As is known, prevention of maladies and providing necessary care and management for patients who are suffering from diseases or disorders are the major tasks of physicians, whether GP or specialist. Medical doctors, who are the contemporary extension of archaic magicians, are scientific persons, who have essential evidence-based knowledge and responsibility with respect to the healthiness of patients, and, moreover, significant liability with regard to associated professional legal issues, and, therefore, they have a duty to try their best to avoid any inaccuracy, malpractice or medical slip-up. On the other hand, promotion of public knowledge with regard to medical data, techniques and probable complications, and legal complexities with respect to said possible slips or complications, which, may, sometimes, be unescapable or unpredictable side effects of medical management, though have positive outcomes for help seekers, may not be devoid of covert or overt aversive effects, too. For instance, previously, an increase in age and experience of physicians was, publicly, supposed to increase their ability concerning diagnosis and treatment, an assumption which perhaps was not unseemly. But, currently, legal difficulties and the frequency of lawsuits against doctors, who are being accused to inaccuracy in diagnosis or malpractice, may, sometimes, cause an inverse linkage between clinical experience and medical practice. For example, a skilled, cautious or obsessed physician may evaluate the medical situation on the basis of risk vs. benefit, or care vs. side effect. Accordingly, if the said medic perceives a huge risk of complication, then he or she may avoid appropriate management and prefer to refer the patient to another daring, unwary or inexperienced colleague, to avoid conceivable hitches, unexpected results, claims and legal inconveniences; a maneuver which is not usually taken by a fresh or medical doctor, who is generally in search of reputation and revenue. Or else, he or she may, stereotypically, ask for a great number of laboratory tests or examinations, which may have little chance of finding a positive result, to provide, consistent with his confidence, a complete shield for himself or herself against imaginable slip-ups. Obsessive patients and patients with somatoform disorders [Somatic Symptom and Related Disorders], as well, may potentiate the said unfavorable cycle by their repeated futile demands and visits. On the other hand, the non-ending stress of possible error and subsequent claims by complainants, may create a persisting mental pressure on clinicians, which survives...
consciously and unconsciously and physicians try greatly to end or reduce that, though no true salvage is usually imaginable during clinical practice. The end-result of such a subjective mental tension or obsessive preoccupation may be either burn out, with its behavioral manifestations, like tiredness, nervousness, desperation and intolerance, premature retirement or alteration of their career. On the other hand, while burn out syndrome in physicians may increase the risk of medical error, financial concerns may not permit desired retirement for many physicians. Moreover, a tired or anxious physician may increase the risk of induction of negative transference in patients and subsequent non-compliance, or, similarly, raise the possibility of formation of counter-transference in himself or herself, due to plausible inappropriate verbal and non-verbal communication.

On the other hand, physicians, especially those who are working in emergency units, are prone to post-traumatic stress disorder [PTSD], acute stress disorder [ASD], adjustment disorder [AD], or other specified and unspecified types of Trauma- and Stressor-Related Disorders [1], which may sometimes be more prevalent than the aforesaid disorders. Tenseness, ceaseless preoccupation with medical events that have been occurred heretofore in the clinical field, avoiding debate around the said unfavorable accidents, inability to forget some specific events that had induced great tension in the medical doctor, avoiding movies or images that reminds him or her the aforesaid mishaps, excessive worry respecting repetition of the previous happenings, extreme preexisting anxiety regarding starting new shift, undue excitation respecting page or calling up, disproportionate avoidance re reply to call or telephone conversation, frequent dreaming of prior unfavorable occasions, sleep problems and continued alertness after ending the daily or nightly shifts, frequent absences, loss or reduction of patience in interpersonal relationships and increased hostility towards other colleagues or staffs are, more or less, among the signs and symptoms of clinical or subclinical forms of trauma and stress-related disorders. Though most physicians believe that recalling unfavorable events is just an ordinary remembrance, at least in some of them the related recurrent reminiscences seem to be more than just a simple recalling and maybe those events are living with them and have been internalized in their mind-sets, a process which is similar to re-experiencing of traumatic events in PTSD or ASD, especially if it is accompanied with increased arousal or persistent avoidance of stimuli that is associated with the trauma. For example, a general practitioner who was working in emergency department for around three decades, could remember that among thousands of patients, who had been visited by him during the last years, memories of a few of them were really living with him and he could not get rid of them. One of them included a teenage girl, who died due to an illegal abortion, another one was a young boy, who had been murdered by an unknown housebreaker, and finally a young girl, who had been killed accidentally by a car. The deadly images and scenes of those victims had never left his mind, even after some decades, and he could not forget them, though he was eager to do so, because they were bothering him, especially whenever he tried to be joyful and thoughtless.

