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How our patients make us ill

Robert Hale

This paper will address the ways in which all of us as doctors respond to the impact of illness in patients. The constructs used are psychoanalytic and the experience comes from running a psychological service for doctors for the past seven years. In line with the Nuffield Hospitals Report (1996) it is a service funded by the Regional Postgraduate Medical Dean.

The term 'stress' is shorthand for a multiplicity of anxieties experienced both consciously and unconsciously by a professional. The nature of the job will determine the nature of the anxieties. Thus if we observe medicine as it is practised in its various settings, we will discern in the professional patterns of anxiety specific to the job being performed: this is a normal phenomenon.

To deal with these anxieties we build defensive structures both at an individual and an institutional level. For the most part, our defences serve us well. They allow us to work. But they may become excessive, turning us into malfunctioning doctors; or they may fail – in which case we become psychologically or physically ill.

Anxieties

What are the anxieties specific to medicine? Fundamentally, I would propose three, each posed in one of the institutions where medicine is practised: the general hospital, the psychiatric hospital, and the forensic setting (Box 1). In the general hospital, the fundamental and specifically medical anxiety is that of coping with disease and dying. In the psychiatric hospital, it is the fear of insanity, of falling apart psychologically. In the forensic setting, it is the anxiety associated with patients who are corrupt and corrupting: the anxiety of being coerced, seduced or taken for a ride. In general practice, all three become overlaid.

Let us look a little more closely at the anxieties of the general hospital, because the anxieties associated with disease and dying ramify. The doctor who works there faces not only disease and dying, but also the effects of ageing and decrepitude: for young people, especially, a painful experience, because it reminds them of their own mortality. However, it is a particular anxiety associated with terminal illness that young doctors dread most; that of breaking bad news to relatives.

Box 1. Sources of anxiety in institutions

The nature of anxiety is specific to a profession
Within medicine, anxiety is specific also to the institution
General hospital, psychiatric hospital and forensic settings generates particular, identifiable anxieties, while general practice has a mixture

General hospital
Dying
Disgust
Pain
Deformity
Disease

Psychiatric hospital
Madness
Psychic pain

Forensic setting
Corruption

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We all have had the experience of hoping that we would not be on call when a terminally ill patient died; that it would be someone else's task to inform the relatives. There are also the anxieties aroused by observing pain, whether physical or psychic; and of powerlessness, facing disease and being able to do little about it. (Surgeons are perhaps fortunate that they are often able to watch well patients walk out of hospital. Much harder in this respect are specialities such as psychiatry where patients do not get better in a dramatic way.)

The last anxiety is caused by disgust. While we pretend otherwise, patients present their doctors with physical disorders that can be quite repellent. The same holds for psychiatry and in the treatment of criminals. A patient expects the psychiatrist to listen to revolting fantasies and find them perfectly acceptable. Whatever the sphere, doctors are required to transform the unacceptable into the mundane. Some of us succeed, some fail.

Individual defences

How do we as doctors cope? Some of the defensive strategies we employ are more obvious than others. I would suggest six (Box 2).

(a) We *deny* that we are experiencing anxiety or tension.

(b) We become *hypomanic*, workaholic. I call it riding the tiger. As the saying has it: "he who rides the tiger dare not dismount" (because the tiger will eat him). Pertinent here is a finding from a study of junior doctors (Hale & Hudson, 1992) in which it has been shown that those suffering the greatest stress were in many instances working the least hours. If you stop, you have to face the pain.

(c) We can *intellectualise* – or medicalise.

(d) While a neurotic symptom, of course, *hypochondria* can also serve as a specifically medical form of defence. The doctor borrows his patients' illnesses – the lethal ones especially – in order ultimately to control them personally. No-one becomes hypochondriacal about eczema. There can surely be few medical students who have not 'had' Hodgkin's disease or leukaemia. (This account does scant justice to complex issues, which deserve fuller explanation elsewhere.)

(e) *Erotisation*, the stuff that television medical soaps are made of, can also play a part. An escape into multiple sexual relationships seems to confirm that we are alive and vibrant in the face of disease and decay.

