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When the Patient is a Doctor:
Dilemmas Faced by Physicians Treating Their Peers

by

Heidi Elyse Kirsch

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A thesis submitted in partial satisfaction of the
requirements for the degree of

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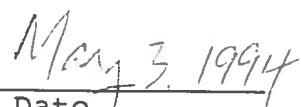
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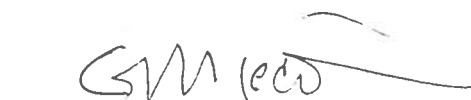
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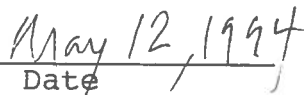

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INTRODUCTION

Most patients believe
dying is something they do
not their physician,
that white-coated sage,
never to be imagined
naked or married.

--W. H. Auden,
"The Art of Healing"

I like to see doctors cough.
What kind of human being
would grab all your money
just when you're down?
I'm not saying they enjoy this:
"Sorry, Mr. Rodriguez, that's it,
no hope! You might as well
hand over your wallet." Hell no,
they'd rather be playing golf
and swapping jokes about our feet.

Some of them smoke marijuana
and are alcoholics, and their moral
turpitude is famous: who gets to see
most sex organs in the world? Not
poets. With the hours they keep
they need the drugs more than anyone.
Germ city, there's no hope
Looking down those fire-engine throats.
They're bound to get sick themselves
sometime; and I happen to be there
myself in a high fever
taking my plastic medicine seriously
with the doctors, who are dying.

--James Tate,
"On the Subject of Doctors"

The topic of doctors as patients, as those who also
cough and die, has captured the attention of the publishing
and entertainment industries recently. Witness these
provocative book jackets:

The true-life story that inspired the major motion picture.... As a physician, Dr. Rosenbaum had long enjoyed all the benefits of medicine; as a patient, he suffered all its indignities. He experienced fear, frustration, and rage. *THE DOCTOR* offers a vivid, often disturbing look at life inside a hospital. But more than that, it is the intimate, deeply moving story of a doctor who became a powerful patient's advocate--the story of how a terrible disease became an inspiration. (Rosenbaum 1988: cover)

This fascinating personal story of a surgeon turned patient should help all prospective heart patients understand their options better. With characteristic humor and candor, Dr. William A. Nolen, bestselling author of *The Making of a Surgeon*, frankly describes what it was like to discover he had angina and then to have a by-pass operation performed on his heart. (Nolen 1976: book jacket)

Why this interest? Perhaps it is a question of "lo, how the mighty are fallen": do laypeople rejoice in seeing patronizing doctors reduced to helpless dependence? If so, they must relish even more their tearful descriptions of the epiphanies that came to them in such a state: how they resolved to be more humane, now that they can empathize with their patients. Almost every autobiographical account of a physician who became ill ends with emotional testimony concerning his improvement as an empathetic healer and as a human being. These tales of redemption are intended to suggest that doctors, when they become patients, are transformed into better physicians.

This idea that illness¹ can humanize a physician has recently made its way into the medical school curriculum.

Students are regularly asked to imagine themselves as patients; at some schools, students are even required to spend time in the hospital as mock patients, hooked up to IV lines and subject to the frustrations and humiliations that attend the inpatient experience.

Recovered physicians can also serve as examples of model patients with textbook recoveries. Dr. Oliver Sacks² (1984:43-44) recalls the heartening effect of a visit from a surgeon as he lay injured:

A young man--dressed, preposterously, in a white coat, for some reason--came in *dancing*, very lightly and nimbly, and then pranced round the room and stopped before me, flexing and extending each leg to the maximum like a ballet dancer. Suddenly, startingly, he leapt on top of my bedside table, and gave me a teasing elfin smile. Then he jumped down again, took my hands and wordlessly pressed them against the front of his thighs. There, on either side, I felt a neat scar.

"Feel, yes?" he asked. "Me, too. Both sides. Skiing... See!" And he made another Nijinski-like leap.

Of all the doctors I had even seen, or was later to see, the image of this young Norwegian surgeon remains most vividly and affectionately in my mind, because *in his own person* he stood for health, valor, humor--and a most wonderful, active empathy for patients. He didn't talk like a textbook. He scarcely talked at all--he acted. He leapt and danced and showed me his wounds, showing me at the same time his perfect recovery. His visit made me feel immeasurably better.

Here, the surgeon's model recovery has transformed him into a model clinician, precisely because he can use himself as an example.

For those who seek to explore the physician-patient relationship, the idea of a doctor facing illness raises issues that are even more intriguing. The study of doctors and patients has been eagerly undertaken over the past twenty years, and much of the focus has been on the sources and maintenance of the power and dominance of physicians, both as a political and social group, and as individuals facing patients in the examining room. Because of this focus, the study of physicians as patients proves that much more enticing: what happens when a priest of biomedicine, previously invested with the institutional power of his order, falls prey to his foe, disease? The sources of the physician's authority can be scrutinized closely as they fall away during illness.

The study of physicians as patients can also bring up more general questions about the physician-patient relationship. Mismatch of the explanatory models³ held by the patient and the physician is often the focus of studies of physician-patient relationships. Much is also made of the knowledge differential between doctor and patient; the physician's power and authority is thought to follow from this knowledge differential, which can also produce dissatisfaction and frustration on the part of both doctor and patient (e.g. Shorter 1991, Starr 1982, Turner 1987).

When the patient is himself a physician, though, would not these sources of frustration, confusion, and miscommunication be minimized? The physician/patient⁴ ostensibly holds the same explanatory model of his illness as does the treating physician, since medical school curricula vary little; he also, supposedly, must have faith in the offered therapies, since has devoted his youth to mastering them. The knowledge differential, and thus the power differential, between the physician/patient and the treating physician is thereby minimized inasmuch as is possible, considering the specialization of individual physicians. Since these variables, knowledge and explanatory models, are largely held constant when the patient is a doctor, we can get a clearer look at other problems attending the physician-patient relationship, as well as at patienthood itself.

Perhaps being a patient, or rather being doctored, is not a simple matter of having less knowledge and experience than does one's physician. As Hunter points out (1991:126),

As patients we often tolerate this incommensurability because it accompanies the promise of health. We consult experts precisely because they are knowledgeable and experienced. But the experience of physicians as patients suggests that incommensurability is not entirely a matter of knowledge differential. Even with a full grasp of the medical facts, the gulf yawns wide between that question that obsessed Tolstoy's Ivan Ilych, "Is it very serious?" and the one that absorbed his

physician, "whether it was a matter of the vermiform appendix or a floating kidney."

Thus the extraordinary case--that of the physician/patient--can provide a more powerful prism through which to refract our ideas about the meaning and experience of patienthood itself.

The literature concerning physicians as patients focuses largely on physicians' failure to accept the sick role gracefully (e.g. Lear 1980, Mandel and Spiro 1987, Nolen 1976, Pinner and Miller 1952, Rabin 1985, Sanes 1979, Widome 1989). The cliché "doctors are bad patients" appears repeatedly, followed by case studies that are intended to support the phrase, but are often ambiguous. Little space is devoted to exactly how and why doctors are "bad patients," or, in fact, on what constitutes patienthood, good or bad; the analysis accompanying the case reports is usually limited to a brief discussion of denial and control issues. The actions of the treating physician, and the motivations behind these actions, are also ignored. Although physicians are often blamed for the failure of doctor-patient communication (e.g. Millman 1977, Shorter 1991), in this case, the patient--who happens to be a physician--is usually blamed for any difficulties, while the participation of the treating physician is not scrutinized.

After reviewing many such case histories, whose sources I describe below, as well as speaking with physicians who treat their peers, I believe that we need to focus on the

problem presented by the physician/patient by looking more closely at the treating physician. I reach this judgment for two reasons. The first is that although physician/patients, as do many patients, often have difficulties with the transition to the sick role, these difficulties are almost always compounded by the attitudes and actions of the treating physicians. The second is that intervention, if any, can only focus on the treating physician. It would be an almost impossible task to teach physicians to be "better patients," to some degree because the mechanisms that make them "bad patients" are necessary for their function as physicians, as I discuss below. It is more practical to devise recommendations for physician behavior when confronted with an ill peer.

To investigate what happens when doctors become patients, I undertook open-ended interviews of physicians who had suffered from illness that they considered significant, as well as interviews with physicians who had treated their peers. I also distributed surveys at an American Medical Association convention on physician health; the surveys asked open-ended questions about participants' illness experiences and experiences treating ill peers. Both of these methods shared a problem: many, but not all, respondents tended to speak theoretically about physicians as patients, rather than sharing their own experiences, even when prompted to provide specific anecdotes. Perhaps this was because I informed respondents that I was a medical

student writing a thesis on the topic of physicians as patients. Desire to be maximally helpful or to express their own hypotheses may have guided them. Alternatively, reluctance to provide details may reflect a need, conscious or not, to differentiate their stories from clinical case histories of patients; this may represent an attempt to achieve distance from the traditional patient role (I will discuss other such attempts below).

Rich sources of data have been autobiographies of ill physicians, which have proliferated recently as the interest of the public in such volumes has grown, as described above. These books generally provide a great deal of detail, both technical medical detail and lengthy descriptions of the authors' emotions throughout. The level of detail in these narratives is often intended to provide clinical information to laypeople with similar ailments, and is also meant as a testament to the humanizing power of illness.

My major sources, however, have been two volumes, published 35 years apart, of short descriptions by physicians of specific episodes of illness that they have faced. Again, these tales, 33 in the first volume and 50 in the second, are meant to inform lay readers, but also to aid physicians. The earlier volume, edited by Pinner and Miller (1952), emphasizes that physician/patients are able to accurately record their symptoms and gain invaluable subjective experience of various diseases, and thus can make a scientific contribution to medicine with their reports.

Similar aims are expressed by Mandell and Spiro (1987), but they add the hope that the cases can shed light on the way in which illness changes physicians--another example of the recent focus on the perfection of physicians through purifying illness. It is noteworthy, though, that the titles of the case reports in both volumes are overwhelmingly the names of the diseases addressed thereby, in the tradition of reducing illness experiences to cases of disease. Also, the actions and reactions of the treating physicians, vital to my inquiry, are mentioned only in passing in these stories, since they are not meant as criticisms of the care received by the physician/patients.

I will use these data to point out common reactions of physicians to their illnesses, and then to show how these reactions are facilitated or maintained by their peers, from whom they sought treatment.⁵ Each chapter will focus on a broad category of response, arranged in the sequence in which they commonly appear. Within a chapter, examples of the physician/patient's difficulties will be presented along with possible explanations; then the colluding responses of the treating physician, and their origins, will be outlined.

Before setting out on these tasks, I would like first to briefly review the literature on peer relations between physicians. This theoretical background will be useful for the phenomenological discussion of the cases. The way in which physicians have learned to interact with their peers

in all other situations inevitably colors the way they treat them as patients.

Notes

1 I will be using the word "illness" as distinct from "disease," in the same way as does Arthur Kleinman: "By invoking the term illness, I mean to conjure up the innately human experience of symptoms and suffering. Illness refers to how the sick person and members of the family or wider social network perceive, live with, and respond to symptoms of disability" (1988:3).

2 Throughout my discussion, I have used the title and first name of a physician when I cite his autobiographical account of illness, in order to identify these citations and to personalize their authors.

3 I am borrowing the term "explanatory model" from Arthur Kleinman, who defines it in this way:

Explanatory models are the notions that patients, families, and practitioners have about a specific illness episode.... They respond to such questions as: What is the nature of this problem? Why has it affected me? Why now? What course will it follow? How does it affect my body? What treatment do I desire? What do I most fear about this illness and its treatment? (1988:121)

4 I will use "physician-patient" as an adjective; for example, the relationship between a doctor and a patient is

the "physician-patient relationship." To designate an ill doctor, however, I will use "physician/patient"; the term is itself symbolic of the riven, problematic person that is the physician/patient.

⁵ I would like to state at this point that I have not considered gender roles and relations in this analysis, due mainly to the relative lack of case histories by female physicians, which makes general comments on gender roles difficult at this time. Anecdotes from U. S. and British physicians were considered; I made no effort to speculate on differences between their stories due to their nationality. For the sake of brevity, I have also omitted a discussion of the relationship between ill physicians and other medical professionals. Finally, the cases that I have chosen to analyze do not include physicians who have been diagnosed with mental illnesses or physicians who were ill before they entered medical school, as these circumstances add still more levels of complexity to the subject, and as I need to limit my investigation at some point.

CHAPTER 1: PEER RELATIONS BETWEEN AND AMONG PHYSICIANS

Sociologists such as Turner (1987) and Freidson (1970a, 1970b, 1975, 1978, 1986), and historians such as Shorter (1991) and Starr (1982) present schema delineating the structure of medicine as a profession that must guard its myths of authority and autonomy. Such models posit that the American medical system of the late 20th century has evolved almost exclusively to maintain the power of physicians; this evolution can even extend to the social meaning of illness itself. As Gerhardt (1989) points out, Freidson's model, for example, "clarifies that social construction of illness denotes power relationships between doctor and patient which reveal *professional dominance*," leaving out other interpretations of the meaning of the illness experience for both doctors and patients.

