

Physician Heal Thyself: The Paradox of the Wounded Healer

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The 'caring professions' suffer from higher levels of psychological morbidity, suicide and marital breakdown than many other social groups. The reasons for these excesses are explored. A model taken from transactional analysis is used to describe the *malignant symbiosis* that may develop between doctor and patient as the result of the doctor's background, upbringing and medical training. Suggestions are made as to how the re-thinking of medical attitudes towards patients, but even more so towards doctors themselves, might help to prevent the syndrome of the 'wounded healer'. The integration of the 'masculine' and 'feminine' aspects of the doctor's make-up is essential in this regard.

'The stoical scheme of supplying our wants by lopping off our desires, is like cutting off our feet, when we want shoes.'

Jonathan Swift, *Thoughts on Various Subjects* (1711)

Those who care for others, out of vocation or compulsion, often have difficulties in caring for themselves. Doctors are notoriously 'bad' patients, and the doctor who is required to help a sick colleague is likely to be himself confused and distressed by the complex tangle of feelings and distorted communications that follow. In the last two decades there have been many interesting, though ominous, studies on the morbidity and troubles of doctors. Perhaps the most striking data concern suicide statistics. All the studies concur in demonstrating a rate of suicide among doctors that is at least double that of the rest of the population (Rose and Rostow, 1973; Editorial, 1974). It is significantly higher than comparable economic and 'non-helping' professional classes. Among hospital doctors, the highest rate is found amongst psychiatrists, followed by physicians, surgeons and, finally, paediatricians (Blackley *et al.*, 1968; Rich and Pitts, 1980). Studies from the USA imply that psychiatrists, overall, are more likely to commit suicide than their patients.

In concurrence with suicide, the rate of drug abuse and marital breakdown amongst doctors is similarly high (A'Brook *et al.*, 1967; Vincent *et al.*, 1969; Editorial, 1970; Vaillant *et al.*, 1970; Emschwiller, 1973). Quite as important, though less easy to measure, is the common tragedy of 'marital dry-rot'. By this I mean the marriage that has atrophied in terms of emotional closeness, intimacy, and enriched sharing. As with the dry-rotted timber, the outward form may remain, but the underlying strength and substance has eroded – collapse or crumbling is a matter of time. *McCall's Magazine*, with its own brand of journalistic prophylaxis, warned its readers in an article entitled 'Never Marry a Doctor' that 'Physicians are poor husbands, poor fathers, absent companions, prima donnas and about as useless in bed as an electric blanket when the power is cut off'.

Other studies are equally illuminating in filling the pattern. Doctors are more likely to break down than others, but usually do so in ways that are private and socially obedient; the formal diagnoses describing the doctor's difficulties are expressed in terms of *neurotic depression* rather than *schizophrenia* or *personality disorder* (Duffy and Litin, 1964; Editorial, 1967; Murray, 1977). They are less likely to be convicted of crimes of

violence, burglary and causing an affray. Clearly, even in illness and distress, the doctor's exemplary persona remains intact. Doctors' frequent but concealed alcoholism repeats this theme (Vaillant *et al.*, 1972). Typically the problems will be borne and hidden by his colleagues and family, but the wider community will be left in peace.

Humanising the data

What can we infer from such statistics? It seems that doctors, together with others in the caring professions, are relatively incapable of acknowledging or allowing themselves the frailties they may look after so assiduously in others. When it comes to a crisis in our own lives, there are many doctors who prefer to be seen dead (literally) than in any way compromised, dependent or weak. Our armour of assumed omniscience and omnipotence has taken years to develop and is hard to discard. Many of us have developed a compulsive persona of exemplary independence, strength and rationality which we are both ashamed and afraid to relinquish. Regression is for patients, not doctors. Both the structure and nature of many medical transactions and rituals create the illusion, and then conserve, the doctor's executive and emotional power. The medical model itself, with its didactic style of defining health, normality, sanity, pathology and therapy, is clearly a major vehicle in this authoritarian circus (Zigmond, 1976; 1977).

