Beginning in medical school, every physician faces the tension of doctoring other members of the medical profession. While physicians become comfortable caring for the usual patient, caring for a physician can present certain challenges. Although most patients have less medical knowledge than the treating physician and do not have the ability to direct their own medical care, physicians who are patients often do possess the knowledge and ability to make decisions and carry them out. Ordinarily, the roles of physician and patient are relatively separate. We are physicians at the office and individuals at home. Physicians traditionally struggle to find a meaningful balance between these two roles under ordinary circumstances. When a physician becomes ill, however, the two roles necessarily overlap around that physician’s health and well-being. The overlap of these two roles creates a special set of circumstances that is different for physicians because of our specialized knowledge and experience as well as our status within the health care system. Physicians participating in their own care may perceive a line between their roles as physicians and patients that creates cognitive dissonance between what they believe they should do and what they actually do.

There is thus a process of negotiation and discussion of evidence-based medicine, which often occurs in the interaction between the treating physician and the physician who is the patient. The best approach to a physician who is a patient is asking what the physician would do if a patient in a similar circumstance with similar symptoms and/or illnesses presented to the physician. Physicians must become comfortable with this approach to caring for the physician-patient. Instead, there is often a tendency for the treating physician to defer to the physician-patient in this decision making. This may be especially true when there are differences in perceived status or experience, such as those patient-physicians who are older or in positions of authority. When this occurs, there is a risk of over ordering and treating or under ordering and treating due to the fact that physicians encountering illnesses (especially those that are life-threatening) may be in denial and/or lack objectivity in making such decisions when those decisions involve one’s own medical care. It is therefore important for the patient and physician to be clear in their respective roles. Physicians who treat their colleagues may identify with them, since they are in the same profession. In some ways, this is similar to a physician who becomes a lay caregiver for a loved one. Physicians who accept the responsibility for acting as a caregiver to someone who is loved may face a conflict in the personal and professional roles they take on in the care of that loved one. In a similar manner, physicians who care for a colleague may be conflicted in their roles as friend/colleague (similar to being a loved one in some ways) and physician. Since patients are often in denial regarding their illnesses when they are life-threatening or involve significant emotional triggers, physicians may be at risk of colluding with their patients due to their own denial. Physicians who care for their colleagues may often order too few or too many diagnostic or therapeutic interventions in an attempt to compensate for these feelings.

Physicians who face these challenges and conflicts in caring for a colleague may cope with their intense feelings about these conflicts by withdrawing from the patient. Withdrawal from the VIP or physician colleague can increase the patient’s isolation, which may eventually lead to a further decline in clinical care. When caring for a loved one, the physician can decide to what extent he/she may be involved in the loved one’s care. One admonition is to question what the physician could do if he/she did not have a medical degree in order to determine what would be ethically and psychologically safe for that individual and to eschew any other involvement. However, when the physician is caring for a colleague or VIP patient, he/she cannot make such a decision since there is medical responsibility for that individual. Instead, the physician must try to consciously treat that patient as he/she would any other. However, if the physician is unable to follow this guideline, transfer of care to another physician who can follow this guideline is warranted.

References
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