



## Physicians as Patients: Private Psychiatric Hospital Experience

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**P**ARADOXICALLY, the healing profession paid little attention to its own morbidity for years. Concern about the unique problems of specific groups has led to the formation of new specialties such as industrial, aviation and space medicine, but as a group and as individuals physicians still tend to ignore their own health problems. Thus, Mackie<sup>1</sup> stated "It is notorious that the doctor himself makes a bad patient; [he is] inclined as Richard Gordon wittily observes, to carry on as though nothing were wrong until his temperature reaches 104°, and then to retire to bed in complete panic. Most of us know of tragic instances of competent practitioners who have ignored the manifestations of, for example, a malignancy in themselves in a way that they would never have done in their patients."

A recent Boston study suggests that this attitude is encouraged by the pattern of medical care offered to house officers and their families.<sup>2</sup>

In recent years a number of studies have been reported in the U.S.A. and in Great Britain on psychiatric illness in the medical profession.<sup>3-6</sup> All concur in the extreme reluctance of physicians to admit and to seek help for emotional problems. One psychiatrist has stated, "I would emphasize the degree of humiliation, helplessness and guilt attaching in the minds of many doctors and nurses to the presence of emotional

disorder, not only in themselves but in their relatives."<sup>1</sup>

Pearson and Strecker,<sup>3</sup> reviewing their experience in private practice over a 15-year period, reported on 66 physicians and noted, "Psychiatric illnesses account for a considerable amount of the morbidity among doctors. . . . The most common long-standing, unhealthy life attitude was a morbid, self-sacrificing, driven existence, best described as masochism since it always exposed him to exploitation by others. Much delay was the general rule before a doctor got into therapy, even though therapy turned out satisfactorily in spite of stressful situational problems."<sup>3</sup> This study also indicated a tendency on the part of physicians in the Philadelphia area to seek private rather than public hospital care.

Duffy<sup>7</sup> of the Mayo Clinic noted, "As a group, they [physicians] resisted, to the point of emotional collapse, any suggestion that they were suffering from psychopathology and needed psychiatric treatment."

Recently the first study of psychiatric illness in the medical profession in Great Britain appeared.<sup>6</sup> This noted that the average physician broke down in the prime of life—15.8 years after registration. Compared to a control group, there was an excess of addictions to alcohol or other drugs (32.8%) and a low rate of neurosis. Many addicted physicians began to use amphetamines or barbiturates when they were medical students or house officers. The British authors found psychiatrists over-represented in the outpatient population. However, they felt that there was no other significant specialty bias in either their inpatient or outpatient group.<sup>8</sup>

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## PRESENT INVESTIGATION

As we are unaware of any Canadian studies on psychiatric morbidity of physicians, it seemed relevant to present a preliminary report based on our experience in a private psychiatric hospital, The Homewood Sanitarium of Guelph, Ontario. This hospital admits patients aged 14 years and over with all types of psychiatric problems. It has operated as a private hospital continuously since 1883. During the period under study it had a 270-bed capacity and an annual admission rate of approximately 1200 patients. As it is a private hospital, patients are not accepted on the basis of their geographical location only; however, over 90% of our patients in recent years have been residents of Ontario. One of the authors (M.O.V.) has been attached to the male division of this hospital throughout the period under study.

## METHOD

We have studied the case histories of 93 physician-patients who were admitted to Homewood during the seven-year period from July 1, 1960 to June 30, 1967. We have compiled statistics under various classifications and evaluated our results in the light of similar British<sup>6</sup> and American<sup>4</sup> studies. In some instances we have made comparisons with the total patient population at Homewood.

Neither our own study nor those from British and American sources can claim to represent accurately the picture of psychiatric morbidity of physicians in their country. In each instance there are certain uncontrollable factors of selection. For example, none of them has a homogeneous and circumscribed area from which it draws all its patients.

## RESULTS

A large percentage of the physician-patients in the Homewood study are residents of Ontario (Table I). Therefore we felt justified at times in drawing comparisons between our patient group and the total group of physicians registered in Ontario.

The fact that a greater-than-average number of our physicians were salaried may indicate that they tend to accept, on qualification, institutional positions which require fewer working hours and involve less tension. Some of them may gravitate to these positions when they get into difficulty.

