
Le syndrome du Bon Dieu

... a fatal malady affecting doctors

by Dr J R Kriel

"... many of the problems in medicine today result from the lack of feed-back to doctors about themselves and the positions of power they are expected to hold".

(Meighan and Osborne)

IT IS a fact that some people live their lives better than others. Furthermore, successful living does not seem to correlate well at all with academic training, professional expertise, social standing or economic rating. Some people simply do very poorly at living effective, productive, creative and happy lives – and medics more often than not fall into this latter category.

Academic success achieved within the parameters defined by the Medical Schools, or even professional or scientific success achieved in the hurly burly of professional clinical or scientific medical practice, does not necessarily guarantee a fulfilling and satisfying professional career nor a meaningful and joyful life.

In fact, success within these and other academic and professional parameters might even increase the incidence of those psychological, emotional and mental risk factors that turn so many medics into cynical, frustrated, uncaring and unhappy biological mechanics and have made the medical profession the one with the highest incidence of divorce, alcoholism, drug addiction and suicide.

Statistically speaking you and I are more likely to destroy ourselves with drugs or alcohol or suicide and more likely to have a disastrously unhappy emotional and married life than almost anyone else in our society.

From this, one can deduce that there must be something adrift in our medical education – that we are excellently trained to function as medical practitioners, but we are not taught how to live as medical practitioners who also have to function within the context of social and family life. It is also possible that our profession is so structured that it produces exactly those pressures and stresses, those self images and experiences that cause us to drift imperceptibly but inevitably in the direction of frustration, cynicism, meaninglessness and consequent personal and family unhappiness.

Such analysis of the pitfalls in the life of practitioners of medicine are being made all over the world in the hope that fore-knowledge will enable us to skirt the pits. In the rest of this paper I would therefore like to analyse one such pitfall which seems to be an integral part of the structure of our profession. It is so much part of the warp and woof of our professional life, that we have come to regard it as normal.

In the literature this is called the "deity syndrome" or the Mr-God-complex, while in French it is sometimes colloquially called *le syndrome du Bon-Dieu*. It is one of the most destructive forces undermining our professional functioning and personal happiness because it creates in us a self-image which gradually isolates us from the reality of the world of our patients and of our loved ones whether it be wife or children.

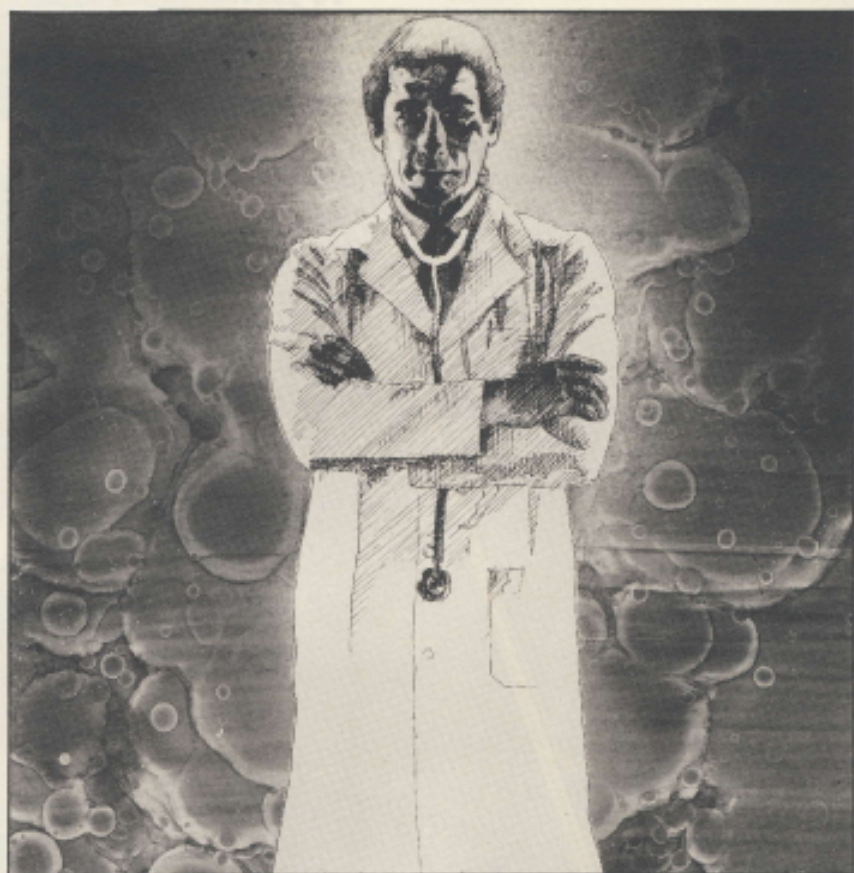
How does this complex arise? To answer this question we have to look at the work environment of the doctor. The only people a doctor comes into contact with during his working hours are his patients, colleagues and nurses.

