“Post-Residency Disease” and the Medical Self

identity, work, and health care among doctors who become patients

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ABSTRACT  Doctors who become patients due to serious illnesses face many challenges related to issues of identity, work, and professionalism. In-depth interviews with such doctors reveal the complex ways in which illness threatens identity in these professionals. In comparison with “medical student’s disease,” these doctors now exhibit “post-residency disease”—minimizing physical symptoms that are in fact present, leading to decreases in care sought. Doctors often feel they are somehow invulnerable to disease and have to remain strong, not burdening others. Many describe themselves as “workaholics,” which can prove to be a double-edged sword, posing problems as well as providing benefits. This professional commitment could interfere with preventive health behaviors and with “practicing what they preach.” Some view their illness with their “medical self”—as if they were a physician observing another patient rather than themselves. These doctors often support their approach by choosing a colleague as a doctor who will not challenge them, thereby establishing a “denial system” as opposed to a support system. These doctor-patients confront difficult issues of how much their physicianhood is an identity or an activity, illustrating the intricate relationships and tensions between work, identity, professionalism, and health in contemporary medicine.
“What do you do?” In the United States, strangers commonly ask each other this question when initially meeting—for example, on a plane or at a dinner party. Often posed within seconds of being introduced, this query offends many Europeans but suggests an essential element of American identity and culture. In many ways, Americans define themselves by their work, molding their identity based on what they do.

Issues of work and identity arise in particular among physicians. Perhaps more than any other profession (except possibly the priesthood), medicine forces novitiates to endure a physically demanding and self-sacrificing apprenticeship or process of socialization that deeply ingrains the values and identity of the field. But what then happens when these physicians become patients themselves? These doctors are suddenly forced to face a number of crucial concerns, including those related to identity and the roles and meanings of professionalism. How do they view and approach these challenges to their work and identity, and what, if anything, do their responses suggest about the relationships between identity and professionalism more broadly? As they confront illness and disease in themselves as well as in their patients, physicians face ongoing challenges. To a degree, physicians are supposed to place patients’ interests above their own (Lasagna 1964). But when doctors get sick, to what extent should they sacrifice their lives for their patients? Doctors who have been patients can potentially provide important insights on these issues.

Aspects of physicians’ experiences when they become patients have been examined anecdotally, and issues of self-doctoring have also been explored (Fromme and Billings 2003; Fromme and Hebert 2004; Heymann 1995; Mandell and Spiro 1987; Mullan 1985; Pinner and Miller 1952). Issues of spirituality and risks and benefits among such doctors have also been examined (Klitzman, 2006; Klitzman and Daya 2005). But no systematic research has addressed the other critical questions concerning identity, work, and responses to illness. Such research can potentially assist health care workers and others who face these challenges.

Issues of identity and self have become central in other academic realms, such as feminist, post-colonialist, and queer theory studies (Butler 2004; Sedgewick 1990). The ways multiple professional and other identities interact—what constitutes the boundaries of each within oneself, and how these are shaped—may vary over time and, in the case of illness, with one’s physical condition.

In Their Own Words

A crucial way of understanding these and related issues is to listen to physicians as they candidly reflect on these topics. Hence, I interviewed a series of doctors who had become patients (Klitzman and Daya 2005). I first conducted 20 pilot interviews, developing and refining an instrument concerning experiences of being health care workers and becoming a patient. I then recruited—through e-mail queries (“Are you or do you know a physician with a serious ill-
ness?”), Web sites, word of mouth, and ads in newsletters—48 doctors, a dentist, and a fourth-year medical student, all of whom had serious illnesses. Among the 50 interviewees, who were from several cities, ages ranged from 25 to 87. Forty-nine were Caucasian and one was Latino; there were 40 men and 10 women. The participants had HIV, cancer, heart disease, hepatitis C, and other medical problems. With each individual, I conducted two in-depth semi-structured interviews of two hours each. I conducted all the interviews at participants’ offices or homes or in my office, whichever was most convenient for them. I asked participants about their experiences as patients and as health care providers, and about other aspects of their lives. Serious illness was self-defined and then confirmed by me. Interviewees generally discussed not only their own illnesses, but those of family members—many of whom were also health care providers—and colleagues. I sought to obtain detailed descriptions of these issues and conducted interviews until major and minor themes became clear (Geertz 1973). For a qualitative study of this nature, a sample of this size can provide critical insights into the patterns of issues that emerge.