In Table II the numbers and age-groupings of in-patients in the Homewood, British and American studies are recorded. The Mayo Clinic study, like our own, was over a seven-year period; the

TABLE I

A. RESIDENCE OF HOMEWOOD PHYSICIAN-PATIENTS		
Ontario.....		85 (91.4%)
Other Canadian provinces.....		4 (4.3%)
U.S.A. (New York State).....		4 (4.3%)
B. NATURE OF PRACTICE		
	<i>Homewood patients</i>	<i>Ontario physicians*</i>
Urban†.....	79 (84.9%)	6922 (86.6%)
Rural.....	14 (15.1%)	1071 (13.4%)
*From a study by the College of Physicians and Surgeons of Ontario of physicians registered for practice in Ontario (March 31, 1963).		
†Communities of 5000 population or larger.		
C. TYPE OF EMPLOYMENT		
	<i>Homewood patients</i>	<i>Ontario physicians*</i>
Self (private practice)...	66 (71.0%)	3912 (77.5%)
Salaried (institution)...	27 (29.0%)	1134 (22.5%)
*From Ontario Medical Association study of physicians in active medical practice in Ontario (1966).		

British study was conducted over 10 years. The higher percentage of female physicians reported in the British study can be attributed to the greater percentage of women in medical practice in Britain.

Our patients were grouped by specialty (Table III). Despite the small number of psychiatrists in our study, we kept this group separate in order to compare its features with those reported in the British and American studies. Our group of anesthetists was classified separately because of its unexpectedly large size. The table also includes a comparison with the figures for the Province of Ontario.

In the British study the category "Medical Specialties" is said to include "the recognized

TABLE II

	<i>Homewood study</i>	<i>British study (in-patients)</i>	<i>Mayo Clinic study</i>
1. Number of in-patients....	93	114	93
Males.....	87 (93.5%)	103 (90.4%)	—
Females....	6 (6.5%)	11 (9.6%)	—
2. Ratio of physicians admitted to total first admissions.....	1:44	1:65	1:64
3. Average age (years).....	51.0	44.2	54.0
4. Age span....	28-80	22-83	28-86
5. Average breakdown period (years)*.....	21.3	15.8	—

\*In our study we considered "breakdown period" as the number of years between graduation from medical school and first admission to hospital for psychiatric reasons. The criterion in the British study was the number of years between qualification and first psychiatric consultation.

TABLE III.—FIELD OF PRACTICE

	Province of Ontario (1963)*	Homewood study	British study (in-patients)	Mayo Clinic study
1. General practice . . . . .	4739 (59.3%)	47 (50.5%)	61 (53.5%)	44 (47.3%)
2. Medical specialties . . . . .	1259 (15.8%)†	14 (15.2%)†	4 (3.5%)	23 (24.8%)
3. Anesthesiology . . . . .	278 (3.5%)	8 (8.6%)	—	0
4. Psychiatry . . . . .	242 (3.0%)	4 (4.3%)	10 (8.8%)	4 (4.3%)
5. Surgical specialties . . . . .	1475 (15.8%)‡	19 (20.3%)‡	15 (13.2%)	22 (23.6%)
6. Other . . . . .	0	1 (1.1%)	24 (21.0%)§	0

\*From a study by the College of Physicians and Surgeons of Ontario of physicians registered for practice in Ontario (March 31, 1963).

†Includes internal medicine, neurology, physical medicine, dermatology, pediatrics, radiology and pathology.

‡Includes general surgery, ophthalmology, E.N.T., urology, neurosurgery, obstetrics and gynecology.

§Includes anesthesiology, radiology and pathology.

sub-specialties". This probably includes internists and possibly neurologists, whereas our own grouping includes several other sub-specialties. This may be the main explanation of the difference in the figures within this group.

Our figures concur with those of the Mayo Clinic study in showing a lower percentage of psychiatrists admitted as in-patients than in the British study. This may be explained by a high concentration of psychiatrists in the geographical area around their treatment centre, or it may be that a higher percentage of psychiatrists is referred to the adjacent centre than to other psychiatric institutions in Britain. The reason for the significantly high number of anesthetists in our group of patients is not readily apparent. The increased contact and availability of drugs may be a major factor. However, only three had any addiction problem; the diagnosis in the other five was psychoneurosis or affective psychosis.

The percentage of general practitioners in our group was lower than that in the physician population of Ontario. Neither the British nor American papers considered that this was the case in their own studies; with regard to the latter, it may be that there is a lower percentage of general practitioners in the U.S.A. than in Ontario. It is interesting that Pearson, in his private outpatient practice, saw 17 general practitioners, 36 specialists and 13 interns and residents. In other words, for every one general practitioner he interviewed at least two specialists.<sup>3</sup>

*Primary Diagnosis*

We compared the three groups with respect to primary diagnosis (Table IV). Our own figures for psychoneurosis and affective psychosis were lower than those recorded in the other two studies. This may be explained in part by a different nosological emphasis on the same type of patient. For example, the Mayo Clinic study shows only 22 patients with the primary diag-

nosis of drug addiction and 7 with that of alcoholism. In their monograph they report that 47 of their cases had an active problem of alcoholism and/or drug addiction. They go on to state that 18 patients suffered from alcoholism and 37 had some form of drug dependence. Undoubtedly some of these patients have been given a primary diagnosis of personality disorder, psychoneurosis or affective psychosis. In both the British and Mayo Clinic studies more patients were given the primary diagnosis of drug addiction than that of alcoholism. In our own group the primary diagnosis of alcoholism is slightly more common than that of drug addiction. Our incidence of both drug addiction and alcoholism is higher than in the other two groups.