Certainly these models are flawed, limited in time and space, and ignorant of the human nature of individual doctor-patient interactions; they tell a simplified story about historically established professional norms. However, I have chosen to examine Freidson's model of peer interaction, and his analysis of its importance to the maintenance of the profession of medicine, in hopes that it will shed light on the relationships between physicians and their ill peers, if only on a systemwide, impersonal level. Using his model, it seems that much of the awkwardness associated with the care of physician/patients hinges on the

rules defining behavior within the medical profession, rules that are necessary for its maintenance.

Of these rules, those dealing with communication between physicians are most relevant to my inquiry. Freidson (1975, 1978) offers the view that communication between colleagues in medicine often operates on two levels: a formal level, tailored to protect the legitimacy of medicine by asserting the self-sufficiency and perfect judgment of individual practitioners, and an informal level, which doctors use to gain information without jeopardizing their legitimacy and privilege.

Formal Communication: Criticism and Consultation

Medicine requires privileged modes of communication in order to protect its sovereignty, autonomy, and authority, and in light of this need, Freidson (1986) defines a set of formal knowledge used by physicians (or, indeed, members of any profession) that is different from informal, shared, everyday knowledge in its opacity to outsiders. He looks at "practices" (informal means of communication) versus "texts" (formal means of communication), asserting that texts are invented and applied by a professional in order to garner and maintain power over the client.

According to Freidson (1970b), physicians hold tightly to the myth of independent practice. A pretense must be made that each physician is self-sufficient, is perfectly capable, and has perfect knowledge so that he could handle

any diagnosis and treatment imaginable (or at least would refer in a timely and correct fashion). To assume anything less on the part of the individual physician would be to criticize the education and competency of that individual, and thus to cast doubts on medical education and physician competency overall. Although the reality of individual self-sufficiency has broken down significantly in the years since Freidson put forth this idea, the attitude that it fostered remains. Even when a physician refers to a specialist, the implication is that he is inviting the specialist to join a team caring for the patient, rather than giving up in frustration or ignorance, and the consultation is both invited and accepted in this spirit, as I describe below.

The myth of self-sufficiency has important ramifications for criticism of the medical profession, both within and outside it, and also affects the way in which a physician's mistakes are perceived by fellow physicians. Mechanic (1979), citing Freidson's (1975) work, points out that peer review is severely limited by physicians' values of autonomy and clinical judgment in individual cases; since cases vary and outcomes are unpredictable, mistakes are inevitable but forgivable. Similarly, Freidson (1970b:179) notes:

While self-criticism is acceptable, criticism by others is not. . . . In looking at others' apparent mistakes, the physician is inclined to feel that

"there, but for the grace of God, go I"
and that "it may be my turn next."

The emphasis on the need to project each individual physician as error-free and superhuman begins on the first day of medical school. As advice to beginning physicians, in an essay published in an anthology intended for first-year medical students and sponsored by the Robert Wood Johnson Foundation (which certainly has a stake in the maintenance of the reputation of biomedicine), Martí-Ibáñez (1991:221) writes:

To your colleagues you have the obligations of civilized men sharing a great and noble social task and fighting for a common cause in a great crusade. Medicine lives and is nourished by the great social prestige it enjoys. Hence, never speak ill of a colleague, since to do so would be the same as speaking evil of medicine and therefore of yourselves. If you have something good to say about a fellow physician, say it everywhere; if you have not, then keep silent.

This is an astonishingly blatant, almost conspiratorial statement, especially in view of the year and the context of its utterance.

Millman (1977) expands upon the theme that physicians learn throughout their training to refrain from criticizing their peers, both to protect the reputation of the profession and to maintain its power, and because they identify with the erring doctor and cannot comfortably speak against him, since they may someday be in an analogous position. Certainly this taboo is broken when physicians, especially academic specialists, informally criticize the

primary care physician known as the "local medical doctor (LMD)," who often refers difficult cases to them, or when physicians are hired as expert witnesses in court cases. In neither of these cases, however, is a physician forced to criticize a peer directly: in the former case, the LMD is regarded as a faceless bumpkin, not a recognized peer, and is ridiculed but not formally spoken against. In the latter case, testimony escapes being criticism, couched as it is with frequent references to the difficulty of making blanket statements about individual cases, and to the impossibility of assigning blame to a physician for his actions, because he is assumed to have acted according to his best judgment given the facts in his possession.

Hilfiker (1991:384-385) also addresses this reluctance to criticize, and the confusion surrounding mistakes made by a peer:

A physician is even less prepared to deal with his mistakes than is the average person. Nothing in our training prepares us to respond appropriately.... when a hospital physician did make a significant mistake, it was first whispered about in the halls as if it were a sin. Much later a conference would be called in which experts who had had weeks to think about the case would discuss the way it should have been handled. The embarrassing mistake was frequently not even mentioned; it had evaporated.

Bosk (1979) goes further in his analysis of the constitution of and the reaction to medical (specifically, surgical) errors. He distinguishes between technical errors, which

are pointed out only with the utmost delicacy and forgiven quickly, and moral errors, which are not tolerated. Moral errors result from failure to meet the surgeon's role and standards of behavior, and are seen as breaches of the physician-patient contract. Examples include dishonesty, placing one's own needs above those of the patient, and insubordination. These errors are seen as violations of the physician-patient contract: deviation from expected professional norms is more upsetting than technical errors, since it does not have the excuse of accident.

Still another description of the taboo against criticism is provided by Freidson (1970a:94): "There seems to be a certain reluctance to exert active influence over another's performance....each practitioner tended to keep his complaints about others to himself," only showing his judgment in refusing to refer to those that he has observed to make mistakes.

This comment about the refusal of referrals brings up the issue of consulting and referral within this framework. If each physician is supposed to be self-sufficient, what is the role of medical consultations and referral to specialists? Referral of a patient and concomitant consultation with another practitioner is dangerous not only in that it admits less-than-total knowledge on the part of an individual doctor. It also, Freidson points out, reveals certain aspects of the referring physician's practice and methods to others, and thus makes him

vulnerable to criticism and assessment by others. Thus, consultation and referral are bounded by strict sets of taboos against gossip and criticism and are delimited quite strictly by well-defined procedures for referral.

Clearly, such a formally circumscribed set of procedures for obtaining information from another physician without revealing weakness would hamper any attempt at actual medical practice today, since general practitioners could never assimilate current research in every field. Freidson (1978) includes in his discussion of colleague communication a second tier of less-formal communication: "informal consultation," or consultation without referral. Because the consulted physician does not see the patient, the communication is based on the first physician's observations only, and thus is less "scientific," more off-the-cuff. However, Freidson's "informal consultation" is still bound by strict rules: the competence of the original physician shall not be questioned, and he shall be protected by taboos against criticism and gossip. Therefore, despite his terminology, it is still clearly a form of formal communication, and distinct from truly informal communication, which Freidson also describes.

Informal Communication: Curbside Consults

Freidson (1978) defines a third level of informal communication, that of "casual shoptalk," which is outside the accepted formal communication model. It includes not

only the two physicians in question but also, potentially, a limited number of observer/participants and covers social and personal subjects as well as problems of medical practice. It is often organized around loose fraternities based on past referral patterns, which have fostered trust between individuals.

Here, an individual's uncertainties can be allowed to surface, and the doctor can reveal himself as fallible and human to his colleagues; after all, they have already given him their vote of confidence by referring to him in the past. Criticism is still muted, though, and it is considered poor form to refuse future referrals to a colleague based on a mistake revealed during casual talk. Note, though, that a physician may refuse future referrals based on material covered in a formal consultation; but there, such judgments are allowed and the encounter is delimited and structured in order that they are made only on the basis of medical information, and not on personal traits or limitations of the physicians concerned, as they might be if such judgments were allowed on the basis of casual talk. In fact, though, formal review as such does not really exist (although quality assurance committees have certainly grown since Freidson's work); defined sanctions are limited to "talking-tos," and at the worst, dismissal, but mostly involve exclusion from casual groups at the informal level or reluctance to refer to the offender (Freidson 1970b:139; 149-151).

Everyday casual talk thus falls outside of the myth that is needed to maintain the fiction of medicine as homogenously perfect; it thus also lacks the totalizing power of formal medical discourse. Medicine, like any society, "is...composed of certain foregrounded practices organizing its normative institutions *and* of innumerable other practices that remain 'minor'" (de Certeau 1984:48), and casual talk represents one of these minor practices. It falls into de Certeau's category of "ordinary language":

We are subject to, but not identified with, ordinary language. As in the ship of fools, we are embarked, without the possibility of an aerial view or any sort of totalization. That is the "prose of the world" Merleau-Ponty spoke of. It encompasses every discourse, even if human experiences cannot be reduced to what it can say about them. In order to constitute themselves, scientific methods allow themselves to *forget* this fact....[they] have excluded it in order to accord themselves an actual mastery (1984:11).

Like the sciences, then, medicine separates casual talk from the formal talk that gives it mastery, excluding it because it is approachable, nontotalizing, and thus a threat.

Implications for Treatment of Ill Peers

The first implication of Freidson's model arises from the idea that every physician must be seen as a repository of perfect knowledge, and that anything else would constitute a threat to the profession of medicine as a whole. When a physician becomes ill himself, then, how does

the treating physician offer him information and advice without implying, however implicitly, ignorance on the part of his colleague? How does he tell his sick peer something he should already know, without embarrassing his colleague, and without violating the taboo against criticizing another's knowledge? How does he remove decision-making responsibility from a colleague who has been rendered incompetent by his illness (or by his reaction to it) without acknowledging this incompetence, since to acknowledge it would be tantamount to undesirable formal criticism?

Another implication for peer treatment comes out of Bosk's discussion of errors. Does an ill physician, by becoming ill, fail to behave as his professional role demands, thus committing the equivalent of a "moral error" in Bosk's formulation, and therefore subject to sanctions? When a doctor becomes ill, he violates the rule forbidding surprising deviations from expected behaviors. Dr. David Rabin (1982:508) echoes this idea: "The dichotomy of being both doctor and patient threatens the integrity of the club. To this fraternity of healers, becoming ill is tantamount to treachery." Perhaps the ill physician should face sanctions for this error, this treachery. However, this would violate one of the fundamental tenets that physicians have been taught regarding the sick role (although they frequently fail to follow it, at least in their secret feelings toward an individual patient): that the patient shall not be

blamed for his illness or for his adoption of the sick role (Parsons 1951, Turner 1987). The error of being ill, then, may be ignored from fear of criticizing a colleague. Alternatively, the treating physician may prevent his peer from adopting the sick role, thereby preventing this problem entirely.

A third implication follows directly from these taboos against formal criticism and admission of less-than-perfect knowledge, and concerns the two-tier nature of physician communication which Freidson outlines. In his formulation, physicians should not be criticized for errors, or given advice that presumes their lack of knowledge, using a formal scheme of communication. However, as Freidson describes, both criticism and information may be freely given as informal communication, in the form of a curbside consult or a friendly, brief admonishment. Informal communication, while serving an important need in physician peer relationships, is quite limited, however, and is an inadequate means by which to conduct a patient-doctor relationship. It is often the only forum left, though, in which a physician can relate to an ill peer who comes to him for help. The throwing of the physician/patients back onto this secondary, informal level of communication may result, as we shall see, in their perception, often disturbingly accurate, that they are receiving less-than-adequate care.

Although Freidson's model bypasses any mention of the human, personal aspects of peer interaction or of the

meaning of illness--such as the guilt that an erring physician feels, or the fear that an ill physician may suffer--it can nonetheless be useful for understanding the implications for the medical profession as a system when one of its privileged members becomes ill. Given this, it can also predict the responses of the treating physician to his ill peer, but only insofar as he is a stereotyped actor in Freidson's framework, an actor that must above all uphold the power and dominance of his profession. The doctors' stories that I will present are illustrative of his schema, and can aid in filling out our ideas about the medicine as a social system. They have value far beyond this use, however; in their power and eloquence, they also reveal the humanity of both physician/patient and treating physician as their shared experience with illness removes them from their roles as undistinguished cogs in the professional machine and personalizes them.

CHAPTER 2: DENIAL

Without doubt, throughout both interviews and published accounts, the first concept that emerges from physician's stories is the denial of illness. Denial is an important defense mechanism whenever anyone becomes ill; it preserves hope, and thus function, in otherwise paralyzing, terrifying situations, and may even have therapeutic value. For a physician, denial of illness is especially crucial, as we shall see; in spite of its usefulness, it nonetheless complicates the care of an ill physician, by self and by others.

This complication can arise because of the tenacity with which ill physicians cling to denial. Often it is amazing in its extent: Dr. Mallory Stephens (1987:215) recalls that he had bloody diarrhea for six months before seeking care, attributing it first to viral gastroenteritis and then to internal hemorrhoids. Finally he consulted the hospital physician at the employee clinic, rather than a gastroenterologist; it was as if he sought a less competent physician rather than one who would tell him what he did not want to hear: that he had ulcerative colitis.

