The Doctor as Patient

How do we react to being ill ourselves?

Chris Davidson, Brighton UK

The Doctor as Patient

- Personal Case History
- Factors determining our reaction to illness
- Factors affecting the management of our illness
- Impact of illness on our performance as a doctor

Case History: 2001

- 2001: aged 57
- Sudden onset of severe pain in the right lower leg on going to bed
- Otherwise fit: training for London-Brighton Bike Ride
- PH: Minor surgery

Case History: 2001

- Self-examination: no local tenderness or discolouration, ill-defined loss of sensation foot.

- Pain eased by posture and movement; weight-bearing and walking normal

- Settled partially with analgesia

What would you do now?

Case History: 2001

- NEUROLOGIST

- Examination: back movements normal; power and reflexes normal; patchy loss of sensation outer right foot and outer part of sole

- Investigations: Spine X-ray normal; MRI spine - no disc protrusion; routine blood tests - normal

Pain continued to be troublesome, especially at night in bed

Case History: 2001

DIAGNOSIS: TARSAL TUNNEL SYNDROME

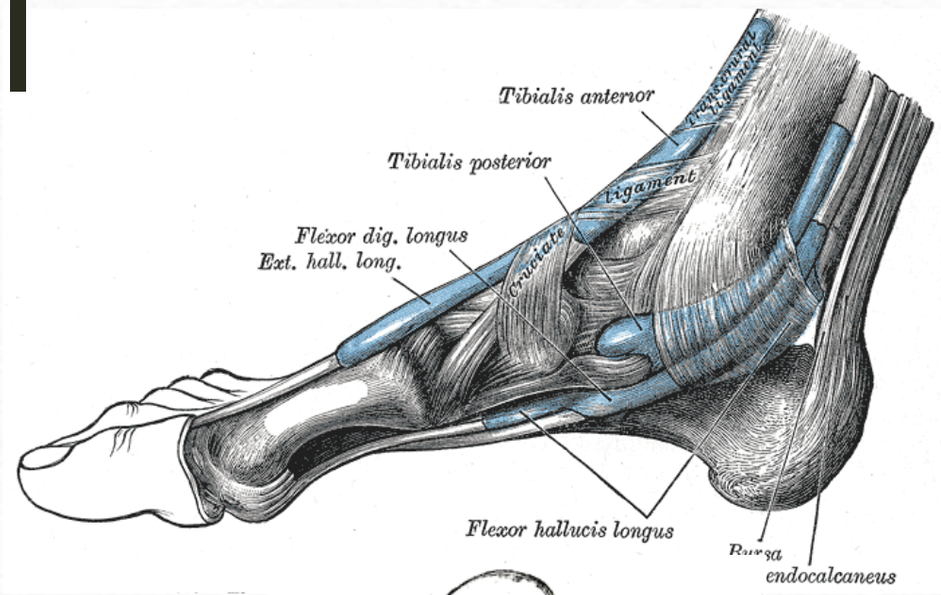
- Further investigations: EMG studies equivocal; ultrasound of foot showed cystic degeneration of tendon sheath compressing posterior tibial nerve; findings confirmed on MRI

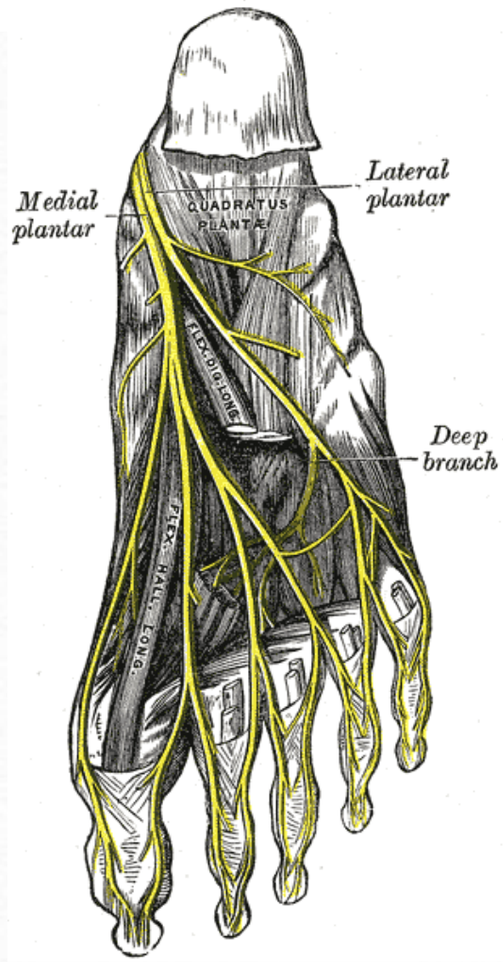
- Rx: local corticosteroids partial relief