TABLE IV.—PRIMARY DIAGNOSES

	Homewood study	British study*	Mayo Clinic study
1. Psychoneurosis	13 (14.0%)	16.4%	19 (20.4%)
2. Affective psychosis	13 (14.0%)	27.9%	20 (21.5%)
3. Schizophrenia	5 (5.4%)	8.6%	11 (11.8%)
4. Personality disorder	4 (4.3%)	12.5%	9 (9.8%)
5. Organic brain syndrome	5 (5.4%)	5.2%	5 (5.4%)
6. Drug addiction	25 (26.9%)	17.2%	22 (23.6%)
7. Alcoholism	28 (30.0%)	12.2%	7 (7.5%)

\*These figures include both in-patient and outpatient groups.

Comparison of our male physician-patient group with our total male patient population of 422 patients admitted in the year 1967 paints a rather striking picture (Table V) and illustrates the magnitude of the addiction problem among physicians. As Homewood does not admit many "street addicts", our figures are not representative of the picture of addiction in the whole province; nonetheless it is fair to say that drug addiction is almost an "occupational hazard" for the medical profession.

TABLE V

	Homewood male physician-patients (1960 - 1967)	Total of Homewood first male admissions 1967
1. Psychoneurosis . . .	12 (13.8%)	57 (13.5%)
2. Affective psychosis	12 (13.8%)	47 (11.1%)
3. Schizophrenia . . . .	5 (5.7%)	16 (3.8%)
4. Personality disorder . . . . .	3 (3.5%)	23 (5.5%)
5. Organic brain syndrome . . . . .	5 (5.7%)	16 (3.8%)
6. Drug addiction . . .	23 (26.5%)	7 (1.7%)
7. Alcoholism . . . . .	27 (31.0%)	256 (60.6%)

We divided our patients in each specialty on the basis of diagnosis to find out if there were significant trends (Table VI). In many cases the numbers are much too small to permit even tentative conclusions to be drawn.

TABLE VI.—HOMEWOOD PHYSICIAN-PATIENTS—DIVIDED BY SPECIALTY AND DIAGNOSIS

	Psycho-neurosis	Affective psychosis	Schizophrenia	Personality disorder	Organic brain damage	Drug addiction	Alcoholism
General practice . . . . .	7	7	3	3	4	12	11
Medical specialties . . . . .	2	0	1	0	1	4	6
Anesthesiology . . . . .	1	4	0	0	0	2	1
Psychiatry . . . . .	2	1	0	0	0	0	1
Surgical specialties . . . . .	1	1	1	1	0	7	8
Other . . . . .	0	0	0	0	0	0	1

*Patients' Attitude to Treatment*

A number of studies have indicated that physician-patients are resistive to treatment; our experience confirms this view (Table VII). A high percentage of our group was admitted on medical certification. Many voluntary patients signed themselves out "against medical advice". Many who did not actually sign out were discharged "prematurely". A very low percentage had previously been patients at Homewood, and

TABLE VII.—ATTITUDE TO TREATMENT

	Homewood male physician patients, 1960 - 1967	Total of first Homewood male admissions, 1967
<b>A. Previous hospitalization</b>		
1. Homewood . . . . .	22 (25.2%)	208 (49.3%)
2. Other institutions . . . . .	25 (28.8%)	41 (9.7%)
3. None . . . . .	40 (46.0%)	173 (41.0%)
<b>B. Admission status</b>		
1. Committed . . . . .	17 (19.6%)	23 (5.5%)
2. Voluntary . . . . .	70 (80.4%)	399 (94.5%)
<b>C. Discharge</b>		
1. On consent . . . . .	*61 (70.1%)	382 (90.6%)
2. Against medical advice . . . . .	19 (21.8%)	24 (5.7%)
3. In residence . . . . .	3 (3.5%)	5 (1.2%)
4. Died . . . . .	4 (4.6%)	11 (2.5%)

\*Of these, 21 were discharged "prematurely".

a high percentage had had previous psychiatric hospitalizations. This may suggest a tendency on the part of physicians to look for short-term treatment and indicate an unwillingness to stay long enough or return frequently enough to any one facility to have their problems seriously dealt with.