A similar pattern of denial characterizes many of the case histories. What differs from case to case are the reasons behind the denial, often stated explicitly by the narrating physician. Also evident from the cases is the collusion of many of the treating physicians in propagating

and maintaining the denial of the ill physician. I would like first to give examples of physician/patient denial, and then present anecdotes that illustrate how, and possibly why, this denial is fostered by treating physicians.

Denial by the Physician/Patient

Control, power, and identity

When I asked one of the physicians I interviewed for his response upon getting ill, he replied

How does a physician feel about being sick? Denial. That's obviously number one. Denial that you're sick. That's the dominant thing. Denial. You're above that. The psychology of that is that you, as a physician, see patients that are sick, and you are paternalistic --patients are beneath you, and you are in a position of being a giver of gifts. So that the position is reversed, and number one, there's denial, because you're not used to being in that role.

The fear of loss of the power of the physician's role, of no longer being a "giver of gifts," is a straightforward fear, coming as it does from individuals who often base their identity in their ability to control situations successfully. As Dr. Maurice Fox (1987:5) wrote, when his angina increased and he realized that denial was no longer an option:

Ultimately, I had to surrender to my greatest fear--not of death, which I considered without apprehension, not of disability, which I did not consider seriously enough, but fear of giving myself up to the doctors. It had to get

very bad before I was willing to become a patient. I had to be quite desperate and afraid before I was willing to give up control of my body, my future, myself.

Since medical training comes at a time in life when a student may be struggling to learn who he is, being a doctor can represent far more than just a profession, but can instead encompass the physician's personhood. For example, Dr. Edward Rosenbaum (1988:66), who was trained in the military as well as in medicine expresses his frustrations and fears when he became ill:

I am used to commanding, but now I have no power. Medical training demands years of subservience. In my case there were fourteen years: four in medical school, five in residencies, five in the army. Fourteen years of someone else looking over my shoulder. Fourteen years of "Yes sir, no sir, you're right, sir." Then suddenly you're through training and you are on your own. You alone must make decisions that mean life and death, and at first that's scary. Then you taste the power and the glory of being supreme, and you like it. Soon you brook no dissent.

I am the chief. I was chief of medicine in the army. I was chief of medicine in my hospital. I was chief of the arthritis clinic at the medical school. Now they have stripped me of my command. No one asks me what to do. Instead, they tell me what to do, and I submit.

Submission thus means a loss both of power and of identity. Through our training, we have somehow become doctors and often little more. A poignant example is provided by Dr. Harold Lear's confession to his wife after he was forced to retire because of severe heart disease:

"You take someone like myself, who was taught that you are what you achieve, you are what marks you get, you are what society says you are. I had been an 'A.' A *macher*, a leader in my profession, running around giving papers, getting kudos and green stamps. And suddenly your public persona is wiped off the board. And then, who are you?

"I used to wander through those blocks between home and the gym, asking myself : If who I am is what I can do, who am I? When I was Dr. Lear of Urology Associates, or Dr. Lear, head of the Medical Center Sexuality Program, that's who I was. But now, *who the fuck am I?...* (Lear 1980:192)

Of the multiple roles in Dr. Lear's life, only his professional roles held his identity, his self. The loss of these roles stripped away his ability to define himself.

Invincibility and immortality

Another threat to the physician/patient's professional role, and thus to his identity, comes when he loses the mythic invincibility that supposedly comes with medical training. Some physician/patients feel that their ability to escape illness was bought with their sacrificial offering of time and effort. When it comes, then, illness is a betrayal of a contract as well as a denial of their status as physicians:

I remembered now the hypochondriasis of my years in medical school, when learning each new disease evoked subliminal fear of contracting it. Subsequent years had strengthened my denial, and I marveled at my seeming immunity to all the disease to which I was daily exposed. I had, I now realized with awful clarity, come to

regard myself as having entered into a pact with God. I would devote myself and my energies to the care of my patients, relieving pain and suffering in others.... Now, the contract had been broken, my illusion of moral and intellectual superiority was shattered. Nitroglycerine and morphine had relieved the pain beneath my sternum. The rage and anguish were not to be so quickly allayed. (Dr. Robert Seaver 1987:31)

Authority over patients

After his contract with God was broken, Dr. Seaver discovered a related phenomenon which further stripped him of his identity of a physician: loss of authority in the eyes of his patients. Returning to practice after hospitalization for a myocardial infarction, he says

...I was astonished that they returned reluctantly or not at all. It was not that they preferred my replacement or even doubted my skill. (Indeed, their cards and notes were laudatory and sympathetic.) It was that I had proved to be fallible and mortal, even as they. The therapeutic magic, the constancy of care, and the implied assurance that I would always be available to ensure their welfare had been disrupted. I was no longer to be completely trusted. (1987:33)

Dr. Seaver's patients were perhaps reluctant to burden him with their care during his convalescence, but this reluctance seemed, to him, tantamount to a loss of trust.

Such a loss of trust was also imagined by Dr. Joyce Dunlop. Recovering from a bilateral hip replacement; she admitted "I still have the ridiculous notion that somehow we should not get ill, that we must appear 'fit' when treating

patients. I was horrified when someone suggested that I do home visits with a walking stick" (1987:85). Somehow ceding to illness makes physicians less credible to their patients. After all, if a doctor is unable to conquer his own illness with his superior resources, how could he hope to cure a patient's? This query leads to the next theme that leads to denial in the physician/patient: fear of giving in to the foe, disease.

Ceding to illness

Disease is often anthropomorphized and characterized as "the enemy" by these physicians; it can even embody evil in a circumscribed form. Illness can seem willfully malevolent to a physician such as Dr. Leo Davidoff, who refers to his migraines as "a demon" (1952:67). If physicians are encouraged through their training to adopt this view of disease, what happens when they become ill? Do they become traitors?

Dr. Martin Grotjahn describes this fear clearly (1964:119):

A physician hates sickness. The fight against this enemy is the physician's most noble motivation for his profession. To submit to the enemy and to concede victory to him is tantamount to treason; it cannot be true, and a fateful development begins.

This "fateful development," denial, is certainly preferable to facing defeat.

Failure, shame, and guilt

The idea of yielding to illness brings up the more general feeling of failure that can be experienced by all physicians, leading to denial. Often this feeling is ill-defined and seems to originate from physicians' past experiences with negative outcomes: that they are a result of a lack of effort or character. After all, such episodes have in the past revolved around academic and professional misfortunes which are directly attributable to personal failure.

For example, of his bout with viral hepatitis, Dr. Kenneth Barwick says "Years later the emotions I recall as being most profound were loneliness and a nagging sense of failure.....a nagging suspicion that if I had been of stronger character I would not have been so affected by the infection..." (1987:398). Dr. Samuel Sanes (1979:27) and Dr. Robert Seaver (1987:32) also identify a sense of failure as important in their concepts of their illnesses, and in their tendency to deny them.

This feeling of failure leads to shame, both personal and professional, as expressed by several physicians (Dr. Joyce Dunlop 1987:80, Dr. Max Pinner 1952:23, Dr. Robert Seaver 1987:30). Guilt is also mentioned as a consequence of failure, as Dr. Judith Brice recounts. She was actually studying ulcerative colitis, the disease with which she was diagnosed. "One of the unspoken tenets of my medical training was the belief that there is an answer out there;

if you only knew more, if you were a little smarter, you could find it.... I kept feeling that if I only knew enough, if only I were smarter, I could find the way out" (1987:172). Thus she believed herself primarily and personally responsible for her own illness, which marked her not only as powerless and mortal, but also as too stupid to find a cure and save herself.

Identification with patients

Dr. Brice's illness, ulcerative colitis, is particularly stigmatizing, not only for the reasons above, but because it was for many years thought to arise from a patient's psychological difficulties and to herald a particular neurotic personality. Although physicians, ideally, are not supposed to hold patients responsible for their illness, they often develop biases toward so-called "hateful" patients. A physician with such an illness is forced to compare himself to such odious patients; denial is preferable to this identification, as Dr. Maurice Raskin found:

...I was especially sensitive to the generalizations that seemed prevalent among fellow physicians about patients with ulcerative colitis--whining young women with emotional problems. I recall in particular my personal physician during medical school taking me with him to see a patient in the emergency room: a young woman with inflammatory bowel disease.

The patient was lying on a stretcher, crying uncontrollably and complaining of abdominal pain. Her exam

was benign, so my physician tried to calm her by revealing in a voice loud enough to be heard through the sobs, "See this young doctor here? He has colitis, too!"

I felt my face redden. I wanted to look behind me to see if anyone had heard him. Could I be compared to a patient who shared only a disease process with me? I felt, "Certainly not," and proceeded to make that clear. My method consisted mainly of denial of illness. (1987:202)

Identification with patients is also problematic for a more important reason: patients die. As we have seen, the myth of invulnerability is important to physician identity, and so for a physician, equating oneself with a patient is risky. Patients also lack control. Dr. Donald Hackel (1987:120), struck with rigidity and tremor, "...had, of course, begun to think of the possibility of Parkinson's disease--although I hoped it might be almost anything else. My dislike of this disease was particularly strong because of my experience with the helplessness it produced in people I knew who had had it...". Stoudemire and Rhoads (1983) identify denial of illness as a crucial part of adapting to physician role precisely because it distances physicians from powerless and mortal patients.

The other aspect of identifying with patients works in an opposite direction: that patients are equal to physicians. That is to say, if a physician is equivalent to a patient, then a patient is at some level equivalent to a physician, and thus worthy of similar respect and circumstance. Perhaps it is this which bothers Dr. Miriam

Chellingsworth (1987:89), who recalls "I remember thinking vaguely that I must have a tumour or MS; I rapidly discounted the latter. The only patient with MS I had even seen was a young man, wheelchair-bound with a catheter--that couldn't be me!" If she could also be, just as easily, "wheelchair-bound with a catheter," and if this state of being seems intolerable to her, then perhaps it is just as intolerable to her patient; perhaps he is just as worthy and sensitive a being as she. Physicians' distancing themselves from patients allows them to uphold fantasies of invulnerability, but it also allows them to keep patients in their less-than-human, objectified state.

Medical student's disease

Separation from patients is achieved partially through the experience, and the gradual repudiation, of "medical student's disease," in which students, studying a new illness, discover in themselves its symptoms. Delbanco (1993:15), a professor of medicine, explains:

...the people who work in hospitals, even with the best intentions, and even though they are nurturing people, will tend to separate from those they care for. You can see how this happens when you look at what our students go through about the second year of medical school. At about that time they begin to read about awful illnesses, and then if they feel a lump here or a bump there, they'll say, "Well, here I go, I've got the symptoms of this or that terrible illness." Over time, we begin to get over this--but there's always the lingering thought: "My gosh, there but

for the grace of something go I." So we keep our distance from the person that we're lucky to be different from.

I would argue that medical student's disease not only forces us to distance ourselves; it also makes us wary of assigning illness to ourselves.

It can also cause us to doubt a colleague's symptoms of illness even as we disbelieve our own. For example, both Dr. Martin Grotjahn (1964:119) and Maxmen (1972) identify medical student disease as a primary reason for peers to discount a physician's illness. Fear of this discounting can be a powerful impetus toward denial; Dr. Miriam Chellingsworth (1987:89) put off seeking care for the early symptoms of multiple sclerosis because of previous embarrassments with it.

During training, such experiences combine with a pervasive attitude of disapproval toward malingering, somatizing, or other so-called "neurotic" patients. The result is a deep fear of being labeled a hypochondriac, as when Dr. Allen Widome refuses to visit a physician because of vague feelings of malaise and nausea (which eventually turned out to presage cancer of the spleen): "It's just...just that if they can't find anything wrong with me, I'll be labeled a *neurotic*" (1989:4). Dr. Widome's fear was actually borne out; as he consulted multiple specialists, with no diagnosis, many of his peers believed his illness to be psychosomatic, and therefore failed to provide him with thorough and adequate care.

Dr. Martin Grotjahn (1952:92-93) suffered a similar experience as he passed a kidney stone.

They could not understand my complaints, and were obviously delighted to look for psychological reasons for my "hypochondriasis." They reassured me in a patronizing and deprecatory way, until I felt like a naughty child who had complained unnecessarily. At first, I tried to accept this role with a smile. Later, I tried to agree with them readily to save myself the embarrassment of listening to their "psychosomatics." Finally, I simply stopped my complaining but suffered grievously.... My complaints were taken as the typical behavior of a psychoanalyst who always sees the psychogenic mote in his brother's eye, but never the hysterical beam in his own. My colleagues took it upon themselves to give me some of my own medicine--psychosomatic medicine--and to give it to me in the way they saw fit. It did not taste good. According to them, everything was fine and under control. Again I stopped complaining, but continued to suffer.

