The sick doctor, a patient like any other?
Qualitative study amongst 33 french doctors

Pr Eric GALAM (*), Dr Sandra Bonneaudeau (*), Dr Madeleine Lhote (*)

(*) Département de Médecine Générale Université Paris Diderot
contact : eric.galam@univ-paris-diderot.fr

METHOD

2010 semi-directed interviews :
- 13 by one researcher with practicing general practitioners (GP) between the ages of 26 and 58 (average 47 years, 6 men and 7 women) "**who have had a personal contact with disease";**
- 20 by another researcher with medical or surgical specialists and GPs "**who have been treating others doctors**": 4 GPs and 14 specialists.

12 men and 8 women among whom were 15 doctors working in a hospital setting and 5 in an urban setting.
- Average duration of interviews : 36 minutes recorded, transcribed, anonymized and coded using the method of data triangulation by the 2 researchers and their research director.

Interviews were stopped at data saturation.

MAIN FINDINGS

The sick doctor (SD) is a **knowledgeable patient**.
SD is a **mirror** for the doctor's doctor (DD) who treats him as he would like to be treated.
After the **identification can come the pressure**
Emotional aspects and professionalism.
Distance and **proximity**.
Not to do **more** than for others, but **not** to do **less** either
Not to let the patient carry his disease but implicating him
<u>3 traps :</u>
- not to establish a **formal framework** of consultation with physical examination and medical discussion
- **thinking it is only an individual prob**lem
- believing that things will sort themselves out without a **real mobilization**

FURTHER RESEARCH

- How to **position** oneself as a Doctor's Doctor
- What place for GP as DD ?
- What place for **dedicated structures** ?
- What place for **attending physician** ?
- What place for **self-prescription** ?
- What place for **preventive medicine**?
- What are the **specific constraints**?

General questions :
- What does it mean **to be ill** ?
- How **to care for the other** ? how to **integrate what the patient knows, wants, fea**rs ?
- How should one treat **someone who is close** ?

STRENGHTS AND LIMITATION

1) **burnout** excluded. 2) **sample** bias: word of mouth, same region, intimate 3) **declaratory** bias 4) researchers **touched** by the interviews 5) **qualitative** method

WE CAN UNDERLINE :

1) Position : **familiarity and reciprocal identification**.
2) Past and future : for the SD, the **nostalgia** of not being the doctor anymore, reflects the **fear** of the DD of being one day in the position of the doctor he is treating.
3) **accelerated process**: immediacy of the link to the disease, shortened clinical examination, absence of interaction for the SD, also impacts the DD who can hardly sugar-coat the illness to his knowledgeable patient.
4) **temptations to hide or to forget information**: "telling or not telling" that he is a doctor to his DD, mirrors for the DD about his patient "acting as if he were not, while remembering that he is".
Patient's temptation to refuse the symptoms reflects the DD's attitude of not taking into account the patient's profession.
5**) SD's tensions** between freedom (self-prescription, easier and targeted access), fidelity to the role of doctor, the constraints of 1) his work conditions (private practice), 2) his own patients (thinking of others, overcoming), 3) his friends and family, 4) his DD and 5) himself.
DD's tensions : to be attentive he is treating a SD and to treat him like any other patient
7) **reciprocal judgment**
8) **delicate nature of interaction and relationship**
- patient's need for letting go without giving up and being implicated
- DD's acceptation to lead the treatment without neutralizing his patient.

CONCLUSIONS AND RECOMMANDATIONS

1) the **sick doctor is a patient above all**:
2) **looking after a sick doctor is looking after a patient** .
3) **patient and doctor are partners** for an optimal care
4) **motivation to look after sick doctors needs personal and institutional investment** : reflexion about methods tools and procedures: attending physicians, preventive medicine, establishing correct and negotiated self-prescription, specialized structures, insurance and prevention mechanisms....
5) **sensitize doctors to the fragility they share with all human beings**

QUOTING

✓ To be sick when one is a doctor is unthinkable, the sick one is usually on the other side of the desk

✓ I do not have a long enough stethoscope to auscultate my own back

✓ Certainty makes you very powerful and the disease teaches you that you are like others, and that is a good thing

✓ I believe it is better to be a patient and not to know

✓ I returned to work with the cast still on

✓ Finding a locum before stopping their activity was also an important obstacle : An emergency almost more urgent than getting diagnosed and treated

✓ I dropped my ideologies

✓ I did not stop telling myself that he knew more than I did , that he had already examined himself because he knew what to look for and how

✓ They have the same symptoms, the same diseases, the same anxieties

✓ I think I built a succesfull relationship when I feel I am close to the patient but have left sufficient distance as well

✓ Having a doctor in front of you, you feel judged : if things are turning out badly, it feels like he "awaits us at the turning

✓ I am the other since the other is like me, which adds a difficulty

✓ Fellow doctors resemble us, are closer, therefore they touch us more

✓ It is necessary to preempt all attempts by the patient to intervene in the treatment

2012 AMA-CMA–BMA International Conference on Physician Health 2012
Montreal, Quebec, Canada, October 25-27