*Marital Status*

A comparison was made with our total male patient population to see if there was an unusual amount of marital strife among our physician patients (Table VIII). The number of single patients among total male admissions is higher than that among our physicians because of the number of adolescents and young adults in the total group. There were no figures available for "unstable" or "separated" marriages in our control group. An "unstable" marriage was con-

sidered to be one in which there had already been a serious threat of separation.

TABLE VIII.—MARITAL STATUS

	Homewood male physician patients (1960 - 1967)	Total first Homewood male admissions (1967)
1. Single . . . . .	8 (9.2%)	69 (16.3%)
2. Married or separated . . . . .	*71 (81.6%)	318 (75.4%)
3. Widowed . . . . .	3 (3.5%)	21 (5.0%)
4. Divorced . . . . .	5 (5.7%)	14 (3.3%)

\*Of these, 20 were in "unstable marriages" and 6 were separated.

The Mayo Clinic study did not include mention of marital status. The higher percentage of single physician-patients in the British study (Table IX) is probably indicative of more interns in their group than in ours. Pearson and

TABLE IX.—MARITAL STATUS

	Homewood study	British study
Married . . . . .	67 (72.1%)	68.4%
Divorced or separated . . . . .	12 (12.9%)	7.9%
Widowed . . . . .	3 (3.2%)	7.0%
Single . . . . .	11 (11.8%)	16.7%

Strecker's<sup>3</sup> group contained 15 single patients and 51 married and included nine residents and four interns. Our study suggests that there is a significant difference in the number of divorced and separated physicians in our group as compared with the British one. A study of Modlin and Montes<sup>9</sup> on narcotic addiction in physicians included a group of some 30 physician-patients; of the 24 who were married, only 3 were considered to be partners in "stable, healthy marriages".

## CONCLUSION AND DISCUSSION

### *The Pattern of Morbidity*

Although there are minor differences between our findings and those in the British and American studies, one is impressed by the overall similarities. It is concluded that emotional problems are frequent in physicians in all three countries and are the cause of much personal and family suffering for the physicians concerned. That they also adversely affect the supply of medical manpower is emphasized strikingly by the statistics in the obituary column of the *Journal of the American Medical Association* which now records "suicides" as such where this fact is known. This will, of course, give a conservative figure, but it has averaged in excess of 100 per year since J.A.M.A. began recording this information in the May 17, 1965 issue. This represents the equivalent of one graduating class per year from an average medical school.

A great many physicians are unprepared or unable to admit their emotional problems and to accept them as medical problems to be taken to a colleague. They go through a phase of resisting treatment and denying illness; this undoubtedly results in a marked increase of psychiatric morbidity. Some physicians suffer psychotic breaks at this time, while others resort to treating themselves with alcohol or drugs. The latter cases frequently result in alcoholism and drug addiction which only compound the original problems. Over half of the physician-patients in our hospital and those studied at the Mayo Clinic had an active problem of addiction to alcohol or other drugs at the time of admission. The reluctance of these patients to accept adequate treatment is also seen in their premature departure from the hospital, with a tendency to use its services mainly for immediate treatment needs while denying the overall seriousness of the problem.

### *Role Strain*

While it is true that some physicians break

down in practice owing to personality difficulties that they bring to the practice of medicine, we believe a significant number falter under life's vicissitudes encountered after graduation. Each occupation and profession has its own particular problems, but few carry such constant responsibility for the well-being and lives of others. There are many occupations and professions in which one can learn to perform excellently so that their practice will have many rewards. Medicine too has its rewards, but it has a built-in "role strain", in that the physician is trained and committed to the relief of suffering, disease and death and yet he is constantly confronted by the suffering, disease and death that occur in spite of his best efforts. The tension so produced can often cause feelings of inadequacy; this is a common occurrence in physicians who become emotionally ill. In some cases insecurity may have begun in childhood. In others it may be that their philosophy of life does not prepare them to cope with constant failure. Or perhaps they have never established priorities in their lives so that they have the appropriate periods of relief and rest that are essential to facing the stresses of life.

