CASE REPORT

Pending appendicectomy: a personal experience and review of a doctor's own illness

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SUMMARY

Doctors will inevitably 1 day become patients. Whether as an acute emergency or as part of routine screening, doctors often find it difficult to recognise and act on their own healthcare needs. This article aims to provide a personal account and reflections from the point of view of a doctor in denial about his acute appendicitis, and a friend and fellow colleague's attempts to convince him to seek help. We review the challenges, learning points and literature about why doctors ignore their health needs, both physical and psychological, and suggest potential changes to tackle this issue based on the current literature, support networks and personal experiences.

CASE PRESENTATION

A few months ago while on my week of general surgical nights, following a discounted midnight microwave meal, I began developing abdominal pain. I mentioned it in passing to my registrar, who jokingly suggested I get a urine B-hCG gonadotropin 'just in case'. By the next shift, I was limping, the pain worse, and the house officer had offered to book an ultrasound scan of my ovaries. Not wanting to appear like the anxious junior doctor, diagnosing himself into a panic, I persevered. By the last night, I was in agony. No matter how I lay on the overused sofa in the doctor's mess, I could not get comfortable.

Sitting around the morning handover table, I felt nauseated. The pain persisted when I got home, where I spent the day trying and failing to sleep. By evening I decided to phone a friend—an anaesthetic trainee. Her advice was simple: "this is probably appendicitis, go to hospital!". I insisted it would settle, but after almost 2 hours of intense 'discussion', I agreed.

Driving to hospital an hour later, the pain was excruciating. The accident and emergency department was busy, but I was seen quickly by the surgical registrar. I was tender in the right iliac fossa with localised peritonism and raised inflammatory markers—relief I was no fraud! This proved it! And yet...I still felt guilty.

Three scars, 2 days and one necrotic appendix later, I was free to leave. Surprisingly, despite recent claims, I was admitted on a weekend, had my operation out of hours by a consultant *and* survived! #iminworkjeremy. It took 3 days to overcome the postoperative vertigo and a further week to return to my clinical duties.

On reflection, I learnt a lot. Not only about my body's limitations and my obstinate refusal to seek

help but also about my patients. On occasion, I inwardly smile while clerking patients with appendicitis who present with signs and symptoms similar to my own. I feel resensitised to the needs of my patients as well as a renewed sense of empathy that I thought I had lost. I am extremely grateful for the care I received and to an anaesthetic trainee more stubborn than I.

GLOBAL HEALTH PROBLEM LIST

- ▶ Doctors frequently fail to recognise when they are unwell and need help.
- ▶ Doctors fail to follow guidelines put in place to safeguard and protect doctors when sick.
- ▶ Healthcare workers have among the highest levels of presenteeism out of all work sectors.

GLOBAL HEALTH PROBLEM ANALYSIS

Why doctors do not seek help

From the obstetrician fainting in clinic with an ectopic pregnancy to the depressed psychiatrist self-medicating at work,¹ evidence shows that doctors have one set of standards for patients and another for themselves when it comes to being unwell.²

Many doctors view seeking help as a sign of 'weakness and failure'.³ Despite General Medical Council (GMC) guidance to register with an impartial general practitioner,⁴ most choose a close friend, relative or spouse.⁵ And while directives advise to 'consult a suitably qualified colleague' and 'not rely on your own assessment',³ many doctors admit to self-diagnosing, preferring to seek informal advice if needed and not considering self-treatment a major issue.⁶

One of the many reasons why doctors fail to address illness is that they find it difficult to admit they are not superhuman, that they—like their patients—also get sick. While standard mortality rates of doctors are lower than in the general population,⁶ doctors in fact have similar rates of chronic illness and preventative health needs, and higher levels of significant mental health problems.⁷

Doctors also neglect their own health due to a sense of responsibility towards their patients and colleagues, instead worrying about the repercussions on both if they were to take sick leave,⁶ citing difficulties in arranging cover² and finding a good physician.⁸ Of more concern, doctors detail worries regarding confidentiality and the possibility of their medical details being divulged to colleagues or within the workplace.⁹