Interviews were audiotaped, transcribed, and content-analyzed (Strauss and Corbin 1990). I have not provided percentages of respondents who articulated particular themes, since my goal was to understand the range of themes and issues that emerged, and to explore the meanings of these issues for understandings of physicians and their identities. Rather than proffer a research report of these interviews, I am presenting some of the material that illustrates the several themes that emerged, along with several key conclusions that these suggest.

Overall, these doctors revealed how physicianhood became a highly significant part of their identity and gave them a sense that they were invulnerable to disease. They felt they wore “magic white coats” and were not supposed to be weak emotionally when confronting disease. These traits, though helpful in treating patients, proved impediments when confronting their own illnesses. These physicians then had to navigate the ensuing tensions.

**Workaholism, Retirement, and Identity: The Meanings of Work**

Many physicians who became patients contemplated retirement, though the possibility of leaving work proved difficult to confront. Work provided meaning, identity, structure, gratification, and income. To give up these rewards often left doctors feeling lost and adrift.

Many of these physicians spontaneously described themselves as “workaholics.” This characteristic stemmed from a variety of motives and had both good and bad implications. On the one hand, workaholism resulted from dedication to the profession and to the practice of medicine. Yet it also permitted these doctors to avoid other issues, such as finding or maintaining personal, intimate relationships, or confronting their own diagnosis. Implicitly, the profession of med-
icine itself expected such dedication. (“You could spend every waking moment reading and learning, and still not know it all.”)

In fact, medicine may pre-select for types of individuals who value such commitment. A pediatrician said she was “the kind of person who never calls in sick”—indeed, a “type”—compulsive, and conscientious. She didn’t want her life disrupted because of her illness, but as a result, she received sub-optimal medical care.

A range of motives from financial considerations to poor self-esteem could fuel workaholism. As one internist said, “The only way I could get affirmation was by my academic achievements.” These physicians were frequently influenced by how others judged them. (“I derive self-worth from external approval.”)

Long hours also provided excuses to spend less time with others in one’s personal life. Socially awkward physicians could hide behind the cloak of the professional, interacting with others as “doctors,” rather than as mere human beings. Physicians who used their profession to avoid intimate relationships had an excuse that could not be easily challenged. (“It sounds so socially acceptable: ‘I have to see my patients.’ What’s the response? ‘Let them drop dead’? It puts others in a strange corner.”)

Illness can either reduce or increase this level of dedication. On the one hand, several doctors went to extraordinary degrees to continue to perform their duties and remain responsible, even after getting sick. Some worked harder, feeling more committed and seeking maximum meaning from their job because they were ill (for example, by becoming experts in their own disease). If they were healthy, some felt they might now opt for easier practices. Financial considerations could also lead physicians to try to see more patients, so that if they had to go on disability, their income would be higher. Long hours, resulted, too, from magical thinking about working as healing. As a psychiatrist said: “It’s basically the “myth of productivity”: if I can’t be sick, then I won’t be. If I am very busy ... then it just won’t happen. I know that’s magical thinking.” Awareness that this thinking was irrational did not diminish it.

Workaholism can reflect not only magic, but also a form of bargaining. An internist reported:

I know I was bargaining—if I took on this and that—see how healthy I am? I will prove to the world that I can do all of this, and be “Superdoc”... If I’m really, really good, and help more people, and take on more, and never say no, then I won’t get sick. I won’t die. The bargaining was with God or a higher being: if I work really hard, and I’m really good ... You won’t let me die.

Some physicians felt that this bargaining was effective medically (“good for my immune system”).

Yet for other doctors, illness reduced this workaholism. Once ill, they became less obsessed and guilty about work. Revealingly, they tended to be surprised at the possibility of this change, highlighting the depth of their prior workaholism.
But the point at which this change occurred varied. Some reevaluated long hours and now worked less, due not only to illness but, importantly, to the feeling that they were passed over for a promotion as a result.

