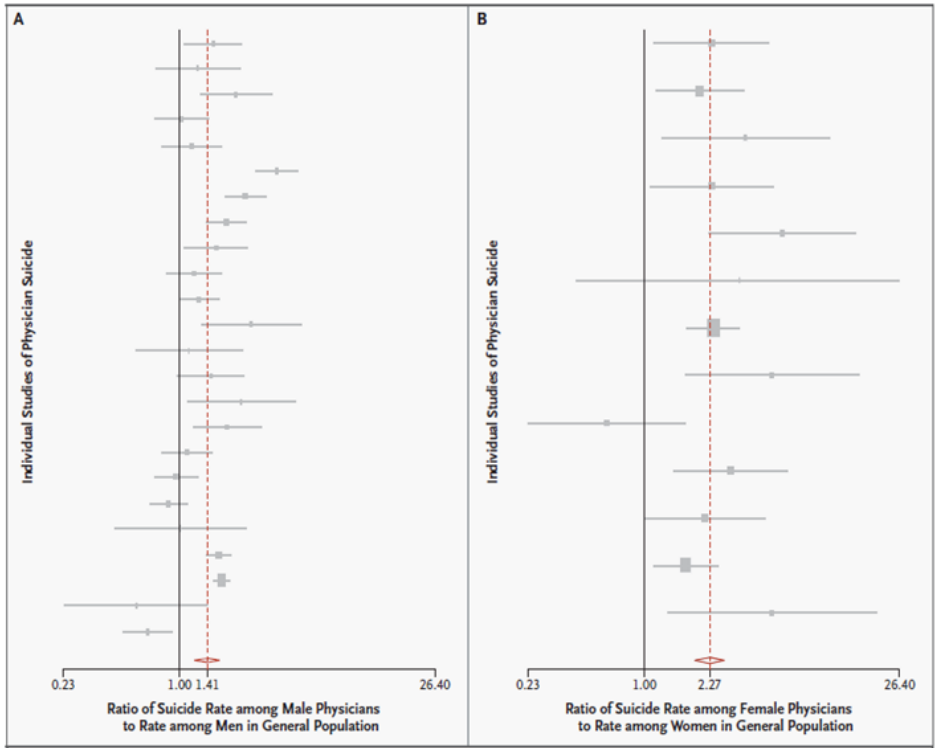
Im Spannungsfeld zwischen Erkrankung und Professionalität

DIE BIPOLARITÄT ALS ÄRZTIN UND PATIENTIN

Übersicht

- Die Ärztin als Patientin
- Die Patientin als Ärztin
- Fazit

„Taking their own Lives – The High Rate of Physician Suicide“ Schernhammer E (2005)



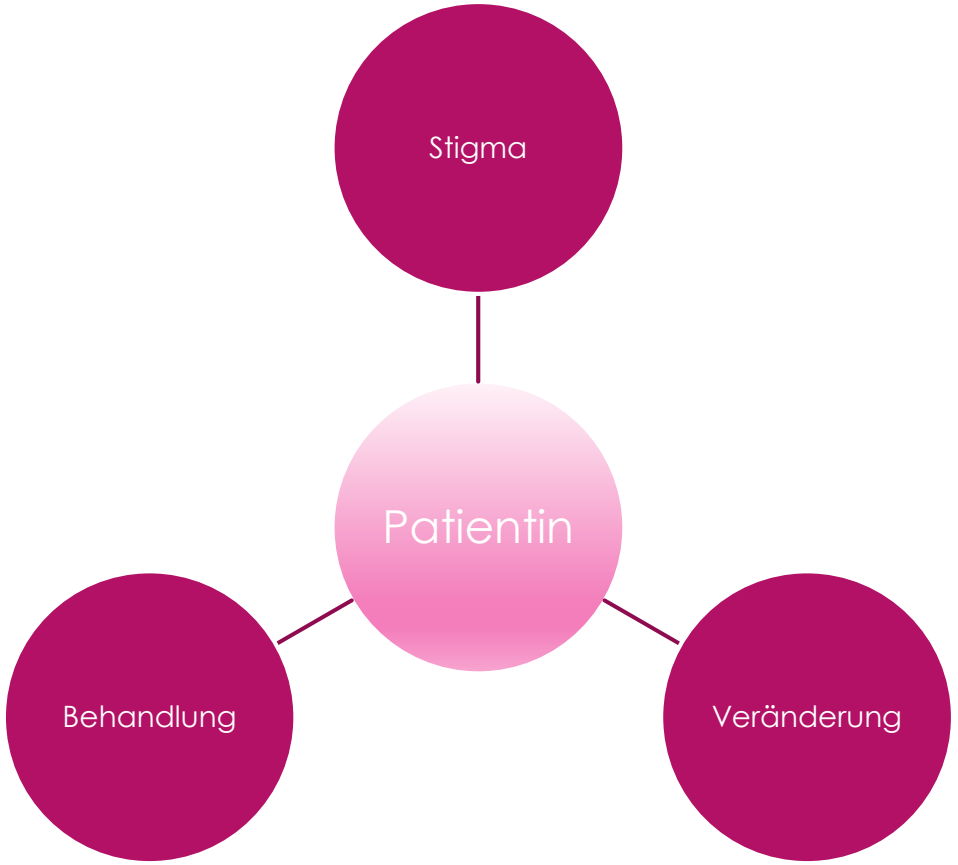
Suicide Rates among Male Physicians (Panel A) and Female Physicians (Panel B) in Relation to the Rates in the General Population of the Same Sex.

