BJPsych | The British Journal of Psychiatry (2022) 220, 7–9. doi: 10.1192/bjp.2021.52

Analysis

Doctors' identity and barriers to seeking care when unwell

Clare Gerada

Summary

Doctors have a deep-rooted sense of professional identity 'the medical self'. This allows them to do the jobs society expects from them, but also acts as a barrier when seeking care when unwell. This article discusses how the medical self is formed drawing on psychoanalytic, anthropological and psychiatric literature.

Keywords

Identity; mental illness; doctors; group psychotherapy; professionalism.

Doctors and identity

For more than a decade I have been leading a confidential service for doctors with mental health and addiction problems (NHS Practitioner Health). What is striking is despite having high levels of mental illness, and working within the medical system, doctors have low rates of presentation to treatment services. Although there are systemic barriers,[1] such as frequently moving address or long and irregular shifts that make it hard for doctors to seek help if needed, stigma,[2] shame[3] and secrecy[4] are the main factors that keep them in the corridors rather than the consulting room.[5]

To understand why these are so prevalent we can draw on the literature on identity,[6,7] especially professional identity,[8] a popular theme of study for decades and defined in different ways in different discourses. Most theories propose, in one way or another that individuals proceed through life continuously organising their experiences into a meaningful whole that incorporates their personal, private, public and professional 'selves'[9] and it is in this process that one's identity is formed.

Everyone has conflicting identities for different times and contexts, work or home, with family or friends, as parent or professional. However, for doctors, their core identity, is particularly strong as during training, their personal (the 'I') and their group (the 'we') are merged to create a single identity referred to as the 'medical self'.[10] The German sociologist, Norbert Elias described this phenomena when he argued that each of us derives our 'we' identities from the groups to which we belong; and that 'we' identities are inseparable from what we might call our 'I' identities; 'who I am' is always inseparable from 'who we are'.[6] So powerful is the medical self that doctors find it hard to leave their working identity at the hospital gate or consulting room door and to adopt any identity other than that of 'The Doctor'. A doctor is therefore something you are, not something that you do.

The medical self, as a mature psychological defence mechanism, protects doctors from feelings of disgust, fear and shame. It also ensures doctors internalise the characteristics expected of their group: altruism, perfectionism and self-sacrifice, as dictated by the first line of the World Medical Association Geneva Declaration 'I solemnly pledge to dedicate my life to the service of humanity'.[11]

Creating the medical self

The purpose of medical training is largely two-fold. The first is to make sure individuals learn the vast body of scholarship and expected behaviours needed to do the job. This is the meaning of professionalism and underpins the trust the public has in doctors. The second and occurring in parallel, is the need to absorb the unwritten rules, myths and beliefs, which the profession demands from each other. This includes self-sacrifice, as dictated in the first line of the Hippocratic Oath 'to dedicate oneself to the service of humanity'. This could be thought of as the essence of vocation.

Personal

The transformation from lay person to healer actually begins even before the individual starts to cross the threshold into medical school and continues throughout training and working life. This learning happens not just in the formal lectures, ward rounds or tutorials, but as part of the hidden curriculum in the spaces in-between. This has been written about in personal experience[12] and the influences leading to choosing medicine as a career, and how these shape one's identity years ahead of arriving at medical school.

Many students start their training with a pre-established notion of being different, special even. Specialness is reinforced during training as doctors learn a new language, wear new clothes and carry special objects, such as the stethoscope and bleep. Once qualified, the transformation is complete with the new name, 'Dr'. All of these create the external publicly recognisable 'doctor', but unseen, below the surface feelings have also developed, namely, power, authority and invincibility. The medical self, 'who I am', emerges.