### *Suicide*

Suicide, too often, is the end result of a doctor's emotional problem. We do not have sufficient data at present to enable us to discuss suicide in our physicians. However, the high incidence of suicide among physicians in general is well documented.<sup>10</sup> In Great Britain this is approximately two-and-a-quarter times higher than that for all males. Also, seven out of eight of these suicides are by doctors under the age of 50 years. Some writers emphasize the relationship between a high suicide rate and a high incidence of drug and alcohol addiction among medical practitioners.<sup>11a, b</sup> DeSole<sup>12</sup> pointed out that an analysis of the figures on suicide in the J.A.M.A. by type of practice over a 92-week period showed the rate to be highest for psychiatry—70 per 100,000 per year. The rate for general practice was 26 per 100,000 per year and the lowest rate was that for radiologists at 12 per 100,000 per year. DeSole also pointed out the alarming fact that 26% of all deaths occurring in physicians between the ages of 25 and 39 years are the result of suicide. In a retrospective study on seven physicians who committed suicide, he emphasized that frequently their colleagues noticed an increased indecisiveness, disorganization and depression for two to four months before death, but did nothing to try to help them.

### Addiction

Alcoholism and drug addiction were both major problems to the physicians in our study. Typically, alcoholism took some years to develop. Some of these physicians were noted for "tying one on", even in medical school or internship days. Others used alcohol moderately during their days in medical school and as house officers. The next step consisted in beginning to use alcohol to meet various needs such as to relax, to sleep or to gain confidence. Gradually the number of needs increased until addiction resulted, at which time alcohol itself created the need for more alcohol. It is also significant that at this time alcohol ceased to meet the original need and tended to compound the primary problems.

A number of studies have noted that alcoholic physicians tend to move on to the use of other drugs, very often sedatives and stimulants and occasionally narcotics, to help control their discomfort and withdrawal symptoms. Our findings concur with those of others that physicians often take a mixture of whatever pills are in their desk-drawer along with alcohol. Our addicted physicians seem to underestimate the addicting potential of drugs that modify mood, whether these be barbiturates, stimulants, minor tranquilizers, narcotics or even alcohol. Though many physicians are emotionally disturbed before developing their addiction problems, we were impressed by the fact that a number of relatively well-adjusted physicians developed serious addiction problems.

During a 15-year period at the Menninger Clinic, 65 persons were diagnosed as addicted to narcotics.<sup>9</sup> Of this number 30 (46%) were physicians, their average age was 38, and all were in private practice and all but one were married. Most of them had poor relationships with their parents. The physician-patients gave three main reasons for starting narcotics: overwork, chronic fatigue, and physical disease. In many cases an inability to say "no" was the chief cause of their becoming overworked; this, coupled with the lack of appropriate periods for recuperation, resulted in chronic fatigue. Many of these physicians actually did have physical diseases. Four complained of severe headaches and three of refractory insomnia. In nearly half of the cases the original narcotic was prescribed by an attending physician. The authors note: "We were particularly impressed with the patient's magical belief in the non-addictive properties of Demerol. They believed that: (1) it won't hurt me, and (2) I can stop anytime I want to." As in our physicians, they note:

"Despite the numerous individual differences among these patients, the majority consistently denied serious addictive difficulties and shared the illusion that they could stop drugs anytime they wished." They also share our opinion that hospitalization is a necessary first step in treatment, and no compromise should be considered. They note that estimates of the incidence of narcotic addiction in physicians vary from 30 to 100 times that in the general population. Other reports from the United States, England, Germany, Holland and France all indicate that of the known drug addicts, about 15% are physicians, while another 15% belong to the paramedical professions.

It is important to emphasize that the general gloomy prognosis for narcotic addiction does not seem to apply to the medical profession. Dr. Harris Isbell, Consultant at the Addiction Research Center of the National Institute of Mental Health Hospital in Lexington, Kentucky, expressed the belief that "the outlook for addicted physicians is very good, 70-90% of his patients having made an adequate adjustment after one period of treatment". He felt that among the most important reasons for the success of treatment were "the close surveillance of these physicians for a number of years by State Medical Boards and major changes in the physician's life patterns. . . . Usually, the physician was involved in some form of psychotherapy during the treatment and post-treatment periods".<sup>9</sup>

The Chairman of the Committee on Dangerous Drugs for the California Medical Association reports. . . . "Much misinformation exists as to the myth of the problem of the addict. Withdrawal symptoms, while severe, only last 3-4 days, as evidenced by many consultations with physician-addicts. Physician-addicts in California have shown a 92% rehabilitation rate, largely because motivation can be created."<sup>13</sup> Jones<sup>14</sup> recently concluded that the underlying factor in most narcotic addictions is depression, and recommends that part of the treatment-approach should therefore be directed toward the depression. Of course, more important than treatment is the prevention of addiction by encouraging depressed physicians to seek medical help rather than treat their depression with narcotics.

