The Doctor: A Professional under Stress

Possible causes for the high incidence of stress-related diseases

— S Levenstein

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Curriculum vitae

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Summary

The personality make-up of medical doctors as well as the exceptionally high professional expectations they have to fulfil at all times, may be the reason why their stress-related morbidity and mortality rates are higher than the general population. The author discusses studies from several countries done in this field and concludes with some practical advice.

I would like to begin by making an earth-shattering statement: Doctors are human! To give you an indication of just how human doctors are, I will start by quoting from the UK Registrar-General's figures[1] for 1978 which showed that doctors were three times more likely than members of the general population to die through suicide (in female doctors this figure has been shown to be four times higher than the general population), three times more likely to die of cirrhosis of the liver, and twice as likely to die in road accidents. All these conditions may be considered to have at least a partly psychological aetiology.

Murray[2] in a controlled study of the admissions and discharges of male doctors from all Scottish psychiatric hospitals between the years 1963-1972, found that the figures were more than twice as high among doctors as among a socially comparable group. The rates for drug dependence, alcoholism, and affective illnesses were all significantly higher among doctors than non-doctors.

Murray[2] found that Scottish male doctors were 2 to 7 times more likely than socially comparable males to enter psychiatric hospitals because of alcoholism.

Modlin and Moutes[3] (1964) estimated drug abuse among US doctors to be 30 to 100 times the rate in the general population. The doctor's ready access to drugs has traditionally been blamed for the high incidence of drug abuse in the profession, but the fact is that a similar misuse of drugs has not been well documented among pharmacists or dentists[4]. Vulnerability factors such as the individual background and personality traits coupled with the stress of medical practice seem to be more important. Modlin and Moutes studied doctors addicted to narcotics and indicated that those studied, tended to have had a

difficult childhood (real or perceived parental deprivation) and troublesome adolescence.

Bissel[5] and Geller estimated that there were 23 000 alcoholic physicians in North America in 1979. Kearney's[6] comment on this figure is 'a comparable number of drunk pilots or bus drivers would surely cause alarm'.

Various explanations have been put forward to account for the high incidence of psychiatric disorders in doctors. Two theories which have been put forward are the 'role strain hypothesis' and 'the susceptible personality theory'.

Doctors caring directly for patients are significantly more anxious than non-clinical doctors

According to the 'role strain hypothesis' theory, society and the doctor as part of society share certain ideals about the role of doctors. The doctor's duty is not only to bring relief to the suffering, using the whole arsenal of medical knowledge, but also 'to function at the maximum level of competence at all times'. In order to fulfil these expectations, the doctor may have to work hard, often at the expense of leisure pursuits, and this could contribute to the development of mental illness. Cramond[7] (1969) demonstrated that doctors involved in direct care of patients were significantly more anxious than non-clinical doctors. He suggested that the doctors' rise in level of anxiety and neuroticism was a result of their assuming clinical responsibility. The greatest stresses for doctors were the effects of treatment, diagnostic difficulties, the impact of practice on family lives, and death of young patients.

According to the 'susceptible personality theory', susceptibility to psychiatric illness *antedates* entry into medical school. Individuals of a particular personality type, the obsessive-compulsive, are attracted to medicine and accepted into medical school with disproportionate frequency. In one study[8] medical students were found to be more reality-orientated and more disciplined than non-medical students. They scored significantly higher on endurance and need for achievement, lower on impulsiveness and play. Interestingly, their scores on 'flexibility/adaptiveness' and 'ability to tolerate uncertainty' were lower than those of non-medical students. This trait seemed to be at variance with a characteristic of clinical practice that involves a high degree of uncertainty associated with complexity of diagnostic and therapeutic situations.

In a 30-year longitudinal study[9] of 268 college students, chosen on the basis of academic success and good mental and physical health, it was found that doctors differed significantly from controls in that they had more unstable childhoods and emotional difficulties in adult life.

It will be noted that these two aetiological theories of psychological disorders among physicians – i.e. the 'role strain hypothesis' and the 'susceptible personality theory' – are not mutually exclusive. An interacting model has been suggested: stresses that are inherent in the practice of medicine precipitate mental disorder among those predisposed to it; practice is particularly stressful to the ambitious, inflexible individual with a family history of mental disturbance and an unhappy or unstable childhood.