(f) Lastly, we can *act out*. We do things that are destructive or self-destructive. We take drugs; we drink excessively – medical students are very good at this. We also commit suicide. Doctors have high rates of suicide, and are often the worst at seeking help. We may become medically overactive. We may give prescriptions patients do not need; we may even perform unnecessary operations. Typical is the surgeon who said that he could not cope with the anxiety of not operating so opened the patient's abdomen: the anxiety of impotence.

Box 2. Individual defences

Denial
Hypomania
Intellectualisation
Hypochondria
Erotisation
Acting-out

Institutional defences

So much for doctors as individuals, but institutions have defences too. The seminal work in this context is *A Case-Study in the Functioning of Social Systems as a Defence Against Anxiety* by Isobel Menzies Lyth. In it, she reports work with nurses from the 1950s and 1960s, but it is equally pertinent today. The territory is difficult, and there are three separate but related points to make.

First, institutions such as hospitals take the form they do in order to protect those who work within them from anxiety. As Menzies Lyth showed, the internal organisation and routines of hospital life – the cardex, the notes, the ward rounds, the uniforms, the stethoscopes, the insignia of office, the hierarchical structure itself – can all be seen as serving this purpose. Typical is the general practitioner (GP) who, when signing a section on a psychiatric patient, would don his stethoscope as though it were his mayoral chain and as if it magically empowered him. The patterns of on- and off-duty, the switching of rotations, are commonplace features of hospital life which help break up patterns of relationship that are potentially stressful to the hospital's staff, but they do this without necessarily being in the patients' best interests.

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Second, there is a sense in which a hospital can be defined objectively, in terms of bricks and mortar, budgets, staff allocations, organisational flow-charts, and so on. There is also a sense in which the life of a hospital is a collective creation: the sum of the needs and fears of all those who enter its doors. There are respects, accordingly, in which hospitals can sensibly be said to be designed by their patients. What actually occurs on a ward, day by day, is to a considerable extent under the control of patients, just as the everyday life of a prison is controlled by its inmates. We fall into the roles our patients 'appoint' to us, without either patient or professional being aware of what is going on. It is this process which 'One Flew Over the Cuckoo's Nest' illustrates. There are also respects in which the roles played by the doctors and nurses in a hospital are shaped by patients' expectations. The form these expectations take will depend on whether the person in question is a general medical patient, a psychiatric patient, a forensic patient or a patient paying a visit to the local GP, because in each case a different fundamental anxiety will predominate. But in each of these settings, doctors can find themselves acting as spokespersons for their patients' unconscious or disavowed selves.

Third, there are also respects in which it is helpful to think of an institution as though it were an individual. Like individuals, institutions can become pathological, acting against the interests of staff and patients alike. They have atmospheres which are the equivalent of an individual's mood: sanguine or more sullen. Like individuals, they can act as the receptacles for systems of value; an altruistic commitment, say, to the needs of the patient. Also like individuals, they can counterbalance such overt ethical commitments with more cynical preoccupations – with career advancement, for example, or financial reward.

The successful hospital responds appropriately to the unconscious as well as the conscious needs of its patients. When it fails in this primary task, it is in danger of becoming a 'sick' institution.

To illustrate these phenomena let me offer some clinical material from a doctor in treatment – material, it should be stressed, which she has seen and given permission to use. This question of permission is important. It is essential that the doctors who come for treatment know that they are protected by a barrier of confidentiality, and that there will be no reports made about them to the hierarchy within which they work. The treatment is that of psychoanalytic psychotherapy: the focus is therefore to recognise and understand the conscious and unconscious anxieties of the patient. Within the structured setting of the sessions one of the basic therapeutic tools is that of transference interpretation.

Case material

Tall, elegant and trendily dressed, Sarah is for all the world the epitome of the successful young doctor. She comes from a medical family and, despite a rebellious adolescence in which she became a punk, she managed by the time she was seventeen to have a choice between art school, medical school and music school. She was by any standards a success. By the time Sarah was 26 she had a first in her BSc, honours in one part of her finals, and had passed both parts of her MRCPsych at first attempt. Now, two years later, she is established in a registrar's post on the 'golden circuit'. The session in question was as usual on a Saturday morning. Sarah's words are placed in italics.

