

# The Dilemma of Treating a Doctor-Patient: A Wrestle of Heart Over Mind?

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“Care more particularly for the individual patient than for the special features of the disease.”

– Sir William Osler<sup>1</sup>

Sir William Osler (1849-1919) was a great proponent of the patient-as-a-person doctrine that became influential in the decades after 1900. Such a doctrine was a paradigm shift from 19th century practice in which bedside manner and social graces often counted for a great deal.<sup>2</sup> Should the individualism of the patient override the state of disease? Broadly speaking, should it really matter who the patient is? Should his or her background (eg, profession, social status, education, culture) be a decisive factor in the management of a clinical condition? What if the patient is a doctor?

When a doctor becomes a patient, perspectives may change and emotions can run high.<sup>3</sup> The trusting relationship between doctors and their patients is essential to the quality of care.<sup>4</sup> As attending clinicians, should we follow Osler's footsteps and allow our decision-making processes to be affected by the fact that the patient is one of us?

## OLDEN TIMES

Does Hippocrates provide the answer? The Hippocratic Oath states, “To reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required.”<sup>5</sup> Appreciating a teacher or offering assistance is different from providing clinical care to a colleague. Furthermore, differences of conduct and belief in all societies continually evolve, leading to fundamental changes over time. Therefore, the relevance of such eternal oaths or solemn declarations, even of a secular nature, remains open to debate in today's society.<sup>6</sup> The current consumerist model of healthcare exemplifies this point.<sup>2</sup> So, if the past does not provide the answer, what about the present?

## CURRENT LITERATURE

A search of the Cumulative Index of Nursing and Allied Health Literature, MEDLINE, and Google databases through December 2014 using the keywords doctor, patient, physician, colleague, relation, and treatment identified articles discussing the issues that arise when a physician has to deal with the illness of a close family member.<sup>7-9</sup> These feelings ranged from despair, anxiety, denial, and contempt to gratitude and a sense of relief. These experiences sometimes helped doctors revisit their own practices and attitudes toward patients.<sup>9</sup> However, a paucity of articles address the clinical issues that may arise in a

doctor-patient relationship and the decision-making process that may follow when the patient is a doctor. What do professional bodies say in this regard?

## PROFESSIONAL ORGANIZATIONS AND REGULATIONS

The General Medical Council in the United Kingdom advises doctors not to treat themselves and states, “Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care.”<sup>10</sup> Such advice can perhaps also be interpreted as a potential argument for not treating a close colleague. However, no professional body advises not to treat an ailing colleague. This omission is understandable as such a prohibition would otherwise breach the fundamental duty of a doctor, namely, “Make the care of your patient your first concern.”<sup>10</sup>

Reporting an illness is a different situation. An individual's ability can sometimes be affected by illness. Medical regulatory bodies usually provide clear guidelines about reporting the illness of a colleague if the illness appears to impair his or her ability to perform as a professional of good standing. For example, the Australian Health Practitioner Regulation Agency states, “Practitioners, employers and education providers are all mandated by law to report certain notifiable conducts relating to a practitioner or student. This includes a health impairment that may place the public at risk of substantial harm.”<sup>11</sup> The British Medical Association (BMA) also emphasizes, “Doctors also have a duty to take action if they become aware that a colleague's health is affecting patient care.”<sup>12</sup>

## CONVENIENCE VS CORRECTNESS

It is imperative that doctors recognize all patients as fellow human beings and value their autonomy to meet patients' expectations to be treated with respect, kindness, and compassion, expectations that have remained unchanged throughout the last hundred years.<sup>2</sup> However, a doctor can sometimes overidentify with a doctor-patient and become too sociable. Furthermore, interpersonal and professional relations can sometimes influence the level of communication and convenience of management.<sup>13</sup> For example, a doctor may be more at ease using medical jargon with a doctor-patient than with a lay patient. Similarly, because of his/her knowledge of medicine and the healthcare system, the doctor-patient may choose to exercise a greater say in some

management issues than a lay patient.<sup>8</sup> Although these are relative issues, a cynic may question, and quite correctly so, the righteousness of such acts. Do the latter reflect a special rapport between the attending doctor and the doctor-patient? This may well be the case.<sup>3</sup> However, to understand the potential bond that may exist between a doctor and a doctor-patient, one has to put the matter in context and consider a doctor's personal journey through medicine.

### **GROWING UP AS A DOCTOR: TRIUMPHS AND TRIBULATIONS**

Doctors grow to know one another with the intimacy and the contention of siblings, affirming one another's triumphs, hearing about one another's errors, and comforting one another's grievances.<sup>14</sup> They rely on each other for honesty, criticism, and forgiveness. In this background, it is understandable that when the colleague becomes a patient, the interpersonal outcome as well as the underlying empathic process may vary.<sup>5</sup> Given this backdrop, is it not tempting to offer a different treatment to a colleague?