The patients are on the whole submissive, respectful, admiring or even sometimes adoring. Even if a patient does not like his doctor or is less than satisfied with the treatment, he will probably not say so. Nor will he rebuke the doctor if he is not satisfied with the manner in which he has fulfilled his broader professional duties and responsibilities. He may of course switch doctors, but rarely does he tell his former doctor why he is leaving, so that from the doctor's point of view he is just seen as another 'unthankful patient'. Rarely will the patient say anything true about the doctor within earshot.

Nor is he likely to get any honest feedback from the nurses he comes into contact with. Whatever they might say about him behind his back or in the duty room, in front of him they are polite, supportive, submissive and even admiring. They would not dream of yelling back or telling him he is an unmannered, insensitive, egotistical oaf, because the professional hierarchy resembles a pyramid with a doctor sitting on top. As Meighan and Osborne (1978) put it: "he is The Boss, the sole reason for everyone's being there, including the patient".

Doctors rarely fall out with colleagues even though they may have little regard for the other's professional ability. On the surface they maintain all the trappings of a mutual admiration society and remain friendly with each other — unless of course there is absolutely no choice of exchanging referrals!

Professionally the doctor falls in the class of the so-called 'top managers'. He is a decision maker, what Meighan



calls a 'fast-answer-man'. Not only is he continually called upon to make decisions and to give answers, but he eventually begins to think that he really has all the answers: he begins to think that his decisions in fact always have a basis in reality and affect reality. Not only does he have all the professional answers in his consulting rooms, but as an esteemed member of society his opinion is highly regarded even on non-medical issues.

The doctor is therefore surrounded by people boosting his ego and rarely ever questioning his competence and *modus operandi*. He gets little or no honest feedback about himself from anyone in his professional environment. The very structure of our profession is therefore the seedbed for the nurturing of the Mr-God-complex.

But let us now follow our hero back home where he has to take on the role of homeowner, husband and lover, father, friend and neighbour. These words cover a multitude of mundane chores, irritations, responsibilities and expectations. He is suddenly faced with arguing teenagers, and a wife who does not unnecessarily perpetu-

ate the atmosphere of respect and adoration which he has by now come to expect as his right.

In his office or in the hospital, as Vincent (1977) points out, he is rarely expected to carry out the garbage, mow the lawn, hammer in a nail, help the kids with arithmetic or listen to his wife's tale of woe regarding the day's problems. This will suddenly appear pretty mundane to the busy saver of lives. He can find more admiration for much less effort in his professional environment.

This transition between roles is not easy. Most doctors cannot understand that they have to play different roles in different situations and within different relationships.

The doctor therefore immediately concludes that the fault must lie in the home with the wife and children because at work he is greatly appreciated — and quite rightly so! So he starts spending more and more time at work and thus enters the 'cop-out phase' of this fatal syndrome.

The more time he spends at work
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the more he is admired and appreciated by nurses and patients and the stronger the Mr-God-complex becomes. This leads to a worsening of relationships back at home and he spends more time at work where the complex is again reinforced. This is of course a typical example of a positive feedback loop which has such disastrous physiological consequences in the *milieu interieur*; the consequences in the socio-professional environment are no less disastrous.

It is tragic that very often the wife also accepts that it is her fault. Everyone tells her how great her husband is and how lucky and happy she must be to be married to such a wonderful and saintly man. The more she hears this, the more depressed she feels and concludes that it must be her fault that they cannot get on anymore.

Allan Morgenstern, a psychiatrist specialising in the counselling of physicians and their wives, says that it is not uncommon for a troubled physician to consider his wife to be emotionally and psychiatrically unstable. Controlled and longsuffering he sees himself as a tower of rational strength while his wife is seen as the sick one (Meighan and Osborne, 1978).