- Surgery: complicated decompression with only partial response; loss of pain but paraesthesia and muscular weakness persisted

Tarsal Tunnel Syndrome

- Much less recognised than Carpal Tunnel syndrome
- Occurs in middle-aged ‘athletes’
- Response to surgery only 50% successful





Case History: 2014

- Pain in lower back and left gluteal region. Tennis troublesome and walking intermittently painful with left leg sometimes “giving way”

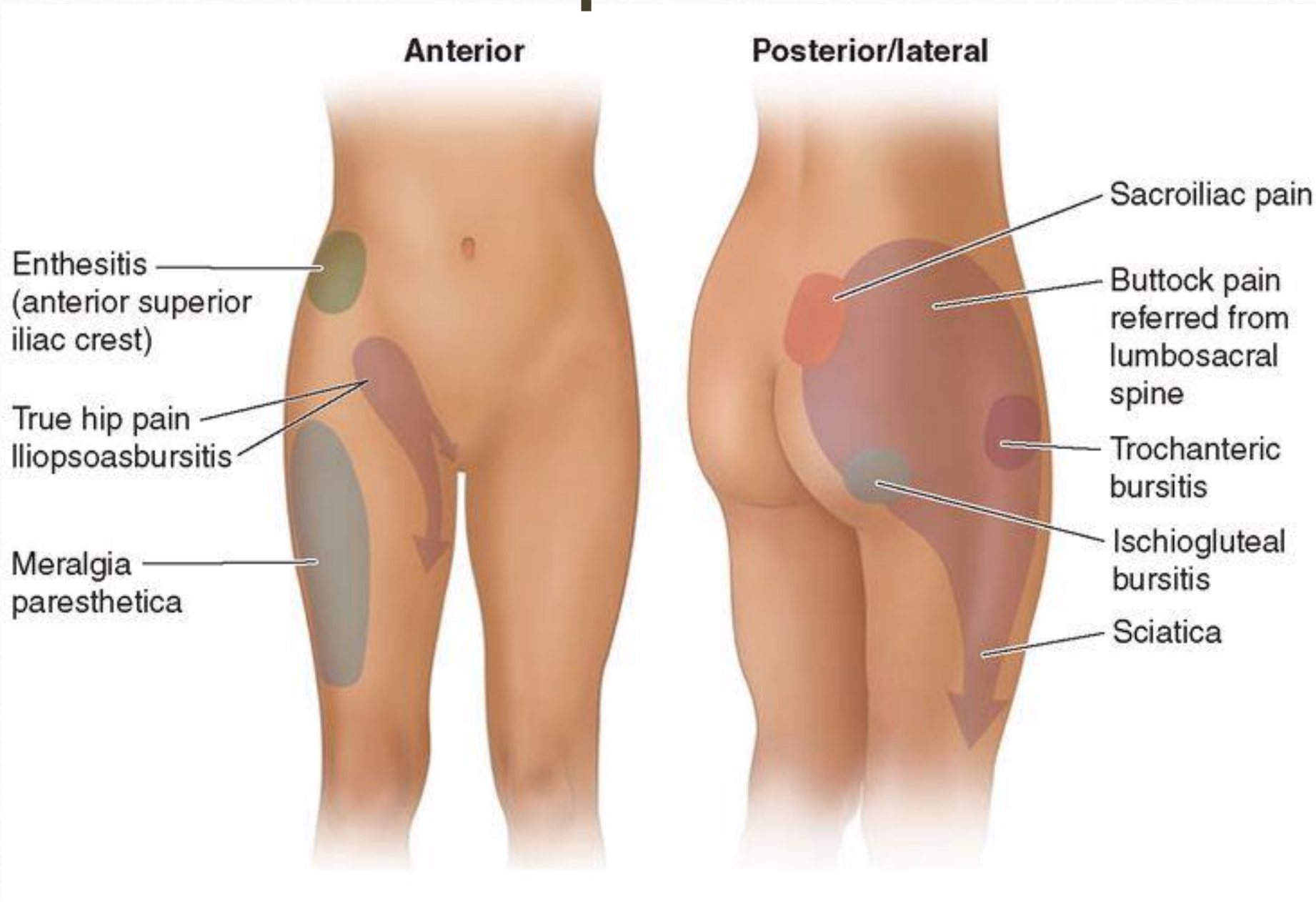
- Examination: Lumbar spine movements and hip mildly limited; deep gluteal tenderness.