When discussing the question of stress in doctors we need to consider the question of *why* someone chooses a medical career. Common answers to this question are 'to follow the family tradition', 'to help others', 'to achieve economic security', and 'to pursue the challenge of scientific learning'. There can be little doubt that these factors are applicable in most cases, but the truth goes deeper than this. Psychological testing[10] of medical school applicants has resulted in most medical students tested being described as 'achievement orientated' and many psychologists apply the label of 'obsessive-compulsive' to the future physician. Derdeyn[11] attributes this inner drive for accomplishment as possibly emanating from a desire to *please others*. Hence the physician has been characterised as having unresolved dependency needs and feelings of inferiority. Medicine offers the opportunity to respond to needs of others and, thereby, develop a feeling of self-esteem and accomplishment. Taubman[12] says that the physician's characteristic personality traits enable him to cope with the stresses of medical training, to work hard, to persevere in times of adversity, and to postpone personal gratification. On the other hand, Taubman says, the physician's profile – single-minded, goal-orientated and detached – may describe good physicians but, unfortunately, 'relatively insufferable husbands and fathers – and I suspect mothers'.

Doctors are 3 times more likely to die of suicide than members of the general population

Dechert[13] has characterised physicians as needing, as a consequence of their psychological profile, to care for others and to be *in control*. Therefore, they seek to act out a caretaker role, even, in some cases, marrying spouses likely to be chronically ill. Research studies[14] on medical marriage have identified the physicians' wives as having strong dependency needs which may presage subsequent

psychiatric problems. To date, scant data are available on male spouses of female physicians.

James Knight[15] describes some of the motives for choosing medicine as a career as stemming from *inner needs* of the individual concerned. He says that one reason for the choice of medicine as a career may be 'to control one's own excessive *fear of death*. By becoming a physician, the person secures him or herself against the jeopardy of death and obtains dominion over mortal anxiety by having the power to cure'. In this regard, it is interesting to note that the famous psycho-analyst, Adler,[16] observed over a hundred years ago that many doctors that he knew of had been seriously ill as children, and he postulated that their choice of medicine as a career was an attempt to compensate for the feeling of helplessness and fear of death that they must have experienced earlier in their lives.

The doctor's 'duty' is to function at the maximum level of competence at all times

The sense of control and power which doctors experience is strongly reinforced by the public they serve and among whom they live. Taylor[20] et al, say that 'from the day of acceptance into medical school there is a magical transformation in the way people interact with the future physician. The family rejoices, (ex)-classmates are jealous, and neighbours offer congratulations. This chosen individual will learn the mysteries of life and death, and safeguard our most precious possession - human life'.

In addition to receiving special rights and privileges, the physician is held up as an example of virtue in the community, and leadership is bestowed simply on the basis of the profession of medicine. In an emergency the crowd will make way for 'the person in the white coat'. At a community meeting people will listen to the comments of the physician. In a Gallup Poll conducted by the American Institute of Public Opinion in 1981, the results showed physicians to be second only to the clergy in the opinion of the respondents. The poll rated physicians as number one in 'prestige or status' and in 'stress or pressure'. The respondents also believed that clergymen and physicians provided the greatest contribution to society. From this data it is easy to understand how many believe that medicine is a mission, similar to the calling of a minister or priest. Osmond[17] proposes that the power of the physician in the minds of the public is derived from three ingredients:

- knowledge, gained from years of study and not easily available to others;
- moral authority, derived from expectations of service to others rather than to self or family; and
- Aesculapian authority, thought by some to be God-given with charismatic features.

Small wonder then, perhaps, that doctors find it very difficult, if not sometimes impossible, to relinquish the idealised image which the public has of them.

Medical students find it hard to tolerate any uncertainty

But doctors pay a heavy price for this image. Taylor et al[10], point out that society sanctions a physician's devotion to duty, even if it means neglect of family obligations. This attitude has been inculcated into medical students for generations. The famous physician-teacher William Osler, said to a group of students in the late 19th century: 'What about your wives and babies if you have them? Leave them. Heavy as the responsibilities are to those nearest and dearest, they are out-weighed by your public. Your wife will be glad to bear her share of the sacrifice you might make'.