After I saw you a fortnight ago I felt really pissed off. You made me recognise how hard a time I was giving my boyfriend, Ben. I apologised and all he could do was chuck it back in my face. He said he couldn't cope with my moods. He couldn't understand that I was telling him that I recognised how much I loaded onto him. He said he just couldn't cope with me.

I said that she must feel angry with me for making her vulnerable. She seemed to be telling me that therapy was removing her defences – initially an inevitable consequence of therapy.

Well, it's been a pretty lousy fortnight anyway. My boss has been away, and there has been this terribly sick woman; we thought she was going to die. The awful thing was that we couldn't find out why. We just had to watch her going downhill. My boss has been away. The other consultants came and gave their opinions but they didn't really seem concerned in the way my boss does. She had septicaemia and we couldn't find the cause. It was all very well for those consultants. She wasn't their patient. They could just walk away from her. On my nights off, I just couldn't sleep.

Her last session had evidently shaken her, and I asked why.

It was realising that I was still the Princess who gets what she wants, and people do what she wants.

I noticed then that she was crying. On a previous occasion, I reminded her, she had turned up at the clinic, although I had told her well in advance I would be away. Again, I pointed out to her the omnipotent nature of her thought: the assumption that I would be waiting for her, when she knew, consciously, that I was not going to be there. At the time, she had jumped back into her car with a mixture of anger and disappointment and real relief – relief that there were things inside that she would not have to face.

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You are just not expected to be weak when you are a doctor. The day before yesterday, I was caught in the corridor by the wife of a man who has leukaemia. The consultant was going to tell him at lunch-time, but his wife had already guessed. She was furious with me. Why couldn't I tell her? I had been up all the night before and really couldn't cope with her shouting at me. I didn't handle it at all well. I went to the sluice and locked the door and cried for a bit. Then I realised I had to tell the patient straight away. As I was going to tell him, his wife came in. I had to tell her to go away. I hated myself for what I was doing because I knew she was so frightened.

I replied that she was telling me about two life-shattering events for which she felt responsible and with which she was expected to cope. At the back of her mind, she was uneasy about where her boss had been – and, more importantly, where I had been. I pointed out that she had rung me the previous week to say that she could not make the session because she was still coping with the patients she had admitted the night before. She must feel, somewhere, that I should make time for her in the way that she made time for her patients.

Yes, but look what it does to you when you really care about your patients. My boss, Brian – he has been a consultant for only two years. He's thirty-nine, but he looks 20 years older. He's balding and going grey.

I made no comment.

He's the one that everyone wants to refer patients to because he cares. He works morning, noon and night.

I said that she was worried about who looked after Brian, and that she felt responsible for him as well as for her patients.

Well, I don't want to look after him, and I'm not sure now that I want to be him. The other day, I found myself sitting in the middle of the ward saying out loud 'Where am I going', and people said 'Now Sarah is really losing her marbles'.

I asked how people cope without losing their marbles.

Well, most medics do. They can just shut off. They can look at it as an intellectual exercise. Even Brian does that at times. We had a post mortem over the woman who had just died. We all sat round and talked about the pathology findings. Nobody really talked about what they felt inside.

I said that I thought she was struggling to find a place where she could talk about these feelings, and that in a way she was bringing the need of her whole unit with her to our sessions.

Yes, but that's not much use, because how can I feed it back into them when they can't hear it?

I said that she was telling me today about the dilemma of being the omnipotent medical Princess yet of having to face the reality that people die and that you can do nothing. Part of her was telling me too that therapy didn't always help either.

It was the end of the session. She got out her diary, and we made the next appointment, fitting it in with her time off-duty. Another theme had emerged in the session, which was connected with the experience of having to switch off life-support machines: that it was often her job rather than her consultant's, and that you depend in practice on nurses as well as other doctors.