Clearly, it is not only as individuals that we suffer and perpetuate this dilemma. We collude together to minimise, conceal or deny these problems. The ethos of the stiff-upper-lip and coping-at-all costs is learned (by imitation and taboo) early in our training. It is ubiquitous, and played extremely hard, particularly in hospitals. How many of us have allowed ourselves to be openly depressed and comforted by a colleague? We are much more likely to maintain a stoical and inscrutable front and urge others to do likewise – unless they are patients, of course.

From my own experience, and from what other doctors have told me in psychotherapy, workshops or friendships, I can only deduce that there is a tacit and severe conspiracy of silence regarding this painful area. Traditionally, and still prevalently, the lack of emotional rapport and support within the caring professions is paradoxical but gross. Our expectations of ourselves and others to remain strong and intact, whatever the conditions, are unyielding, and frequently far exceed the conduct required for humane and competent clinical practice. Default from this Spartan code is allowed only in

ritualized and contained settings. Publicly and manically it surfaces in the beer-saturated mess party. With more secrecy and restraint – commonly if the doctor is a psychiatrist – it appears in the framework of psychotherapy which can, in any case, be claimed as ‘part of his training’. However, in many ways what he is doing is stealing away to a special place where, in total privacy, someone will listen to, and accept, the vulnerable, dependent and sometimes violent parts of himself. He is paying someone to respond to him as a permissive and feeling person. It is remarkable and ironic how other groups who claim no expertise or particular concern about human suffering, such as ourselves, cope with it so much better in their own groups. The emotional support, accommodation and latitude that people allow one another in shops, industrial organisations and so forth, frequently outstrip our equivalent performance and attitudes within the caring professions. The following account illustrates the tragic nature of such collusive and defensive responses.

The case of Dr X

Dr X was a junior hospital psychiatrist who started his first post in this specialty at the same time as myself. He had only just arrived in this country from the Middle East, had no family or friends here, and was resident in the hospital. As a late recruit to medicine he was in his mid-thirties, despite his junior status. His manner at work was tense, obsessional, earnest and very introverted. He seemed an extremely lonely man, who spent his off-duty time either studying or impassively watching television in the Doctors’ Mess.

Over the months he became increasingly capricious, prickly and withdrawn. Nursing staff became uneasy with his odd and irascible behaviour with patients. On one occasion he sprinkled a patient with water while chanting from the Koran, explaining to an attendant nurse that ‘the patient’s being would be made pure’. This was followed by his writing a long, untrue and defamatory account about another doctor in a patient’s case notes. Largely to satisfy the nursing staff’s insecurity, it was decided that Dr X’s clinical responsibility should be undertaken by another doctor. However, this was done in an oblique manner, so that Dr X was not confronted directly with the concern that was felt about him, and he continued official tenure of his post. This strategy seemed designed to ‘paper over the cracks’ so that no one needed to encounter the alienated and unstable Dr X until his contract had expired.

At this point I asked to see Dr Y, the senior consultant at the hospital. Although

inexperienced, I was clear in my view that this approach was not only confusing and jeopardising to patient care, but that Dr X's increasing paranoia and depression required more in the way of concern, compassion and confrontation. I said that, for fear of encountering him in this way, Dr X was being treated with duplicity, and this fed into his sense of mistrust, powerlessness and alienation. It would be far better, I suggested, openly to acknowledge his painful and serious difficulties, to relieve him of his work in a decisive and kindly-parental way, and find him help outside the hospital. Dr Y's response was authoritarian, defensive and dismissive. I was made to feel that such a breach of conspiracy of silence was inept, impudent and unethical. I was sent on my way. Dr X, soon after, died from a suicidal overdose while still an employee of the hospital. It is doubtful that this man would have died amidst these circumstances in any other than a 'caring' profession. He would have received help.

