A framework for treating doctor–patients

Claire J Hutton, Margaret Kay, Jill Benson, Shaun Prentice, Chris Barton

This article is part of a longitudinal series on doctors' health and wellbeing.

Background
All doctors are encouraged to have a general practitioner. When doctors seek medical care, the treating doctor can struggle to provide optimal treatment. Guidelines state that doctor–patients should be treated like any other patient, yet this is challenging for the treating doctor.

Objective
This paper speaks to these challenges and presents a framework to assist the treating doctor to deliver compassionate, comprehensive care when their patient is also a doctor.

Discussion
After first outlining the key concepts of respect and collegiality, which play a central role when building a therapeutic alliance, a number of practical challenges that can emerge are identified. A practical framework is then presented and illustrated with examples designed to help the treating doctor navigating the important role of being a doctor's doctor.

A DOCTOR IS LIKE ANY OTHER PATIENT EXCEPT …

Treating a doctor–patient can be a rewarding and meaningful experience; however, it can also lead to discomfort about clinical expertise on both sides, unease about what each think of the other, and boundary issues can be challenging to navigate, especially if they are likely to cross paths (professionally or socially) outside the consultation. Importantly, these challenges can result in the doctor–patient receiving less than optimal care.[1]

The complex dynamics of a doctor–doctor consultation are receiving growing recognition. The directive to 'treat them like any other patient' while not in itself inaccurate, does oversimplify the challenges for treating doctors as they attempt to put this approach into practice.[2] Although being a doctor's doctor is relevant to all specialities, it is especially important in general practice, as all doctors should have their own general practitioner (GP).[3] This article outlines some challenges faced by treating doctors, then provides a framework to guide GPs who treat doctor–patients, highlighting similarities and differences to treating non-doctor patients, with practical suggestions made (Table 1).

The challenges for treating doctors

The study by Hutton et al[2] that investigated GPs' experiences treating doctor–patients identified three principal challenges:

1. The impact of collegiality: treating colleagues can make the consultation more enjoyable and meaningful but can impact the consultation (eg using medical language that might not be fully understood, and a reluctance to ask sensitive questions or perform unpleasant tests).
2. Apprehension: the treating doctor might fear they will be judged on their knowledge or skills. They might worry about making a medical error in their assessment or diagnosis and the criticism from the wider medical community they fear might follow this.[2,4]
3. Boundaries and control: determining boundaries within the consultation can be challenging when treating doctor–patients. Although there is a need to respond compassionately to the doctor-patient, there is also a need to maintain the treating doctor role, ensuring appropriate leadership within the consultation.

Framework for the treating GP

The proposed framework below is divided into sections that follow the logic of a typical GP consultation: prior to the consult; during the consult (history-taking/examination and management plan); and follow-up.

Defining the consultation

The role of a treating doctor in a therapeutic relationship is very different to a collegial chat in the tearoom or a corridor consultation.[5] Although it is natural to seek supportive counsel from colleagues, when that colleague is medical, there is a risk that the advice can appear to be clinical care, even though it has

not been provided within an appropriate therapeutic consultation. When providing such advice for a medical colleague, the focus should be on supporting a colleague and ensuring they access independent care from their treating doctor.[6]

Before the therapeutic relationship is established

As with any patient, consider your existing relationship with that person, including familial, friendship or professional connections. In considering these relationships, ask yourself:

- Can I remain objective and maintain appropriate boundaries in this doctor–patient relationship?
- Could my relationship with this person (or related others) outside the consultation be impacted (eg if the presenting issue turned out to be sensitive, like substance use, mental health or intimate partner violence)?
- Would heightened anxiety jeopardise my ability to care for a colleague?[7–11]

Payment can also create discomfort for both parties when treating doctor–patients. Some doctor–patients expect to be bulk billed. Although often appreciated, this professional courtesy should not be assumed. Some prefer to be billed like any other patient.[2] Having an overt discussion about payment with the doctor–patient can avoid incorrect assumptions about the billing arrangements (Table 1).[12]

During the consultation

The therapeutic relationship

As with any patient, treating doctors should allow adequate time to get to know the patient and to identify their key issues. Likewise, maintaining accurate medical records is imperative. This includes ensuring appropriate consent (eg for sharing of health records, using artificial intelligence tools).