Meighan and Osborne (1978) put it as follows: "if you take the doctor out of his work situation where there is little criticism and a whole lot of power, and place him back home where the issues are more mundane and where he is simply John Doe married to Jane Doe, it is no wonder there may be trouble. It is not an easy transition to make".

Although not being able to let go of his work is a sign of incipient trouble in a doctor's personal or professional life – no time to listen to music, read a book, play with children or relax with his wife – The extra time spent in the study or with patients often has beneficial economic effects.

Many doctors thus try to cover the unhappy family life with the conspicuous trappings of affluence. The sports cars, swimming pool, motor-bikes for the kids, rambling mansion and tennis court he sees as objective evidence of how well he is caring for his family. He is doing all this slogging for their sake – so he says and thinks.

The fact that they do not necessarily want these things but only want a father and a husband in the house does not enter his mind, because there

is no room for such concepts within the framework of the Mr-God-complex. Dr Morgenstern calls this approach "an effort to feel good from the outside in" (Meighan and Osborne, 1978).

A further problem lies in the fact that doctors as a group find it difficult to admit that they are having trouble or to seek help. Accustomed to the role of the great helper and adviser they find it difficult to accept the role of the person needing help and advice.

Thus, if things go wrong, they refuse to admit it to themselves or their spouses and do everything in their power to cover it up and keep it a secret – until it is too late.

"We can no longer hear what the patient is trying to tell us because we already have all the answers."

The treatment of this syndrome is extremely difficult. Our patients expect us to assume a role of godlike dedication and self-assurance, and it is for all practical purposes a necessary part of the motivational framework of our profession. Jacob Lourenz Sondereger (1826–1896) said the following: "medicine must be (and everything depends on this) your religion and your politics, your fortune and misfortune. Therefore, do not advise anyone to become a physician: If he still wants to become one, warn him against it repeatedly and earnestly: If nonetheless he persists, then give him your blessing: If it is worth anything, he will have need of it" (Vincent, 1981).

He therefore encourages us to approach medicine as a form of idolatry. This idolatry may in fact be a necessary ingredient of adequate service to the needs of our patients. The problem however, arises when a shift takes place from idolising our profession to idolising our professional selves, and thus start assuming such attitudes as omniscience, omnipotence and infallibility.

The first step towards healing lies in recognising the existence and the destructive effects of this syndrome. It is always salutary to watch out for its occurrence in one's behaviour patterns of which they are completely unaware and especially to note how the clinical environment reinforces the mythology of the great infallible healer.

We should constantly call to mind the story of the king who was talked into believing that he was wearing the finest clothes while in fact he had nothing on. We are like that king, strutting naked across the stage of human suffering. We need to learn to see ourselves through the eyes of the child who called out "look at the king ... look at the king" or perhaps we should learn to see ourselves as Shakespeare depicts the human condition, because his poetic image is equally true of and applicable to the antics of the medical profession:

*"But man, proud man
Dress'd in a little brief
authority,*

*Most ignorant of what he's most
assur'd,
His glassy essence, like an angry
ape,
Plays such fantastic tricks before
high heaven
As make the angels weep"*

*(William Shakespeare –
Measure for measure –
Act II Scene ii) –*

The next step would be to realise the limitations of our profession in general and of our own efforts in particular. There is no time to analyse these limitations now, but we are in fact only able to heal occasionally – and even then, more often than not, healing would have occurred in any case. But we can relieve often and we must comfort always.

We are in the last analysis only 'siek-troosters'. All our patients, like we ourselves, are going to die. If we truly understand the nature of our comforting profession, both illness and death need not be experiences of failure but can be experiences of great fulfillment for both patient and doctor alike. We must realise that our professional role is not the whole of our life and that professional expertise and even success is not all that is required for leading a full, meaningful, joyful and zestful life.

The obvious environment where healing of *le syndrome du Bon-Dieu* can take place is within the context of the family. But healing is not possible if we do not realise "the important but poorly recognised fact that achieving
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personal and family happiness is vastly more complicated than becoming a successful doctor", (Meighan and Osborne, 1978) and that consequently we have to work much harder and with more studied effort and discipline at achieving personal and family maturity, than we have to in order to achieve professional success.