Addicted physicians do not have the sufficient fear of drugs they should have. On the other hand, it is our experience that they have an irrational, inappropriate fear of admitting the problem to: (1) a fellow-physician, (2) the Division of Narcotic Control in Ottawa or (3) the provincial college or licensing body. The physician in difficulty is most unlikely to stop

the use of drugs by himself. He needs the help of a responsible colleague who can arrange his treatment and hospitalization before the need for involvement of the Division of Narcotic Control or the Provincial College of Physicians. If this step is not taken, inevitably the addicted physician will come under the view of the Division of Narcotics Control because of the pattern of his drug use, or will come to the notice of the Provincial College because eventually addiction impairs performance and ability to practise. From our experience, physicians should be encouraged to be open, above-board and co-operative with both of these bodies, as their prime concern with the addicted physician is not a punitive but a rehabilitative one. Only when physicians refuse to follow their suggestions for treatment and rehabilitation are they forced into disciplinary action. The 1967 Bulletin of the College of Physicians and Surgeons of Ontario states in part . . . "When it is dealing with an addicted physician, in addition to its disciplinary responsibility it has a moral duty to assist in his treatment and rehabilitation. If a member's personal use of these drugs comes to the attention of the College before the Division removes his prescribing privileges, it is the policy of the College to advise its member to voluntarily surrender his full registration and in its place accept registration on the Special Register with full practice privilege, except that he may not prescribe or purchase narcotics and/or controlled drugs. At the same time he is advised and required to seek treatment."<sup>15</sup>

### *The Family*

All psychiatric illness invariably involves the whole family as a closely interacting unit. One's vulnerability to emotional illness is either lessened or magnified by one's marriage. "In choosing a marital partner and raising children, he initiates a new set of close relationships which may either give him added protection against mental illness or aggravate his inclination toward it."<sup>16</sup> Consequently attention has recently been turned upon the doctor's wife and marriage.<sup>17</sup> As would be expected, our studies show a high rate of marital and family difficulties among our physicians.

### RECOMMENDATIONS

Physicians are always faced with problems for which there are no clear-cut answers. In trying to improve prevention and treatment of emotional disorders in physicians it is suggested that attention be given to the following areas:

1. Further studies of physicians, both of an

epidemiological and individual nature which will clarify both the unique stresses to which the physician is subject and the qualities that best meet these stresses. Publication of such studies will help reduce the stigma to the individual physician, who so often feels that he is alone in his problem and therefore procrastinates in seeking help. Such studies will show where and how help may be obtained.

2. An increasing emphasis on psychological factors in selection by medical schools of prospective students. Additional studies of the mental health of physicians will help here also, as selectors are at present handicapped by having only vague concepts about the nature of what emotional problems will interfere with being a good physician.

3. Medical school education that relates meaningfully to the mental health of the student. Students must be made aware of the potential personal danger of drugs that are mood-altering. They should be informed that drug addiction is an occupational hazard of the physician. Efforts should be made to teach psychiatry in a manner that brings about personal involvement of the student, having in mind the importance of his understanding that all people have emotional problems. In this way he will be encouraged to discuss and attempt to resolve his problems rather than hide and deny them.

Student Health Services in medical schools often provide physical check-ups as a routine but do not provide a psychological check-up, which suggests that the former is appropriate and acceptable, the latter inappropriate and unacceptable. This tends to perpetuate denial of emotional problems in medical students and physicians. We would recommend the Harvard Plan . . . "The philosophy of the Harvard University Medical Center Health Service is that psychiatric assistance is an integral and routine part of health services for the medical student. Each incoming student undergoes a complete physical examination and interview with a psychiatrist. It is felt that such an early contact with a psychiatrist as part of a general health evaluation creates a proper frame of reference, in which the student meets the psychiatrist as a member of the health team. The usefulness and need for such a service is reflected in the Harvard statistics which revealed that an average of 13% of the student body consults the psychiatrist in any one year. Treatment for the most part has been short-term, intensive psychotherapy; however, an effort is made to expand therapy if possible, particularly in character neuroses or other more severe emotional problems."<sup>5</sup>

4. Improved conditions for house officers are important. Formerly, most interns and residents were single, but today it is not uncommon for a married resident, with several small children, to be earning \$300 a month, living in crowded quarters, working 80 hours a week in a hospital and spending his time at home preparing for specialty board examinations. Such a program is hardly conducive to good mental health for the young physician or his family. On the British scene, a Brook and his colleagues<sup>6</sup> commented, "We feel that the long hours which housemen have to work and their ease of access to drugs may be factors in the genesis of amphetamine addiction amongst doctors. We would therefore support any move to limit the number of hours a week that junior hospital staff may be on duty, and would welcome further measures to tighten drug control." Supervising physicians must become increasingly aware of the impact that their relationship has on the young physician. This relationship can breed confidence and security in the hands of the skilled and empathetic teacher. The present situation often results in a great deal of stress to the young family at a critical period. Since childhood insecurity is a common source of later emotional problems, and since many physicians' children themselves enter the medical profession, improving the lot of the family of the current generation of house officers might improve the mental health of the next generation of physicians.