- X-rays: some degenerative change both hips, more marked on left. Lumbar spine: marked OA of L2/3 joint

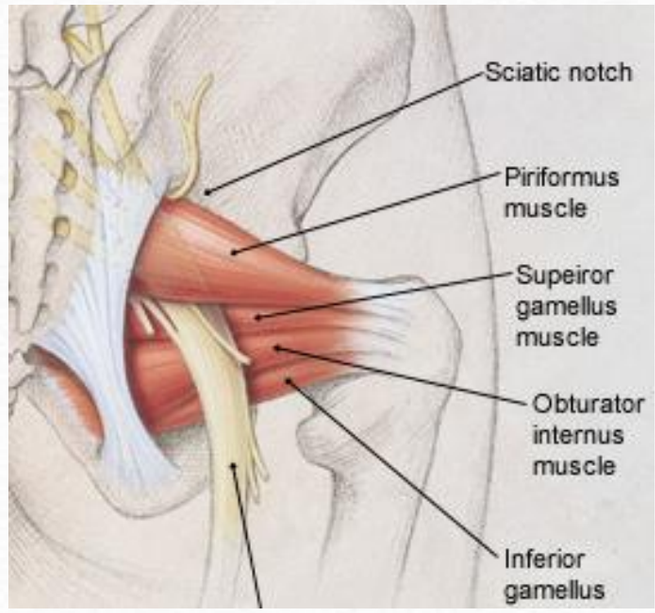
- Saw sports physiotherapist at tennis club

- Diagnosis: PYRIFORMIS SYNDROME

Causes of hip/buttock pain