The label of hypochondriasis is not always shunned, however. Fear of the label can precipitate denial, but acceptance of the label can facilitate denial. Dr. Grotjahn explains:

I feared and simultaneously hoped to be "only" neurotically sick, which means, in a physician's "inner" language, not "really" being a patient. I tried to mislead my colleagues; I tested them skilfully. I talked about anxiety, and they were happy to follow my lead.
(1964:123)

Thus, if Dr. Grotjahn was forced to accept his hypochondriasis, he would simultaneously be free to deny his illness as merely its manifestation. As it happens, the

physician who finally offered him relief did so by giving credence to his complaints, by predicting the course and nature of his pain and anxiety, and by offering him unconditional guidance.

Denial and the Treating Physician

Although they commonly identify the physician/patient's denial as a barrier to their care, treating physicians often collude with this denial and facilitate it in a *folie à deux*. A vivid example is provided by the story of Dr. Harold Lear, told posthumously by his widow, Martha Lear. After having a heart attack, he returned to his primary care physician, complaining of chest pains; his doctor told him that they were "healing pains" and advised him to exercise and return to a full work schedule. As the pains continued, and were accompanied by shortness of breath, Dr. Lear finally decided to consult a cardiologist, who found that he was in heart failure. He later ran into the primary care physician and informed him of the cardiologist's opinion; his doctor angrily blamed Dr. Lear for allowing his disease to progress, accusing him of denial and noncompliance. Several years later, after Dr. Lear's death, the cardiologist explained to Martha Lear that the denial was not Dr. Lear's, but rather his doctor's:

What I found on that first visit was a very, very sick, very courageous man. Here was a man who had been pushing himself, who would not resign himself, who kept walking, walking,

walking, doing everything *he could* to get better, in the face of a condition that was not overcomable. It was not denial. Denial is when I say to a patient, "you've had a bad heart attack and now you must do so-and-so"...and the patient does not do so-and-so. That is denial. Hal did what his doctor told him to do. In this case, *the doctor* was denying. (Lear 1980:96)

As I describe above, much of this denial on the part of the treating physician is a reaction to the lesson of the medical student's disease. Dr. McCool describes visiting a consultant neurologist as a medical student, complaining of headache, dizziness, and nausea, all symptoms that he believed might herald elevated intracranial pressure and perhaps a brain tumor. Upon telling the consultant of his suspicions, he was sent home cheerily with a diagnosis of tension headache, most likely brought on by coming exams. Three days later, when he returned to the consultant complaining that his symptoms had worsened, he was told "had I been anything other than a medical student, he would have admitted me to hospital at our first meeting, but that he was now doing so and that he would arrange a computerised tomography (CT) scan immediately" (1987:279). Even upon admission to the hospital, though, another physician

declared that I had no physical signs and could not, therefore, have a brain tumour. I was under stress, he said, and had been suffering from tension headaches, though, he "generously" added, this could be *muscular* tension. Later, other doctors who examined the central nervous system (CNS) found nothing and, blithely ignoring my history (of vomiting and unsteadiness), dutifully reassured me that all was

well: that I was suffering only from "tension" headaches. My friends from the same year, who visited en masse the night before my CT scan, agreed. They clearly thought that I had lost my nerve, that I was "chickening out" of finals. (279)

Dr. McCool was convinced by his peers and superiors that his headache did not represent a tumor, but he went through the CT scan as scheduled; this was fortunate, because, as it turned out, he did in fact have a tumor in his cerebellum.

Minimizing seriousness

Facilitation of denial often begins when treating physicians attempt, through word and deed, to minimize the seriousness of colleagues' complaints. Curbside consults regarding a large lump in his arm prompted no concern from Dr. Hugh Dwyer's peers (1987); he was forced to act as his own primary physician and to refer himself to a surgeon, who eventually amputated his arm because of the malignancy. Dr. Samuel Sanes (1979) tells an almost identical story of having to twist his physician's arm to have a biopsy of an axillary lump, which turned out to be the first sign of his malignant lymphoma.

Dr. Edward Rosenberg (1988:94) identifies this minimization as an aspect of professional courtesy. He doubts that he is being fully informed of the progress of the radiotherapy for his laryngeal cancer:

I know that nowadays, the emphasis is on being truthful, on sharing all the facts with the patient, no matter how gruesome they are. But there are exceptions.

There is supposed to be a professional courtesy; doctors don't treat a colleague like a patient. It is possible that I am being spared the truth.

The courtesy in this case consists of distinguishing the ill peer from run-of-the mill patients, of treating him differently by not informing him in the same way as are patients.

A physician I interviewed also identified this minimization as part of professional courtesy, although he believes that it has roots in the treating physician's identification with his ill peer. "You go along with it, reinforce their denial--but you order the tests anyhow! You downplay the importance of the test verbally, even as you order it: 'I doubt it's your heart, but what the hell, let's get a treadmill [stress test] anyhow'." He believes that minimization arises because empathy for the ill physician makes straightforwardness too difficult for the treating physician to bear.

Minimizing seriousness can sometimes become outright avoidance, as described by Dr. Harvey Mandell. After having a small, benign-appearing polyp removed from his neck, he ran into both his surgeon and the pathologist that reviewed the slide. With each man, he made jokes about the lesion having been skin cancer--jokes met with uncomfortable mumbling in both cases. The next day, his surgeon called:

"Yes, Fred," I answered, assuming he wanted to discuss a patient. It turned out that I was the patient to be discussed. The conversation was brief.

"It's about the lesion I removed from your neck."
Pause.
"Well, what about it?"
Longer pause.
"Not too good."
"Well, what is it--a basal cell?"
"No, worse--go up to pathology and review the slides with the pathologist."
"Can't you tell me what it is?"
"I don't want to discuss it over the phone." (1987:288)

Dr. Mandell visited the pathologist, only to receive this reception:

He must have seen me coming because he continued peering into his microscope without raising his head to greet me as he usually did. Ordinarily he encouraged practicing physicians to come into his office and chat about pathology, the Boston Bruins, and almost any other topic.

"Jim, can I go over my slides with you?"

"What slides? Do you mean the liver biopsy you did last week?"

"No, I mean my slides, the lesion removed from me."

"I don't remember the results. I sent the report to Dr. A."

"Jim, I'm not leaving until I see the slides and you describe the pathology to me."

"Christ."

Finally, after a fumbling search designed to get rid of me, the mysterious slides were on the microscope stage and I had a chance to see them.
(987:288-289)

This amazing display of buck-passing was designed to keep the diagnosis--malignant melanoma--from Dr. Mandell. Note that it is by showing the slide that the subject is finally breached; I will discuss the importance of showing the physician/patient his pathology in Chapter 4.

A similar scenario unfolded when Dr. Albert Luther, an accomplished researcher in oncology, was found to have a neck cancer. His surgeon reasoned that he was unable to break the news gently to Dr. Luther because he already knew all the answers:

Al's surgeon was distinctly uncomfortable. How could he tell Al, a physician who knew most of the answers, that it was an anaplastic carcinoma; that it already had metastasized out of the neck, down into the mediastinal nodes; that they didn't get it all out? "It was a growth, a malignancy," he mumbled.

"Hodgkin's?" inquired Al.

"No."

"Cancer?"

"Maybe."

"Stop the crap. Where did it come from, thyroid?"

"We're not sure."

"You're lying through your teeth,"

Al replied. "Damn it, I want facts."
(1987:270-271)

Instead of telling Dr. Luther what he supposedly already knew, and risking offending him by implying that he was ignorant, the surgeon forced him to play a surreal guessing-game. This is a good example of how the awkwardness of trying to break news gently to a patient who knows it all can become cruelty.

Paradoxically, avoidance can quickly turn to brutal forthrightness in such cases. In order to minimize seriousness, the treating physician may adopt a breezy manner that is a hold-over from an informal level of peer communication, such as the curbside consult. Faced with the uncomfortable task of presenting a serious diagnosis to a

peer, he retreats into a comfortable, well-worn pattern of peer interaction. This pattern is often grotesquely inappropriate and even harshly coldblooded.

Dr. Arthur Rogers (1952:272) described a mild version of this process:

I was working in the out-patient department of the hospital. Stooping to pick up something from the floor, I discovered stiffness and swelling of both knees, and at the same time became conscious of some fever.... My colleague at the next booth took one glance at the thermometer, another at my knees, and chased me home to bed with the cheerful comment, "Young fellow, I hope this isn't rheumatic fever. I'll drop by to see you after the clinic."

Or consider this exchange, which occurred when Dr. William Sharpe was engaged in despondently worrying that his symptoms of Menière's disease were due to a brain tumor:

Dr. S. ran me to the ground and said
"Congratulations, you don't have a tumor. You have Menière's disease."
"What the hell is that?"
"Nobody knows."
"Will it get better?"
"No, but you'll get used to it and think that it is."
"Will it get worse?"
"Possibly."
"Will I go totally deaf?"
"In one ear, possibly."
"Will the dizziness get better?"
"It will come and go."
"Can I do anything about it?"
"No."
"Should I worry about it?"
"No."
"What do I owe you?"
"Don't be silly." (1987:60)

What a way to inform someone of a chronic, often disabling, illness! Flippancy and bluntness may characterize all of

the conversations that Dr. Sharpe's physician has with his patients, but it also follows a common pattern of brusqueness which may be a misguided attempt to minimize the impact of the diagnosis by presenting it casually; this is the paradoxical counterpart of the too-cautious description that is more commonly seen.

Reluctance to name

A special case of minimizing seriousness concerns the reluctance to make the diagnosis, to *name* the enemy. Somehow naming an illness and transforming it into a disease gives it totemic power and makes denial impossible. Dr. Max Pinner tells of how his chest pain finally spurred him to seek help from an internist, of course a friend.

And during the first consultation, the taboo was established, the verbal taboo "angina." Did I get pain on exercise? No. (But I hardly ever did any real exercise.) And there, we had the semantic straw: it was not "angina of effort." Well, then, did I have it. No. But I had the pain. I was quite willing to play the game--more and more consciously. One must avoid the word because of its disagreeable and prognostic implication.... The pact was silently agreed upon: angina is taboo; I have pain, but it is not caused by any damage to myocardium or coronary arteries. (1952:20-21)

Similar diagnostic contortions allowed the feared "paroxysmal nocturnal dyspnea" and "pulmonary edema" to be called "asthmatoïd symptoms" and "allergy" (1952:27). Dr.

Pinner eventually died of the heart disease which his colleagues, and he, had denied.

Dr. Quintus West tells a similar tale: while hospitalized for an upper respiratory infection, chest X-rays were taken that showed lesions characteristic of tuberculosis. His physician, a friend, suggested that he had pneumonia, in order to "break the news...gradually and indirectly," and Dr. West "grasped eagerly at the relatively attractive diagnosis of pneumonia" (1952:253). In this case, specialists made the diagnosis of TB in the following weeks, and the internist was only faced with the task of conveying the taboo name. He did, though, attempt to minimize the diagnosis, emphasizing (incorrectly) that the lesion was small and the necessary therapy would be minimal. (It is interesting to note that the identifying footnote at the bottom of the first page of the case history reads "Dr. Quintus West employs a pseudonym derived from the fifth-floor, west wing where he cured his tuberculosis," (1952:252) implying that he healed himself; considering the reticence of his physicians, this is almost accurate.)

Ignoring ill colleagues

Possibly the most disturbing way in which the colleagues of an ill physician reinforce his denial is by denying his very existence. Dr. Robert Seaver (1987:33) describes feeling, during his convalescence from a myocardial infarction, as if he were already dead to his

colleagues, who ignored him and stopped referring patients to him. Dr. Sam Sugar, hospitalized with a herniated disc,

...was surprised and stunned by the lack of sensitivity my colleagues showed in not at least *sending* their regards to a colleague who was ill....my colleagues simply didn't know what to say. I can recall vividly being wheeled into the myelography room and running into one of the surgeons at the hospital, to whom I had sent many cases. He just looked at me and waved as if it were perfectly normal for me to be on a stretcher... (1987:109)

Here we see snubbing of Dr. Sugar by his colleagues, both as a person and as a patient.

Peers disregard fallen colleagues often, and not just symbolically. Dr. Barbara Young describes the reaction of her peers to her anaphylaxis after she took an antibiotic to which she was allergic:

There were five other doctors in the room with me, all just newly qualified and with no idea what to do. This being the case, they obviously decided to pretend nothing was happening and went about their ordinary business. As I lay on the floor I had a worm's eye view of their legs and feet as they stepped over me. I idly wondered if anyone was going to do anything or if they were just going to let me die there. (1987:385)

A similar story is told by Dr. David Rabin and his family, who survived him after he succumbed to ALS (Rabin 1982; Rabin, D., P., and R. 1985; Rabin, D. and P. 1985; Rabin, R. 1985).