### **DOES DIFFERENT MEAN BETTER?**

However tempting it may be, a different treatment should not necessarily be perceived as a better treatment. As far as the key decisions are concerned, treating a doctor-patient differently is likely to be detrimental. Why so? Well, the reasons are simple. If one can offer a better treatment to a colleague, why can't one offer the same treatment to others? On the other hand, if the doctor is offering the best possible treatment to others anyway, how can he or she possibly offer a different kind to a colleague and claim it to be any better? A similar thought has been echoed by the BMA, "Treating a fellow health professional can be challenging. Doctors providing care for other health professionals need to treat them like other patients."<sup>12</sup>

### **DOCTOR-PATIENT: REVERSAL OF ROLE**

Several factors may influence doctor-patients' perceptions of illness and ultimately influence their care. These factors can range from anxiety, denial of illness, need to feel omnipotent, and loss of self-esteem to fear that illness equates to weakness and an inability to reverse roles and become a patient.<sup>13</sup> Some doctor-patients may fall victim to very-important-person syndrome. Nurses and other healthcare professionals may find it challenging to deal with a doctor-patient, and the situation can be compounded by their circumvention of administrative and medical regimens. Such issues can affect a doctor-patient's care and may result in confusion, hostility, and poor outcome.<sup>15</sup> Altering the decision-making process and providing a different treatment to a doctor-patient can potentially augment such hostility and be counterproductive. Professional payments can become an awkward issue and a cause for embarrassment.<sup>13</sup> Intense economic and social fears may follow, accompanied by the undue anxiety of worst possible outcome of a particular clinical condition. Such factors may explain the view that doctors make the worst patients.<sup>15</sup>

### **DOCTORS' DOCTOR: ACCOLADE OR CHALLENGE?**

Being a doctors' doctor can be a worthwhile experience. However, it can be a daunting encounter for some. Caring

doctors may experience feelings of inferior professional competence and overidentification and become too sociable. They may be misled by the patient's use of medical terms and thus omit essential questions or examinations. While some doctors may deal with these difficulties easily, others may feel pressured, strained, and insecure. Some doctors may even choose to avoid such encounters.<sup>13</sup> Therefore, it is prudent to consider a few relevant issues before taking on the role of a doctor's doctor (sidebar).<sup>13</sup>

Failure to consider these issues may give rise to unforeseen circumstances and explain the origin of the commonly held view that things are more likely to go wrong with medical patients than with nonmedical patients.<sup>16</sup>

### **WHAT IS THE WAY FORWARD?**

It would be a great misjudgment on the part of a doctor who treats a colleague to think that the sick colleague must be regarded differently because he or she is a doctor. The only remedy is for both sides to acknowledge such a reality. Doctors should forbear from treating themselves and take the valuable opportunity of adding to their knowledge of human nature through their own experiences as a patient.<sup>17</sup> Narrative medicine, a model for humane and effective medical practice, may provide some insight into a doctor's personal journey through medicine as well as acknowledge kinship with and duties toward other healthcare professionals.<sup>18</sup> In Norway, this issue has been addressed by the physicians-for-physicians program organized by the Norwegian Medical

#### **Dos and Don'ts for Treating a Doctor-Patient**

##### **Dos**

- Take history and perform examination thoroughly (as for any other patient).
- Deal with the patient's anxiety directly.
- Clarify the doctor-patient relationship as early as possible.
- Avoid overly close identification because of empathy or sympathy.
- Discuss the management plan in detail to allay anxiety.
- Leave plenty of time for a clear discussion of opinions and recommendations.
- Speak to the patient directly, or if desired, along with the relatives. If relatives need to be spoken to separately, this should be done with the patient's consent.
- Discuss issues of privacy, confidentiality, insurance, and payment early.
- Maintain professional courtesy; the relationship should be more than a financial arrangement.

##### **Don'ts**

- Accept the responsibility if you feel an excessive degree of anxiety.
- Walk away until you find someone who is willing to undertake the responsibility.

Association. General practitioners who are specifically trained in treating physicians as patients are recruited as mentors.<sup>19</sup> The programs are successful, with doctor-patients appreciating most the psychosocial aspects of care.<sup>13</sup> Such an approach is akin to the special training given to the priest who has the unique role of the Pope's confessor.<sup>15</sup>

## HOLISTIC APPROACH

Good healthcare should be available to all and should be based on clinical needs. This was one of the core founding principles of the National Health Service in the United Kingdom, established in 1948, some hundred years after Osler was born.<sup>1,20</sup> It is imperative that doctors base the treatment of colleagues on clinical needs rather than on who they are. It took many decades for the pendulum to swing from the patient-as-a-person doctrine to the modern needs-based healthcare.

## CONCLUSION

On balance, a doctor should not treat a doctor-patient differently from a lay patient. Alterations of treatment do not necessarily lead to a better outcome and could even be counterproductive. The focus of treatment should strictly be on the nature of the ailment, rather than the profile of the patient. Being a doctor's doctor can be a challenging prospect for some, and relevant issues should be considered before taking on such a role. Perhaps it is time that medical schools start addressing these issues to teach future doctors how to decide whether to treat ailing colleagues in their time of need.

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