"Marriage is a life work" says Merwin Vincent (1977), psychiatrist from Guelph, Canada, "which some scarcely begin and only a minority ever fully achieve. We must not deceive ourselves into thinking we (physicians)

says Vincent. "It doesn't work because the sort of things we do with our wives and family tend to be routine; that is they can be done today or they may be postponed to another day. The things that come up in medical practice are not routine, they are urgent or emergencies and must be dealt with immediately. Therefore the urgent constantly pushes to one side the routine so that good intentions pave the way to insufficient time with the family. Then suddenly the whole family situation becomes an emergency, if not a catastrophe" (Vincent, 1977).

munication. "Here perhaps one of the most important things is to realise that the wife does not want a consultant she wants a partner" says Vincent. A partner is one who will make a conscious effort to sit down and talk things over, to listen, to share, to empathise and support, and one "who will arrive at a consensus with her about handling situations within the family". A partner is someone with whom it is nice to be.

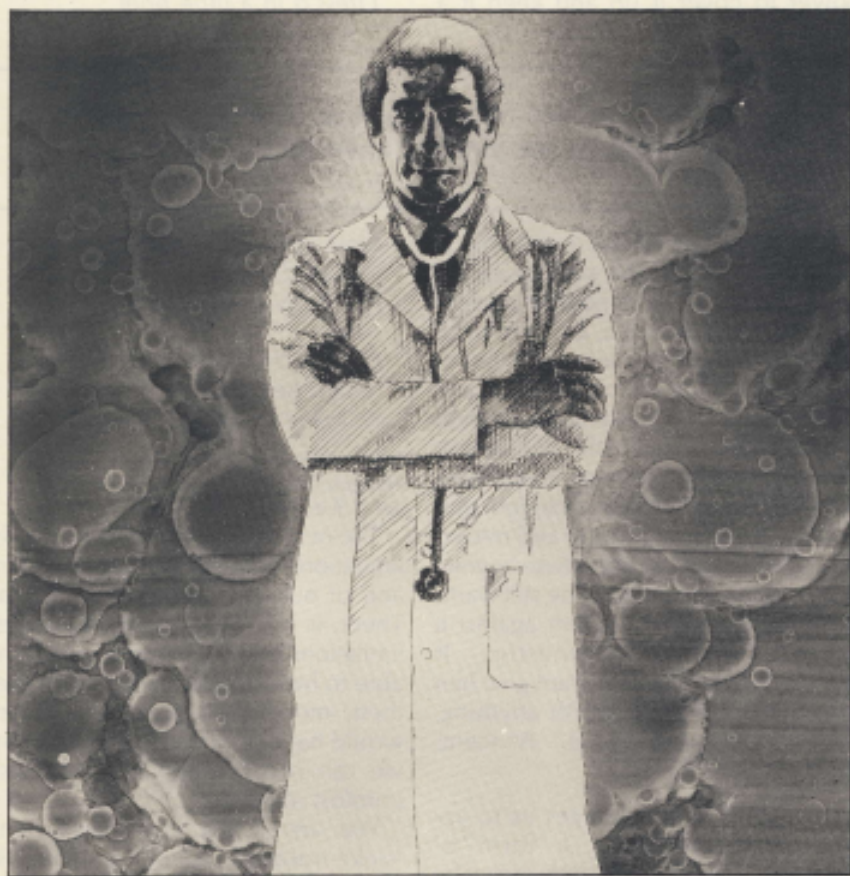
A mature family relationship has practical benefits for the physician. As the relationship matures he will find his own needs being met more effectively by his family. Moreover, within the family he can learn more about himself, his wife, children and marital (including sexual) and family relationships, than he could ever learn on any continuing medical education course. This will help him not only to understand and help patients with their marital problems, but it will give him greater depth of understanding of what it means to live a full life. It will give him greater depth of care and comforting. It will make him a better doctor.

In the final analysis, the healing process demands that we must gain clarity about our goals in life – and this we must do both alone and with our wives and with our children. From these goals we must establish priorities around which we can organise all the pressures and demands impinging on our lives.

Simply recognising that the marriage needs a little attention may be enough to put it back on track, say Meighan and Osborne (1978). On the other hand, the healing may require "radical surgery".

Doctors who have decided to give serious attention to the task of building up their private and family lives have had to make radical decisions like cutting back on office hours to find more time to renew the family relationships, or even to change the nature of their practice altogether.