On the other hand, he could not explain why such specific memories, among plenty of similar ones, should have retained their power after around three decades. Similar experiences are not rare among medical doctors in different fields of medicine. For instance, a general surgeon could remember that after an emergency operation by him on a woman with an extra-tubal pregnancy, due to lack of a gynecologist in that area, which ended eventually with the demise of the patient due to huge internal bleeding, everything changed in his life. Ever since then, he had felt guilty regarding her death and lost his self-confidence with respect to all types of surgical operations, even a simple circumcision. He, also, had re-experienced, a couple of times, the said event, partly or completely, during dreams at night, and was unwilling to go to hospital for a few weeks. He eventually left that area and returned
to his own country. Likewise, a female pediatrician had become excessively obsessed regarding the safety of her own little son after losing one of her little patients due to meningitis. With respect to gender, age and figure, the expired child was very similar to her baby and his demise had dramatically influenced her mentality. Ever since then, she has had sleep problems, dysphoria, nervousness and a bit of irritability, which has caused frequent arguments with her husband and other family members for insignificant causes during the following year. On the other hand, it seems that job-related stresses may abuse, easily, earlier mental problems, and may augment, remarkably, the existent distresses. Maybe, in medical fields, where the likelihood of absolute cure is low and the risk of long-term complications is high, like neurology or psychiatry, or fields with the highest rates of mortality, like oncology or emergency medicine, the mental health of personnel seems to be more vulnerable than other specialties. For instance, a fresh specialist in emergency medicine attempted suicide when a catastrophe with huge number of fatalities occurred during his shift, and he felt helplessness in front of the piled up bodies. Perhaps, nihilism can be accounted for as one of the most challenging aftermaths of medical practice in a susceptible or skeptic medical student or physician, who repeatedly fails to find a sublime spirit in smelly blood or a malodorous cadaver. Anyhow, though different psychodynamic, behavioral or cognitive explanations can be supposed for such a burden, the end-result seems to be nothing except the possibility of mental exhaustion of physicians. While some personality traits, like obsessive-compulsive, paranoid, narcissistic, avoiding, and schizoid or schizotypal traits, may aggravate the said psychological maladies, a higher rate of suicide among medical doctors [2], in comparison with other professions, shows that job-related stress among this group of experts is more distressing than what was thought before, and demands special care by mental health services.