There are additional considerations when establishing the therapeutic relationship with a doctor–patient. There is room for individual differences in how treating doctors and doctor–patients negotiate their relationship, being aware of how collegiality and the desire to respect your colleague can shift the dynamics of the consultation.[2] Although collegial conversation (about hospital practice, training, social issues) might come naturally when seeing doctor–patients,[2] and indeed can be enjoyable, the doctor–patient might feel that this reduces their ability to express vulnerability and embrace their patient role, and might subliminally threaten their perceived assurance of confidentiality.[7,9,12–16]

Treating doctors might worry that simplifying their language will come across to the doctor–patient as condescending, yet using complex medical language and abbreviated explanations can impede communication. Doctor–patients can struggle to admit that they do not understand a medical term or a test that is being recommended. Explaining things as you would for a non-doctor patient can be helpful (Table 1).

Explaining to your doctor–patient that they will be treated as a 'normal' patient can be reassuring. Doctor–patients might avoid identifying that they are a doctor because they worry that being a doctor will change how they are managed.[2] It is useful to address this 'elephant in the room'[2] by openly acknowledging the potential challenges when both doctor and patient are doctors (Table 1).

History-taking and examination

There are also some areas that introduce greater challenges by virtue of the patient being a doctor. Although asking sensitive questions is difficult no matter your patient's occupation, doctors might choose to selectively disclose their history.[10,17,18] This includes information about substance

Table 1. Some possible phrases to help manage potentially tricky situations[2,12,21]

Issue/stage of consultation	Possible phrases to use
When approached for a corridor consultation	*I'm not sure I can give you an answer on that now, why don't we make an appointment in my office to discuss it further; then we can ensure a proper history and examination*
Acknowledging the 'elephant in the room'	*I know we're both doctors, my aim is to treat you like any other patient, if you're OK with that. If you feel you disagree with anything, or feel I'm over-explaining things, please let me know …*
History taking	*I'd like to understand what is concerning you most about your current situation/symptoms. It is my usual practice to ask these questions for completeness* (then ask about self-care, substance use, sexual health, mental health as appropriate)
Examination	*Normally at this time, I would examine* (describe the examination that you would now usually undertake at that time). *Are you comfortable with that?*
Explanations	*The way that I normally explain this to my patients is (…); Do you have any questions about what we've been talking about?* Or prefacing an explanation with *'I recognise you likely know this but, …'*
Treatment plans	*It is my normal practice to do (…) in this situation. How you feel about this approach?*
Follow-up	*I know you will be interested in your results and usually I arrange* (describe the usual process for follow-up and be prepared to discuss appropriate follow-up while carefully managing boundaries)*; If you need to contact me after hours then …* (describe an acceptable method of contact that maintains boundaries).
Payments	*I know that many doctors prefer to pay for their medical treatment so that they feel they are being treated like a normal patient. However, I also want you to know that I am very happy to bulk bill you for this appointment. What would you prefer?*

use, sexual health and mental health, suicide risk and self-medication. As with any patient, provide a supportive therapeutic rapport that enables disclosure.[19] Taking a thorough history and performing a comprehensive examination can support the doctor–patient's readiness to engage. Building trust might enable later disclosures as the therapeutic relationship strengthens over time. A compassionate professional response provides a safe space for the therapeutic conversation while ensuring that both patient and doctor can maintain appropriate boundaries during the history and examination.

The treating doctor might worry that gaps in their knowledge will be identified, especially since the health literate doctor–patient might have researched a specific diagnosis they are concerned about before their consultation. Enquiring about self-diagnoses and openly exploring them while sensitively addressing concerns can strengthen the therapeutic alliance (Table 1).[7,12,13]

The treating doctor might also consider avoiding unpleasant or sensitive examinations. However, the doctor–patient might expect to be examined and feel disappointed that this was not done. Touch within the therapeutic consultation is an important aspect of the delivery of compassionate care to all patients, including the doctor–patient. The intended examination should be discussed, enabling the consultation to progress as per usual practice (Table 1).

Management plan

Involving the doctor–patient in their management can be a source of tension. In the effort to maintain boundaries, the treating doctor might project paternalistic behaviour. Conversely, when trying to be collegial, the treating doctor can seem like they are stepping back from their responsibility and expecting the doctor–patient to determine their own diagnosis and suggest their preferred management. Shared decision making is relevant for all patients. Being clear what you as the treating doctor have determined to be best practice and ensuring this is explained to the doctor–patient can ensure that their expectations are addressed (Table 1).

Avoid the pitfall of making assumptions about the doctor–patient's knowledge of their health issue, including the role of their health behaviours in their illness and their understanding of the medications prescribed. Health education should be provided despite the doctor–patient's medical training.[20] Prefacing the discussion with a recognition of the patient's knowledge usually ensures that this information is received gratefully.