**Post-Residency Disease**

In contrast to “medical student’s disease” (Moss-Morris and Petrie 2001; Woods, Natterson, and Silverman 1966), these doctors appeared to exhibit what I term “post-residency disease.” In medical student’s disease, trainees fear that they have symptoms of the diseases about which they are learning. The trainees then overdiagnose themselves when physically they are in fact completely healthy. In post-residency disease, physicians established in their professions minimize symptoms that are in fact present, leading to decreases in care sought or inappropriate self-doctoring. While medical student’s disease is a response to nonexistent physical symptoms, post-residency disease involves ignoring physical symptoms that could threaten to impede or terminate one’s career. Thus, the consequences can be more serious. Post-residency disease consisted of several components, as described below.

*Having to Be “Strong”*

These doctors felt that, even as patients, they had to remain “strong” and not burden others. Trained “not to be emotional” when confronting disease, several felt, for example, that it would be “weak” to cry. One physician said she did not know, after receiving her diagnosis, if she was “supposed to” weep—suggesting questions of appropriateness and norms. Their own doctors often reinforced this norm of not expressing emotion, ignoring these doctor-patients’ emotional distress or handling it poorly. One endocrinologist said she wanted to discuss her fear of dying, but her oncologist “immediately tried to medicate away my distress.”

*Under-Accessing Care*

Partly as a result of attitudes related to workaholism, these physicians often found it hard to access or fully use external supports that help many lay patients cope. Workaholism can contribute to reductions in the quality and quantity of care accessed. (“I was too busy dealing with other people’s health even to think about my own.”) Some doctors suspected a diagnosis but resisted diagnostic testing until the symptoms became undeniable. Several of these doctors had failed to consult doctors themselves for decades, even when now displaying symptoms, until becoming seriously ill—not wanting to be patients or know about possible disorders.

*Not Practicing What They Preach*

To practice what they preached concerning preventive health behaviors proved hard for the doctors. Many did not follow the very advice they gave to others concerning diet—for instance, consuming a high-fat diet (“ordering Big
Macs”) despite having high cholesterol—exercise, and substance abuse. At times, these doctors did not adhere to treatment regimens (taking “drug holidays”). Such unhealthy behaviors often continued even in the face of pressures from colleagues. Physicians were “only human,” yet these discrepancies illuminated the nature and degree of the divide between medical training and the experience of being a patient.

Failure to practice what one preached arose from several causes, including anxiety about being sick and arduous work hours to which physicians become inured through their training. A variety of rationalizations could arise. Some recognized the disparity between what they preached and what they practiced, but did not seem able to reconcile the two—to advise their patients more sensitively and effectively, or to engage in healthier behavior themselves.

The fact that these doctors did not practice what they preached illustrated, too, the degree to which alterations of health behavior require not only knowledge, but changes in attitudes and behaviors as well. Physicians appeared to “put on” the role of doctor without always fully integrating it into their lives. These doctors were trained to view illness as residing in the patient, not in the abstract; and since disease was in the patient, it couldn’t reside in these doctors, too.

_Magic White Coats: Physicians as Immune to Illness_

Magical thinking arose—that M.D.s were somehow invulnerable to disease. As one physician said, “We doctors wear magic white coats. We destroy disease all the time. How could it ever attack us?” Doctors conquer disease, not vice versa. This notion was at times recognized as illusory, but still persisted. (“It’s arrogance: ‘I’m a doctor, I’m protected.’ It’s a myth: ‘I know how to take care of myself, and diagnose my problems.’”) Thoughts arose, too, that physicians somehow should not get sick—that they implicitly had a moral imperative not to. (“I tell myself, ‘You said you were going to take care of a patient and now you can’t. You have to hold onto your end of the bargain.’”) Illness was not part of the contractual bargain that doctors had made with their patients. Moreover, some doctors thought that to be a patient was “the worst possible thing” that could happen to them. (“If you have an illness, you become one of them.”) These beliefs were inculcated and reinforced through medical training.

When symptoms became intolerable, the subsequent loss of this sense of invincibility could prove shocking. These physicians’ surprise was itself striking, indicating the degree to which they had previously been socialized to believe in their own invulnerability.