Group

In parallel to changes to the individual's personal identity is the transformation to their collective (group) identity. Previous articles have discussed group processes in relation to the creation of the medical matrix[12] and how during the making of a doctor, individuals become entangled within it. The matrix, is a concept that underpins group analytic theory and describes a complex, hypothetical web of communications, projections and relationships between individuals, subgroups and the whole group. The Jewish German emigree S. H. Foulkes and founder of group analysis hypothesised that:

> '… I have accepted from the beginning that even a group of total strangers, being of the same species and more narrowly of the same culture, share a fundamental mental matrix (foundation matrix).'[13]

https://doi.org/10.1192/bjp.2021.52 Published online by Cambridge University Press

Elsewhere Foulkes included body images, language, social class and education as elements of the foundation matrix.

> 'What we traditionally look upon as our innermost self, the intrapsychic against the external world, is thus not only shareable, but is in fact already shared'[14]

What Foulkes is saying and what is evident given the many symbolic, mythological and cultural factors which for doctors is that individuals are linked past, present and even into the future.

The medical self is therefore individual and collective and as such results in a formidable group identity and sense of belonging.

Group identity

This sense of belonging is an important component of any community of practice, and exerts forceful social influences on its members as compliance with professional norms emerge.[15] For doctors, their group becomes so important that their work (as a healer) becomes centre stage to their lives and for some almost replaces their family, becoming what the psychoanalyst, Jean Claude Rouchy considered to be secondary group of belonging.[16] Our secondary groups provide us with structure and meaning and with roles that reinforce our sense of personal identity. Although medical schools and hospitals might not fit Goffman's description of a physically confined space,[17] rather, as the anthropologist, Simon Sinclair suggests, they are in terms of time spent within the conceptually and cognitively limited organisation of the profession itself.[18] The individual is, therefore, not so much restrained in a concrete space rather, and one would argue more powerfully, within the boundaries of their collective unconscious.

The medical self and patient hood

Although the rules of medicine's community of practice might change over time, each individual wishing to join this community must adhere to them. Failure to do so can impede career progression, or even risk sanctions or exclusion from the group. This is largely what happens when doctors become unwell as the expectation that 'Physician Heal thyself' (Luke 4:23)[18] is a core competent of the medical self. Or in more modern times, as George Bernard Shaw, in the Play, *The Doctors Dilemma*, wrote 'the most tragic thing is a sick doctor'[19] and as such is too be avoided at all costs.

Doctors and patients are therefore distinct but interdependent. Doctors need patients to define themselves as 'doctors' (invincible, authoritative and so on), and patients need to believe that doctors are impervious to illness, on a pedestal even, to contain their own fear of death. This collusion is vital for doctors and patients and part of defensive interplay of projections between them both.

> 'The helpful and the helpless meet and put pressures on each other to act not only in realistic but also in fantastic collusion and in collusive hierarchical systems. The helpful unconsciously require others to be helpless while the helpless will require others to be helpful.'[21]

This is born out in the literature on both patient's perception of unwell doctors, and doctors' perception of being unwell themselves or having an unwell colleague.

A study asked patients how they perceived their doctor's wellbeing and whether this belief (as the mental state of the doctor was not disclosed) had an impact on the care they received. The results found patients noticed cues that they interpreted as signs of physician wellness. These include overt indicators, such as the doctor's demeanour or physical appearance, along with a general impression about their 'wellness'. Patients also formed judgements based on what they noticed, and these judgements affected views about their care; feelings, such as trust, and actions, such as following treatment plans.[22] Patients placed less trust in doctors who they saw as 'less well'. The same result was found in views of patients if their doctor was overweight. Overweight doctors were seen as less credible or trust worthy than those of normal weight.[23]

Even if a doctor appears 'worried' this has an impact on the patient's view of that doctor, seeing them as less empathetic.[24] Patients also described feeling less comfortable with and less trusting of unwell doctors, even to the point of seeking care elsewhere.[22] Given that mental health is negatively associated, in the minds of patients, with a doctor's competence and capability it does not behold well for doctors to disclose their vulnerability. This was the case for one general practitioner, who after receiving a complaint from a patient about her online blog describing her bipolar disorder, took her own life.[25]

