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The art of medicine

Physician narratives of illness

In psychiatrist Linda Gask's memoir *The Other Side of Silence*, she describes an exhaustive experience of depression during medical school. "There came a point when I couldn't go on. My head was splitting open and I struggled to hold the pieces of my brain together", Gask writes. Her candid memoir is part of a changing trajectory of physician narratives of illness that have moved from often anonymised accounts in the early 20th century to deeply personal, owned contemporary works. We've examined a selection of physician narratives of illness from the UK and USA and discovered how illness can conflict with doctors' professional identities and how difficult it can be for health professionals to be open about illness, especially mental health problems. The oppressive nature of the traditional identity of physicians as strong and stoic is evident in these narratives that highlight the resistance of doctors to forgive themselves their own frailty.

These narratives suggest how uncomfortable it is for some doctors to assume a patient's identity. Physicians' responses to personal illness are inevitably rooted in the medical knowledge and culture that has shaped them. In some of these narratives, physicians typically turn their illness experience into medical case descriptions, thus "case-ifying" themselves, partly as an attempt to preserve a perceived control over their illness. This approach is evident, for example, in physician illness narratives published in 1949 as part of a *Lancet* series, Disabilities: and How to Live With Them, in which patients shared their illness experiences. On his experience of a heart attack and coronary thrombosis, one general practitioner described the onset of his pain with a near-perfect clinical precision. Another doctor with diabetes recalled testing his own urine during a hypoglycaemic attack. In 1982, in a revival of the series, a medical student described interpreting his own cancerous tumours from an x-ray.

The anthropologist Robert Hahn has explored the points of stress where clinician identity and personal illness collide, suggesting the "use of medical knowledge, self-diagnosis, self-treatment, and reluctance to give up control" are common responses to illness. Problems that arise from such responses feature in

another narrative of heart disease in Harvey Mandell and Howard Spiro's 1987 collection *When Doctors Get Sick*. One physician describes how "After two intense days of self-testing, my defences were exhausted. Denial was no longer possible; it was not effective…I had to relinquish the need to control my case and myself."

In some narratives, doctors relate the struggle to find a balance between having expert scientific knowledge and the sudden influx of emotions and adversity that comes with personal illness. Recurring themes are denial, self-stigmatisation, shame, and concerns about their professional reputation and competence. These emotions feature in narratives across the past 100 years in which physicians consistently discuss feelings of fear, failure, and guilt—towards themselves and the wider profession. In John Pekkanen's *M.D.: Doctors Talk About Themselves* from 1988, one physician writes about addiction and how "The pain of exposure, the shame to myself and my family and to my profession—that would be death to me." Such fears are especially prominent in physician narratives about mental health problems. W Robert Gehring, in his 1985 memoir, *Rx for Addiction*, reflects on his apprehension about seeking help: "I don't want to be seen at an AA meeting…what about my reputation?" In an account of depression in Mandell and Spiro's book, a general practitioner reflects: "I thought it would go away by itself…Add to that concerns about professional reputation, insurability, status in the community, and quite simply, a fear of the truth, and you have my reasons for denial."

The lack of acceptance and chaotic response to personal illness can then result in continued denial, poor health-seeking behaviours, concealment of ill-health, and the projection of an outwardly high-functioning persona. The exploration of shame within physician illness narratives seems to become more prominent in the late 1980s, following research into physician suicide and addiction during the 1970s. Extraordinarily, physicians researching physicians with mental illness during that period sometimes evidenced beliefs that mental illness was a result of pathological personality or unstable childhoods, identifying those deemed not appropriate for the profession. Furthermore, although support programmes tailored for doctors with mental health problems developed during this time, in Gehring's experiences of treatment the impact of shame and stigma is tangible: "I was told my defeatist

attitude was detrimental to the other doctors who seriously wanted to recover…The chair-man of the program sent me home with these final words: 'You're dying, Bob. God help you'." Narratives from this period often highlight how doctors perceive only two choices: continue without help and risk deterioration of mental wellbeing or seek help and face the breakdown of career.

From the 1990s onwards, following Kay Redfield Jamison's groundbreaking memoir *An Unquiet Mind*, more narratives of mental illness were published. More recent collections include Robert Klitzman's *When Doctors Become Patients* and Petre Jones's *Doctors as Patients* that tell the stories of practising doctors with mental illness. There's also been an abundance of memoirs, such as Cathy Wield's *Life After Darkness: A Doctor's Journey Through Severe Depression* and Elizabeth McNaught's *Life Hurts: A Doctor's Personal Journey Through Anorexia*, as well as blogs and other personal accounts of physician health. Many of these modern texts hope to draw attention to the common experience of illness in physicians, especially hoping to target the stigma surrounding mental illness within the profession.