These beliefs also led some doctors to protect themselves less than they should against infectious diseases. Despite having lowered immunity, several doctors continued to see patients or did not sufficiently plan for the possibility of disease or death, not writing or updating wills. Thus, many doctors felt they had to be strong not only by minimizing emotional expressivity, as mentioned earlier, but by exposing themselves to potential physical danger.
The Medical Self: Self-Prognosing

Not surprisingly, given these difficulties in integrating identities as doctor and patient, some viewed their illness as if they were a physician observing another patient, rather than themselves—“almost as a third person.” As one internist stated matter-of-factly, “When I discovered that I had brain mets, I spent this very funny weekend, thinking, ‘This is the last weekend with my brain.’” She suggested a wide distancing from herself—a surreal, otherworldliness. After all, it is not clear what it means to have one’s last weekend with one’s brain. What happens the following weekend? Is one no longer “with one’s brain,” and if so, what does that mean? Who and what is one without “one’s brain”?

Another internist referred to his “medical self,” which said, “A lot of people survive Hodgkin’s. You can get through that,” based on the statistics. He was surprised by this “medical self”—observing himself separately from other, emotional aspects of himself.

Similarly, at times, doctors viewed themselves as though they were “a case”—barely a full person. One internist went so far as to consider writing up her own case for publication in a medical journal, and another was asked to present his own case in departmental rounds, suggesting the degree to which colleagues, too, had difficulty distinguishing between these roles of doctor and patient. Difficult choices arose as the doctor-patients had to decide whether to check their own lab results. Some found that picking up or reading one’s own results could be “a mistake,” as lab results could seem to confirm their own worst fears, unbuffered by the “framing” that their physicians may have been able to provide.

Denial Systems: Avoiding Challenges from Colleagues

Physician–patients often chose, to be their doctors, colleagues who would support these aspects of post-residency disease and be complicit in denial of the severity of the illness. Such colleagues frequently avoided criticizing a physician’s treatment of his or her own disease, given taboos about criticizing each other generally. At times, colleagues only gingerly suggested better follow-up: “Colleagues would say, ‘You really ought to come in and be checked.’ But that’s where it began and ended... Colleagues were willing to be cornered in the hallway for quickie consults. If it’s a quickie consult in the corridor, it’s not really serious.” In part, colleagues didn’t want to offend their physician-patients by implying that the latter were incapable of managing their own disease. Norms of not criticizing each other are so strong that they can outweigh colleagues’ responsibilities or concerns regarding one another’s health. This dynamic of avoidance was exacerbated by the fact that physician-patients had the status and power simply to avoid following colleagues’ admonitions and recommendations.

To alter such a “denial system”—as opposed to a support system—could be difficult. Physician–patients avoided confrontations or conversations that might pose challenges, avoiding colleagues who might question this denial or mini-
mization of symptoms. Doctor-patients were also able to “outrank” and resist family members or friends who challenged their denial. As one doctor-patient said, “I know how to handle my illness. I know what I am doing.”

**Working Part-Time, Retiring, or Volunteering**

As a result of workaholism and post-residency disease, many of these doctors worked as long as possible and were not always sure when and how to alter or reduce their professional schedules and habits. Particular questions arose when doctors became sicker than their patients. These doctors felt that if their patients were healthier, then the physician had de facto passed a certain boundary between the roles of physician and patient. It was then hard to integrate the roles of patient and healer and to treat patients, potentially compromising the care provided. Some realized it was probably not best to work when ill, but did so anyway.

Short of stopping work entirely, some physicians found that the profession could allow for wide fluidity in career activities. In response to illness, many physicians altered their mix or type of professional activities, taking on more administration or research and doing less clinical work, teaching, or consulting. By transitioning into other roles, these physicians avoided having to leave the field entirely but reassessed and reprioritized their personal and professional values and changed their responsibilities.

Yet such fluidity was not universal. Trainees, in particular, faced difficulties altering key components of their professional lives. Still, diagnoses received before the completion of training could enable even these individuals to choose fields and jobs that posed the least physical risk to themselves or others. Job fluidity had limits as well, since retraining might be necessary. Attempts to scale back work to part-time were difficult, too, since clinical practice demanded long hours of following-up with details, compelling high levels of commitment. Patients were often sick, requiring full-time attention, and phone calls and emergencies occurred at all hours. Thus, to “transition out” of full-time clinical work to practice only part-time was hard. As one internist explained: “You could cut the number of patients, but not stop the number of phone calls. So, you ended up squeezing in emergencies. There wasn’t enough money to hire another doc to do what I was doing, or even a nurse practitioner.” Clinical medicine seemed to “take on a life of its own.”