For doctors, as discussed, crossing the invisible divide between health professional and patient is therefore a challenge to their medical self and comes with the perceived, and to a large extent, real loss of the trappings of power, knowledge, status and authority defined by this self. In the first instance doctors do not believe they can get unwell. In a study of general practitioner attitudes to their own health, one doctor is quoted as saying, 'we think we're superhuman and that we don't get ill, or if we do, we can cope with it.'[26] Another study, this time of junior doctors, quoted a young doctor (who had become unwell herself) reporting that, 'I had this bizarre misconception that like as a doctor you don't get ill …' maintaining that '… because you're the doctor and they're the patients, and there's some kind of line between you.'[27]

Over the centuries there are many personal testimonies[28] that describe doctor's disbelief that they could become unwell. These can also be found in fiction, for example, the 'Fatman' in the satirical book, *The House of God*,

> 'There's a law you've gotta learn …. the patient is the one with the disease.'[29]

Self-stigmatisation among doctors who are not working is common, with doctors describing themselves as failures and internalising the negative views of others, these views of course partly real as they represent the norms of the medical identity.[30] In a study of the impact of not working on a doctor's identity, the authors found that participants described being sick as associated with a fundamental change in their identity and that doctors incorporated negative views of themselves into their new 'sick self'. Being away from work, especially with mental illness, then left many feeling lost, isolated and sad and another reported that 'once you try and put that doctor persona aside, I realised there wasn't much left of me'.[30] Doctors attending Practitioner Health often start their consultations by admonishing themselves for being there in the first place, suggesting that they are charlatans and that others are more worthy of the time given aside for them.

Doctors can also be blind to the distress in their peers (as well as in themselves). It is often not until after the doctor's illness has come to the attention of 'authorities' that colleagues begin to realise that they missed, in plain sight, signs of distress, such as a colleague smelling of alcohol, obvious weight loss, behavioural change, social withdrawal or even needle track marks. This collusion is part of the medical self.

When doctors do eventually reach a consulting room, they tend to act differently, as they visibly try to regain control of their medical identity, by for example, 'talking shop' and underplaying their symptoms. The treating doctor can be embarrassed at treating a colleague, especially if of a more senior rank than themselves. It is not unknown for the treating doctor to organise their own care

https://doi.org/10.1192/bjp.2021.52 Published online by Cambridge University Press

and/or follow-up – mirroring the Biblical suggestion of 'Physician Heal thyself' (Luke 4:23).[18]

Conclusion

As discussed, doctors find it difficult to become patients and this is related to their medical identity. As it is formed, it becomes all-powerful, and one is never 'off-duty'. Responsibilities permeate all aspects of life, similar to a religious vocation or as with members of the military, and members are constantly compelled to define themselves by their work. For all these groups there may be elements of self-selection – by virtue of pre-existing beliefs, family experience or indeed privileged backgrounds, with individuals joining the profession even before identity has been fully formed.

However, since caring for thousands of doctors with mental health problems the tide may be turning, more so since the focus on mental health and well-being of health staff during this pandemic. Despite doctors' fears of being shamed if they do admit to being unwell, once there are services that can offer confidentiality, containment and skill in managing their problems, they are willing to present to care, and in so doing reduce their fear of seeking help.

The training of medical students and the power that doctors have is changing. Both are becoming more egalitarian and multiprofessional. So to is an honesty, certainly by this generation, that doctors suffer as well. This is to be welcomed and hopefully this trend will continue, and doctors can both retain their strong identity to the chosen profession but also unchain themselves from their conviction that they are invincible.

Clare Gerada, MBBS, FRCPsych, FRCGP, Riverside Medical Centre, UK

Correspondence: Clare Gerada. Email: clare.gerada@nhs.net

First received 23 Feb 2021, final revision 25 Mar 2021, accepted 5 Apr 2021

Declaration of interest

C.G. is the Medical Director of NHS Practitioner Health and Chair of the charity Doctors in Distress (aiming to reduce the rate of suicide among all health staff). She is also the author of *Beneath the White Coat, Doctors their Minds and Mental Health*. All proceeds to the charity, Doctors in Distress.

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