Doctors' dilemmas

Doctors in clinical practice are confronted by some of the most private, primitive and powerful experiences that can be shared with another. Consider the following perennial situations that many of us become seasoned to:

- Mr A has cancer and he does not know. What should I say? Shall I tell him, or if not he, his wife?
- Mrs B's condition warrants my exploring her vagina and rectum.
- Mr D has had ulcerative colitis for 10 years. I think he should now have his colon removed and be left with a life-long ileostomy.
- I will not resuscitate Mr E. The probable quality of his future existence seems unworthwhile to me.
- I don't understand Mrs F's sexual problem. I shall ask her about her masturbatory fantasies.
- Although Mrs G. denies any problem, does not want treatment and has committed no crime, I postulate a mental illness, which puts her at risk. I will have her taken to an institution and treated against her will.

Each of these cameos is dramatic or devastating for the patient, but paradoxically commonplace for the doctor. Being crucial and decisive for our patients, our licensed tools and protocols are correspondingly powerful and dangerous. In consequence we can only use them legitimately if we are, or at least seem to be:

- strong
- patient
- worldly
- sagacious
- unselfish
- responsible
- impressively knowledgeable
- highly ethical and scrupulous
- uncorrupted by power, aggression, sexuality and greed
- always intact and alert to the most demanding and diverse situations.

Conversely in the face of such demands we cannot be:

- demanding for ourselves when others need us
- unable to face what is there
- uncomprehending
- self-indulgent
- indecisive
- ignorant
- weak.

Such formidable requirements tend to involve 'blocking-out', or at least controlling to an extreme degree, natural feelings and actions that would otherwise emerge. Disgust, fear or overwhelming sadness may be spontaneous, healthy and authentic reactions to situations that are unsavoury, offensive or tragic. The doctor's armour of detachment and continence is necessary – at least in part – if he is to get on with the job. The desensitising effect in doctors by constant exposure to pain, distress, tragedy and horror has yet to be studied in depth, but I believe it frequently to lead to a kind of emotional anaesthesia or woodenness. It may be impossible to remain a vulnerable, feeling or spontaneous person when subject to years of these kinds of demands and controls. Perhaps doctors become hardened and petrified in the same way as professional soldiers. The effect it has on intimate relationships is then, predictable, for, above all, intimacy derives from spontaneity, emotional expressiveness and accessibility. It is not possible to be close to someone who is relentlessly sensible and responsible. They may seem more, but are really less, than human.

Transactional analysis; an organising language

I want here to divert briefly, and present in an extremely simplified form, the concept of 'ego-states' from transactional analysis, as my further points can be illustrated more succinctly using this language.

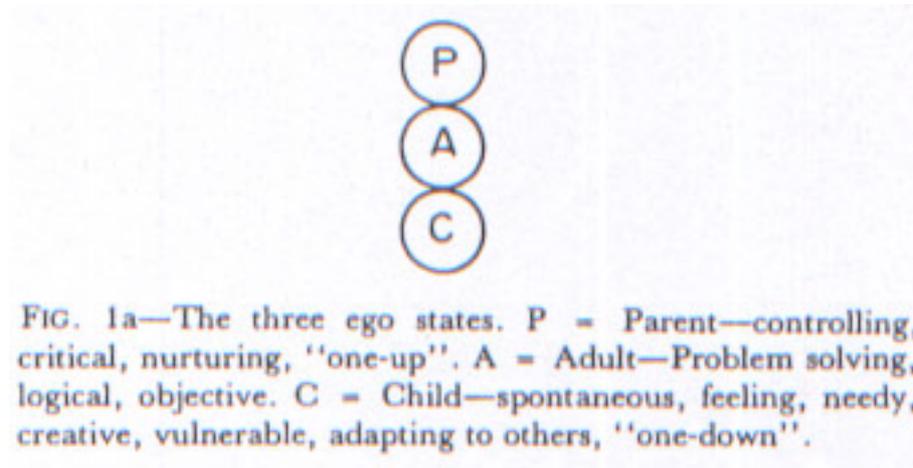
An ego-state is a system of thinking, feeling and behaving, all of which are interlinked. We all have three ego-states, although in each of us the content and strength of each ego-state will be different. The three ego-states are called *Parent*, *Adult* and *Child*. The content of the Child is largely complete by the time we are eight years old; Parent and Adult by adolescence.