Other physicians formally retired from paid employment, but then sought to volunteer their services to help with grants and teaching, to provide meaning in their lives. Yet volunteerism provided meaning, not status. Hence, at times such physicians implied to colleagues that they were working more than they actually were. Even after getting diagnosed, many continued to work, since they felt that the alternatives (volunteering, working part-time, or retiring) were unacceptable. Several stayed at their jobs despite having metastatic cancer.
Identity Post-Disease

After diagnosis, these doctor-patients struggled with questions of whether they were still physicians if they no longer saw patients, and whether and how much of being a physician was either an identity or an activity. For instance, one physician, now teaching as a volunteer at a university, asked, “Who are you, compared with what you do? Is a doctor always a doctor?” He wondered: if he retired or no longer saw patients, would his identity change, and if so, how. Physicians who no longer worked disagreed as to whether to continue to use the prefix “doctor” before their names. Some shifted their identity to encompass only the parts of their role that they maintained (now thinking of oneself as “a researcher” more than “a physician”). A neonatologist who now worked part-time teaching and no longer saw patients felt “merely an educator.”

This notion that physicianhood constituted an identity lent support to the idea that, despite the onslaught of managed care, medicine still involves “professionalism” rather than “merely being a job.” Physicians clung to the role of the doctor—fixed and well established as a result of professional socialization—even when they no longer practiced.

The question of to what degree to maintain this identity arose profoundly when seeking health care—for example, whether to self-doctor or seek VIP treatment. The internist who now volunteered as a teacher said: “Now when I get blood drawn at the lab, I’m just myself. I don’t use the title ‘Doctor.’ Some of the techs remember me, and some don’t. I don’t . . . walk through the back entrance.” Yet when teaching students, he still used the title “doctor,” since they otherwise might not respect him. His decisions about trying to maintain his identity thus shaped how others responded to him.

Conclusion

These doctor-patients defined themselves by what they did, and they subsequently encountered difficulties maintaining this identity in the face of illness. Professional identity provided meaning, satisfaction, and self-definition, even after retirement. But while medical training offered strong senses of meaning, gratification, and self-esteem, it did not always improve—and in fact could interfere with—healthful behavior.

At times, physicians may make work decisions suboptimally, staying in their jobs too long—and jeopardizing their health—or retiring too early. Continued work can potentially harm patients both in the short term and, indirectly, in the long run, by decreasing these physicians’ potential future availability to patients. Clearly, professionalism remains strong, but at times it can be too strong, not always allowing flexibility or rationality with regard to one’s own health.

Yet the fact that physicianhood can prove to be a double-edged sword is rarely discussed within the profession, and important implications have been underexamined. For example, physicians may stay in practice, despite job dissatisfactions,
and even disease, because of the high sense of meaning and purpose that they derive from work. Indeed, studies have indicated that many physicians say they intend to leave practice, but then continue to work, perhaps in part because of these issues of meaning (Rittenhouse et al. 2004).

The fact that pursuit of meaning and purpose can trump the pursuit of health suggests the depth to which professional socialization operates. Despite the adage “Physician, heal thyself,” many do not do so. Perhaps medical schools could help physicians learn to care for their own health. Such educational sessions may help, too, to make physicians more appreciative of the challenges, struggles, and efforts patients face. Medical training could also increase physician awareness of the complex relationships they have with colleagues who are ill, and who may request “quickie” hallway consultations rather than appropriate care. Physicians may inadvertently become complicit in perpetuating post-residency disease among colleagues.

Physicians who become patients may still have skills to offer that can be better utilized in education and research. Programs could be established to aid physicians who are contemplating full or semi-retirement to use at least some of their knowledge and abilities (for example, through education of trainees). Increased attention to these issues within the profession could assist physicians in making optimal and appropriate decisions when responding to their illness.

My investigations raise fundamental questions, too, of the interconnections and tensions between identity, work, and health more broadly in contemporary society. The physicians I interviewed, and no doubt others as well, struggle with questions of who and what one is when no longer practicing one’s profession. This emphasis on work may impose costs not only on the physicians themselves, but also on their families and social networks. More attention to these issues is crucial, since almost all physicians will one day face these difficult personal and professional challenges.

References