Avoid changing your usual practice for investigations (eg avoid over-testing because of the fear of missing something). Ensure that the investigations that you are arranging are explained. It can be difficult for the doctor–patient to ask when it is assumed that they would already know (Table 1).

Ultimately, ordering of investigations, prescribing and health referrals remain with the treating doctor. Some doctors might find it difficult to relinquish previous habits of self-treatment that extend beyond what the non-medical patient can do. Clear boundaries are important and appropriate documentation is required.[12,18]

Treating doctors might fail to suggest that their doctor–patient take leave, even when they would provide such advice to another patient. Medical culture results in doctor–patients rarely asking for leave, and they might well resist the idea even when offered. Frank discussion regarding this issue can help the doctor–patient feel comfortable taking this time.

Concern about medico-legal issues can also arise when caring for doctor–patients (and other health professionals). The high bar needed to trigger a mandatory notification remains highly misunderstood. It can prevent a doctor–patient raising mental health or substance use concerns. Ensure you understand these issues, including voluntary notifications and self-notifications, and the role of the medical indemnity insurance organisations in providing support to enhance these understandings.

Finally, there is always the potential that the treating doctor might meet the doctor–patient through social or professional meetings. These planned or unplanned encounters can be awkward if the potential for such engagements has not been anticipated and an approach considered. In some circumstances, this type of encounter might need to be overtly discussed. Most importantly, it is the treating doctor's duty to be mindful of the need to maintain professional boundaries and ensure confidentiality is maintained at all times.

Follow-up

All patients benefit from having a regular GP. Maintaining a therapeutic relationship with a doctor–patient can be challenging especially when they are relatively healthy. Have an open conversation about how to best maintain the therapeutic alliance now it has been established. Encouraging appropriate follow-up will enable this relationship to grow as both treating doctor and doctor–patient practise their roles and better understand each other. Explain to your doctor–patient how the results will be communicated and ask whether they wish to receive copies of the results. Ensure they know how they can contact you and what arrangements are in place when you are not available. Explaining the expected process for follow-up can reduce the risk of non-standard contact occurring that might threaten professional boundaries.

Conclusion

GPs can expect to become a treating doctor for a doctor–patient at some stage in their career. Although the role might appear challenging (and support is available – refer to Table 2), this article provides a framework to guide the treating doctor. All therapeutic relationships are unique. Being honest about the potential complexity of a doctor–doctor therapeutic relationship, acknowledging your shared professional collegiality and ensuring that boundaries are established early can enable the treating doctor to step into this therapeutic relationship confidently and enjoy the positive experience of supporting doctors to maintain their wellbeing.

Key points

- Treating the doctor–patient like any other patient can be challenging.
- Proactively build a confidential therapeutic relationship with clear boundaries.
- Openly address the 'elephant in the room' – this can reduce apprehension for both the treating doctor and doctor–patient.
- Avoid making assumptions about what the doctor–patient might know.
- Be prepared to ask 'difficult' questions.

Table 2. Seeking support when treating a doctor–patient

It is equally important that you, as the treating doctor, have support when caring for a colleague. Most general practitioners already have a mentor who they can turn to for advice when a patient is more complex while maintaining confidentiality. Doctors' health services, in every state and territory, can also provide confidential advice about caring for a doctor–patient. Medical indemnity insurers can provide support regarding medico-legal issues.

Location	Phone number
Doctors' Health Line	1800 006 888 – available 24/7 (this connects you directly to a doctors' health service in your local area)
Australian Capital Territory	1300 374 377
New South Wales	(02) 9437 6552
Northern Territory	(08) 8366 0250
Queensland	(07) 3833 4352
South Australia	(08) 8366 0250
Tasmania	1300 374 377
Victoria	1300 330 543
Western Australia	(08) 9321 3098
New Zealand	0800 471 2654

Authors

Claire J Hutton BA (Hons) (Psych), MPsych (Forensic), Department of General Practice, School of Public Health and Preventive Medicine, Monash University, Melbourne, Vic; Lecturer in Counselling, School of Psychology, Faculty of Health, Deakin University, Melbourne, Vic

Margaret Kay MBBS (Hons), PhD, FRACGP, DipRACOG, Senior Lecturer, General Practice Clinical Unit, Faculty of Medicine, The University of Queensland, Brisbane, Qld

Jill Benson AM, MBBS, DCH, MPH, PhD, FRACGP (Hon), FARGP, FACRRM, AFRACMA, Clinical Associate Professor, Discipline of General Practice, The University of Adelaide, Adelaide, SA

Shaun Prentice BPsychSc (Hons), MPsych (Clin), PhD, MAPS, Clinical Associate Lecturer, School of Psychology, The University of Adelaide, Adelaide, SA; Research Officer, General Practice Training Research Team, The Royal Australian College of General Practitioners, Adelaide, SA

Chris Barton PhD, MMedSci, BSc, Senior Lecturer, Department of General Practice, School of Public Health and Preventive Medicine, Monash University, Melbourne, Vic

Competing interests: None.

