought help. Chew-Graham et al (2003) postulate that a reluctance to seek help might result if the mental health problem is regarded as a form of weakness and a hindrance to a successful career.

Indeed, if a doctor has mental health problems, stigma is arguably one of the greatest challenges they face as a patient. The beyondblue (2013) survey demonstrates that stigmatising attitudes regarding the

performance of doctors with mental health problems persist: forty per cent of doctors felt that medical professionals with a history of mental health disorders were perceived as less competent than their peers. It is also possible that psychiatrists with psychiatric disorders may feel an increased sense of shame that they have not been in total control of their feelings or thoughts and have been unable to maintain mastery over their own minds, despite their knowledge of mechanisms of illness (Adshead 2005). Interestingly, Adshead notes that many doctors will prefer to be labeled with burnout rather than clinical depression as it is a less stigmatizing label and appears to be an occupational disorder that can be fixed.

Tagore (2014) is a psychiatry trainee who wrote about his paranoid psychotic episode in the Psychiatric Bulletin, despite advice that 'to openly admit to a psychotic illness would be career suicide'. Tagore proposes that many doctors 'expect or anticipate that there will be inevitable discrimination against fellow medics who have had a mental illness'. He explains that 'the stigma associated with mental illness is just as debilitating as the symptoms' and persists as a 'functional impairment' after the symptoms have subsided: 'Despite evidently needing acute assessment and treatment, through my psychotic haze…. I felt the need to distance myself (both physically and psychologically) from the other patients - I needed to reassure myself that I was not one of them'. Tagore then describes his realization: 'I was no better than or different to them - I was just as unwell, and just as human as the rest of them. I was just as vulnerable and susceptible to mental illness as the rest of them [...] I was no longer this superior being, the 'doctor' to their 'patient,' I was their equal'.

Leading on from stigma is the concept of confidentiality, which may be a further barrier for doctors to step into the patient role. The beyondblue survey (2013) identified the major barriers to seeking treatment for a mental health condition as a fear of confidentiality, embarrassment, impact on registration and concerns about career development or progress. In rural and remote areas, the avenues for referrals and the ability to seek medical care outside of one's network may limit complete anonymity and confidentiality. As such, intimate histories, examinations, procedures may need to be performed by acquaintances rather than a completely unfamiliar practitioner. A close-knit community may be particularly problematic for a doctor with mental health or substance use issues although, obviously, confidentiality must always be breached if it is required to maintain patient and staff safety, as detailed in the AHPRA (2014) policy on mandatory reporting.

If the doctor-patient manages to arrive at the consultation room despite the issues thus far, there are challenges for his treating doctor. In 'corridor consults' with a colleague, the lines of responsibility are blurred, which exacerbates the stress of the situation for both doctors (Garelick 2012). In a formal consult, however, the treating doctor may feel under scrutiny and experience anxiety, which can hinder their performance. A psychiatrist treating a doctor needs to be aware of countertransference and may be susceptible to minimising their difficulties in their terminology or diagnosis (Adshead 2005). There

are, however, some potential benefits in the consult. The similar background knowledge may be advantageous as the treating doctor can speak ‘medicalese’ fluently and safely assume a baseline clinical knowledge of the patient. In certain situations, a doctor-patient should also be able to research effectively and have the confidence to ask questions and clarify treatment options.

Accepting the patient role leads on to workplace-related hurdles. The ability to call in sick is part of a structural and cognitive challenge. Sick leave is a basic right in the public health officer award. When workplaces do not have staff to cover those off sick, however, it is difficult to take adequate leave. Doctors commonly cite lack of time and pressure from work as a main obstacle to seeking help, with shift work and frequent relocations making it hard to see a GP (Garelick 2012). In a UK survey, three-quarters of the GPs said they had taken no sick time in the previous year and the average, self-reported sick leave was 2.9 working days (significantly lower than the 6.8 days reported by the United Kingdom general public) (cited in Gautam, 2008). The concept of ‘presenteeism’, attending work when unwell, is common amongst doctors, who often have traits of perfectionism and feel obliged to stay back regardless of their mental or physical state. A survey of doctors found over eighty per cent reported ‘presenteeism’, with a reluctance to burden colleagues as a common reason to continue working when unwell (Sanderson and Cocker 2013). Michael Peters from the British Medical Association (2014), argues that ‘doctors often regard taking sick leave as exposing weakness, jeopardising ambitious career paths, or letting down colleagues and this is where employers need to work to change the culture’.

Fortunately, the challenges facing doctors accessing medical care and the requirement of particular skill sets for doctors treating doctors is increasingly recognised. There are specialised services for doctors expanding across Australia to facilitate access to acceptable standards of care, such as the Doctors’ Health Advisory Service and the Victorian Doctors’ Health Program. There are also policy statements from many specialty colleges and resources to help members maintain their health (see, for example, the policies and resources on doctors’ health from the RACP, the RANZCP, the RACGP and the RANZCA).

In conclusion, an unwell doctor faces psychological, sociocultural and structural challenges along the way to becoming a patient. He must shift into the sick role, negotiate leave, accept care and manage a dual identity of patient and doctor. It is not always a path beset by obstacles; there may be some benefits to the encounter, such as clinical knowledge and the ability to navigate the complex healthcare system. There is also hope that with the much wider recognition and increasing specialised health services for doctors, the adoption of the patient role will be less challenging. Despite this, we still need to be mindful of the potential difficulties, particularly the stigma of mental health, facing a colleague opening the door to our consulting room. Doctors are only human, after all, and primum non nocere holds true to both patient and doctor.

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