

Virtual Mentor

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CLINICAL CASE

Is Physician Self-Disclosure Ever Appropriate?

Commentary by James E. Sabin, MD

Dr. Goldberg is a primary care physician in a small rural town. She has been caring for Mrs. Hunter and her grown daughter, Karen, for the past decade. Mrs. Hunter has just been diagnosed with amyotrophic lateral sclerosis (ALS), and she and her daughter have been struggling to cope. Mrs. Hunter lives alone, and Karen is her only child.

Karen comes to Dr. Goldberg one day with severe anxiety and gastrointestinal symptoms. She isn't sleeping, she has no appetite, and she has been getting frequent colds. In addition to dealing with the emotional burden of her mother's diagnosis, she has financial worries. She confides in Dr. Goldberg that she is at a complete loss about how to deal with her mother's illness.

Dr. Goldberg is acutely sympathetic; her own mother passed away from ALS about 5 years prior. She remembers the intense struggle her mother had, as well as her own feelings of powerlessness as a caregiver. She isn't sure whether it would be appropriate or helpful to share this information with Karen.

Commentary

Research on the patient-physician relationship tells us that physician self-disclosure (PSD) is not rare. In one study, PSD occurred in 15 percent of primary care and surgery appointments. Most important for our advice to Dr. Goldberg, and contrary to what their physicians may have expected, patients were *less* satisfied with primary care appointments in which self-disclosure occurred and reported feeling *less* warmth, comfort, friendliness and reassurance in those appointments. By the same measures, however, surgery patients reported positive reactions to PSD [1].

In another study physician self-disclosure occurred in 34 percent of initial primary care appointments. Patients were not asked about their reactions, but a team of experts reviewing the transcripts concluded that 85 percent of the PSD was not useful to the patient [2]. In the study, PSDs were often non sequiturs, more focused on the physician's than the patient's needs. The researchers found little evidence that PSD strengthened the patient-physician relationship. And in psychiatry, review of situations in which a physician-patient sexual relationship occurred showed that seemingly harmless boundary crossings like PSD sometimes preceded and appeared to lead up to serious sexual violations [3].

Given these red flags, Dr. Goldberg’s initial handling of the situation is exactly on target. She recognized the impulse to share her own experience with Karen but questioned whether or not PSD would be useful to Karen’s treatment. The impulse to share *might* be good guidance, but it needs to be assessed in the most self-aware and evidence-based manner possible.

All we know at this point is that Karen has a number of symptoms that could be stress-related and that she has told Dr. Goldberg that she is at a complete loss as to how to deal with her mother’s illness. But we don’t yet know what Karen is at a loss about. Given the remarkable coincidence that, like Karen, Dr. Goldberg has experienced a parent’s illness with ALS, it would be easy for her to project her own feelings onto Karen and conclude that she understands Karen’s situation. But rather than make assumptions based on her experience with her own mother’s ALS, Dr. Goldberg should delve more deeply into Karen’s reactions. There are no rules that will give Dr. Goldberg the “right” answer about whether to disclose her own experience. In order to assess the potential risks and benefits she’ll have to gather more “data.”

It’s important to ask questions in an open-ended manner and to probe for clarification. We human beings are very idiosyncratic. We react in terms of our own histories and private thoughts. Karen’s term “at a complete loss” doesn’t give us the precision we need to know how to be most helpful to her. We can imagine the following dialogue between them. Dr. Goldberg’s thoughts are in italics:

Dr. G: (*Karen is clearly distressed. But lots of different things could be causing the distress. I need to validate that it’s OK to feel distressed and try to get a more precise sense of what is specifically most difficult for her.*) You and your mother are dealing with a very tough situation. What aspects are most difficult for you?

KH (crying): I don’t see how I’ll be able to see my mother through to the end.

Dr. G: (*I’m not sure how much the problem is fear of losing her mother and how much it’s about how she will deal with her mother during the illness.*) Can you put the tears into words?

KH: I can’t stop working—my mother and I depend on my income. But how can I leave her alone?

Dr. G: (*I think Karen needs practical advice, and this isn’t a problem I had to deal with when my mother was ill.*) Suppose I put you in touch with the visiting nurses. They’re very good with this kind of practical problem.

KH: That sounds like a great idea.

Dr. G: OK. Is there more that you're having trouble dealing with?

KH (crying): It breaks my heart to see my mother so weak. I can't let myself cry in front of her. I have to be strong when we're together, but I don't know if I can do it. I hate myself for being so weak!

Dr. G: (*I've known Karen for 10 years. She's a strong, independent, hard-working person, who likes to take care of others. I think she expects herself to be a Rock of Gibraltar. She may need to feel that she has "permission" to feel so distressed. Karen and I have had a good relationship. Mentioning my own experience might be useful for her, and I don't see any major risk in bringing it up.*) ALS in a parent is very tough to deal with, especially since you're an only child. I know about this first hand—my mother also had ALS. I found it was helpful to me to talk with my friends and to get regular exercise. What could be most helpful to you in a really tough situation like this?

Dr. Goldberg's disclosure is brief, she focuses her comments on Karen, and she promptly comes back to Karen's needs. This is the way disclosure should be conducted. In the real office situation, her thought process would happen fast, and some of it would be implicit. It's important for Dr. Goldberg to have a sense of her "medical personality." Does she have reason to be concerned about her use of PSD, as from previous incidents where she found herself talking about her own experience in ways that didn't help her patients? Did she detect in herself any eagerness to share her experience with Karen apart from a clear sense of how disclosure would be useful for Karen? Is she at peace with the trauma of her mother's illness and death, or is it a raw wound that might make her seek solidarity with Karen to serve her own needs? And, in simplest human terms, given that she thinks sharing her experience might be helpful for Karen, is she comfortable talking about herself that way? If she is shy and private, even if sharing would be useful in principle, she might not be able to transact the exchange effectively. Instead of responding with disclosure, she might have proceeded this way:

Dr. G: (*I've known Karen for 10 years. She's a strong, independent, hard-working person, who takes care of others. I think she expects herself to be a Rock of Gibraltar. She may need to feel that she has "permission" to feel so distressed. I'll try to clarify the problem for her and reframe what she's calling "weakness."*) ALS in a parent is very tough to deal with, especially since you're an only child. I've known you for 10 years, so I know what a strong person you are and how much it matters to you to be able to help others. You haven't had much practice feeling needy yourself! If you were trying to help someone like yourself whose mother had ALS, how would you do it?

KH (laughing): You've got my number! I guess with someone like myself I'd just listen and let them cry on my shoulder.

Dr. G: Do you have people you can talk to that way? My guess is that doing that will help you feel better. The situation isn't going to get easier, but we can work together to take care of your mother and of you at the same time.

Self-disclosure is a common part of human relationships. When friends bring up a problem, it's natural for us to talk about a related problem we've encountered. But in medical practice we have a distinct responsibility to put our patient's needs ahead of our own. And since the time of Hippocrates we've asked ourselves to pay special attention to avoiding harm. We should be prepared to use PSD as a tool, but only after we've defined the rationale for disclosure, considered the potential risks, weighed it against other ways of addressing our patient's needs, and scrutinized our own motivation, to make sure PSD is intended to serve our patient and not ourselves.

References

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