Funding: None.

Provenance and peer review: Commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript.

Correspondence to:
Claire.hutton1@monash.edu

References

References are available online only.

References

1. Hutton CJ, Kay M, Round P, Barton C. Doctors' experiences when treating doctor-patients: A scoping review. BJGP Open 2023;7(4):BJGPO.2023.0090. doi: 10.3399/BJGPO.2023.0090.
2. Hutton CJ, Kay M, Round P, Barton C. "Do they think I'm good enough?": General practitioners' experiences when treating doctor-patients. BMC Prim Care 2024;25(1):340–12. doi: 10.1186/s12875-024-02592-1.
3. Medical Board of Australia, Aphra. Good medical practice: A code of conduct for doctors in Australia. Ahpra, 2020. Available at www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx [Accessed 3 September 2024].
4. Avinger AM, McClary T, Dixon M, Pentz RD. Evaluation of standard-of-care practices among physicians who treat other physicians: A qualitative study. JAMA Netw Open 2022;5(10):e2236914-e. doi: 10.1001/jamanetworkopen.2022.36914.
5. Kay M, Mitchell G, Clavarino A, Doust J. Doctors as patients: A systematic review of doctors' health access and the barriers they experience. Br J Gen Pract 2008;58(552):501–08. doi: 10.3399/bjgp08X319486.
6. Kay MP, Dawes V. Working together to ensure health care access for doctors. Med J Aust 2019;211(11):497–98.e1. doi: 0.5694/mja2.50421.
7. Schneck SA. "Doctoring" doctors and their families. JAMA 1998;280(23):2039–42. doi: 10.1001/jama.280.23.2039.
8. Debnath D. The dilemma of treating a doctor-patient: A wrestle of heart over mind? Ochsner J 2015;15(2):130–32.
9. Krall EJ. Doctors who doctor self, family, and colleagues. WMJ 2008;107(6):279–84.
10. Forbes MP, Jenkins K, Myers MF. Optimising the treatment of doctors with mental illness. Aust N Z J Psychiatry 2019;53(2):106–08. doi: 10.1177/0004867418818358.
11. Programme d'aide aux médecins du Québec (PAMQ). Guide for physicians who treat other physicians 2012. PAMQ, [date unknown]. Available at www.pamq.org/wp-content/uploads/2021/08/guide_medecins_en.pdf [Accessed 1 October 2024].
12. Koppe H. Optimising the medical care of doctors – part 3 – during the consultation. Aust Fam Physician 2010;39(4):247–48.
13. Anderson W. Doctoring doctors. BMJ 1999;319: S2-7205. doi: 10.1136/bmj.319.7205.2.
14. Capozzi JD. Caring for doctors. J Bone Joint Surg Am 2008;90(7):1606–08. doi: 10.2106/JBJS.H.00044.
15. Kay M, Mitchell G, Clavarino A. What doctors want? A consultation method when the patient is a doctor. Aust J Prim Health 2010;16(1):52–59. doi: 10.1071/PY09052.
16. Nisselle P. The doctor-patient. Aust Fam Physician 2012;41(10):747.
17. Gorman D, Gorman E. Collegiality and the sick doctor. Intern Med J 2013;43(4):351–53. doi: 10.1111/imj.12098.
18. Kaufmann M. When the patient is a doctor: Becoming an effective physician's physician. Ont Med Rev 1998;(Oct):50–51.
19. Kasiviswanathan K, Enticott J, Madawala S, Selamoglu M, Sturgiss E, Barton C. The impact of smoking status on trust in general practitioners: A nationwide survey of smokers and ex-smokers. J Public Health (Berl) 2023. doi: 10.1007/s10389-023-02097-8.
20. Fischer-Sanchez D. Risk management considerations when treating fellow physicians. Psychiatry online 2018;53(13). doi: 10.1176/appi.pn.2018.7a21.
21. Stoudemire A, Rhoads JM. When the doctor needs a doctor: Special considerations for the physician-patient. Ann Intern Med 1983;98(5 Pt 1):654–59. doi: 10.7326/0003-4819-98-5-654.