Pyriformis Syndrome: SYMPTOMS



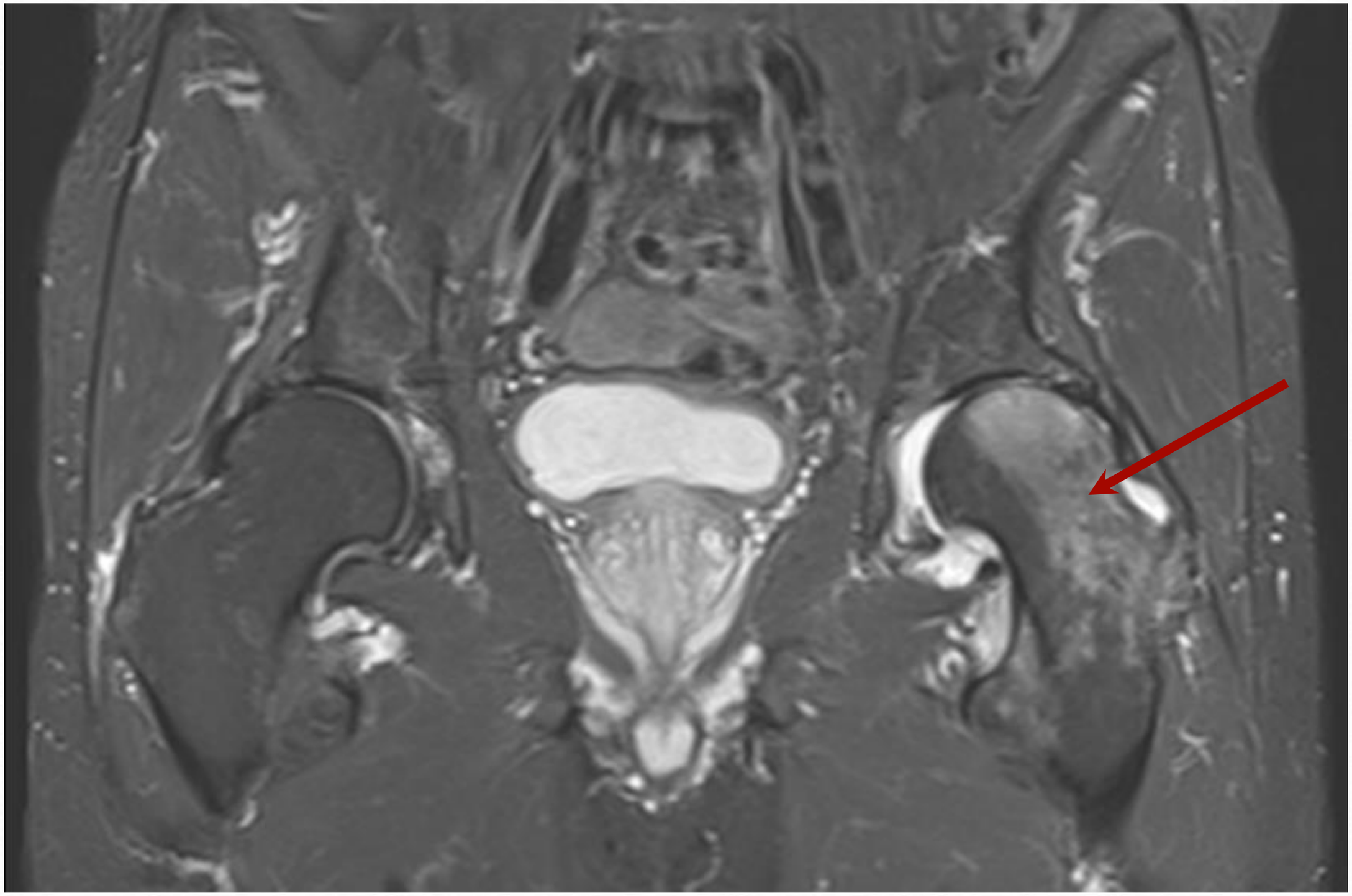
- Acute tenderness in the buttock and sciatica-like pain down the back of the thigh, calf and foot.
- A dull ache in the buttock
- Pain when walking up stairs or inclines
- Increased pain after prolonged sitting