By the fall of 1979 I was walking with a limp. I countered the queries I received in every corridor by saying

that I had "a disk." This was not threatening to my colleagues, who proffered advice on how to deal with it and regaled me with their own back problems. I was still a full member of the fraternity, in excellent standing. By early 1980, however, the limp was worse, and I now held a cane in my right hand. The inquiries ceased and were replaced by a very obvious desire to avoid me. When I arrived at work in the morning I could see, from the corner of my eye, colleagues changing their pace or stopping in their tracks to spare themselves the embarrassment of bumping into me. This dramatic change in their behavior occurred when it became common knowledge that David Rabin had ALS. I state with total conviction that my colleagues never meant to hurt me. On the contrary, I was of Vanderbilt, and they grieved for me, yet were unable to express their grief. (Rabin, D. 1982:507)

And, later:

One day, while crossing the little courtyard outside the emergency room, I fell. A longtime colleague was walking by. He turned, and our eyes met as I lay sprawled on the ground. He quickly averted his eyes, pretended not to see me, and continued walking. He never even broke his stride. I suppose he ignored the obvious need for help out of embarrassment and discomfort, for I know him to be a compassionate and caring physician. (Rabin, D. 1982:508)

This pathetic scene clearly demonstrated that Dr. Rabin's suspicions that he was falling out of "the fraternity" were on target.

Why these unforgivable cruelties? The most likely answer is that peers, by blinding themselves to the physician/patient's pain, escape identification with him, and need not recognize in him their own mortality and

vulnerability. As Mandell and Spiro note, again invoking the idea of fraternity,

...for the doctor's doctor there is always a sense of fraternity, an immediate merger of identities with physicians. We know him or her. We know what he or she wants or knows. They know what we know and what we may hide from other patients.... Immediately the sick physician becomes us. We view his illness as our illness, we merge--as the psychoanalyst might put it--in a final confrontation with our own illness. Our past, our present, and our future confront us in the body of the sick physician. (1987:454)

Dr. Denise Bowes (1987) recognizes this phenomenon, and suggests that her peers resented her absence while ill and pressured her to return to work soon in part because they wanted to be reassured that they would also recover easily from illness, if and when it struck them.

I have already spoken of the ways in which illness in a physician can be seen as a moral error, using Bosk's terminology, or as an act of treachery and submission to the enemy. Perhaps inhuman abandonment of an ill peer represents an attempt to punish him for these transgressions, although convincing evidence for this conjecture is lacking.

A simpler, more straightforward explanation is found in physician's frequent orientation to patients as less than human, and to peers as invulnerable. When a noble peer becomes a patient, the cognitive dissonance that he represents is hard to bear, so he is ignored:

...I'm uncomfortable visiting colleagues in the hospital now. We are never really sure whether our medical colleagues are patients or doctors. We don't know whether their shields of invulnerability have been pierced or not. We don't know how to act in front of them because we don't know what they need. (Sugar 1987:110)

The idea that treating physicians collude with denial *because they do not know what their peers need* offers an important clue to the satisfactory physician-patient relationship. We are taught in medical school that it is crucial to determine a patient's desires and needs and to attempt to fulfill them, even if we discover, during our history-taking and physical exam, other medical problems that need to be addressed. When a patient denies his illness, we try to work through and around his defenses to assess his needs. However, it is a far more delicate matter, as we have seen, to assess a physician/patient's denial, and to repudiate it; it is far easier to collude with his denial and to deny his illness ourselves. Facing abandonment by confused peers, physician/patients, even if they overcome denial and face their illness, often feel forced to undertake self-diagnosis and self-treatment, which I describe next.

CHAPTER 3: SELF-DIAGNOSIS AND SELF-TREATMENT

Self-diagnosis and self-treatment are, not surprisingly, also quite common elements in anecdotes of physician illness. Few attempts to quantify the tendency to self-care have been made. In one such investigation Chambers and Belcher (1992) found, surveying 275 British general practitioners, that 84% of the drugs they took and 33% of the studies undertaken in their care were self-prescribed or ordered. These numbers, although in a limited sample of physicians, are not surprising in view of the stories I reviewed.

Sometimes self-care, widely held to be unwise even as it is practiced, is vindicated, as when a physician correctly self-diagnosed polio (Dr. Merritt Low 1952) after observing the classic signs and symptoms and ordering his own lumbar puncture and white blood cell count. Hoping for such a rare success, physicians commonly order their own consultations (Dr. Hugh Dwyer 1987, Dr. Walter Myers 1952, Dr. Abraham Myerson 1952), lab tests (Lear 1980, Dr. Myers 1952, Dr. Mallory Stephens 1987), and imaging studies (Dr. Lewis Dexter 1987, Dr. Samuel Zelman 1963).

Sometimes self-investigations have tragic results, though, as when Dr. Charles Kleinman ordered a chest X-ray because of a persistent cough, which he assumed had an infectious origin.

...I approached one of the X-ray technologists whom I knew and asked if she would take a chest X-ray of me, despite the fact that I did not have a patient identification number. She did so reluctantly and I awaited the developed film at the Xomat developer. When the unlabeled film emerged, I looked at both views and complimented the technician on an excellent practical joke. She had taught me not to impose on the X-ray techs anymore; now, where were *my* films? She convinced me that these were, indeed, my films. I know I was convinced, because I started to cry. The mediastinal mass was staring me in the face. The brassy cough and mediastinal mass reminded me of the slightly tender supraclavicular node that I thought I had imagined one or two weeks earlier. My life--what was left of it--was collapsing around me. No one was there to break it to me gently; in fact, no one knew about it but me.
(1987:307)

Dr. Kleinman's past experience with Hodgkin's disease made this self-diagnosis cruelly easy for him. However, once the diagnosis was made, he found himself trapped between two worlds: he had lost the control and distance of his professional training, but he was unable to escape into the sheltered, passive role of the patient. Certainly such disastrous outcomes are foreseeable to self-diagnosing physicians; in fact, similar stories constitute a significant folkloric body of medical legend. Why, then, engage in self-care when even correct diagnoses can have dire consequences?

The Need to Self-Diagnose and Self-Treat

Privileged observer

Physicians often have ready justifications for self-care. Many of the physicians I spoke with, as well as some of the published anecdotes, mention that physicians, with their training, are the best possible observers of their own symptoms and signs, as well as the best possible interpreters of their medical histories, and thus are best-qualified to diagnose and treat themselves. Although there seems to be an even stronger belief that a physician's "objectivity" (always spoken of as if it is a sacred talent or gift, justifying, as it does, medicine's claim to the status of scientific discipline) is damaged when he cares for himself or his family, this belief does not stop at least some attempt at self-diagnosis.

Inconveniencing colleagues/professional courtesy

The fear of being labeled a hypochondriac, discussed in Chapter 2, is often expressed as a desire not to trouble colleagues or waste their time with a problem that is probably inconsequential. Dr. Max Pinner (1952:26) also attributes this fear of inconveniencing colleagues to professional courtesy, the custom of not charging physicians (or in some cases, their families as well) for medical care. This often creates embarrassment and awkwardness for the physician/patient at the thought that the treating physician is losing time better spent with a paying patient. A

physician I interviewed concurred that it can contribute to a delay in seeking care. Stoudemire and Rhoads (1983), Bass and Wolfson (1978) and Bowden (1983) also identify it as an issue, believing that it unnecessarily distinguishes physician/patients from other patients, and makes it harder for them to seek second opinions because of their perceived obligation to the treating physician.

Maintenance of denial

Maintenance of denial is a clear benefit of self-care, although, as we have seen, the actions of the treating physician often in fact end up promoting physician/patients' denial. Fear of having the defense mechanism of denial stripped away is valid, though, since it means embarrassment and loss of control.

Loss of denial can have more important ramifications in select cases. Sometimes this denial is of crucial importance, as in the case of Dr. Lucie Adelberger (1952), who was a prisoner in Auschwitz, and served as physician to the other inmates. Upon noting the classic signs of typhus in herself, she "knew" that she had typhus, but did not "think" that she had it, preferring instead to give herself a diagnosis of peritonitis. Lurking in her mind was the knowledge that prisoners with infectious diseases were the first to be killed.

Preservation of control

As mentioned above, loss of denial leads to loss of power, and self-diagnosis and self-treatment can often be a perverse, ego-preserving demonstration of control for the physician/patient. Even when a physician "knows better" and tries to be a "good patient" with a patient's limited knowledge, he often plays power games. An example is provided by a physician with Menière's disease, an inner-ear ailment that can impair balance, who was hospitalized before his diagnosis was made, and who thought that his vertigo was caused by an antibiotic that he was taking for another illness:

From the beginning of my illness, I had resolved to try to be a patient and not the combination doctor-and-patient hybrid which often makes the care of one physician by another so difficult. Hence, at rounds that morning, I had reported only my symptoms [e.g. vertigo] to the ward medical officer and restrained myself from asking him to discontinue streptomycin [a drug that can damage the inner ear]. (Dr. John Crawford 1952:58)

Even though he supposedly cedes control in order to be a good patient, Dr. Crawford instead almost spitefully withholds crucial information--that he is taking an ototoxic drug--from his doctor, thus remaining tacitly in control. He has made the link between medication and symptom himself, and he waits to see if his doctors are good enough to figure out the connection for themselves, reporting only his symptom as any patient would. Used to the intellectual

jousting and one-upsmanship that characterizes grand rounds, Dr. Crawford cannot break the old habit of competition, even when his own health is at stake. In this case, also, his self-diagnosis of iatrogenic inner ear damage turned out to be incorrect, despite his cleverness.

It is worth mentioning the fear of loss of privacy that is cited by some physicians (Dr. Robert Seaver 1987:32, Dr. Sam Sugar 1987:108). Once a physician/patient is ill, or worse, hospitalized, news of his misfortune travels quickly through the medical community. His record soon becomes common knowledge among his peers and among other medical and ancillary personnel, and he loses face along with privacy, as he is shown to be no more than human.

Self-body split

One of the more unusual themes to emerge from the stories recapitulates a Cartesian mind-body dichotomy. Physician/patients often see themselves as split, as my name for them implies, into their physician-selves and their patient-bodies. This allows them to separate themselves from their sick parts and to simultaneously repudiate and treat them, while preserving their identities. In fact, self-treatment enhances their physician identities, since such a victory, accomplished in spite of a treacherous ill body, is all the more laudable.

As Dr. Martin Grotjahn (1964:120) explains,

The back-and-forth of medical interaction is not limited to the relationship between sick doctor and treating physician. Within the patient-doctor, a similar ambivalent relationship is repeated. The patient-doctor can not easily relinquish being a physician. The patient-doctor is always a deeply split person, within whom the one part (the doctor) watches the other part (the patient) with suspicion, sometimes malice, and often with antagonism. The sick part of the patient-doctor is an enemy who asks for help.

Dr. Judith Brice (1987:174) echoes this idea: "I began to hate my body.... It was if my body had suddenly and unpredictably turned on me; my most trusted friend had transformed itself into my biggest enemy."

In contrast to seeing the body as an outright enemy, some physicians instead feel a detachment from their bodies, and even from the fate of their physical selves. Dr. James Hayes, after receiving a diagnosis of colon cancer, and noting no emotional reaction in himself, wonders why:

What is this? I asked myself. Where is my reaction? Is my lack of reaction my reaction? Is this the denial that characterizes cancer psychology?

I didn't consider it denial. I knew perfectly well the facts associated with it, the possibility of metastatic disease, the need for surgery. I felt under my rib cage for the liver, not really expecting to feel it but prepared for the possibility, in a way that was characterized more by curiosity and detachment than by anxiety. I stood outside myself and peered in, wondering and interested, but no more than that. (1987:317)

This detachment thus allows the physician to self-diagnose and self-treat without acknowledging any of the associated risks, and while maintaining their professional personae and control. Dr. Robert Kravetz, a gastroenterologist, noticed that his stool was loose and maroon in color.

I told myself that "Doctor Bob would take control of the situation and things would be just fine." "A maroon-colored movement," I say; "well, that means the bleeding is moderately brisk." The best approach to a rapid diagnosis would be a gastroscopy since I suspected that I was probably bleeding from an ulcer. It was now 5:30 p.m. I had eaten lunch at noon, so I made myself NPO (nothing by mouth) and took a Reglan tablet to assure gastric emptying prior to gastroscopy. (1987:429)

It turns out that "Doctor Bob's" diagnosis was correct, although by driving his body to his hospital to arrange gastroscopy of his body by his colleague, instead of going to the local hospital, his body--with him as unwilling passenger--collapsed upon arrival.

Perhaps the finest expression of the self-body split is provided by Dr. Oliver Sacks in his autobiographical *A Leg to Stand On* (1984). Again, we see the physician maintaining his persona by diagnosing (and in order to diagnose) the problems of a body that is only coincidentally his. After injuring his leg while hiking, as he lay on a mountain path in Norway, Dr. Sacks engages in a clinical exercise:

...it was much less the pain that so horribly frightened me than the flimsy, toneless giving-way of my knee and my

absolute impotence to prevent or control it--and the apparent paralysis of the leg. And then, the horror, so overwhelming for a moment, disappeared in face of a "professional attitude."

"OK, Doctor," I said to myself, "would you kindly examine the leg?"