5. Means must be found to persuade physicians to seek psychiatric help earlier. A general change in current attitudes would undoubtedly reduce the rates of alcoholism, addiction and suicide in the profession. Individually, too often physicians ignore evidence of emotional problems in their colleagues or tend to avoid such colleagues. "It is indeed ironic that a profession committed intellectually to the concept of mental illness as a disease all too often ignores, denies, or punishes emotional illness in its ranks."<sup>7</sup> Personal interest and concern may save a colleague's life. Collectively, medicine must experiment with efforts such as that of the San Francisco Medical Society which has established an advisory committee for physicians. "The purpose of this committee is to serve physicians who have emotional problems. Other physicians may contact the committee when they feel that a colleague is in need of its help. The physician in question would then be contacted, confidentially, in an effort to help him understand his problem." It is too early yet to know how successful this experiment will be. It has the advantage of not being related to

any body that has potential disciplinary function.

6. Doctors must establish a hierarchy of priorities in their lives. It is hypothesized that some physicians already on the way to emotional problems could prevent breakdown by personal inventory, noting their own needs and abilities, and the needs and abilities of their families, and establishing an appropriate priority scale for their lives. Since the commonest complaint of physicians has been the excessive demands on their time, such a hierarchy is essential to survival. Priorities, however, involve conflicting needs and demands. They include such things as time for practice, being available to patients, time for spouses and children, time for the doctor's own spiritual, cultural and recreational needs. How much time is to be devoted to keeping up one's professional acumen; to the local hospital committees; to the county, provincial and Canadian medical societies and/or specialty group organizations; to the church and community?

Emotional illness is the end result of a pattern of personal vulnerability compounded by a variety of contributing stresses—finally the individual's defences crumble. Hope lies in the possibility of the physician's modifying those factors which, if left unchecked, would precipitate this disease process. Such prevention the physician may be able to accomplish by himself. If he cannot break the chain of events, then he should seek professional help. Doctor Pearson<sup>18</sup> stated, "Doctors are so poorly treated not only because of their own neglect but because of the general unrealistic idea fostered both by the doctor and the public, that he is a superman."

Three illustrative case reports are appended.

CASE 1.—Physician A, a 41-year-old married general practitioner, was admitted to this hospital on transfer from a provincial hospital where he had been admitted following the heavy use of meperidine (Demerol) over a period of two years. Also, despite denial of their use, large amounts of barbiturates were found in his urine.

His history indicated that he had been a sensitive, insecure child and young man who had, however, adjusted quite well in university and medical school. He then married and had three children. His marriage had been quite stable before the use of narcotics. The patient was prominent in his local community, a member of the school board and active in community organizations. He gave a history of migraine at about six-week intervals since childhood. One afternoon at 2.00 p.m. he was confronted simultaneously with a full waiting room and schedule plus a severe attack of migraine. For the first time he took an injection of meperidine, with prompt relief. Consequently, for several years he



took an injection of meperidine at intervals of one or two months in what he regarded as a harmless fashion; he had no tendency to use it except for migraine. After carrying on for two years like this, he suffered a mild reactive depression due to happenings in his personal relationships. He had no psychiatric treatment and might not have required it for his depression had it not been for the following sequence of events. He continued to practise as usual despite his mild depression until one day a migraine again developed and he took meperidine. To his surprise the drug not only relieved his headache but also his depression. This was the beginning of a new use for his meperidine, namely to treat depression. Subjectively, his depression improved over the following weeks. However, the need for the drug continued and he began to use it for fatigue.

When hospitalized, this patient tended initially to deny the degree of his addiction, but over a period of weeks gradually opened up and came to understand himself and his problems much better. He was discharged after two months in hospital and was followed up for a two-year period with brief three- to four-day admissions to the hospital approximately every three months. He has now had five years without a return to any addictions. He is re-established in practice and his migraines are both less frequent and less severe.

#### COMMENT

This patient illustrates a common phenomenon in physician addicts: they do not recognize the danger of using narcotics in a seemingly safe fashion. The safe fashion turns out to be dangerous because of subsequent events. None of us know what vicissitudes lie ahead.

CASE 2.—Physician B, a 49-year-old married physician with a surgical specialty, married since 1942 and the father of five children, had a childhood history indicating a rather hostile-dependent relationship with his mother. He was an excellent athlete in high school and the class president on graduation, and made good grades effortlessly. He graduated in the top 10% of his class in medical school. After serving in World War II he specialized and passed his board examinations without difficulty. His marriage was reasonably happy, and his achievements in his career were above average. He was always a mildly tense, striving individual with a resultant life-long history of insomnia.