Symptoms of pyriformis syndrome often become worse after prolonged sitting, walking or running, and may feel better after lying down on the back.

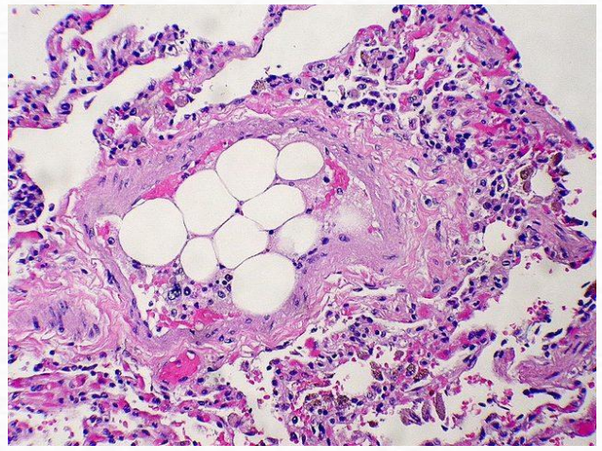
Case History: 2014

- No improvement with physiotherapy; pain remains in gluteal region
- Examination: no change in findings
- Referred for MRI scan

MRI Pelvis Apr 15



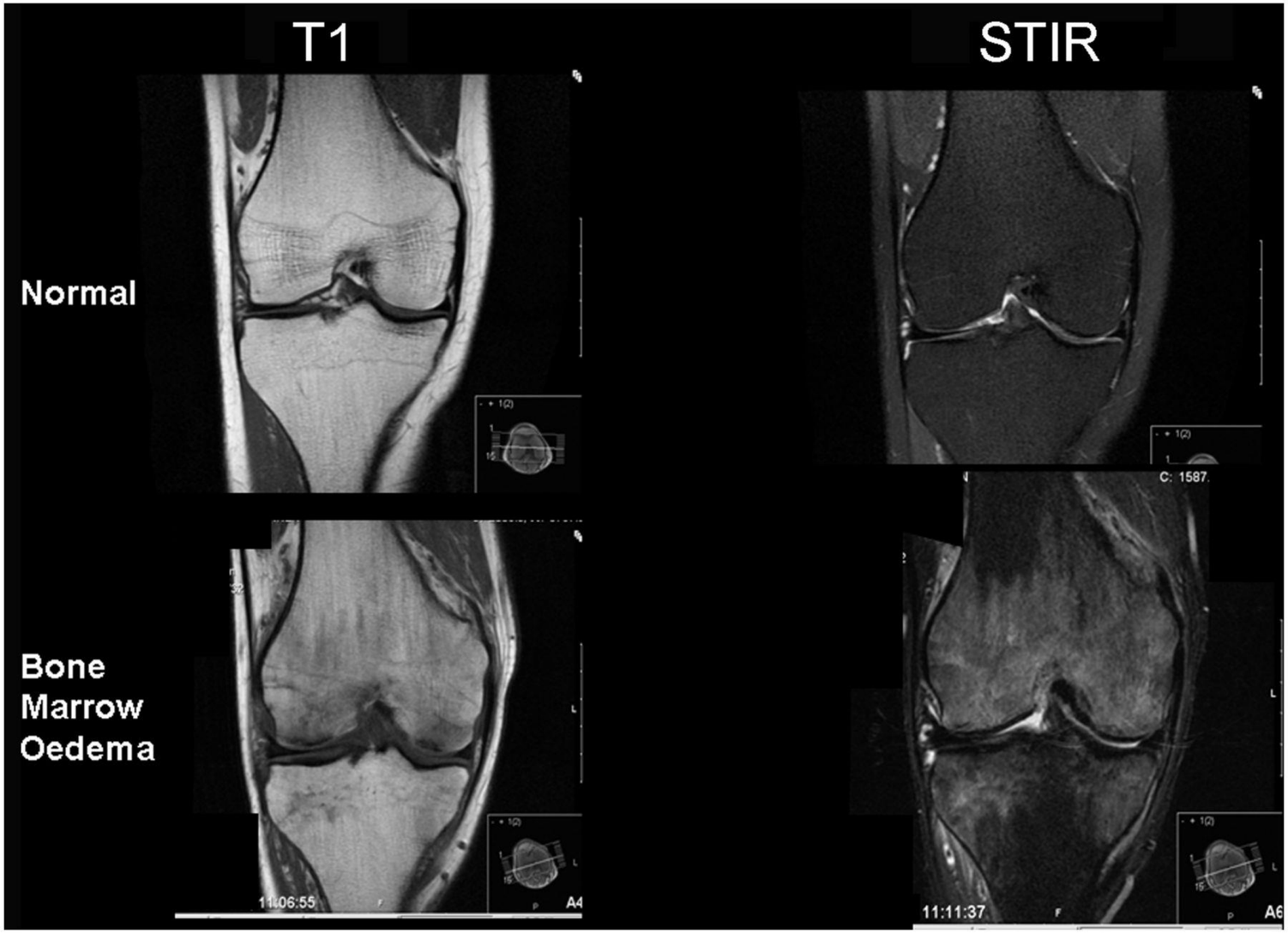
Bone Marrow Oedema Syndrome
Transient Osteoporosis



- First described in 1988
- Identified by MR imaging - rarely identified on plain X-rays.
- Cause uncertain ?vascular
- Localised pain in affected area
- Seen in pregnancy (3rd trimester) and men aged 40-60 yrs
- Changes and symptoms resolve over 3-6 months
- Rx: Avoid weight-bearing and avoid NSAIDs

Patel Sanjeev: Primary Bone Marrow Oedema Syndromes Rheumatology (2014) 53: 785-792.

