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Informal consultations: a case report of a young doctor as a patient

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RESUMO

Introduction: Informal consultations are medical acts characterized by the individual's self-referral to a doctor, without clinical record or adequate follow-up. Despite controversy, this practice is an integral part of medical culture. This case report highlights the importance of understanding the consequences of informal consultations and the desirability of a preventive attitude towards one's own health.

Case description: A 28-year-old female health professional requests an informal consultation due to low-back pain after two months of evolution where a tentative diagnosis and treatment plan were brainstormed. Symptom aggravation led her to a formal ortho-traumatology consultation, whereupon she was definitively diagnosed with a herniated lumbar disc, and a treatment plan was discussed and implemented, with good outcomes.

Commentary: This case reveals the complexity of clinical communication and psychosocial context involving informal consultations. Healthcare professionals are particularly susceptible to belittling signs and symptoms, using informal consultations to tackle the clinical situation quickly and be able to work, but without really addressing the underlying problem.

Keywords: Hallway medicine; Informal consultations; Communication; Physicians; Case report.

INTRODUCTION

Informal doctors' consultations, outside the formal appointment context, are medical acts characterized by the individual's 'self-referral' to a physician, for an assessment or treatment, without clinical records and adequate follow-up. This reality occurs independently of medical specialty and geogra-phic location and is based on socio-psychological factors such as relationship, trust, and access to informal healthcare providers.[1-4] The Deontological Regulation of the Portuguese Medical Association grants its members the duty, right, and ethical responsibility to treat all colleagues and family members under their care free of charge. This provision facilitates access to a quick assessment and differentiated opinion, inducing a greater predisposition to the occurrence of informal consultations, commonly known as 'hallway/corridor', 'kerbside' or 'off the cuff' consultations.[5] This type of consultation encompasses counseling or treatment of colleagues, friends, or family, but the phenomenon is particularly prevalent within the medical community.[1-4]

Informal consultations are unstructured conversations that do not follow the typical consultation steps and diverge considerably from their formal counterparts. As such, informal consultations are labile in nature, and susceptible to subjective factors and phenomena, such as the relationship between the patient and the doctor providing health care, the type of request, and the perception of risk/benefits for both parties involved. Essentially, formal medical appointments are associated with better clinical care and lower risk of ethical, legal, psychosocial, and economic issues, while informal consultations are associated with

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a potentially worse outcome and lower satisfaction with the support provided, particularly in health professionals, who are the most problematic patients.[6]

Previous research on the attitudes and actions of physicians found a particular reluctance to accept the role of patients themselves, and a greater predisposition to deny and devalue their own symptoms.[5] This phenomenon is mainly owing to negative countertransference reactions and feelings of inferior professional competence towards the health care provider.[7] In addition, a request for an assessment is also often perceived as an imposition and an increase in the colleague's workload.[8]

The habitual denial of symptoms also evokes other socio-psychological mechanisms at work, such as the mourning process due to a personal loss (herein, a loss of health). Kubler-Ross described the first phase of the grief process – denial – as a protective mechanism against psychological damage: the individual chooses to deny and avoid addressing the problem, preferring to keep their reality 'untouched'.[9] Concurrently to this grief process, and due to an understandable lack of objectivity in the situation, doctor-patients tend to adopt ineffective and inappropriate mechanisms of self-care, self-medication, and, when other actions fail, self-referral for informal consultations.[10-12]

When the patient is a doctor, the informal health care provider is prone to subjectivity-inducing mechanisms, and often joins the informal patient in the process of denial and trivialization of symptoms, if the doctor-patient possesses the same degree of knowledge. This increases the risk of clinical communication failure, especially in regard to shared decision--making. Thus, it is advisable that physicians' resort to formal medical appointments, in which the doctor--patient views the care provider as any patient would view their physician and where the healthcare provider regards the doctor-patient as a patient and not a colleague.[5]

Despite the problems inherent to this practice and the recommendations issued by various medical associations that advise against it, hallway consultations persist in the medical community. In this article, we describe a clinical case of a patient who came to the family doctor for an appointment following a situation in which she, a doctor, had been a patient who found herself falling into the informal consultation 'trap'. During the appointment, while discussing the reasons why she sought informal and then formal consultations, we concluded that her path was not the correct or desirable one. This case report seeks to explore the issue of informal consultations and analyze the behavior of health professionals when faced with a problem in their individual health.

Informed consent for publication was obtained from the patient, and CARE guidelines were observed.

CASE DESCRIPTION

The patient is a 28-year-old Caucasian female, in the second year of medical residency in family medicine, with a surgical history of adenoidectomy at 12 years of age and reconstructive surgery for radial nerve injury at 18 years of age. Denies any other relevant personal or family medical history, use of chronic medication, or drug and/or food allergies.

The doctor-patient presented with shock-like lumbar pain: sudden onset in September 2020, intensity 6/10 on the *Pain Visual Analogue Scale* (Pain VAS), after exertion. After one month the pain began to spread to the gluteal region, and she resorted to self-medication with acetaminophen 1 gram tridaily, with no improvement. She asked for an orthopedics 'hallway' consultation with a colleague in the emergency department. Trying to take hardly any of the colleague's time or be a burden, she briefly described her symptoms, the physical limitations, and what she thought her own diagnosis was: a simple muscle contracture. A brief physical examination was performed with no relevant findings, and she was thus diagnosed with piriformis syndrome. The colleague advised analgesics and rest, accompanied by physiotherapy if the pain persisted. Following this evaluation, the doctor-patient self--medicated with acemetacin 90 mg once daily, and thiocolchicoside 8 mg bidaily, but did not pursue physio-therapy.