The Parent develops from what we are *taught* by actual parents and other influential adults. It derives not only from what we are told explicitly, but also from what we observe them doing. The Parent is thus the seat of both *nurturing* and *controlling* impulses and behaviour, whether to ourselves or others. Subjectively our Parent feels protective or critical, and has the conviction of *knowing* what is correct and ethical, even when we might be mistaken. Generally, when we are in our Parent, we feel secure, and relate from a one-up position of 'right' and strength.

The Child, reciprocally, is the world of experiences and derivative thoughts and feelings that we had as children and re-experience and re-enact now. It has all the qualities of the unfettered natural child, as well as the child that has learned to adapt to survive amidst more powerful grown-ups. The Natural Child is fun-loving, pleasure-seeking, pain-hating, emotionally labile, demanding, impulsive, spontaneous, creative, curious, sexual, unashamed, greedy and loving. This part of us believes in magic, and may feel either omnipotent or completely helpless, just as we all did as small children. It is the part of us that shares and experiences with vividness and immediacy, and is thus the spring of our capacity for vitality and intimacy. As children, however, we had both to be socialised and to learn strategies of living with those we are dependent upon, and these dependent patterns of compliance or rebellion make up the Adapted Child. We relate here from a feeling of being 'one down', by justification, appeasement, rebellion or struggle.

The Adult is the reality principle in the personality. It is capable of observing, assessing, storing and patterning information in an objective way. It can turn these logical powers

externally to the outside world, or internally to monitor and mediate between the other two ego-states. In many ways the Adult may be seen to function like a computer. For simplicity we can represent these personality functions diagrammatically (Figure 1a).



The doctor's personality

In the preceding sections I have reviewed both how doctors take better care of others' needs than their own, and how the nature of their work calls on them to be uncompromisingly 'grown-up' in their conduct. Using the ego-state model it seems that doctors' personality structure and function is confined largely to the Parent and Adult. We may spend our lives looking after those who are sick or compromised, and consider ourselves expert in knowing what is 'good for' others. Many of us pride ourselves on our accurate observation, fund of factual knowledge and problem-solving ability. What we are often out of touch with is our Child. The world of chaos, irrationality, strong feelings, spontaneity and vulnerability is kept strongly in check, if not denied and defended against, by our Parent and Adult ego systems. Such armour may at first serve as a protection, but such security is bought at the price of inaccessibility and shutting out the joy and intimacy that keeps us vital. A diagram of this process is illustrated in Figure 1b.

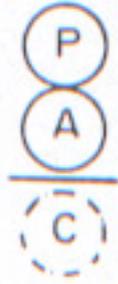


FIG. 1b—The doctor's personality. Strong Parent and Adult but blocked or atrophied Child.

Symbiosis – helping the needy and needing the helpless

When we deny powerful needs or impulses in ourselves, we will either be intolerant or compulsively solicitous of these attributes in others. If it is the latter, then we can professionalize this problem by working in one of the caring professions. In this area we have licence to seek out and look after the part in other people that we disown or suppress in ourselves. Our needs may then be fulfilled, in an illusory and vicarious way, through a state of mutual dependence. Such an interlocked relationship may be diagrammed as in Figure 2, and may be termed 'symbiotic'. Symbiosis may be thought of as 'benign' when our own needs are peripheral to 'helping the needy'. Conversely, 'malignant' symbiosis is enacted when our own needs become more central, and we are then 'needing the helpless'.