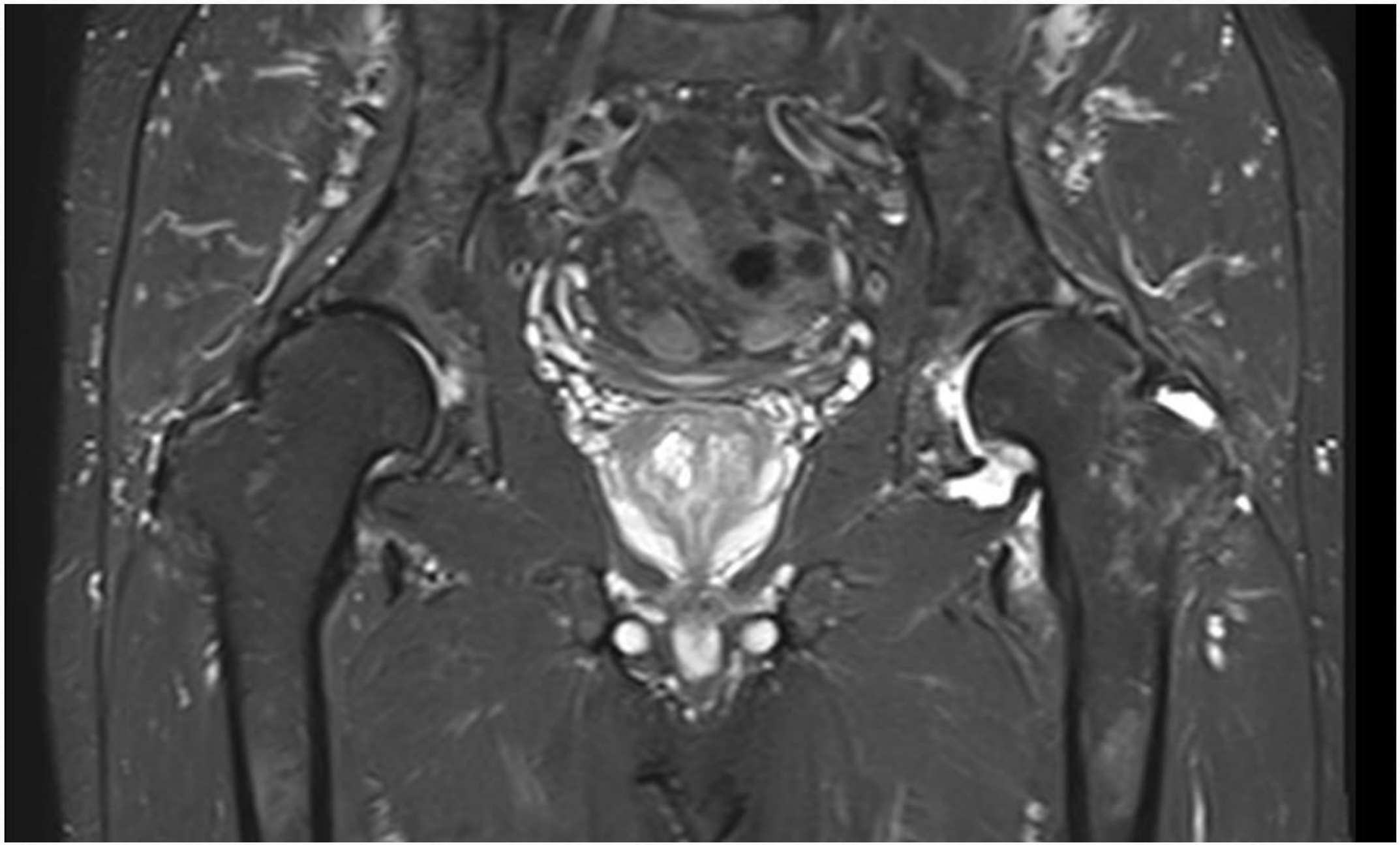
T1 and STIR MRI coronal images of a normal knee and similar sequences in a patient with primary bone marrow oedema syndrome.



Sanjeev Patel Rheumatology 2013;rheumatology.ket324

RHEUMATOLOGY

MRI Pelvis July15

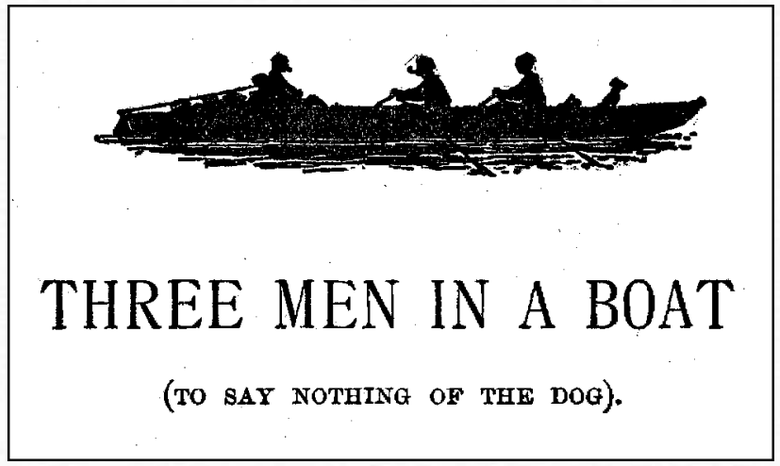


Learning Points

- Outcome: successful Hip replacement Oct 2015
- “Atypical” site of pain from hip in gluteal region*
- Seeking help in Initial Management
  - which health care worker to approach?
  - which Specialist care to seek?
- Seeking help with Definitive Management
  - was surgery the right option?
  - which Surgeon to choose?