Very professionally, and impersonally, and tenderly, as if I were a surgeon examining "a case," I took the leg and examined it--feeling it, moving it this way and that. I murmured my findings aloud as I did so, as if for a class of students:

"No movement at the knee, gentlemen, no movement at the hip.... You will observe that the entire quadriceps has been torn from the patella. But though it has torn loose, it has not retracted--it is wholly toneless, which might suggest nerve injury as well. The patella has lost its major attachment, and can be flipped around--so!--like a ball-bearing. It is readily dislocated--there is nothing to hold it. As for the knee itself--" and here I illustrated each point as I made it--"we find abnormal motility, a quite pathological range of motion. It can be flexed without any resistance at all--" here I manually flexed the heel to the buttock--"and can also be hyperextended, with no apparent dislocation"--both movements, which I illustrated, caused me to scream. "Yes, gentlemen," I concluded, summarizing my findings, "a fascinating case! A complete rupture of the quadriceps tendon. Muscle paralyzed and atonic--probably nerve-injury. Unstable knee-joint--seems to dislocate backwards. Probably ripped out the cruciate ligaments. Can't really tell about bone injury--but there could easily be one or more fractures. Considerable swelling, probably tissue and joint fluid, but tearing of blood vessels can't be excluded. I turned with a pleased smile to my invisible audience, as if awaiting a round of applause. And then, suddenly, the "professional" attitude and *persona* broke down, and I realized that this "fascinating case" was *me--me myself*,

fearfully disabled, and quite likely to die. (Sacks 1984:21-22)

He escapes into his role in order to separate himself protectively from his mangled body, and plays the part of clinician to the point of excruciating physical examination.

The language Dr. Sacks uses in the passage above is also revealing in its formal detachment, as he rejects all possessive pronouns, referring to his leg as "the leg," not "my leg". He does not even use the "I" to refer to himself as a physician, preferring instead "we" and passive verb constructions, and leaving out the subject entirely near the end of his disquisition. He is using the very structure of his verbalization, the classic British neurological case presentation, to calm and soothe himself with familiarity.

Examples of the use of language, both aloof diction and routine medical structure, to distance the self from the body abound in the doctors' stories. An hour before his death from heart failure, Dr. Harold Lear was still maintaining his shelter of normalcy, his detachment from his body, by dictating progress notes on himself--or rather, on his body--to his wife, who recalls the incident in her biographical account of his illness:

At 2:15 he began to shake violently. "Here we go," he said. The thermometer registered 102. I said, "I'm going to call Andy now."

"Not yet. I want to watch the fever. My notebook."

I brought him the notebook, but his hand could not control the pen. He dictated to me the clinical note:

"2:15. Severe rigors. Temp. 102."
(Lear 1980:400)

Later, in the ambulance, he continues:

They settled him into the back seat of the car, and I got in beside him. He felt his pulse.

"What time is it?" he said.

"Two thirty-five."

"Please write: 2:35. Shaking chills subsided. Weakness. Irregular pulse. (Lear 1980:401)

The familiar routine of note-taking provides structure and reassurance.

Another striking example is provided by Dr. Walter Myers who notes the signs and symptoms of brucellosis as he would present a case report. The voice is passive, the pronoun "my" consistently replaced by "the": "There was fullness in the lower neck. The shirt collar seemed to be too tight at times.... The blood counts were normal..." (1952:265) and so on. He speaks blandly of the "laboratory studies requested" (266) and later claims "An analysis of certain symptoms may be of interest" (267), following this dry statement with a logical, stepwise review of his symptoms and their differential diagnoses.

We have seen how this detachment both facilitates and encourages self-diagnosis and self-treatment. Even when the physician/patient submits himself to scrutiny by a peer, he is frequently, as I shall describe in Chapter 4, placed in the role of consultant by the treating physician. The self-body split is a key to this process as well.

Collusion by Peers

I would now like to describe responses of peers to physicians' self-care attempts. As outlined in Chapter 2, physicians have many reasons to encourage denial in ill colleagues. Likewise, although they often decry the foolishness of the practice, they participate in tacit approval of self-diagnosis and self-treatment. Again, there are perceptions and attitudes that clearly support this approval.

Insecurity

Many physicians, when asked to treat a peer, feel honored, but also a bit insecure. A colleague trusting you with his body and yielding control to you has a right to expect excellent care. In addition, the physician/patient is in a prime position to examine the examination techniques and the diagnostic approach of the treating physician.

As a consequence, a physician I spoke with says that he is always unsure about his examining technique, and also worries that he's ordering the wrong sort or number of tests, and will somehow look foolish or seems not to be providing adequate care. Another physician brought up the reluctance he feels in challenging any self-diagnosis that a physician/patient has made. Often, he says, he suspects that his physician/patients are somatizing (by which he meant that they are obsessively aware of their physical symptoms, but not in fact suffering from a disease), but he

is reluctant to doubt them, not only to save them embarrassment, but also because they could be right! His attitude is especially notable because, as we have seen, physician/patients are far more likely to deny their illness than to somatize, in part out of fear of the treating physician's suspicion that they are somatizing, a fear that is well-founded in view of this doctor's belief.

Boundaries and shame

Another focus of discomfort is the actual practice of physical examination, discounting questions of proper technique. Crossing the intimate boundary and touching a peer's body is sensitive; it leads to the recognition that he possesses a vulnerable body as does any other patient, and as do you, the treating physician. As a doctor I interviewed put it, "when you examine him [a peer] you say to him 'I'm aware that you're human, and you're aware that I'm human.'"

This awareness can have disconcerting, sometimes erotic, overtones that increase awkwardness. Of all aspects of the physical exam, it was the rectal exam that was mentioned repeatedly as a source of consternation; in many anecdotes, it even came to stand metonymically for the whole exam. No other aspect of the exam was singled out for mention in any of the cases. The intimacy of sharing a body with a colleague, as when consulting with him on a case, is

emphasized when the body is his own, and the rectal exam is often the most blatant symbol of this intimacy.

The rectal exam appears in several forms in the stories, first as something worrisome for the staff, as described by Dr. Robert Scheig (1987:426) or by Dr. Barry Zaret: "Who amongst the house staff would perform the rectal exam on the chief of cardiology?" (1987:407), this exam being necessary to evaluate trauma after Dr. Zaret had been in a car accident.

It also appears as something done apologetically and euphemistically, as the treating physician hopes to diffuse tension by alluding to his discomfort:

"Now," Rich said, "I've got to do the surgical physical. if you know what I mean--check on those things the medical men skip over."

"I know what you mean," I said. "Like the rectal."

"Yeah," he said, "the rectal."

"I've got news for you. The medical resident did it."

"He did?" Rich seemed genuinely surprised. "That's fine. Then I won't bother you..." (Dr. William Nolen 1976:128)

Rich, Dr. Nolen's fellow surgeon, has to protect himself from the intimacy of the rectal exam, and any distressing implications of that intimacy, by showing Dr. Nolen that he is reluctant to perform the exam; at the same time, though, he is obligated to do the exam to show his brother surgeon that he is a real surgeon and not a mere "medical man."

The rectal exam also appears as something done as if it were a surprise instead of a routine part of a physical exam

(Dr. B. Urenn 1952:290), or even as punishment, real or fantasized. For example, Dr. Edward Rosenbaum (1988:85-57) imagines that if he complains of stomach pain, they will send a young female gastroenterology resident to examine him, and she would do a rectal exam and even check him for a hernia, and that he would eventually have to submit to a proctoscopic exam. He goes so far as to use this fantasy as justification for not alerting physicians to his pain. Certainly such fantasies are common to all patients, but it is revealing to find that physician/patients also imagine such scenarios, and in this way are once again similar to other patients.

Other unpleasantries besides the rectal exam are skipped, too; Dr. Maurice Raskin tells, for example, how "I did not receive the standard bowel prep at all prior to my surgery. My nasogastric tube was removed a day earlier than it would have been because I complained about throat irritation. I was encouraged to use narcotics freely for any discomfort. Clinical judgment was compromised for issues of little importance" (1987:209). In this case, skipping the bowel prep could be deadly if the surgeon were to nick the intestine during surgery.

Such omissions give tacit approval to the practice of self-diagnosis and self-treatment. However, as we have seen, diagnoses made by physician/patients, even when correct, are especially problematic, because when the diagnosis is a serious one, the physician/patient is left

without anyone to disclose it gradually to him or to share its terrible impact when it is revealed. Even if the physician/patient is able to separate his body--the diseased part of himself--from his self, and thus to escape, in some sense, the sentence of illness, he is still burdened with a sick body that requires his care. Finally, as Dr. Oliver Sacks found (1984), the mind/body separation fails, and the physician/patient is once again left alone to face his illness. His efforts at self-treatment are hampered by the demoralizing effect of diagnosing and facing a serious illness, the treachery of his physical self, without the support of a physician of his own--other than himself, of course.

Treating physicians, then, should make every effort not to leave their ill peers in the position of self-diagnosis and self-treatment. Most treating physicians realize this necessity and try to comply. Even when a physician is able to overcome the reticence that was illustrated above, and to take on the tasks of examining and diagnosing a peer, though, similar pressures prompt the development of yet another abnormal type of physician-patient relationship. This is best characterized as patient consultancy: the treating physician places the physician/patient in the role of a consultant on his own case. In Chapter 4, I will describe how and why this process occurs, and why it is likewise inappropriate.

CHAPTER 4: CONSULTANCY

Physicians responding to my survey concerning their care-seeking patterns universally said that they would prefer to collaborate on the management of their care with their treating physician, although none of them had suffered any significant illness, or saw a physician regularly for anything more than a Pap smear. Similarly, Dr. Maurice Pappworth (1987:14) feels that "doctor-patients should always be asked for their opinion on the diagnosis and investigations, and their comments should be carefully listened to". The tendency for physician/patients to demand to be placed in the role of consulting on their own case, and the tendency for their physicians to place them in the consultant role, is quite common.

The Physician/Patient as Consultant

As we have seen, it is particularly important for an ill physician to retain a sense of control and of his identity as a doctor. When the treating physician keeps him in a consultant position, asking his advice and deferring to his judgment, these needs are met. This arrangement also reinforces the self-body split, as the physician/patient is urged to step out of his sick body and offer opinions on its care.

Suspicion of inadequate care

Fears about the quality of care provide a straightforward reason for desiring the consultant's role. Many physician/patients feel that they must constantly check up on the work done by their physicians and nurses. Often this fear is attributed to the fact that they have seen many errors and can no longer have blind faith that procedures and decisions will be correctly carried out (e.g. Dr. Sam Sugar 1987).

Often these fears are extreme, and even have a paranoid quality, as in the case of Dr. Harold Rifkin, who had breakbone fever.

...I now began to have very definite doubts about the abilities of the physicians. I constantly questioned the correctness of their diagnosis and felt that they had not completely investigated my condition.... I confess now that I had lost all confidence in the medical group at the hospital, and was sure my case was very serious, that the medical officers were bungling their job, that one couldn't expect very much more from Army medical personnel.
(1952:122)

Later, he admits that, after reviewing his chart, he saw that he could not have received better care.

Fears can also center on the diagnosis and on whether one is being given the full truth. Dr. Denise Bowes (1987:54), when given the diagnosis of Miller-Fisher syndrome (a variant of Guillain-Barré syndrome), "decided that I was being given the name of a nonexistent illness to hide the fact that I had a brainstem tumour;" as it turned

out, she finally was given, and accepted, a diagnosis of Guillain-Barré syndrome. Her fears, incidentally, seem justified when one recalls the lengths that some physicians go to minimize the illness of a peer, as we saw in Chapter 2.

Sometimes the fear of medical misadventure is justified. Dr. Benjamin Felson (1987) realizing that he was being intubated incorrectly, stopped the procedure; recognized that he had pulmonary edema despite the lack of physical findings; and convinced his physicians to treat him for gout while in the hospital. Other examples abound of physicians who caught a mistake in their medication or treatment orders, or who stopped improper procedures from being performed on them. Of course, since it is the physician/patients themselves who report catching these errors, it is impossible to assess objectively their significance or extent.

Habits of association

Another way in which the ill physician is sure to end up in a consultant role is by choosing a physician that allows or insists on such an arrangement. By this I mean that the physicians I interviewed and surveyed, as well as those that wrote the autobiographical case histories, all tended to call on their friends first when ill. These are the physicians with whom they communicate informally, refer to and receive referrals from, and, in some cases, see

socially. Even when a physician is very ill and decides to look for the best physician possible, he turns to his network of friends.

To some extent, though, their friends tell them what they want to hear. Dr. Edward Rosenbaum (1988), seeing a colleague because of hoarseness, was told casually to suck on lozenges. Dr. Rosenbaum was only too glad to comply with this advice, which is what he was doing anyhow, but in doing so, he delayed the diagnosis of his throat cancer. Even when he called other friends for their advice, he was told to relax and do what he thought best, which, in this case, turned out to be quite harmful.

Placing the Physician/Patient in the Consultant Role
Courtesy and assumptions about knowledge

What role does the treating physician take in placing the ill physician in the consultant role? One physician I spoke to said that it is essential to place the physician/patient in the consultant role as a fair exchange for his giving over his authority to you: "You are very uncomfortable placing a colleague beneath you, so you put him in consultant mode out of courtesy to him." Robinowitz (1983:141) links this tendency to fears described in Chapter 3: "Treating physicians are anxious about their own skills and knowledge, and may therefore treat physician-patients as colleagues who can provide consultation and collaboration in this 'interesting case.'"