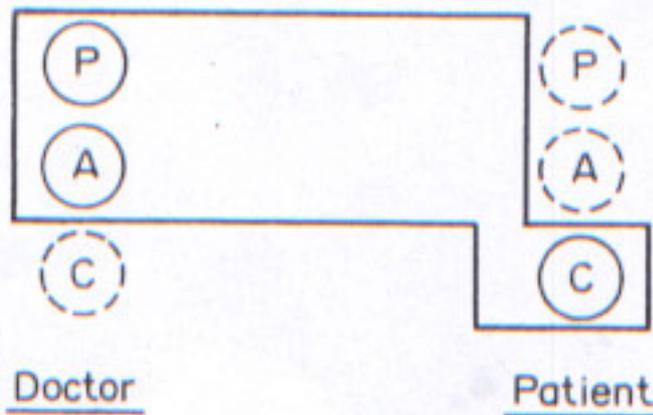


FIG. 2—Symbiosis in the doctor–patient relationship.

There is a tacit contract here, where the doctor's part reads: 'I will be strong if you will be weak. I will be sane/sober/logical/continent if you will be mad/drunk/confused/miscreant. I will support, guide and protect you so long as you

are helpless and obedient. I will not express my feelings or difficulties, so you must have and enact them for me'. Reciprocally, the patient's role in such a collusion reads: 'If you will be my Grown-up then I will make you feel potent, clever and important (or, not infrequently, the opposite). To make sure that is so, I will be passive, aimless and dependent'.

Such dependence upon our patients for our sense of power, self-esteem, worthiness and vicarious expression of locked-up feeling is often not conscious. In the semi-conscious or deeply unconscious mind there are frequently complexes of guilt, and the need for reparation, stemming from our earliest experiences where, in a primitive and irrational manner, we created inordinate notions of the damage we might have done or might still do. Compulsive and malignantly symbiotic patterns of help then represent a ritualistic undoing of the feared damage, but it is an impotent undoing which is never finished and must be repeated endlessly. In the short term this kind of 'helpfulness' may be harmless. The long-term effects, however, may be similar to many other relationships which are based upon rigidity and a radically unequal power distribution. Because attachment and gratification of both partners depends on a rigid status quo where no growth is possible, a sense of entrapment, waste and resentment is likely to evolve. In the interim, it may account for many harried, irritated and depressed doctors who are uncomprehendingly or unconsciously dependent on their patients' dependence. The end point of this process is the unnecessarily infantilised or institutionalised patient and the seriously damaged, or prematurely dead, doctor.

The making and breaking of doctors

The factors that motivate us to become doctors are often those which later lead to the kind of stoical and compulsive unhappiness I have outlined. In this section I shall discuss briefly the kind of family and social backgrounds that make a radical and pervasive contribution to these difficulties.

Altruism, caring and empathic concern for others in distress are clearly ingredients of the most humane and proficient practice, and involve only benign symbiotic attachments, which is a necessary, if temporary, arrangement while dealing with distress and disability. It is the malignant symbiotic patterns that stem from the doctor's personal difficulties and lead, via his defences of workaholism, perfectionism and stoicism, to the even greater difficulties I have

reviewed. In a general sense such doctors are likely to have grown up with the notion that it is forbidden, disadvantageous or damaging for them to express their feelings, make demands or be vulnerable, although they may be permissible or even expected in others. The reasons for this can, of course, vary from implicit social class mores to particular family circumstances. As an example of the latter, the following case history serves as an example:

The case of George

George is a physician in his mid-forties. He sought help originally when things were clearly going wrong in his life. In spite of his outward success, good professional standing and apparently stable family life, he experiences his existence in terms of deadness, hollowness, edginess, joylessness and inauthenticity. Clinically his problems might be described in terms of 'anxiety', 'depression' and an underlying 'obsessive-compulsive personality'. In more ordinary terms he is a man who works inordinately hard, is never satisfied with the work he has done, fears (unrealistically) any criticism from his colleagues or patients, and finds it almost impossible to assert himself or differentiate himself from others' expectations and wishes. His way of relating is thus usually either appeasing or reparative, but in being so, he accumulates much in the way of resentment with others (for their dominance), self-hatred and poor self-esteem (for his acquiescence) and alienation (from his inauthenticity). These consequences are expressed at home, where he becomes depressed, irritable and demanding, and periodically explosive with anger. His attempt to escape his passive-aggressive cycles via alcohol merely amplifies his problems of guilt, remorse, liability and despairing confusion. The effect on his marriage is seriously damaging and needs no further elaboration here.