*Hip Joint Pain Referral Patterns. Pain Medicine. Lesher JM et al 2008, 9; 22-25

What illness have you experienced since entering medicine and how did you react to it?



Three Men in A Boat (1889)

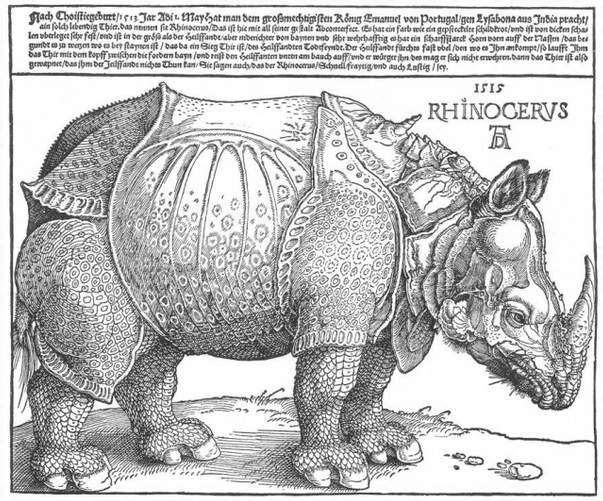
by Jerome K Jerome

I remember going to the British Museum one day to read up the treatment for some slight ailment of which I had a touch - hay fever, I fancy it was. I got down the book, and read all I came to read; and then, in an unthinking moment, I idly turned the leaves, and began to study diseases, generally. I forget which was the first distemper I plunged into but, before I had glanced half down the list of “premonitory symptoms,” it was borne in upon me that I had fairly got it.

I sat for awhile, frozen with horror; and then, I again turned over the pages. I came to typhoid fever - read the symptoms - discovered that I had typhoid fever, must have had it for months without knowing it - wondered what else I had got; turned up St. Vitus's Dance - found, as I expected, that I had that too.

I began to get interested in my case, and so started alphabetically - read up ague, and learnt that I was sickening for it, and that the acute stage would commence in about another fortnight. Bright's disease, I was relieved to find, I had only in a modified form, and I might live for years. Cholera I had, with severe complications; and diphtheria I seemed to have been born with. I plodded conscientiously through the twenty-six letters, and the only malady I could conclude I had not got was housemaid's knee.

Factors affecting Doctors and their Symptoms



- Underlying Personality
- Childhood illness and contact with Medicine
- Exposure to diseases as a medical student - “Medical Student Syndrome”
- Contact with patients and relatives during training - generally acute illness
- Contact with patients and relatives as an Internist - generally chronic illness
- Susceptibility may depend on Specialty

Why Doctors Hide their own Illnesses
The Guardian May 2014

"First, there is a belief that doctors don't get ill, that they themselves see it as a sign of weakness.

Then you have the fact that doctors are put on pedestals, that they wear a white coat and speak a different language.

Then there is the worry that admitting depression or addiction will ruin their careers.

Then you have their obsessive personality traits, a doctor's attention to detail and wanting to work especially hard – the very things that make them good doctors.

Then there is the fact that doctors are frightened they are going to end up being treated by a colleague."

When doctors need treatment: an anthropological approach to why doctors make bad patients

Alex Wessely, Clare Gerada. BMJ Careers; 12 Nov 2013

Psychological barriers to disclosure hinge on the belief that doctors do not become ill, or that the patient is the “one with the disease.”[4] Personality factors are also important: for example (adapted from work by psychiatrist Gwen Adshead), doctors are[5]:

• Perfectionists - *“I must do this right, mistakes are intolerable”*

• Narcissists - *“I am the greatest”*

• Compulsives - *“I must do this, and I can’t give up till I finish”*

• Deny vulnerability - *“People who need help are failures. If I need help, I am a failure”*