Dr. Max Pinner found this proclivity on the part of his physicians quite frustrating (1952:26):

...not more than one or two of my physicians were able (nor did they even make a reasonable attempt) to avoid discussing "my case" with me as if I had been called into consultation. They failed to give definite orders and advice and tended to say, explicitly or implicitly, "You know what to do!" But even if I did know, such an attitude fails to give the psychic relief that every patient expects from his physicians. The assumption "that I knew" was once carried so far that my surgeon indicated in the nurses' order book that I would prescribe for myself, immediately after a major operation and during a period when I had brief episodes of disorientation. And, be it stressed, I had begged each one of my physicians to treat me just like any other patient and to forget that I had any medical knowledge.

This assumption that the physicians "knows" is also reflected in the tale of Dr. Arthur Rogers (1952:279), when he consulted a colleague during a period between flare-ups of his rheumatoid arthritis:

"Doctor," he said, "you are a very fortunate man. Your fate might have been different. You can still practice your profession, but it must be under conditions which will give the greatest possible assurance against another relapse. You know what those conditions are. Good luck."

Thus Dr. Rogers was left on his own to modify his life with neither advice nor education, resenting this burden placed on him by his physician.

Dr. Sam Sugar summarizes the problem: "[There is] a sort of abdication of responsibility when physicians become

patients. For some reason it's assumed that we will follow up on our own abnormalities or that someone else will" (1987:114). I believe that this abdication, this reluctance to tell a colleague something which he already knows, stems from structures described in Chapter 1. Treating physicians, by offering too much information, destroy the myth of self-sufficiency and perfect knowledge, and may also risk insulting their ill peer.

These risks are minimized by the curbside consult, which represents a way that the physician/patient can be advised with more ease, although with poorer results:

[when caring for another physician,] We tend to treat each other with hallway consultations, keep poor records, adopt short-cuts, and display poorer judgment than we do with laymen. There is always the implicit fear that our doctor-patient may know more than we do.... There is a great tendency to assume that the physician-patient needs very little coaching or advice when in fact he may need more instruction in the management of his illness than others. Or, the patient may find his doctor seemingly condescending when he restates the obvious. (Dr. Robert Seaver 1987:34-35)

Telling the physician/patient something he already should know about his illness is tantamount to criticism. Since criticism does not fit into formal communication, the treating physician can only advise his ill peer fully in an informal setting. Instead of a formal office visit, then, physicians may force their peers to see them only in passing, just as they might discuss a patient on whom they

were consulting. The appearance of normalcy may be kept up even further, when treating physicians ask ill physicians to see their patients as consultants (Dr. Charles Kleinman 1987), give advice about other patients (Marzuk 1987), or even to conduct teaching sessions for house officers and students while hospitalized (Dr. Benjamin Felson 1987, Dr. Allen Widome 1989).

Collegiality

As mentioned above, such attitudes toward the ill physician are especially prevalent when he is a friend or colleague, as he often is. Dr. David Hein was diagnosed with Crohn's disease, and chose his "closest medical associate" as his physician:

He had known me for many years and it certainly was convenient to "receive" medical care right in my own office. In retrospect, this decision was not necessarily a wise one, considering my attitude and approach to my symptoms. I do not fault my care or my colleague, yet there were only minimum studies undertaken and I certainly did not suggest others on my own. All decisions were made and advice given after discussion between the two of us. This lack of objectivity presented (what I now consider) major delays in control of my symptoms. Advice was given in a nonauthoritarian manner--from colleague to colleague or friend to friend--and there was little actual follow-up regarding results of the recommendations. (1987:249)

Such practices allow the maintenance of usual roles. It is difficult to place a colleague in a dependent position,

especially if the treating physician identifies strongly with him, or if their relationship includes sharing information and opinions freely, with neither dominant.

The treating physician is in such cases reluctant to assert authority over his ill peer. Upon consulting a cardiologist for angina, Dr. Maurice Pappworth acted as if he was calling to consult on a patient. Because the interaction had begun in this familiar give-and-take pattern, his physician did not insist on his following his advice:

He inquired about my attitude to exercise EKG and coronary angiography. I informed him that I did not wish to submit to either because the results would not materially affect the diagnosis, because they are far from pleasant procedures and not without risks, and because, mainly on account of my age, I did not wish to consider surgery. He, in my opinion correctly, said that in view of my opinion he would not attempt to convince me to change my mind or persist with the suggestions.

What a polite withdrawal this seems, quite appropriate for a consultant, but perhaps less appropriate from a physician to a very ill patient, who at this point may have needed further guidance.

Self-body split revisited

As described in Chapter 3, some ill physicians see no problem with self-care since they are able to separate their physician-selves from their patient-bodies. Treating physicians are likewise inclined to separate their ill

peers' selves from their bodies, so that the selves can serve--supposedly appropriately--as consultants on the bodies. A physician I spoke with summarized this concept like this: "After all, there is something wrong with his *body*, and he *knows* about bodies!.... You speak to him about his body as you would about an interesting patient that you saw." There is nothing wrong, he believes, with keeping the physician/patient in the consultant role if his sick body is removed from his self and placed between the two physicians as would be any other patient (who may also be seen only as bodies). Indeed, physicians, if they are thoughtful, realize that all patients have at least a degree of expert knowledge about their own bodies, but they do not ask patients other than physician/patients to stand outside these bodies as advisors.

To follow up on the idea that physicians' colleagues see them as separate from their bodies, I spoke with several pathologists who perform autopsies. While several physicians told me that physicians have a higher autopsy rate than does the general population, none of the pathologists had experience with performing an autopsy on a physician that they knew. Should such a situation arise, they told me, they would call another pathologist to perform the autopsy. Although they claimed that their training enabled them to distance themselves from questions of selfhood and the body, they actively avoided the bodies of those they had known, making these questions moot.

Insecurities

Another reason for physicians to consult their ill peers about themselves has to do with their insecurities, discussed in Chapter 3. Asking for the ill physician's acceptance of every link in a diagnostic chain, for his confirmation of the necessity of each test ordered, protects the treating physician from embarrassment, and also means that the ill physician cannot claim, at a later date, that his care was inappropriate. The ill physician gains a similar benefit: if he approves of and goes along with all of the treating physician's decisions, he cannot be blamed later for being a noncompliant, denying, "bad patient".

An aspect of self-protection involves showing the results of studies, especially imaging studies, to physician/patients to justify aspects of their care; this recurs many times in the cases. Again, this is a means of communication that characterizes a consult, but not always a normal physician-patient interaction. For example, Dr. Maurice Pappworth was shown his chest X-ray to convince him that he had pulmonary edema and should be hospitalized (1987:16); often, physicians are allowed to see monitors and use teaching scopes during diagnostic procedures (Dr. Benjamin Felson 1987, Dr. Lewis Thomas 1983, Dr. Allen Widome 1989). A side benefit of displaying these images, as Mandell and Spiro (1987:450) note, is that physician/patients often feel great relief at seeing

evidence of their disease, which gives them a feeling of knowledge and thus of control.

Images can also provide a way of communicating painful news without words. Surprisingly, in contrast to brusqueness without images, as described in Chapter 2, physician/patients find simply being shown the image, with little explanation, to be somehow intimate and gentle. As part of a workup for presumed disc disease, Dr. Richard Thompson had a CT scan of his spine performed.

The CT scan Dr. A. mounted on the view box in his comfortable office was of my back! And it didn't show disc protrusion. Instead, where white bony sacrum should be, there was only blackness....

"Dick," said Dr. A., in a gentle manner that I will always appreciate, "you must catch the next plane back to Chicago. Forget tomorrow's meetings; forget your entire schedule for an indefinite time. Your entire sacrum has been replaced by some kind of tumor, and your symptoms are undoubtedly due to nerve root pressure or--worse-- invasion." (1987:336)

Similar is Dr. Ronald Karpick's tale of how he discovered that he had tuberculosis:

One pretty spring afternoon in 1967, the chief medical resident flipped up a chest X-ray for my review. As the junior assistant resident (JAR) on the male medical ward at Duke Medical Center, I thought he was introducing a new patient. The differential diagnosis of a soft left-upper-lobe infiltrate was fairly straightforward, but when I inquired about the person's history, the chief resident knew only his name. It was mine. (1987:401)

Again, Dr. Karpick was effectively convinced of his diagnosis in this way, and he found the style of disclosure appropriate.

Overtreatment

One final aspect of placing physician/patients in the consultant role deserves mention: overtreatment. This observation seems paradoxical, in light of much evidence, already reviewed, which suggests that physician/patients are undertreated. Both under- and overtreatment, though, may be regarded as different but parallel forms of misguided, inappropriate care, care that is compromised by the peer relationship. Often, for example, overtreatment is undertaken not from fears of reprisal for undertreatment, but from identification with the physician/patient, who is often a mentor. For instance, Dr. Lewis Dexter reports that during his coronary occlusion,

The doctors and nurses promptly discovered that I had electromechanical dissociation, often considered to be a good reason for discontinuing CPR....since I had trained, directly and indirectly, most of the physicians in attendance, they were reluctant to discontinue CPR until...the cardiac surgeon [could come] to see me. No one expected him to be willing to operate because there were no coronary angiograms. To everyone's amazement, he said, "Let's operate." (1987:40-41)

Although these efforts to save his life may not seem extraordinary, Dr. Dexter says that he was treated in his

hospital as no other patient would be. It was not just special treatment, but, he believes, overtreatment: in his own judgment, a nonphysician patient in similar circumstances would not have received similar resuscitation efforts.

A physician with whom I spoke, a man that had been a highly regarded and very influential physician in the community, also having trained many of his colleagues, tells a similar story. His serious illness caused him to land in the intensive care unit in a coma; as he says, "My doctor and my wife were the only ones who thought I'd live." The will of these two people was apparently sufficient, however; the resources of his community were used to keep him alive for three months and two weeks, which he says would be unheard of for any other patient of his age and condition. His physician, with whom I also spoke, admitted to me that he had asked himself "with other similar patients, do we pull the plug quicker?....I had put him on a pedestal, since he was my mentor--80% of what I learned, I learned from him. Treating him was tough."

Still more heroic measures are not unheard of. Dr. Bowes recalls that "a medical student who developed Guillain-Barré syndrome before the time of respirators was given artificial respiration by teams of medical students organized by the dean of medicine. He survived" (1987:54).

Regardless of the heroism of the effort, or the success of the outcome, much of the care that physician/patients

receive is inappropriate. Certainly it may be medically adequate, although in many cases it is not. However, as so many anecdotes have shown, it is inadequate in much deeper ways, ways that have to do with authority, responsibility, and trust. When the physician/patient is forced into the consultant role, he is unable to reap any of the benefits of the sick role, such as dependency, absolution from responsibility, and freedom from making painful decisions with minimal support. Just as his treating peers have a responsibility not to deny his illness, and not to force him to self-diagnose and self-treat alone, so they must not keep him in a consultant role arbitrarily in order to meet their own needs or to assuage their own fears of inadequacy. Surely many physician/patients appreciate being informed and consulted, and I do not suggest that these comforts should be denied them. However, information and decision-making capability for the physician/patient do not preclude thoughtful support and advice from the treating physician. How, then, to accomplish this delicate balance? I will attempt to make some recommendations in the following final chapter.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

As is apparent from these anecdotes, caring for physician/patients is a complex and problematic task. Although they have not attempted to assess the adequacy of this care, several researchers have attempted objective measurements of barriers to effective physician care. Braunwald et al. (1967) found that, compared to Ph.D. students, house staff were half as likely to make arrangements for medical care for themselves and their spouses, even though the health services were deemed readily accessible and were prepaid.

When physicians do receive care, they often end up having to make most of the decisions regarding their care, as we have seen. Bunker and Brown (1974) attempted to assess physician decision-making by studying rates of elective surgery among physicians and matched controls. Contrary to their expectations, since supposedly physicians are well-informed about surgical risks as well as benefits, they found that physicians and their spouses had significantly higher rates of surgery, including hysterectomy, than did other professionals. They feel that this difference in rate reflects unnecessary surgeries that result from a lack of careful, informed decision-making.

Objective measures of self-care also reveal flaws. Chambers and Belcher (1992), in their study of physician self-care (see Chapter 3), found that it was often

misguided. When self-treatment measures were judged by a blind jury of seven general practitioners, almost 80% if it was thought to be inappropriate, as were almost 70% of their self-referrals. This data is likewise unsurprising, given the anecdotal data.

Perhaps most disturbing is a 1968 report by Simon and Lumby, who found that the suicide rate among physicians was three times that of the general population. Explanations for this rate could include job stress or self-selection of particularly vulnerable personality types into medicine. The authors believe, however, that it is due, in part, to the fact that physicians cannot escape stress by claiming the sick role periodically, in order to claim temporary respite from responsibility.

What changes would enable physicians to get better care? We can examine positive examples in the anecdotal data for some clues.