George was born shortly before the outbreak of the Second World War. It is possible that his parents were never really happy together. Soon after his birth, his father was conscripted into the forces and saw little of his wife or son in the next six years. Even after the war the pattern continued in a similar way, as father was often away from home travelling in his work. George's mother was an unhappy and lonely woman who sought from her little boy not just the love expected from a son, but also the unavailable love she craved from an absent or unloving husband. During her lonely war years she took the boy into her bed, and when he was old enough to 'understand' she confided in him about her unhappiness with father.

By the time he was six years old, George had formed the decision that mother's stability, love and happiness depended upon his ministering to her. Family triangulations and oedipal conflicts are difficult to resolve even in less exceptional circumstances, but for George there was the added misery of inexorable and increasing alienation from father. Hardly surprisingly, father experienced the intense bond between his wife and son as an alliance against him, and indeed it was true that the closeness of these two depended on keeping father 'bad' or distant. The dilemma of the little boy was that he had to suppress his own feelings and needs and subsume these to another's, but that in doing so he necessarily drove father away or invoked his hostility. 'I just couldn't do the right thing; I couldn't make them happy' George recalls tearfully some forty years later, and it was certainly true that the task this little boy saw for himself was quite beyond his resources or understanding, or powers of influence. And yet he felt responsible and had to keep trying to find a solution.

He cannot remember now when he decided to become a doctor, but he does remember some of the thoughts that went with the decision. He would imbue himself with the powers of healing, but, in so doing, people would be genuinely grateful and thankful. Unlike his family (where he felt compelled to 'heal' his mother but felt bound to fail and instead collect feelings of guilt, fear and inadequacy) as a grown-up healer – a doctor – he would be potent, respected and unassailable.

Little George's compensatory and reparative fantasy has had very different consequences in grown-up reality. Not only did he not make mother and father happy or loving but, inevitably, some of his patients didn't get better. Often they seemed ungrateful, and occasionally they blamed him even when he knew it wasn't his fault. He responded with the same mixture of guilt, resentment and fear he had as a young boy, and tried harder. The characters and backcloth changed, but the theme has remained the same. George's malignant symbiosis with his patients can be seen as his attempt to solve archaic, and probably insoluble, problems within his family, but also, by identification with his patients, to get for himself the love, care and acceptance that were lacking for him. He compulsively gives to others what he has yearned for himself. In the long term, however, this route becomes a cul-de-sac, offering no real satisfaction or resolution. George's symptoms have signalled as much, and it has only been since he has been tackling and expressing his needs, wants and hurts more directly, and for himself, that he has begun to leave them behind. He has realised that charity must begin at home.

George's difficulties and their origins are, in my experience, fairly typical of the common syndrome of the *Wounded Healer*. Others have remarked on how doctors and psychotherapists tended to have had significantly depressed mothers (eg Storr, 1979) which led them not only to an empathic understanding of this in others, but also, less helpfully, to a compulsive need to sacrifice the self in 'helping'. Apart from the current of guilt that underlies this impasse, there are other components of this syndrome which damage and distort our self-esteem. In seeing our lives in terms of what we offer to others, often in a very confined and ritualistic form, we do not value ourselves for what we really are, but only what we *do*. Such a central dissatisfaction with ourselves may account for much of our motivation in seeking out the compromised parts of others. In this symbolic union, we imagine, we can allay our own loneliness and sense of incompleteness. The cruel and inescapable truth, however, is more often the reverse. It is only through loving ourselves that we can enact creatively an authentic and discriminating love of others.