The size of each box represents the relative size of the study sample, and the horizontal line that intersects the box indicates the 95 percent confidence interval. The dashed red line in each panel indicates the combined estimate. The diamond-shaped box represents the confidence interval. The data are from a meta-analysis by Schernhammer and Colditz.[1]

- 25 internationale Studien: Suizidrate bei Ärzten 40% höher als in der Allgemeinbevölkerung, bei Ärztinnen 130%
- Höchste Rate Fachrichtungen Psychiatrie und Anästhesie
- „….we must care not only for our patients but also for ourselves“.

„Ein kranker Arzt, das geht irgendwie nicht…. Wer schickt seine Kinder zu einem kranken Arzt?“

Joachim Meyerhof: Wann wird es endlich wieder so wie es es nie war



Stigma and mental health professionals: A review of the evidence on an intricate relationship

Table II. Comparison studies – summary of results.

Result	Times found	Type of attitudes concerned
Professionals more positive than population	6	Patients' civil rights[1], prognosis[3], attitudes to community care [2,3], stereotypes[7]; helpfulness of psychiatric treatments vs. natural remedies[4]
No difference between professionals and population	9	Social distance[1,2,8], stereotypes[7,8], attitudes to involuntary treatment[9], patients' civil rights[7], perception that mental illness and physical illness are different[7], agreement with informing patients about diagnosis and treatment★[7]
Professionals more negative than population	7	Stereotypes[1], social distance[1], prognosis/treatment outcomes[5,6,7], likelihood of discrimination[5,6]

[1] Nordt et al., 2006; [2] Lauber et al., 2004; [3] Kingdon et al., 2004; [4] Jorm et al., 1997; [5] Jorm et al., 1999; [6] Caldwell & Jorm 2001; [7] Magliano et al., 2004b; [8] Van Dorn et al., 2005; [9] Lepping et al., 2004.
★ Positive attitude.

Schulze, B (2007): International Review of Psychiatrie 19(2): 137-155

Die besondere Arzt –Patienten-Beziehung

Vorteile

- Schnellere Terminvergabe an Wartelisten vorbei
- Bevorzugte Behandlung (Me-Too-Präparate und MRT auch als Kassenpatientin)
- Laborkontrollen und Untersuchungen lege artis