There are also internal pressures which make it difficult for the doctor to escape the god-like role in which he has been cast. As mentioned earlier, the sense of power and control which becomes part of the physician's self-image often compensates for underlying feelings of weakness and inadequacy which the

Doctors do not seek help until they are desperate, and very ill

doctor is loath to become aware of once again. This has been cited as one of the reasons for the reluctance of many physicians to retire. The ever-present need which doctors seem to have to prove themselves often manifests in compulsive work habits which protect the doctor from having to face his own feelings of fear and vulnerability, and the god-like façade is preserved.

But, as mentioned earlier, doctors are not gods - they are human beings. And being human means being subject to the whole gamut of human emotions and experiences, including fear, vulnerability, self-doubt, and yes, believe it or not, even illness! Unfortunately, the need to uphold an entirely artificial and unrealistic facade of medical professionals as superhuman, has resulted in many doctors being deprived (or perhaps depriving themselves) of the basic human right to receive proper care for their

bodies and souls. Waring[18] (1977), in a controlled study of 30 doctors and nurses hospitalised for psychiatric illness, concluded that both groups – as he put it – 'make the worst patients' when compared with a group of psychiatric patients matched for age and sex. He related this to a reluctance on the part of doctors and nurses to initiate 'help-seeking behaviour': doctors do not seek help until they are desperate and very ill.

Doctors find it difficult to relinquish the idealised image which the public has of them – and pay a heavy price for it!

The problem which doctors have in accepting the patient-role is further compounded by the fact that doctor-patients usually receive inferior treatment from their colleagues, probably because of the unconscious attitude of the treating doctor who *identifies* with his patient colleague, and therefore does not treat him in the same way as he would treat other patients with the same problems. Waring[18] blames this attitude for perpetuating psychiatric illness among doctors and nurses, for example, by causing insufficient follow-up or inadequate drug treatment. He argues that the higher rates of suicide and addiction problems among doctors compared with other Social Class I occupational groups, might be seen not as a reflection of the higher prevalence of psychopathology but as a reflection of the poor quality of psychiatric care received by doctor-patients. To me it is a sad commentary on our profession, that although we devote our professional lives to the care of others, we are at our most neglectful, albeit unintentionally, when it comes to the treatment of our own colleagues!

Sad, indeed, but true. I wonder how many doctors can truthfully say that they felt free to express their fears and anxieties openly when they had occasion to consult a colleague, or that they provided colleagues who have consulted them as patients an opportunity to speak openly about *their* concerns in the same way as they would normally do with their own patients. This is not intended to point a finger at anybody, but I feel that we all need repeated reminding of the point I have already made twice in this paper: doctors are human! I would like to illustrate my point now with an incident from my own experience. A few years ago I was on holiday in one of the major cities in our country, when I awoke one morning and noticed spots before my eyes. When these persisted, I suspected that these spots may be the aura of an impending migraine, even though I had never previously suffered a migraine attack in my life. It soon appeared that my suspicions were confirmed, as I started to experience severe bitemporal pain and nausea. Fortunately, the attack was a fairly mild one, but as it was wearing off I remembered reading somewhere that migraine occurring for the first time in middle-age should raise the suspicion of a carotid artery aneurysm. The thought of this possibility made me very anxious, and I phoned a GP-colleague in the area who arranged for me to see a physician the same day. I expressed my fears to the physician who then examined me and expressed the opinion that it was 'something opthalmological'. He phoned an opthalmologist in the building who kindly agreed to see me almost immediately.

The session with the opthalmologist was a highly traumatic experience. To begin with, I realised how difficult it is to keep one's eyes open to have those drops poured into them, when for years I had felt that my patients, who found it equally difficult, were really being unnecessarily uncooperative, even though I never actually told them so. Then I had a powerful light shone into my eye, which was extremely painful, and I realised for the first time why this practice has been used as a method of torturing prisoners!