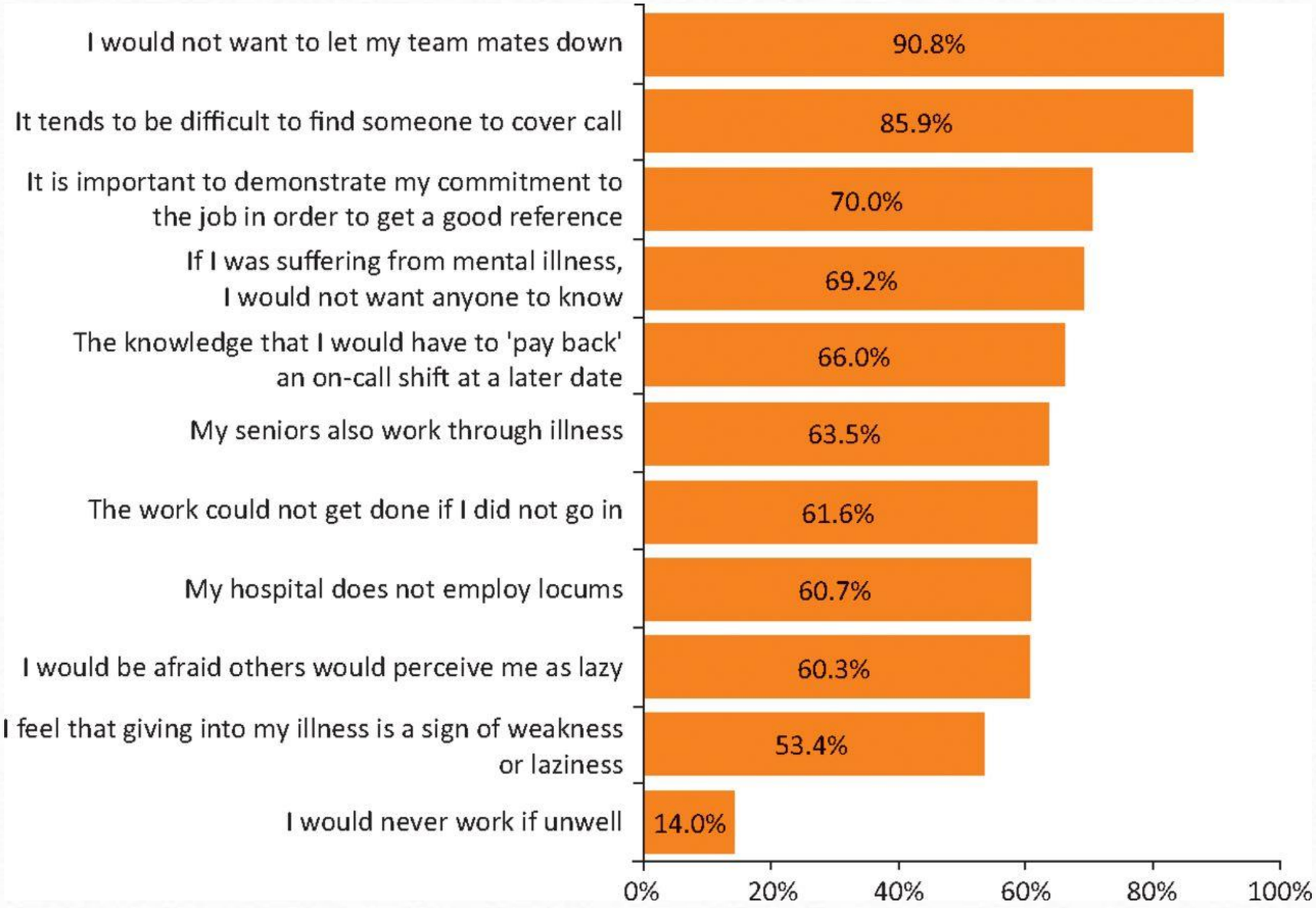
• Martyrs - *“I care for my patients more than myself, and my needs are secondary to those I treat”*

Workshop Groups

- Gp A: Issues accessing healthcare
- Gp B: Investigating Doctors symptoms
- Gp C: Treating Doctors with Illness
- Gp D: Impact of Illness on ability to work

EXCLUDE ALCOHOLISM AND ADDICTION

Practise what you preach: health behaviours and stress among non-consultant hospital doctors



Clinical Medicine 2016: 16, 13-18