This type of decision may be the most important one you are called upon to make and the most difficult. As elsewhere in medicine, prevention is better than cure. In this case the best preventive measure is to develop what Meighan and Osborne call an "egalitarian relationship" with our wives, which is a sound basis for a happy home life. However, it is crucial, they



are immune to having to work at our marriages".

The two biggest problems are that of time and communication – if they are not resolved, none of the others will be.

There are essentially four options in tackling the problem of time. One option is to say "my practice and the needs of the patient must come first". This is the death sentence of the marriage. The converse "my wife and family must come first" is probably incompatible with good medical practice. The third option of "my family and my practice are at all times equally important to me" just does not work

The only satisfactory solution, and one that has been proven to work, is to schedule times with the family that are inviolate while other times are left to the exigencies of the practice.

At certain times the doctor must say: "my practice comes first, and my wife and family must understand this", while at others he would say: "my wife and family are first, and my colleagues and patients will have to understand". These times of family priority cannot be left to chance. They must be planned ahead in consultation with the family and scheduled into the family and practice programme.

The next problem area is com-

warn, not to take this relationship for granted or to think that it is easy to have a happy home and family life.

Although I have made use of a slight caricature in order to describe this syndrome, its recognition is in fact a matter of life and death as it underlies most of the morbidity and mortality statistics within the medical profession mentioned earlier. I have tried to show that the Mr-God-Syndrome is an attitudinal complex which is nearly inevitably forced on us by the very nature of our training and our profession, and that it has disastrous effects on our effectiveness as healing and comforting professionals and also as human beings.

Nurtured in the very heart of the profession, it nevertheless destroys our professional competence by alienating us from the real world of our patients. The doctor who suffers from this malady can no longer meet the patient as one human being to another. We can no longer hear what the patient is trying to tell us, because we already have all the answers. Consequently our service to our patients suffers.

A lady I know died at home in the arms of her husband from a treatable disease. She had consistently refused to go to see a doctor. Her whole life long she had suffered from facial hirsuties and spent an hour every day plucking the hairs from her chin because as a woman she did not want to shave.

Her experience with the medical profession had been that doctors entirely and consistently failed to understand the emotional and psychological role the hirsutism played in her own personal life and in their family life. She was afraid that the doctor would insist that she should be admitted to hospital where (so she believed) her problem would not be understood. So she rather died at home.

A very dear friend of ours (you only learn to know these circumstances when they happen to friends or relatives – your own patients never tell you!) underwent an induction of labour for an intra-uterine death in the fortieth week of her first pregnancy. The specialist in charge completely failed to understand and to meet the emotional needs of herself and her husband.

Although the induction went off technically without a hitch, he failed to relieve and to comfort because he

did not listen to their real needs. Fortunately the next pregnancy was a healing experience for the family because of the sensitive and supportive handling of the pregnancy and the birth by the doctors involved – but especially by the midwife present at the delivery.

A few weeks ago my seventy year old mother emphatically refused to go and see a doctor – she was too ill, she said! She would go and see him as soon as she felt better and has had time to have her hair done! Although I said unrepeatable things over the telephone to her, I fully realised that one needs all your physical, mental and spiritual resources to face a doctor in the formidable environs of his holy of holies.

The most tragic effect of all is that this syndrome prevents us from form-

ing deeply human relationships and therefore prevents us from becoming truly human and deprives us of much joy and meaning in our lives. Preventive measures should be instituted already at Medical School where the first seeds of this malady are sown – the first symptoms often being detectable already in the first year of study!

Learning to live with ourselves as medical practitioners should be part of our professional training, because, as William Havener (1981), Professor of Ophthalmology at the Ohio State University Medical School puts it: "You must live with yourself for the rest of your life. Unless you can do this successfully you cannot fully realise your goals of helping others do likewise".

And that, after all, is what medical practice is all about.

REFERENCES

This paper was first delivered to the Faculty of Medicine Prize Giving Ceremony of the University of the Witwatersrand and then expanded for the annual Memorial Lecture of the Border Coastal Branch of the Medical Association of South Africa at East London. The concepts developed are based entirely on the articles listed, but the literature on the personal and family problems of physicians is extensive.

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Baloo

"Stop right there, Mrs. Whitlow—I just this minute decided to retire."