Of all the forms of illnesses to afflict doctors, psychological conditions are often associated with the greatest taboo and stigma, and can often have a

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dramatic impact on doctors and their colleagues. Symptoms may manifest as depression, burnout, anxiety, relationship difficulties, divorce, substance abuse and even suicide.¹⁰ Estimates suggest that almost one in every five clinicians suffer from clinically significant depressive symptoms. And while these rates are similar to those of the general population, suicide levels are nearly five times higher among doctors, highlighting the often extreme levels of stress encountered and the relative absence of protective factors.¹¹

Previous studies show that many problems start before doctors even qualify. Students enter medical school with their lowest rates of depression, and leave with higher depressive and suicidal symptoms than those in the general population.¹² This trend continues throughout training, where younger clinicians are twice as likely to suffer from psychiatric illness than their senior counterparts with certain specialties (psychiatry, surgery), with women more at risk than others.¹⁰

Occupational and individual risk factors both contribute to mental health problems among doctors.¹¹ Work is often emotionally as well as physically demanding, with clinicians routinely having to deal with suffering and death as well as the responsibility of making potentially life changing decisions under pressure. In addition, the ability of doctors to easily access and administer prescription medications likely contributes to the high levels of drug and alcohol abuse among healthcare professionals.^{11 13 14}

It has also been suggested that the professionally desirable personality traits such as perfectionism can develop into self-criticism, leaving doctors vulnerable to psychological illness.¹⁵ It is also important to note that clinicians who treat other doctors can find it extremely challenging to avoid overidentifying, having different expectations, and to overcome natural boundaries that such a doctor–patient relationship comes with.¹⁶

It is likely that a combination of all these factors as well as a system that is often perceived to punish rather than treat mental health issues, and the fear of ramifications on medical licensing, may deter doctors from reporting illness and seeking help.¹⁷

Many of these issues were exemplified in the recent devastating events surrounding the case of Dr Daksha Emson, a psychiatrist who ended her own life and that of her 3-month-old daughter during her battle with manic depression.¹⁸ In the independent enquiry following, ‘being a doctor and a patient’ was mentioned as an aspect that ‘significantly contributed to the tragedy’. Furthermore, it was noted that ‘the realistic fear of stigma by Daksha and her treating professionals was a much greater driving force for actions, or lack of them’. While this case relates to an underlying mental illness, the conclusions that can be drawn remain relevant and important in physical illness. It is clear that things must change.

A look to the future

There is a general consensus that the culture of medicine itself is a barrier to doctors seeking impartial healthcare advice and help. Accordingly, the highest rate of presenteeism—inappropriately attending work when sick—is found in the care and welfare sectors. There is limited literature surrounding this issue and the ways in which we should tackle it,^{6 19} however, it is clear that attitudes regarding sickness must be challenged as early on as in medical school, with increased emphasis on reflection and insight into personal health needs. This is especially important in mental health illnesses, where the real stigma and fear of repercussions on career progression form a significant barrier to accessing services.²⁰

Additionally, tackling this culture requires an understanding of the facts regarding presenteeism. Doctors as well as managers must be made aware that this is a ‘risk-taking’ rather than a health promoting or courageous activity.²¹ Recent studies show that the cost of decreased productivity as a result of inappropriate attendance while sick can be almost three times greater than the equivalent absence from work.²² This is especially important in a profession where decreased efficiency and concentration can have wider implications on patient care. It is also important to address physical and mental illnesses together, as each can exacerbate the other. Studies show clear correlations between fatigue and the worsening of depression, anxiety, mood and burnout, which in turn can negatively impact on patient care and performance.²³ Furthermore, failure to seek help early can lead to progression of illness and result in longer time off with the potential for more harm to both, clinicians and patients. Evidence suggests that the biggest work factor predicting sickness absence in the workplace is the perceived lack of an encouraging and supportive culture.²⁴ Interestingly, in healthy workers, there is no association between quantitative work demands and sickness absence, highlighting the idea that the quality of time spent at work is more important than the quantity. This is particularly important considering the current heated debate surrounding junior doctors’ contracts. While there has rightly been much emphasis in negotiations on unsociable hours and long shifts, failure to improve support and morale among doctors will likely only prolong the dispute.

