Me doctor, you patient

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We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab…and beyond. In this column, the perils of being a patient, as a doctor, are discussed.

With regard to my title, I think that we sometimes struggle to get this right.

As the years advance, it is almost a certainty that we will acquire some form of health problem along the way – and definite that there will be a terminal issue eventually. That said, our ability to deal with whatever pathology emerges might be seriously hampered by the small matter of being in possession of a medical degree.

In a previous column (*BJC passim*), I alluded to the sad truth that female spouses systematically underestimate any disease process affecting their male partner. The example I used to illustrate this phenomenon was the notoriously unpleasant Influenza Hominis Gravis, or IHD – universally passed off as 'man flu' and roundly ignored, particularly by those who are meant to care for us the most.

If then, added to the already disabling symptoms of a condition, you have some medical knowledge, the traumatising impact of any illness is compounded. This was also demonstrated in another piece (*BJC passim* – yet again) when I had contracted 'pine mouth' – a persistent bitter taste resulting from eating a specific variety of nut. Thankfully, I chanced eventually upon the correct diagnosis courtesy of Google, but not before I had assumed (naturally enough) that I had acquired an illness that – although unspecified – was undoubtedly going to polish me off within the next three months.

Heal thyself

My contention is that when illness strikes and we are obliged to assume the role of patient, doctors are at a major disadvantage compared with their lay counterparts.

To start with, we are decidedly reluctant even to accept the designation of *patient* in the first place. Our knowledge and training allows – if not mandates – us to assess whatever symptom complex has befallen us and make what we think is a dispassionate judgement as to the pathology, its significance, the potential seriousness and treatment (if any). As long as the responses to this personalised diagnostic run do not appear to cross an imaginary line of acceptability that we ourselves have somehow constructed, we feel content to manage the situation 'in house' – as it were.

The much quoted aphorism "Physician, heal thyself", presupposes that the individual in question has insight into the fact that he has succumbed to some condition or other, but refuses to deal with it. My contention is that he cannot have insight in terms of true objectivity and, rather than reluctance to address issues, his training results in him being unable to.

Subjective objectivity

In order to help our patients, we need to be empathetic, understanding and sensitive, but, in addition, we also need to be objective and make our clinical judgements without being clouded by emotion. When we ourselves become the recipients of a disease process, then, as per our training, we try in vain to rationalise our own predicament. The result can vary from mere inconvenience and distraction to downright misery if not, occasionally, disaster.

We tend to either hyper-interpret or over-analyse our own symptoms, ending up with a diagnosis as rare as hens' teeth, or, alternatively, play down and even ignore them by explaining them away on the basis of relatively innocent pathology. Remember, a runny nose is most likely to represent a common cold rather than cerebrospinal fluid rhinorrhoea due to an expanding frontal lobe tumour, and oppressive, central chest discomfort on exertion does not lose its significance because you just happen to have MBBS after your name.

A hopeless case

Essentially, it is hopeless, and we cannot possibly win. Even if we eventually present ourselves to independent medical opinion, we still lose out. Why? Because the essence of the doctor-patient relationship is that 'the patient gives their illness to the doctor' to sort out, in the same way that we might involve a solicitor in a house purchase. The mental burden of disease is, thus, transferred to someone else qualified to deal with it, and the patient will, thereby, experience some sense of relief.

Not with us. Even though we may eventually submit ourselves to independent medical opinion and

see a colleague (usually), I suspect that we still do not share a sensation of that weight of anguish being lifted from our shoulders. We continue to lie awake at night and worry about it, only now it's worse; we have an even better idea of what it is. We read about that at Medical School, and it wasn't very pleasant!

The analogy is illustrated by the business man whose wife asks him why he is still awake at 3 a.m. "I owe Mr Cohen (a next door neighbour) 10,000 pounds and I haven't got it", he answers. The exasperated wife goes to the open window and yells out, "Hey, Mr Cohen! That 10 grand my husband owes you? He hasn't got it so you aren't getting it!" The husband is astounded. "What on earth are you doing?" to which his wife calmly replies; "Now it's *his* problem".

Is it about trying to distance ourselves from those for whom we are caring? We see our profession in the context of 'us and them'; in order to act as doctor, we must be seen as separated from the patient and somehow protected or shielded against the problems that have befallen them. How else can we possibly be in a position to assist?

This is, of course, a falsehood; once you yourself have experienced grief, pain or disease you become a far better physician. I speak from personal knowledge (as usual), having experienced symptoms related to ventricular ectopic beats some years ago and which disappeared in the same way they had begun a few months before – without any explanation. Nevertheless, the whole experience made me assess outpatients with palpitation in a very different light.

As well as with other physical conditions (cardiac or not), the same phenomenon occurs with emotional events, such as parenthood or the loss of a loved one. You become far more in tune with your patients and that is not such a bad thing.

Special treatment

There is another downside to being a doctor/patient, which is well recognised and potentially far more serious. It can be summed up in the oft quoted words of Professor Harold Ellis, a renowned teacher of surgery at the Westminster Medical School (as it then was): "Mistakes happen when special patients get special treatment".

Whether you like it or not, a doctor will not be managed along the same care pathway that directs the care of other, mere mortal, patients. To avoid any inconvenience (naturally), they will come in on the morning of the procedure rather than the night before; they will go home the same afternoon rather than the next day, because (of course) they will be far better able to look after themselves at home ("their wife is a nurse as well, so that will be fine"); they will either have investigations skipped because they are deemed unnecessary ("I doubt we should need to check that in your case") or, conversely, be over investigated because they themselves have more knowledge or concerns about their illness ("we'll do that just to be sure").

They are never straightforward, because they either presented way too early in the course of their disease because of undue anxiety, or way too late because they rationalised it as something else. Whatever management plan, procedure, diagnostic test, operation or treatment is proposed, any quoted risk should be doubled.

Here's my advice. If you become unwell and need hospital admission, turn up at an Accident and Emergency (A&E) department in Fife or Aberystwyth and book in under an assumed name; McKay or Jones are some helpful examples. Claim to be currently unemployed and deny, not only any medical background or knowledge, but also the existence of any living medical relatives. You will get excellent treatment and do absolutely fine.

Footnote: For any readers currently working in the A&E departments in either Fife or Aberystwyth, I look nothing like my photograph