Physician Self-Care: Physician, Please Don’t Heal Thyself

In a book entitled *The Physician as Patient*, by Michael F. Myers, MD, and Glen O. Gabbard, MD, the psychology of physicians and the culture of medicine are aptly described. Gabbard feels that the perfectionistic behaviors that patients seek and that the field of medicine rewards become “personally expensive.” Although perfectionism may lead to comprehensive diagnostic efforts, precision in the ordering of lab tests, and thorough treatment planning—all of which serve the patient well—it is the same perfectionistic expectations that often become maladaptive when they are applied to oneself and to nonpatient relationships. Several investigators, including Gabbard, have concluded that perfectionism is a vulnerability factor for depression, burnout, anxiety, and eventual suicide.¹⁻³

The roots of perfectionism

Clinical work with physicians by the Washington Physicians Health Program (WPHP) confirms that perfectionism in physicians is often associated with a childhood belief that they were not sufficiently valued or loved by their parents. Further, these physicians believed that if their childhood behavior and achievement became perfect, then the love would follow. Low self-esteem could often be overcome with accolades and attention. However, when awards were forthcoming (for the high school valedictorian, the summa cum laude graduate, etc.), the only response from perfect children was to demand even more of themselves. Gratification and contentment, if they occurred, were short-lived and had little real value. Instead, they were replaced with the psychic torment of still trying to be good enough. Unfortunately, it is not uncommon that the perfect child tried to become the perfect physician.

When illness becomes unacceptable

What happens when the perfect physician develops a substance abuse problem, depression, or major mood disorder? Is the physician able to seek help for this disorder as if it were hypertension or diabetes? Unfortunately, more often than not, the answer is no. At the WPHP we know that the ability of a physician to identify as someone who is “ill” instead of “bad” is rare. Additionally, it is compounded by the shame and guilt that arises from the cognitive distortion that “this should never have happened to me and people have finally found out what a fraud I really am.”

In fact, when the self-doubt and shame are combined with an exaggerated sense of self-responsibility and responsibility to others, we don’t believe we have permission to be sick at all. We readily ask our patients not to return to work because they are “too sick” to do so, but how often do we come to work minimizing our own illness when we are just as ill ourselves? We compulsively search for depression in our patients while at the same time rationalizing our own depression as just being “a bad day.” How capable are we of concluding that our alcohol consumption has become as problematic as that of our patients?

Because of the expectations of society and of ourselves that “we should be different,” we are unable to accept any illness in ourselves that connotes a sense of loss of control. We may know that “something isn’t right,” but what it is and what to do about it isn’t usually within our grasp. We search for less egregious explanations, minimize our symptoms, rationalize our response, and deny our own access to adequate care. It seems as if we are not good enough to be “that sick.”
Why self-diagnosis and self-care don’t work

The doubt, shame, and exaggerated responsibility also predispose us to self-diagnosis and self-care. How can we delegate our health to someone else when we should have been taking better care of ourselves? If we do seek care and are appropriately treated, how often do we take the medication as prescribed and complete the prescription? In fact, we physicians are notorious for stopping the medication because of side effects or adjusting the dosage without telling our physician because we know better and “don’t want to bother them.” So the Benadryl becomes Ambien, the ibuprofen becomes Vicodin, and recurrent suicidal ideation is dismissed because “I would never do that.” The physician who self-treats is said to have “a fool for a patient.” And the physician who diverts a controlled substance also violates state and federal laws.

How can physicians get better?

We deserve the same quality of care that we provide to others. We have the same prevalence and incidence of disorders as our patients—and our suicide rate is much higher than that of the general population. What can we do to change this paradigm?

• Acknowledge that our health is as important as the health of our patients.

• Seek adequate medical care, especially preventive care, and be compliant with all treatment recommendations.

• Take all medications exactly as prescribed.

• Avoid all self-diagnosis and especially self-treatment; it is dangerous and we deserve better than that.

• Seek additional education and training that allow us to distinguish the differences among stress, burnout, poor boundaries, maladaptive coping, depression, risk of suicide, substance abuse, and substance dependence.

• Become familiar with resources and services of organizations like the WPHP (www.wphp.org) as well as the American Foundation for Suicide Prevention (www.afsp.org and DoctorsWithDepression.org).

Simple as it may seem, it is true that the healthier we are, the healthier our patients will become!

References:


Mick Oreskovich, MD, is the medical director and chief executive officer of the Washington Physicians Health Program. For more information about preventing and dealing with physician impairment, contact Dr. Oreskovich at moreskovich@wphp.org.