Additionally, system changes must also take place to remove the often negative perception surrounding absenteeism. Sick leave policies often disadvantage employees with illnesses through rigid attendance management systems and placing more emphasis on reducing absence levels rather than facilitating management of disabilities.²⁵ Having such systems independent of the workplace would also avoid pressure on managers from being passed down directly onto the workforce. This, in conjunction with increased early recognition of employee health needs through effective and confidential occupational health services, may prevent unnecessary long-term absence while making workers feel supported in the workplace. In particular, occupational health services have been found to advise employers on employment issues, rather than supporting doctors in their roles.¹⁰ Indeed, in the enquiry, ‘inadequacies in NHS occupational health services’ were highlighted as specifically contributing to the death of Dr Emson. Disappointingly, evidence from almost a decade ago suggests that most doctors are unaware of what the role of occupational health services is in hospitals.²⁶

There are, however, some encouraging signs of improvement. There is increased awareness of the impact of both, physical and mental health issues on healthcare workers, with more charities and support networks available than a decade ago.

Following an internal review by the GMC into the 28 cases over 8 years where doctors have committed suicide while facing fitness to practise procedures, changes have come about to support doctors in these situations.²⁷ This is especially important as concerned doctors are less likely to report colleagues knowing that this may lead to worsening of mental health problems and possibly suicide. While the conclusions of the report are encouraging, it is still too early to report on outcomes, and more must be done to identify and support doctors long before problems begin to impact on work.

Doctors in the USA have long benefitted from specialist treatment services through Physicians Health Programmes (PHP). The UK has been slower to adopt a similar approach, however, a recent initiative, the Practitioner Health Programme (PHP),

aims to provide confidential help for doctors (and dentists) working in the London area, with 'mental health, addiction or physical health concerns', and is a step in the right direction.²⁸ Doctors are able to self-refer, use a pseudonym for telephone advice, and all records are kept on a system separate from the shared NHS electronic database. Early outcome data are encouraging and highlight the need for such a system, however, the service is currently limited geographically and at the time of access, the website states that the PHP is 'unable to accept referrals for eating disorders or physical health issues'.²⁹

We feel that there is a real need to further develop a national framework for the treatment of doctors with illnesses, both physical and psychological, and to provide better guidance for employers, healthcare professionals and sick doctors on what to do when faced with these situations.^{10 30}

Conclusion

There are many complex factors that influence why doctors avoid seeking help and continue to work despite being ill, and no easy solution. Our personal experience is echoed by many in the profession and supported by evidence that doctors have some of the highest levels of presenteeism among work sectors.

We propose that changes must take place in addressing the culture in medicine, starting at university through to the workplace, by educating doctors to have insight into their own health needs, and about the false economy and risk of ignoring health concerns, whether physical or mental.

In addition, sick leave policies must shift the emphasis to supporting rather than punishing workers, particularly in relation to chronic illness. Finally, improving the overall morale among health professionals is especially important in dealing with both current and future workforce challenges, particularly in a climate of austerity and cuts. Ultimately, one needs healthy doctors to have healthy patients.

Learning points

- ▶ Doctors should ensure they seek attention from an independent practitioner, rather than relying on friends or close colleagues.
- ▶ Doctors must be aware that presenteeism is a risk-taking rather than health promoting practice with potential for long-term personal and patient harm.
- ▶ More needs to be done to tackle the current culture and negative perception towards sick leave that exist in medicine.
- ▶ Systems should act to primarily support rather than scrutinise doctors who are unwell and in need of help.
- ▶ We propose a national framework to provide guidance on the management of sick doctors.
- ▶ Confidential help and support for doctors with mental or physical health problems is currently available. For more information: <http://www.bma.org.uk/support-at-work>.

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