On the other hand, mental health personnel, as well, are not exempt from the said problems. For example, among specialists, psychiatrists have the highest risk of suicide [2]. On the other hand, unconscious dynamic forces, especially in susceptible clinicians, may deform their mental structure so slowly and covertly that neither them nor relatives may not easily recognize the onset of mental problems, like depression and anxiety, and usually attribute such morbid presentations to ordinary tiredness or daily conflicts. Then again, while the expiration of every patient may reinforce, unconsciously, the process of loss in the related therapist, patient's misconduct or non-adherence to therapeutic recommendations may cause counter-transference in doctor, which, by changing doctor's verbal or non-verbal communication, may instigate negative transference in patients; processes, which occur unconsciously, and damage therapeutic alliance between doctor and patient. Accordingly, a combination of the said unconscious dynamism with conscious job-related stresses may undermine the mental structure of physicians constantly and relentlessly. Though such complications may not be limited to medical doctors, their specific social position, responsibilities and public expectations, on one hand, and the gap between true capabilities and supposed aspirations, on the other hand, make them more susceptible. As is known, changing job or carrying out non-medical accomplishments, in substitution or in addition to medical practice, is not rare among physicians, which may show, again, a covert dissatisfaction among them, following their initial interest in medical study and practice. Though an alternative style for making money cannot be reproached, the existence of distrust in their primary job or responsibilities, as well, may not be denied. Nonetheless, it seems that, maybe, periodic assessment of medical doctors for probing of psychological problems, especially in high risk groups, is valued. Besides, they may be advised to self-analyze themselves for evaluation of possible mental difficulties and contact with related specialists if they feel any need; a process which is similar to Freud’s advice to clinical psychoanalysts for enactment of self-analysis or re-analysis by other analysts, every few years, for
management of unconscious mental conflicts that have been mounted up during preceding years [3]; for avoidance of harmful effects of uncontrolled unconscious conflicts, which may, adversely, influence analyst’s professional pledges or competencies. Anyway, psychiatric training is part of national medical curriculums in all parts of the world and all physicians are somewhat informed regarding the psychiatric signs and symptoms, which is a positive point and should, at least academically, facilitate detection and management of associated problems; though, metaphorically, medical doctors are not, generally, compliant patients, and, usually, see themselves invulnerable. Also, physicians, like other people, avoid psychiatric labeling, and resist long-term drug consumption, which is a usual protocol in psychiatry. Anyhow, while there is a variety of psychological methods or pharmacological medications that may help effectively to restore mental balance in distressed cases, it seems that in such a situation, a psychiatrist or trained medical doctor is more appropriate for primary consultation or later pharmacotherapy and/or psychotherapy because such a specialist may have better insight and experience regarding the responsibilities of a medical doctor and unavoidable complications of medical practice. A consultant who has never had night shifts in hospitals, never got involved in patients with multiple traumas, was never obliged to console the relatives of expired cases or to get data from agitated patients or relatives, has never faced forensic challenges or unsubstantial accusations and has never been called to visit and manage patients in critical care units looks unlikely to perceive the depth of a doctor’s suffering or meaning of his or her words, if he is dealing with a physician who has become burned out, depressed or distressed due to his career’s complications.

The profile of such an attempt is a bit similar to the Balint Group’s approach, which is, usually, performing, academically, for familiarizing medical students or residents with psychodynamic aspects of medical processes, though in present analysis it is not for scholastic purposes and is supposed to deal with real and serious psychological difficulties of graduated and practicing physicians. Accordingly, though hitherto there was not any specific healing maneuver in the realm of primary, secondary or tertiary prevention with respect to only physicians’ psychological complications, planning such a modus operandi and delivering it through available consultation - liaison services or comparable facilities does not seem to be imprudent. Deciphering mental conflicts, enhancement of assertiveness and communicative skills, balancing self-esteem and getting a practical insight regarding factual abilities or shortages of science and medicine may help to create realistic expectations in physicians for avoiding needless self-doubt, self-punishment or unexplainable mourning for unavoidable expiries, and ending excessive feeling of loss due to too much internalization of deceased patients; a series of outcomes which may improve physicians’ function by proper delivery of intellectual and true emotional insight during psychotherapeutic meetings or counseling sessions. Till now, physicians have been known as providers of physical and mental health, and primary care physicians have been the backbone of primary health care worldwide. But, it is usually ignored that the same medical doctors are human beings and are as vulnerable as the general population. They can do their responsibilities thoroughly if their own somatic and mental health is okay; otherwise they may not make public health available. Currently, increasing legal liabilities, growing public expectations and amassed social complexities may have caused increased job dissatisfaction among physicians, who, though they wish to do their best, especially if they are perfectionist, may not handle such huge pressure and may behave morbidly or dismiss that profession totally.

So, the incidence of burn-out syndrome in physicians is a gloomy sign, which demands specific care by related supervisors or decision makers. Dissatisfaction of talented medics may not always be compensated by firing former physicians and recruitment of newer doctors, because the fresher ones, too, will be exhausted, sooner or later, by the same complications, and
substitution of skilled and brilliant doctors with inexpert or unconcerned physicians may not always promise a brighter prospect. Aptitude is not always or easily available, and its subsistence is not free. On the other hand, saving good and responsible doctors may necessitate a series of managerial or scholastic reforms, which may not be likely in the short-term. In any case, in every society, physicians are, professionally, among the vulnerable parts of human capital, and their shortage is equal to deficits in public wellbeing. Without wellbeing, too, no happiness is conceivable. Though the mental health of physicians is an issue that is usually missed by both themselves and correlated overseers, because it is usually noiseless and covered, it is a reality that demands watchfulness by bureaus and academes.

References