In these later narratives, there is a shift away from the implicit stigma and lingering influence of earlier research that suggested mental illness in physicians was due to individual pathology and instability. Research and understanding of mental illness in physicians moved towards reflections on medical culture rather than individual pathology, as shown in a 2003 American Medical Association consensus statement, Confronting Depression and Suicide in Physicians, that highlighted how doctors with mental health issues still experience "discrimination and punitive measures" and that "the medical profession does not encourage physicians to admit health vulnerabilities or seek help". With these new perspectives came a parallel emergence of more support services for doctors with mental health problems. Yet these physician narratives reveal how hard it still is for doctors to seek help, as their illness challenges their sense of self, identity, and perceptions of competence held by themselves and their peers. Engaging with emerging treatment programmes may therefore only follow episodes of catastrophe—with the associated potential of public investigation of competence—which can reinforce the perception that illness disclosure is fraught with personal risk.

The fear of exposure and seeking help is sometimes because stigma appears to be reinforced by the wider medical profession. Sadly, those who have experienced mental illness describe how they are considered to lack resilience, and consistently meet disadvantages in their career due to perceptions of mental ill-health. In Pamela Wible's 2016 *Physician Suicide Letters Answered*, one physician wrote: "My ex-husband, also a physician, committed suicide one-and-a-half years ago…After taking three months off for a major depressive episode and to look after my grieving children, one of which was threatening suicide herself, I was told that I wasn't carrying my share of the load at work and had a 'boutique practice.'" In the later narratives, where stigma is explicitly challenged, all too often doctors discuss being treated differently due to their illness. Taken again from Wible's collection, on returning to work another doctor reflects: "I could go on and on about how I became the 'invisible doctor' to my colleagues after my suicide attempts."

These narratives repeatedly point to a lack of tolerance and empathy from some colleagues, especially when time off work is required. And some accounts expose the assumption that a doctor with a mental health problem will be a liability or is incompetent, and thus in some cases that the individual is unwelcome in the profession. The publication of illness narratives is beginning to create a space for such subjective experiences and the emotional vulnerability of illness to be shared.

It is no coincidence that physicians who have faced their most human limitations and endured struggles similar to that of their patients return to the same message: doctors are humans too, and illness is a key part of the human experience. If doctors hope to accept illness in themselves, the profession must create an understanding and awareness of how to approach personal illness. We need to teach these skills to our students. In postgraduate education, we need to use physician narratives to inform and challenge beliefs and talk about how resilience is not a tool to overcome personal illness. These narratives are beginning to introduce a dialogue that acknowledges illness, explores how to recognise illness and to seek help, and how to support colleagues who may be facing difficulty. Doctors' accounts of their own illnesses remind health professionals and wider society that we are all human and that we are not alone when we are unwell.

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It also compares illness narratives written by physicians-turned-patients to those written by patients without medical training in order to explore questions of who ultimately benefits from these narratives and whether these narratives can engender greater empathy between clinicians and patients. Introduction Binary thinking has been characteristic of Western culture since the time of Plato and Socrates [1], and the same holds true in today's scientific and medical cultures. These dichotomies range from the body and mind and the normal and the Narration in medicine is concerned with the function and analysis of the multiple narratives produced in the context of clinical care and the healing of illness. The study of medicine and narrative can be described along three general lines: narration in the medical case history as an epistemological basis for medical cognition and clinical care; formal analysis of patient narratives of illness; research on the uses of narrative as a clinical treatment or model for medical care. Explication.Â The physician then records the encounter, transforming the patientâ€™s story of illness and physical examination into a medical case history. Physician narratives of illness. Authors: Amy Wilson Chris Millard Ian Sabroe. Lancet 2019 Jul 4;394(10192):20-21. Epub 2019 Jul 4. The Medical School, University of Sheffield, Sheffield S10 2RX, UK. Download full-text PDF. Source.Â Background: Heart failure is a chronic, life-threatening illness with multiple acute events. Palliative care alongside standard treatment is recommended for these patients. There is a lack of knowledge and research literature on how to integrate palliative care interventions for heart failure patients in a general hospital setting. Physician narratives of illness. Lancet. 2019 Jul 6;394(10192):20-21. doi: 10.1016/S0140-6736(19)31501-6.Â Affiliations. 1 The Medical School, University of Sheffield, Sheffield S10 2RX, UK. Electronic address: amy.wilson.4456@gmail.com. 2 Department of History, University of Sheffield, Sheffield, UK. 3 The Medical School, University of Sheffield, Sheffield S10 2RX, UK.