This clinical material concentrates, I think, many of the issues that doctors have to face. It illustrates some of the *normal* anxieties experienced by doctors as well as some of the individual defences – omnipotence projection over activity and the institutional defences, medicalisation and the projection of anxiety into the apparently vulnerable member of the group.

Both the dysfunctional doctor and the dysfunctional hospital may present themselves for therapy. Often it takes a crisis, sometimes with legal implications, before the need is recognised. For anyone, it will be either their own suffering or the way in which they are making others suffer which forces them to overcome their resistances and seek treatment. For doctors those resistances will be all the more acute – the fear of being labelled sick, mad, needy or simply not coping, the shame of being the weak link in the macho team, the doctor who is going to become a liability or cause problems. Small wonder that doctors, be they junior or senior, can regard seeking psychological help as tantamount to professional suicide. This is particularly true for those working in the high prestige, highly competitive specialities.

Providing a service

The central issue which must be addressed in constructing a service which is going to be used properly by doctors is *confidentiality*. The system must be constructed in such a way that it addresses not only the doctors' rational fears, but more importantly the irrational or unacknowledged fears. When the doctor is in a dysfunctional state, these irrational fears will be all the greater. Thus, being treated in a geographically and organisationally separate institution may be crucial, with clear and openly stated agreements between the two institutions that confidentiality is sacrosanct (Box 3). An exception would be where one believes a doctor to be a danger to his/her patients when

Box 3. Good practice points

Any service should be:
- *Confidential*
- *Accessible*
- *Flexible*

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disclosure may be appropriate, having first discussed this with the doctor.

A countervailing issue will be that of *accessibility* – a service can be so discrete that no-one knows of it or can use it.

The third requirement is for *flexibility*. Shift systems are a reality and to interpret them as a resistance is to miss the point. (That is not to say that resistance does not exist.) Such a requirement runs counter to the valuable psychotherapeutic tradition of consistent and unviolable structure. A compromise must be struck.

Within hospitals stress management courses and Balint-type work discussion groups can create a better work environment. Occupational health services are an important intermediary service but their dual loyalty must be recognised. It is, however, my belief that a properly constructed and funded service with both psychiatric and psychotherapeutic expertise is the necessary safety net for the hospital and general practice.

Some final thoughts

Our hospitals grew out of religious institutions which were informed by their values, for example, the altruism that remains central to the practice of medicine to this day. Recently, however, new and more commercial values have been introduced. It can scarcely be a coincidence that a third of the doctors who referred themselves to the service at the Tavistock Clinic as patients last year did so as a result of these changes. Typically, their firms were experiencing difficulty in meeting financial targets; a constraint which was not only unfamiliar but which seemed to violate the doctors' commitment to care. Usually, it was the consultant who came on these grounds; but more than once it was a junior doctor who was under pressure, and who came, as it were, as emissary for a troubled firm. The truth is that the new ways of the National Health Service undermine the existing defences of many doctors, and do so both at a personal level and at the level of the institution.

So to return to Sarah: what can we learn from her experience of dealing with the pressures inherent in the practice of medicine today? Sarah came to therapy not because she was 'ill' or failing professionally, but because she recognised that medicine was taking its toll, exposing parts of her personality which were not always easy for her to accept. I think the experience of therapy helped her, and I think she would say so too. The moral, from the point of view of the institution, is that while many of the pressures exerted on doctors are unavoidable, others may be gratuitous and could be doing harm to the exceptionally talented and the less talented alike. It may not be unduly difficult to design a medical training which acknowledges the severity of the psychological demands which normal medicine makes, and does so without compromising standards of medical excellence in any respect.

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References

Hale, R. & Hudson, L. (1992) The Tavistock study of young doctors: report of the pilot phase. *British Journal of Hospital Medicine*, **47**, 452–464.

Menzies, I. E. P. (1960) A case-study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital. *Human Relations*, **13**, 95–121.

McKevitt, C., Morgan, M., Simpson, J., *et al* (1996) *Doctors' Health and Needs for Services*. London: Nuffield Provincial Hospitals Trust.

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