But the physical side of the examination, though highly unpleasant, was by no means the worst aspect of this experience. While conducting the examination, the opthalmologist explained calmly that my vision had deteriorated considerably since my eyes had last been tested, and that the spots before my eyes had been 'floaters' which were probably due to a vitreous detachment, a fairly harmless condition, but that a retinal detachment (of course I knew this was a much more serious condition) had to be excluded. Then, with what seemed like a laserbeam scorching my eye, and the reflection of the vessels of my retina visible to me like a picture of the galaxies at a planetarium, the opthalmologist said calmly, 'there's the detachment'. I was terrified: he had not said whether it was a vitreous or a retinal detachment! I was too frightened to ask him *what* kind of detachment he was referring to for fear of hearing the worst. So I just sat silently and waited and prayed for him to reassure me. However, he just continued exploring the contents of my orbit, quite unaware of the fact that I had begun to sweat profusely, fearing that I was soon to go blind. When he remained silent I tried to talk, but I became aware of a feeling of constriction in my throat which made it very difficult. Finally, I managed to splutter 'you mean a vitreous detachment, don't you?' At first he appeared not to hear my question as he was engrossed in his examination, but after a few moments (which seemed like hours), he said casually, 'yes'.

After the examination had been completed and we were sitting at the opthalmologist's desk, the physician arrived to ask the opthalmologist what his findings were. The opthalmologist told him it was probably a vitreous detachment and then said, 'we don't have to go about excluding an occipital tumour today. That can wait until he gets back to Cape Town'. I left the opthalmologist's consulting rooms feeling as if I'd just been dragged through a physical and emotional treadmill.

I would like to point out that I have not recounted this incident in all its hair-raising details in order to malign a colleague. In fact, the ophthalmologist had nothing but good intentions. He agreed to see me at very short notice, no doubt at considerable inconvenience to himself. He performed a thorough examination and attempted, as far as he was aware, to keep me fully and honestly informed of his findings. At the end of the consultation, he was adamant that he would not accept any payment from me for his services, and only finally agreed to do so when I was able to impress upon him that I was covered by a medical aid which would pay the fee. However, the cardinal error which this doctor, like many others, made was to speak to me as though I were a colleague, and the patient he was examining was someone I had referred to him. He was quite unable to appreciate the fact that once I was slumped in that examining chair, I was exactly like all his other patients – ignorant and frightened, irrational, and ready to attach the most dire significance to anything he said, or did not say. In fact, if anything, I was in a worse situation than most of his patients, as my bit of medical knowledge only served to heighten my anxiety level.

I hope the point is clear – if we are to strive to reduce the incidence of stress-related problems in our ranks, we need not only to be willing to accept the role of patient far more often than is usually the case, but we also radically need to radically revise our attitude towards colleagues who present to us as patients: remember that they, like us, are human, and that if we do not *allow* them and ourselves to be human, the consequences may be serious.

Consequences

With regard to medical marriages, a special 1970 census survey in the UK showed that white male physicians, aged 35-40, were only half as likely to be divorced as non-physicians. Another survey, however, published in 1979, revealed that the percentage of female physicians divorced or separated was six times that of men. Of those physicians where marriages ended in divorce there are some other high-risk groups in addition to female physicians. Rose and Rosow[19] reported an *inverse* correlation between the rate of divorce, and the size of a city, a *reversal* of the liberal divorce patterns in cities and conservative trends in rural areas. They found that *black* physicians had a 70% higher divorce rate than white physicians. There was also a variation in the divorce rate among medical specialties, orthopaedic surgeons, psychiatrists, and dermatologists

were highest, and preventive medicine/public health specialists lowest.

Even in physician groups where the divorce rate is low, experts have cautioned that this does not necessarily reflect a high level of marital harmony. The apparently low divorce rate may be a reflection of the general conservatism of physicians, their concern regarding their image in the community, financial considerations, or a denial that there are marital problems.

A major survey published in *News Week* in 1979, in which more than 1 000 physicians' wives said they were disappointed in their expectations about their marriage, was followed by nationwide publicity.

Doctors' children too, appear to have a hard time of it. In return for the special status in society, doctors' children are said to be subjected to high expectations from their family, teachers and community members. A survey of physicians concerning problems they have with their children listed 'poor schoolwork' and 'personal appearance' as the top two items.