We need also to consider the way in which our social and class backgrounds contribute to these patterns. Doctors have traditionally been recruited from the middle and upper classes, particularly those which have a strong parental ethic. There is a tendency for this section of society to pride itself on knowing best what is 'good for' other members of society. We take the *Times*, *Telegraph* or *Guardian*; our experience of the world (and often the world itself) is for organisation, edification and improvement – not enjoyment. It is not only doctors, of course, who emerge from this patriarchal mould. We produce a plethora of other parental types: lawyers, clergy, captains of industry and politicians. We are prepared early for these tasks. How many of us can remember being told prematurely to 'grow up', 'don't be silly' or 'do be more responsible' when we were not yet eight years old, and childhood with all its tumult and selfishness should have been our right? Later, this false and precocious acceleration into adulthood may have been compounded even further by education in public schools, with its essential ingredients of rules, responsibilities, hierarchies and titles. In such environments, our emotional life or private world is regarded as a hindrance or aberration, deflecting or subtracting from our more important public performance. We thus become more oriented to achievement than experience; what we *are* is important only in so far as it is expressed in what we *do*. The 'masculine' nature of such cultures has a particularly inhibiting effect on the feeling, vulnerable 'feminine' side of ourselves.

I remember at the age of eleven standing alone with my 'tuck-box' on the station platform, awaiting the steam train to take me to boarding school. I was fighting back the fear and the tears, and trying bravely to look grown-up. Like George, I developed this concealment over the years, to become a 'false self'. Ultimately, it has needed dismantling before I could excavate and pay attention to the buried Child within me. Here, too, charity has had to begin at home.

Physician heal thyself – but how?

Official recognition of the disturbed doctor who may be a liability to his patient represents only a surface layer of a problem which, as I have outlined, is extensive and complex. Public concern about this problem has led, in recent years, to the implementation of the 'three wise men' whose task it was to assess, caution, make recommendations to, and sometimes discipline, the aberrant doctor. However, such a 'casualty department' approach, even if doing a little to protect the public, has little impact on the underlying and seemingly ubiquitous difficulties: these have their roots in deep-seated emotional problems and social mores.

The teaching of psychiatry via a medical-model didactic type of approach is now a well-established discipline conveyed to medical students. More recent, and less developed, is the introduction of the teaching of the psychology of the patient or the person who is ill. What is lacking in both of these approaches is any significant consideration of the doctor and his psychology and distress patterns. It is somehow assumed that these problems do not exist, or are insufficiently important to merit teaching time and expertise, or that somehow the doctor will muddle through successfully. Clearly, the facts indicate otherwise.

All creative acts can be interpreted in terms of some kind of psychopathology. Compensation, identification, projection, denial, escape and sublimation are some of the technical words we might use to describe the mechanisms lying behind many endeavours. The fact that a young person is prepared to spend many arduous years training to license himself for the lifelong task of involving himself with unknown persons' distress is, on the surface, a perverse choice and likely to be based, at least in part, on such covert forces. Yet it would be wrong to assume that these kinds of motivations need necessarily be problematic or pathological in practice. Very real gifts

and predispositions for caring and empathy may arise from such factors in ourselves. Indeed, it is probably not possible to develop a humane and compassionate resonance with another unless we have some identification with them. We have to have faced similar pains, losses, conflicts or needs ourselves. The important point is that we are both aware, and in control, of these forces within us. By doing so we convert a liability into a gift.

Yet the medical educational establishments whose task it should be to help the medical student or young doctor successfully navigate these dilemmas and transitions fails to realise either the presence or significance of this task. By concentrating solely on the 'masculine', scientific, organisational and didactic aspects of the doctor's role, medical education falls short of being an 'education' and remains a 'training' – a constriction or moulding into the required role. What is lacking in this process is the more 'feminine', nurturing approach, where experience is accepted and understood at a more feeling level. It is only via this more candid and allowing attitude that the developing doctor will find himself in an environment where he can successfully engage and transcend what will otherwise become a series of impasses which become translated into the kinds of stoical, insensitive or malignantly symbiotic patterns of lifestyle and practice we have considered.