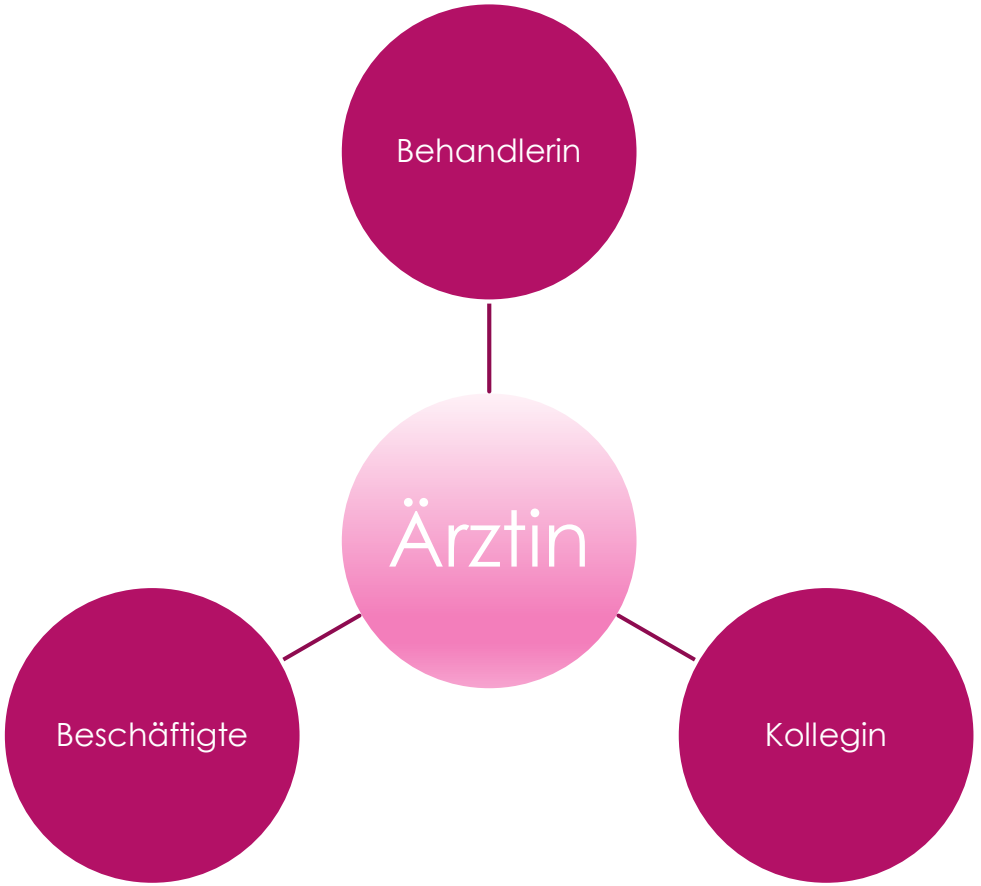
Nachteile

- Zu viel Kollegialität und zu wenig Stringenz, Behandler schrecken vor Strenge zurück
- Wer bestimmt die Therapie?
- Scham und verharmlosende Symptomschilderung / Was wird erfragt?
- Verflechtung in kollegialen Wirrungen
- Deutliche Stigmatisierung

Veränderungen

- Berücksichtigung der eigenen Fragilität:
  - Regelmäßiger Tagesablauf mit frühen Bettzeiten
  - Keine Zeitzonenflüge, weniger Alkohol, keine durchgefeierten Nächte…..
  - Deutlich verminderte Belastbarkeit
- Veränderte zwischenmenschliche Beziehungen

„Glaubte ich wirklich, dass jemand mit einer Geisteskrankheit die Erlaubnis haben sollte, Patienten zu behandeln?“ Kay Redfield Jamison: Meine ruhelose Seele



Behandlerin

- Bessere Softskills
- Therapie ist kein Kampf
- Berücksichtigung von Nebenwirkungen
- Sehr strukturiert
- Schwerpunkt Persönlichkeitsstörungen

Beschäftigte

- Verminderte Belastbarkeit
- Klare Benennung von Grenzen:
  - Kein Akutbereich
  - Keine Nacht- und Wochenenddienste
  - AU bei stärkeren Stimmungsschwankungen
- Enge Abstimmung mit der Ärztlichen Direktorin

„…the experience of communal, professional and self stigma“ RosenA et al., 2009

„Even when they [medical practioners] are at imminent risk of harming themselves or others, they may be left to fend for themselves, with colleagues either oblivous or aware, their responses varying from ‚neglect‘, to innuendo, gossip or derision“

The Royal Australien and New Zealand College of Psychiatrists – Code of Ethics

PRINCIPLE NINE

Psychiatrists have a duty to attend to the health and well-being of their colleagues, including trainees and students.

9.1 Significant incapacity in a psychiatrist may harm the affected psychiatrist, his or her patients, and the profession. Psychiatrists who become aware of their own or a colleague's incapacity have a responsibility to initiate appropriate action. When taking action, psychiatrists must regard the protection of patients as their primary responsibility.[3]

9.2 Psychiatrists who supervise trainees in psychiatry shall identify their supervisory role and functions clearly, ensure appropriate referral and not provide treatment.

Implications for change in psychosocial/psychiatric care for medical practioners

- Psychiatric care for such practitioners should be highly skilled, respectful, humane and particulary mindful to the vulnerable position of being a psychiatrically impaired medical practioner undergoing psychiatric treatment.
- While voluntary treatment is far preferred for most psychiatrically impaired practioners, when there is actual or anticipatded danger, there is a place for hospital or communitiy-based involuntary care. […]
- Being a psychiatrist or medical practioner who has experienced a severe mental illness should not in itself preclude being allowed and encoured to resume training or clinical practice upon recovery, or when in remission. There shoud be no absolute caveats or ‚zero-tolerance' policies or other discrimination against such practitioners entering training, or being certified or reregistered.

Dr. Margaret Tobin
Head of South Australian Mental Health Service
† 14. Oktober 2002

Vielen Dank für Ihre Aufmerksamkeit!

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