The lack of attention from a physician-parent is often cited as a cause of anti-social behaviour among physicians' children. Martin[20] says that the physician-parent may have adequate time for his patients, but little for his family. He may placate children with material possessions as a substitute for his presence. The physician's children may often become 'community rebels', engaging in drug use, promiscuous behaviour, or other anti-social activity to gain a parent's attention. The alienation that may exist in a medical family is poignantly illustrated by the story of the physician's child who, when asked what he wanted to be when he grew up, said, 'I want to be a patient'!

As far as doctors themselves are concerned, they are particularly susceptible to what has alternatively been described as 'role strain', 'the overwork syndrome', and '*burnout*'. The term burnout in essence describes the situation where a person's resources and ability to cope are exceeded by the demands of work.

The *signs* of *burnout*[21] have been well-described. The burned-out person is unable to maintain work performance and shows a consequent decline in efficiency and initiative. He (or she) becomes increasingly cynical and disillusioned about his work. Sometimes he conceals this by a rigid, inflexible attitude which in a more subtle way expresses a basic negativism. He/she experiences many upsets of health including loss of energy, irritability, disturbance of sleep and eating habits, difficulty in concentrating, dejection, depression, tension headaches and other symptoms of stress.
(At this point it may be apposite to mention that according to figures which were kindly furnished to me by the Professional Provident Society, doctors have a significantly higher incidence than other professionals of days lost through illness, not only from mental disorder, but also from stress-related physical disorders such as ischaemic heart disease, etc.)

Not infrequently the burned-out doctor attempts to self-medicate with alcohol or drugs. Although work performance declines, he may spend increasing amounts of time at work in an attempt to compensate. Outside of the workplace he is unable to relax and enjoy recreational pursuits.

Burnout can also manifest itself in more subtle but quite destructive ways, for example, a cold, an unsympathetic and brisk manner that conveys an essential disinterest while going through the usual routine of a medical consultation. Another sign of burnout, which is more or less pathognomic when occurring in middle-aged GPs, is the decision to specialise!

McCawley[21] points out that there are some paradoxes in the practice of medicine which create role strain for the physician. A doctor is required to be sympathetic, sensitive, understanding and compassionate; at the same time there are some very tough decisions that have to be made while maintaining one's performance, unaffected by suffering and tragedy.

Most paradoxical perhaps is the overwhelming attraction that medicine seems to possess for its practitioners, in spite of all the stress: the fascination and challenge keep them returning for more. This maintains and escalates the pressure. Oliver Wendell Holmes advised Phineas Barnes, 'If you would wax thin and savage like a half-fed spider, be a lawyer; if you would go off like an opium-eater in love with your starving delusions, be a doctor'.

Rhoads[22] has described the *characteristics of physicians who overwork*. Some individuals attempt to overcome fear of failure and insecurity through work; in others, identification with a perfectionistic parent is the driving force. Compensation for other defects such as poor health or ageing can also be a motivating factor. Almost all physicians who overwork have in common an excessive need for approval and a compulsive approach to work as a defence against problems of aggression. Rhoads' comments that 'in physicians, particularly, the need to be loved by everyone was a major component of the drive to overwork'. Not only does an exaggerated attention to the practice of medicine enhance self-esteem and gain social approval, it also helps the physician maintain a clear conscience by demonstrating to the world that he or she has even worked to the edge of total exhaustion and is therefore blameless.

The compulsive traits of physicians are well-recognised. Perfectionistic attention to detail and the need for omnipotent control are reinforced by the demands of medical practice. The physician's accessibility to the general public encourages the tendency to take responsibility for everyone. Doctors are always subject to what has been described as the tyranny of 'the should' – things they *should* be doing.

Doctors are always subject to the tyranny of 'the should'

The observations of Rhoads on the problem of burnout indicate factors in the *individual*, rather than the external realities of medical practice, implicating personality problems that go back long before the time of choice of a medical career. Similar conclusions can be drawn from the studies of George Vaillant[23] and colleagues, involved in an intensive study of a population selected in college and followed through their lives over a period of 30 years. Vaillant once again found a much higher incidence of drug, alcohol related problems among doctors than in other professions, and found that the presence or absence of these difficulties appeared to be strongly associated with life difficulties *before* medical school. Only the physicians with the least stable childhoods and adolescent adjustments appeared vulnerable to these occupational hazards. These findings indicated that the stress of a medical career seemed to be less important than is usually assumed. The study also raised questions about the motivation for the choice of medicine as a career. Dr Vaillant suggested that some physicians may elect to assume direct care of patients to give others the care they did not receive in their childhood.