The hospital as home

To begin with, although the care they received may have been problematic, many physicians reported feeling quite comfortable while hospitalized. This seems paradoxical in view of reports by many physicians that they mistrusted the hospital, because they knew better than anyone else the risks associated with hospitalization, including iatrogenic illness and staff errors. However, other physicians are able to put aside their knowledge of the dangers of the

hospital, and to instead see it as a place where they will finally be able to achieve the blessed dependence that their peers withheld from them. In some sense, they regarded the hospital as a home in which they had grown and developed both personally and professionally. It thus provided a safe, known atmosphere when they became ill. For example, Dr. Ronald Karpick reports "It was good being in the hospital. A bachelor with no prior ties to the Durham community, I considered the hospital to be my home and support system" (1987:402). Similarly, Dr. Quintus West (1952) viewed his stay in a tuberculosis sanitorium as a welcome vacation, and even enjoyed its quiet lifestyle, believing that it complemented his bookish personality.

Delbanco (1993:15) speaks of his experience with patients who commonly face heavy responsibility in their daily lives:

They come into the hospital and say,
"You know, it's the first time in my
life I can lay back and relax and have
other people take care of me. I've been
running this house for thirty years.
I've been doing this or that, and now
I'm going to be passive, and I like
that."

Although he is not speaking of physicians specifically, I believe that his statement is quite representative of the experience of many of the physicians who told their stories. Somehow they are able to overlook the constant prodding and broken sleep that make relaxation impossible for most

inpatients, and to instead relish the abrogation of their responsibility.

Dr. Oliver Sacks, once again, expresses the needs which hospitalization can ideally fulfill for an ill physician:

...though as a sick patient, in hospital, one was reduced to moral infancy, this was not a malicious degradation, but a biological and spiritual need of the hurt creature. One *had* to go back, one *had* to regress, for one might indeed be as helpless as a child, whether one liked it, or willed it, or not. In hospital one became again a child with parents (parents who might be good or bad), and this might be felt as "infantilizing" or degrading, or as a sweet and sorely-needed nourishing. (1984:165-166)

The aspects of hospitalization that are especially comforting to physician/patients are those that encourage dependence and renunciation of authority, again perhaps because their physicians have not allowed dependence up to this point.

Treatment by physicians: responsibility and authority

Similar issues run through physician/patients' discussions of their outpatient care. Specific complaints voiced by physician/patients seem to center on assumption of responsibility for their care and the decisions surrounding it. For example, Dr. Joyce Dunlop (1987) laments "My doctor asked me who I wished to be referred to: an orthopaedic surgeon, a neurologist, a rheumatologist, etc. I did not know. All I wanted was to be told what was wrong and what

should be done about it." Dr. Gerrold Maxmen states with conviction "I wanted some doctor to take me seriously; to reach a decision and, above all, to absolve me of the responsibility of being my own doctor" (1972:158).

Physicians that received care from physicians who were willing to absolve them of this responsibility are, in fact, satisfied with their care. In most cases, they are able to contrast this style of care with that of previous physicians who refused responsibility. Dr. Louis Guss (1987:125), at the end of a long string of unsatisfactory relationships with physicians, finally becomes a content patient:

Then I consulted with Dr. R., a local neurologist who had much knowledge and experience with Parkinson's disease. I found him to be compassionate, brilliant, and interested in me not because I was a physician with Parkinson's disease but because I was a patient in distress who needed medical attention.... Even though it seems strange to be on the receiving end, I have readily accepted the role of being a patient. When one is "down and out," there certainly is no choice.

Through being treated as any other patient would be, with respect but also with straightforward guidance, Dr. Guss was able to relax into the sick role and devote his energies to recovery.

Similarly, Dr. David Hein, who as described above had initially consulted his friend for treatment which he later realized was inadequate, finally found satisfaction with "(1) a physician who served as an authority figure for me, [and] (2) an excellent communication channel through my

local physician and concerned partner who could work with me in carrying out my doctor's specific recommendations" (1987:254).

In some cases, a preference for authority and paternalism is explicitly stated: "So far as paternalism goes, I never treat myself. I found an excellent otologist, did what he told me to do, and am not fool enough to think that I know more about his business than he does. If I didn't trust him, I'd go elsewhere" (Dr. William Sharpe 1987:62). Obviously, the choice for the treating physician is not between paternalism and nothing; there are options along this continuum, from simple, nondirected expressions of sympathy all the way to strict dominance of the physician/patient.

Ende et al. (1990:506) attempted to define this preference by comparing physicians' response to illness to that of other patients: "The physicians, like the regular patients, preferred that the principal role in decision-making for their own illnesses be handled by their providers, not by themselves. As illness severity increased, physicians indicated significantly less desire for making decisions". They postulate that the desire for physicians to assume responsibility for the management of an illness, once thought to originate in a "competence gap" between physicians and laypeople, must thus be due to some inherent property of the sick role. As for how well-informed patients want to be, they found that regular

patients were even more likely to want information, perhaps, they say, because physicians are already well-informed or even over-informed. In their conclusion, they recommend that in all cases a physician should attempt to figure out how much input into decision-making an individual patient wants, and then to match it.

Comparison to other patients; trends in bioethics

Is this preference for reduced autonomy unique compared to other patients? Are physicians more prepared to submit to their physicians because they have more faith in biomedicine? Do they cede control as a reaction to their profession, which demands daily decision-making?

The answers to these questions appear to be no. In contrast to a trend in bioethical theory during the 1960's and 1970's, many, like Harold Brody, are encouraging greater balance between patient autonomy and physician authority. This change comes in the wake of research, such as that of Strull et al. (1984), who found that physicians generally overestimate patients' desire to participate in decision-making. Clinicians may offer patients the chance to decide upon their therapy, when the patient may desire the authority of the physician to absolve him from the responsibility of such decisions. "Seriously ill, hospitalized patients, for instance, require of doctors almost continuous decision-making," asserts Hilfiker (1991:382), whose conclusions agree with those of Strull et

al. We have already seen how this situation can often present acute problems when the patient is a physician, since their physicians assume even more that the physician/patient wants control of the case.

Why might patients prefer authoritative physicians rather than significant autonomy? Suchman and Matthews (1988), in an article intended to advise doctors on non-technical aspects of care, say that healing really takes place in a "connexional dimension" which gives meaning to the illness within the context of the culture, and argue that actual curing of a biological illness is secondary. They ask fellow physicians to consider their primary task to be one of support or reassurance, warning that "increased awareness brings increased responsibility, which we may not want (129)," but asserting that the task is essential; physicians must maintain a reassuring aura of authority.

Starr notes that "In clinical relations, this authority is often essential for the therapeutic process. The sick are ordinarily not the best judge of their own needs, nor are those who are emotionally close to them. Quite aside from specialized knowledge, professionals possess an advantage in judgment" (1982:5). It is this authority and judgment to which patients look, taking comfort by trusting physicians. This suggests that struggles against totalizing medical discourse, of such concern during the last two decades, may need to be reexamined in light of patient's needs and preferences.

Recommendations

Certainly I would not call for unconditional paternalism on the part of physicians. However, at least in the case when the patient is a peer, the physician needs to be willing to accept as much responsibility as the patient desires. In fact, he may need to go beyond this limit, which is ordinarily a recommended limit for lay patients, as Ende et al. point out. As we have seen, there are formidable barriers to the acceptance of the sick role by physician/patients, and the treating physician may have to be quite authoritative in order to provide a structure in which the ill physician can cede control.

For concrete guidance, we can turn to Chappel (1981:175), who studied physicians' responses to impaired colleagues (a euphemism for physicians who abuse drugs or alcohol), which can mirror their responses to ill colleagues.

Negative responses include (1) silence, usually based on anxiety, ignorance and pessimism; (2) tentative responses based on stereotyped assumption or distraction by organic problems; (3) judgmental responses that may result in mutual avoidance; and (4) permissive responses that encourage continued use of alcohol or other drugs. Positive responses include (1) confrontation in a concerned, constructive manner as early as possible; (2) assistance to the impaired colleague in obtaining treatment; and (3) education and information sharing to increase awareness of potential and real problems.

Again, these guidelines emphasize variable but clear authority and the dispersal of information, both responses that are similar to those that should be offered to any patient, but that include clearer expressions of the treating physician's willingness to accept control.

Such an attitude can be maintained even through the physical exam. A physician I spoke with makes sure to do a complete physical, "right down to the rectal." He believes that it is a good way to set the tone of the relationship: no-nonsense, and no different from the treatment of any other patient.

Bowden offers another idea of how the treating physician can achieve a balance between respect and authority.

An attitude of friendly, collegial regard helps the sick physician to sustain and repair an already fragile self-respect. The same level of cooperation should be expected and the same limits set that would be with any comparable patient who is not a physician. The difference lies in the fact that in many areas the physician may be quite knowledgeable. Thus, to a greater degree than with most patients, it usually helps to make him or her an active collaborator in treatment.... This policy works well only as long as it is clear that the treating physician is the authority responsible for the treatment. (1983:297)

Here, he sees no difficulty in allowing the physician/patient to maintain a consultant role, but only if he is still allowed, or in fact encouraged, to cede authority to the treating physician.

Siegler and Osmond even offer a humorous solution for physicians who treat peers:

Perhaps doctors who acquire a working knowledge of Aesculapian authority may wish to have a little card or plaque in their offices for the doctor-patients: Doctors, please leave your Aesculapian authority in the waiting room. Doctors becoming patients should reassure their colleagues that "I have left my Aesculapian authority with your nurse or secretary." (1979:138)

Dr. Franz Ingelfinger's well-known article "Arrogance" came out of his own experiences and needs as a patient.

If the physician is to be effective in alleviating the patient's complaints by such intangible means, it follows that the patient has to believe in the physician, that he has confidence in his advice an reassurance, and in his selection of a pill that is helpful (though not curative of the basic disorder).... A physician who merely spreads an array of vendibles in front of the patient and then says, "Go ahead and choose, it's your life," is guilty of shirking his duty, if not of malpractice. The physician, to be sure, should list the alternatives and describe their pros and cons but then, instead of asking the patient to make the choice, the physician should recommend a specific course of action. He must take the responsibility, not shift it onto that shoulders of the patient. The patient may then refuse the recommendation, which is perfectly acceptable, but the physician who would not use his training and experience to recommend the specific action to the patient--or in some cases that frankly admit "I don't know"--does not warrant that somewhat tarnished but still distinguished title of doctor. (1980:1509)

Ingelfinger was discovered to have an adenocarcinoma at the gastroesophageal junction. Being somewhat of an expert on this cancer, and having received much advice from colleagues and friends around the country, he found himself paralyzed with indecision as to his choice of treatment.

Finally, when the pangs of indecision had become nearly intolerable, one wise physician friend said, "What you need is a doctor." He was telling me to forget the information I already had and the information I was receiving from many quarters, and to seek instead a person who would dominate, who would tell me what to do, who would in a paternalistic manner assume responsibility for my care. When that excellent advice was followed, my family and I sensed immediate and immense relief. (1510)

This celebrated arrogance, to be sure, must be tempered with empathy, adequate information, sensitivity, and lack of blame toward the patient. If a physician is able to achieve such a balance in his relationships with his lay patients, in itself a meritorious achievement, then he has only to apply these same principles to the treatment of his ill peers (as if it were only so simple).

I seem indeed, with these recommendations, to be urging unattainable perfection in relationships between physicians and their ill peers. Moreover, all physician/patients do not want the same things from their physician as did Ingelfinger, for example. As we saw, some wish more information, some less; some wish more responsibility, some less. Considering the complexity of the situation, and the diversity of needs expressed by the physician/patients in

the stories we have heard, simple guidelines at this point seem not only impossible to delineate but also ingenuous. Nevertheless, one of the best pieces of advice about being a good doctor, given to me by a physician and mentor with whom I spoke, is quite simply stated: "Find out where the patient is, and meet him at that point". The task is thus to determine what a patient wants from his relationship with you, even if he does not clearly express or even realize these wants, and then to attempt to meet these desires as competently as you can, or else to refer him to another person who would be more helpful to him. This task does not differ when the patient is a physician, although it may be more difficult: the physician/patient may have particular trouble articulating his needs because of denial, fear, pride, a need for control, or any of the other factors we have examined; the treating physician, likewise, may find it difficult to recognize and then to fulfill these needs because of his own denial, insecurity, desire not to embarrass his ill peer, etc.

Physician/patients thus represent a huge challenge for the treating physician; the challenge is not to develop new skills in caring for patients, however, but to stretch and test skills that should already be present. The reward in successfully caring for a peer is commensurate, though, as the physicians I interviewed were quick to point out. I began this thesis by describing how stories of ill physicians are often viewed as narratives of redemption,

telling how they are transformed into better doctors and human beings through the experience of illness. I end it believing that the opportunity for transformation, into better physicianhood and perhaps even into better personhood, belongs even more rightly to the physician who learns to treat his peer thoughtfully, honestly, humanely and humanly. The words of Rachel Naomi Remen, a physician who cares for terminally ill patients, hint at this possibility for growth; although she is not speaking specifically of caring for physician/patients, her observation seems especially appropriate to the care of ones' peers: "Healing is natural. It's not something I do to you, but something that is mutual, that comes out of the integrity of the relationship between us. So both of us will be healed in the process" (1993:351).

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