Three years before admission he had a mild traumatic injury. His physician prescribed meperidine, as required, for pain, which not only relieved the pain but immediately cured his insomnia. The developing of his addiction was related to his continuing and persistent use of meperidine for insomnia. He became quite panicky as his needs for the drug increased and he realized that he was in fact addicted. Following extensive psychological testing by psychologists, it was concluded that "Dr.

B successfully presented a self-picture of 'normal' good health without flagrant signs of disturbance." This physician has been followed up for two years following his period of hospitalization, at approximately six-month intervals. There has been no further use of narcotics. His insomnia has been moderately improved with chlorpromazine, 100 mg. at bedtime.

#### COMMENT

This case illustrates how a life-long problem, insomnia, which was quite well accepted by this physician, became the reason for taking meperidine once he had experienced its sedative effects when it was legitimately prescribed by a colleague for a traumatic lesion. This indicates the caution to be used in prescribing narcotics, particularly for those who have access to them.

CASE 3.—Physician C was a 33-year-old single physician who had completed his surgical residency. In the final year of his residency, although he was a good surgeon, he was concerned about a slight tremor of his hands. He occasionally used secobarbital (Seconal), 1½ grains, to help him get to sleep. He noticed how relaxed he felt before falling asleep, so one day decided to take ¾ grains of secobarbital before a major operation. The effect was excellent, for he felt very comfortable throughout the operation and did not have any tremor. He gradually repeated this many times and over a period of one to two years developed full-fledged addiction. He finally consented to hospitalization after falling asleep at the wheel of his car and driving into a tree.

Following two months of hospitalization he was discharged. In the intervening seven years, I have had regular correspondence with him. He changed specialties and holds an important teaching position in an American medical school.

#### COMMENT

This patient was quite perfectionistic and showed great determination in anything he undertook in life. His determination to get rid of his tremor started his use of secobarbital. In hospital he developed the same determination "never to touch another barbiturate", and to date he has not done so.

*Summary* Several American and British papers in recent years have presented studies of psychiatric morbidity among physicians. This is the first such Canadian report. It consists of a retrospective study of the 93 physicians admitted to a private psychiatric hospital (The Homewood Sanitarium) over a seven-year period ending in 1967. Where possible, comparisons are made with the American and British studies.

In our group, general practitioners were under-represented and anesthetists over-represented in the patient group. The incidence of alcoholism and drug addiction is higher than in the American and British studies. The primary diagnosis of psychoneurosis and affective psychosis is less frequent than in the other two studies.

Evidence of denial of illness and delay in seeking treatment is noted. This is felt to contribute to the high incidence of addictions and family breakdown. Denial and delay are factors that relate to the high incidence of suicide noted in other studies.

Recommendations are made to seek to prevent the sequence of events producing serious morbidity. These recommendations concern the health-care and teaching of psychiatry to medical students and house officers. It is suggested that physicians individually and collectively must meet this challenge.

Physicians, heal yourselves!

**Résumé** Plusieurs études sur la morbidité psychiatrique parmi les médecins ont paru, ces dernières années, dans diverses revues américaines et britanniques. Voici la première qui ait été faite au Canada dans ce domaine. Elle porte sur les 93 médecins admis dans un hôpital psychiatrique privé (le Homewood Sanitarium) pendant une période de sept ans qui s'est terminée en 1967. Lorsqu'une comparaison était possible, les auteurs ont établi un parallèle avec les résultats des études américaines et britanniques.

Dans le groupe considéré, le nombre des généralistes est relativement faible, celui des anesthésistes exceptionnellement élevé. L'alcoolisme et la toxicomanie y sont plus fréquents, les diagnostics primaires de psychonévroses et de psychoses affectives moins fréquents que dans les groupes étudiée aux Etats-Unis et en Grande-Bretagne.

On note des signes de refus d'admettre la maladie et de retard à se faire soigner, ce qui, estiment les

auteurs, explique en partie le grand nombre des cas d'alcoolisme et de toxicomanie et celui des foyers brisés. Ces deux facteurs sont également reliés à la forte proportion de suicides qui a été relevée dans les études américaines et britanniques.

Les auteurs préconisent des moyens d'empêcher le déclenchement du processus qui aboutit à une forte morbidité. Leurs recommandations portent sur l'hygiène et l'enseignement de la psychiatrie aux étudiants, internes et résidents. Ils considèrent que les médecins se doivent, individuellement et collectivement, de relever ce défi.

Médecin, guéris-toi toi-même!

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