There are practical ways of achieving this. From the first day at the dissection table, medical teachers should consider it part of their task to encourage students to talk about their attitudes, feelings and problems. Clinical teachers should share with their students the difficulties they encounter in, for example, caring for the incurable, the inexorably dependent and the dying, or making mistakes! They might enlighten the students too, in discussing with them the human resources they have had to develop to deal creatively with these situations. Integrated into the curriculum, alongside the more formal and traditional teaching, there should be seminars or discussion groups where personal disclosure and interaction about these issues would be skilfully and sensitively encouraged. Many clinical teachers might, at first, be threatened by this requirement that they become humanistic as well as technical teachers. They might feel that self-disclosure would be undermining and would diminish their position of respect and authority. My own experience has been opposite to this. The teacher who can share his difficulties and humanity while remaining a master of his craft grows in the esteem of others and serves as a model as to how these things may be reconciled.

It is clear that many young and established doctors have needed, and will continue to need, professional help for the problems that are likely to emerge within them in the course of their careers. As I have demonstrated, this is to be expected as a natural consequence, at least sometimes, of the nature of ourselves and our work. It should carry no more stigma or alarm than the football player who needs physiotherapy to relieve his pain and heal him so he may again be competent for his task.

I have not said anything about the kind of social mores and public expectations of doctors, which feed into how the doctor feels he should be and compound his individual difficulties. This would require a separate article of equal length. However, I would anyway urge us to desist from this large and formidable task of analysis and intervention until we have our own house in order. We are, of course, already proudly 'expert' in defining what is wrong with others and what they should do.

Charity begins at home; physician heal thyself.

References

A'BROOK, M.F. HAILSTONE, J. D. & MCLAUGHLIN, E. J. (1967) Psychiatric illness in the medical profession. *British Journal of Psychiatry*, 113, 1013-1023.

BLACKLEY, P.H., DISHER, W. & RODMER, G. (1968) Suicide by physicians. *Bulletin of Suicidology*, 1-18.

DUFFY, J.C. & LITIN, E.M. (1964) Psychiatric morbidity of physicians. *Journal of the American Medical Association*, 189, 989-992.

EDITORIAL (1967) Emotional illness in physicians. *Medical Tribune* (March 29), 1.

— (1970) Drug abuse. Growing occupational hazard for doctors. *Hospital Physician*, 6, 60.

— (1974) Suicide among physicians. *Journal of the American Medical Association*, 228, 1149-1150.

EMSCHWILLER, J. (1973) Doctors still drink too much and pop too many pills. *Medical*

Times, 101, 58-61.

MURRAY, R.M. (1976) Characteristics and prognosis of alcoholic doctors. *British Medical Journal*, 2, 1537-1539. [Not referenced in the article]

— (1977) Psychiatric illness in male doctors and controls: an analysis of Scottish hospitals in-patient data. *British Journal of Psychiatry*, 131, 1-10.

RICH, C.L. & PITTS, F.N. Jr. (1980) Suicide by psychiatrists: a study of the medical specialists among 18,730 consecutive deaths during a five year period 1967-72. *Journal of Clinical Psychiatry*, 41, 261-263.

ROSE, K.D. & ROSTOW, I. (1973) Physicians who kill themselves. *Archives of General Psychiatry*, 29, 800-805.

STORR, A. (1979) *The Art of Psychotherapy*. London: Heinemann.

VALLIANT, G.E., BRIGHTON, J.R. & McCARTHUR, C. (1970) Physicians' use of mood-altering drugs. *New England Journal of Medicine*, 283, 365-370.

VALLIANT, G.E., SOBOWALL, N.C. & MCARTHUR, C. (1972) Some psychological vulnerabilities of physicians. *New England Journal of Medicine*, 287, 372-375.

VINCENT, M.O., ROBINSON, E.A. & LAVE, L. (1969) Physicians as patients. *Canadian Medical Association Journal*, 100, 403-412.

ZIGMOND, D. (1976) The medical model, its limitations and alternatives. *Hospital Update* (August), 424-427.

— (1977) Scientific psychiatry: progress or regress? *Update* (October), 675-679.

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