Interestingly, Vaillant's studies showed the highest number of symptoms in the group of non-surgical practising doctors; in contrast, doctors in administration, surgery, and research had significantly less emotional difficulties and also more stable childhoods. These figures have been explained partly on the basis of self-selection, and also partly on the basis of the balance between psychological demands and reward in different types of practice.

At this point, it would seem reasonable to ask which doctors are *less* likely to develop signs of burnout. Rhoads[22] identified two characteristics in particular.

First, such individuals are able to postpone thinking about problems until the time for action on the matter arrived. Secondly, they were able to *recognise* when

they were under strain and take some appropriate action, either taking a holiday, delegating responsibility, postponing a project, or some other response to reduce stress.

It has to be recognised that medical practice will not always allow a doctor to slacken off. Nevertheless, there are many times in every doctor's life when there is an option between a further commitment to work and leaving it to a colleague; often the choice of the practitioner is the former. Recognition of the need to back off occasionally might be an important factor in preventing the development of unmanageable stress.

Doctors as a group receive very little training in administration and management. Skills that could be acquired in such courses are certainly of value in organising a daily schedule, and efficient organisation of work can reduce stress. Effective working relations with colleagues and adequate coverage are also important supports; it has been a common observation that the solo practitioner is at higher than average risk for impairment. Professional association in the societies of the medical community (such as the Academy of Family Practice/Primary Care) is also a great resource to alleviate stress for doctors. They can gain support from relaxing and sharing experience with colleagues.

Many other aids to reducing stress have been advocated including relaxation techniques, jogging, meditation, hobbies, self-hypnosis, and such basic measures as taking reasonable vacation times. Although most people are aware of these possibilities, many do not utilise them; it is surprising how often intelligent, hard-working doctors neglect their most obvious basic needs. It is not uncommon to hear the wife of such a doctor complain that they have not had a holiday in years.

Having dwelt at some length on the ills to which doctors can fall prey, I think it is appropriate at this point to emphasise that the majority of doctors are well-adjusted individuals. They possess several excellent personal qualities and perform a valuable service to the community. It is only a minority of doctors who are alcoholics, workaholics, etc. However, for reasons which have been mentioned earlier, our profession is at relatively high *risk* for developing certain problems, and it is therefore necessary for us to be *aware* of these problems in order to be in a position to counteract them.

What can we do?

I think this question can be approached from two angles:

1. The profession as a whole

It is gratifying to note that there have been some advances in this respect, at least in certain countries. The American Medical Association held its first National Conference on Impaired Physicians in 1975. (Perhaps I should first have mentioned the formation of the 'International Doctors in Alcoholics Anonymous' which was founded in 1948 and now has over 1 000 adherents worldwide).

In the past 10 years many programmes of identification and intervention by concerned colleagues have evolved, which lead the sick doctor to treatment and give him a chance for recovery. The programmes are designed to provide help rather than punishment, and they employ persuasion before coercion. Some programmes monitor the progress of the sick doctor and assist both in rehabilitation and resumption of his professional work.

A few practical points, gained from the experience of these programmes, are worth mentioning here. One of these is that the physician addict is prone to consult the wrong person for the wrong reason. Most often it is a physician friend, who is ill-prepared to treat him and whom he manipulates disastrously.

Doctors consulted in this manner must realise that the greatest kindness they can offer their sick colleague is to insist firmly that he should accept help from a skilled and otherwise disinterested therapist. They should help him make arrangements for this and see that he follows it through. In this regard it is worth noting that a 1976 study showed that being admonished by a colleague was probably effective in getting alcoholic doctors into treatment in 60 % of the cases.

The unrealistic facade of medical professionals as being super-human, is the reason why many doctors do not receive proper care for their bodies and souls

The following suggestions have been made for consideration by colleagues who are concerned about one of their members addicted to drugs, and who want to intervene:

- do not try to intervene on your own; seek trained help
- include a few family members and close associates selected for their personal knowledge of the doctor's problem and for their ability to maintain composure
- plan ahead and school all participants
- introduce reality
- present evidence, not accusations
- be prepared to act promptly; make an advance reservation for admission to a treatment facility
- let the sick doctor know you care
- be prepared to get tough if necessary by reasserting your moral and legal obligation to inform authorities of his impairment if he does not comply.

Another set of suggestions[24] has been offered to all doctors, especially newly-qualified ones, in the hope of reducing the incidence of drug-related and other serious disorders in our profession:

- remember, you were a person before you became a doctor
- recognise your personal needs and attend to them
- pace yourself
- learn to give to yourself in healthy ways
- reach out to one another; and learn to receive
- be alert to problems among your peers in the brotherhood of medicine
- be prepared to help each other
- be your brother's keeper.

2. The individual doctor

There can be little doubt that South Africa is lagging far behind other countries in respect of organised assistance for sick doctors, and it is hoped that serious attention will be given to this matter in the near future. However, even if and when this is done, it will remain true that much will depend on the individual doctor to do all he/she can to maintain optimal mental and physical health. As far as doctors are concerned this means, in my opinion, a constant process of self-appraisal, and a greater degree of honesty with ourselves. My reason for saying this is that unfortunately our society actually encourages us to bluff ourselves, to deny the existence of any personal problems and, as mentioned earlier our personality make-up reinforces this tendency to denial and self-deception. It is therefore all the more necessary for us to try constantly to keep in touch with our true feelings at all times, and to acknowledge our human fallibility and weakness. For, as I hope I have clearly demonstrated, we omit to do so at our own peril.

I would like to put a few questions to all readers:

- Have you asked yourself when last you had a holiday?
- Do you ensure that you have adequate off-duty time (for example, a roster-system for after-hours duties etc.)?
- Do you set aside any time during the course of your working day for a break from work, and stick to it?
- What interests do you have outside your work?
- Do you have a GP?
- Is he a personal friend of yours?
- When last did you see a doctor?
- How comfortable did you feel in the role of patient on that occasion?
- When last was your blood pressure checked?
- How do you feel about self-medication?
- Do you try to monitor why and when you find yourself being irritable with patients, staff, and family?
- Do you find yourself wanting to work shorter or longer hours at times and do you ask yourself why?
  and finally,
- What is your attitude and practice with regard to receiving help for yourself?

I am sure we could all add many questions to that list, but I feel that all the questions have one common theme, which is, that we are all human. For various reasons, both society and doctors themselves seem to have great difficulty in accepting and applying this very obvious and simple truth. I believe that it is this failure to recognise and accept our basic humanness, which implies all our strengths and weaknesses, all our fears and failings, all our doubts and dilemmas, which is the greatest threat to our mental and physical health as doctors.

Doctors tend to treat their colleagues in an inferior way

We are privileged to belong to a noble profession. Our work brings us several rewards, material (though many would dispute this nowadays), emotional, intellectual and spiritual.

Our services are, for the most part, highly appreciated by the communities we serve, who sometimes place us on a pedestal in their regard for us. I do not believe it would be too high a price for us to pay to come down from that pedestal somewhat in the interests of our own health. On the contrary, I feel that it would be in the mutual interests of both doctors and patients if doctors came to be seen (both by their patients and themselves) as *real* people, with real feelings, needs, and problems of their own – *not* that patients should be burdened with their doctors' problems, but just that they should have more realistic expectations of their doctors than is quite often the case.

Perhaps true to my calling, I want to conclude on a professional note. I believe that it is in our *patients'* interests that we accept our own humanness better than most of us do. For if we are in touch with our *own* hopes and fears, doubts and despairs, feelings of weakness and inadequacy, etc., will it not enable us to empathise much more successfully with our patients? To reach out to them in their suffering instead of retreating aloofly into our own cocoons of self-ignorance and denial? Perhaps I could express the same point in a different way: I believe when we are more ready to become patients ourselves, we will become better doctors.

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Learning from Patients

Many medical educationists are encouraging under- and post-graduate students to cultivate the habit of learning from their patients. This is seen as one's main, life-long learning strategy for initial and continued education. We invite you to send us an account of your learning experiences with and from patients. If not in the form of an article, why not write us a letter?

Editor.