The clinical condition evolved unfavorably, interfering with quality of life as symptoms worsened: increased pain intensity (8/10 on the Pain VAS), emergence of paresthesia in the left lower limb, limitation of functionality in activities such as driving, and interference with the sleep pattern with frequent

awakening due to pain, and insomnia that led her to self-medicating with diazepam 5 mg once daily.

Due to this exacerbation, the doctor-patient resorted to a private-sector orthopedic formal consultation four months after the informal evaluation, referring concerns about the chronicity of the pain, and citing disorganization of corridor evaluations as the motive behind the decision to resort to a formal appointment with a doctor who was not a friend. She said that the first evaluation was done in a corridor with no proper physical examination and that the advice of the colleague was not a proper treatment plan. After anamnesis and physical examination, the orthopedics colleague stated a need to request magnetic resonance imaging of the lumbar spine for differential diagnosis. However, the doctor-patient was reluctant since, in her own medical opinion, the symptomatology did not seem attributable to the lumbar spine, but to muscle pathology. The colleague validated her feelings and concerns but stressed the pertinence of carrying out the complementary diagnostic exam and obtained the doctor-patient's assent.

Magnetic resonance imaging revealed lumbar hyperlordosis, disc herniation in the L5-S1 intervertebral space obliterating the foraminal recess with sufficient dimensions to justify the symptoms, and spondylolisthesis. In the second consultation, involving the doctor-patient in her therapeutic plan, the option was for conservative treatment with preventive measures (avoidance of carrying an excess load and high-impact physical exercise, use of a pillow during sleep to correct hyperlordosis and adoption of correct postures); analgesics on a fixed schedule for one week (etoricoxib 60 mg bidaily, metamizole 575 mg bidaily, and intramuscular betamethasone 14 mg in a single dose) and subsequently if necessary; and progressive, low-intensity muscle strengthening. Currently, about two months after the second orthopedics formal consultation, the patient is practicing Pilates, with basal low back pain 1/10 on the Pain VAS, with some moments of aggravation triggered by physical effort in carrying loads with maximum intensity of 5/10 on the Pain VAS, with resolution of paresthesia, no radiating pain episodes, and no interference with quality of life.

In the family doctor appointment, after describing her story, when asked about her clinical condition and why she did not resort to formal consultation after pain onset, she stated that she knew "it was undoubtedly a textbook clinical case, but I did not want to believe that I had a herniated disc" *(sic)*. Her feelings were validated, the importance of maintaining the treatment plan was affirmed, and the door was left open for another consultation.

COMMENTARY

This case reveals the complexity of clinical communication and the psychosocial context that encompasses informal consultations, particularly when the patient is a health professional.

Although the existing literature is not extensive, some authors describe resistance on the part of health professionals, particularly physicians, in actively seeking formal medical advice,[8,13-14] mainly due to embarrassment and discomfort in adopting the role of patient, but also due to concern about the confidentiality of the consultation.[8,15] This constraint was reported by about 50-71% of physicians, mainly due to fear of judgment on the part of the health care provider, fear of resorting to a colleague for trivial pathologies, or belief that seeking their own diagnosis or treatment was wrong, inappropriately using differentiated resources.[13-14] In matters related to mental health, this discomfort was heightened. This fear of judgment is inherent to the human condition; human social relations (whether professional or personal) are dominated by expectations on both sides. When an individual relates to another person, both have expectations regarding the other, and both want to live up to those expectations.[16] Thus, when doctor-patients turn to a colleague for evaluation, they feel the need to demonstrate medical knowledge and reasoning, avoiding perceived failure. This subjectivity, together with the subconscious need to meet expectations, results in a clinical assessment subject to interference from the non-rational scope, which is associated with ethical, legal, psychosocial, and economic problems, with a potentially worse outcome and less satisfaction with the support provided.[15] On the reverse, physicians providing informal consultations suffer from the same fears and expectations and

tend to feel uncomfortable due to the absence of medical documentation available to them, and the possibility of their own lack of objectivity, resulting in a belief that they run a risk of being unprofessional and, in the extreme, negligent.[15]

This constraint can be internalized under the sense of duty to patients and colleagues, inferring a need for physicians to minimize their symptoms, regarding them as insignificant/trivial, and rejecting the hypothesis that they are ill.[8] This reluctance, aided by a tendency to rationalize feelings, creates a serious barrier and reduces the pursuit of medical treatment, as was also reported by Rosvold and Bjertness, who concluded that about one-fourth of doctors hide their illnesses from their colleagues, creating a habit of continuing to work even when sick and expecting the same from their peers.[14] In addition to not looking for medical help when a health problem arises, studies show that about two-thirds of doctors are not regular visitors to their family doctor.[13-14] This situation highlights the need for physicians to take a preventive attitude towards their own health from an early stage in their professional career, in order to avoid the negative impact that changes in health and well-being may cause.[17] Although the doctor-patient in question did not report this type of embarrassment, the issue was not actively explored, and it could be a subconscious process.

To control the symptoms, while avoiding the previously explored discomfort, informal consultations appear as an integral part of the medical culture, which also promotes self-medication.[14]

Self-medication, a process through which an individual decides to take medication on their own to resolve a condition, is reported with high frequency, by 25-90% of doctor-patients. Interestingly, a study conducted by Chambers and Belcher in England, which intended to audit self-medication by physicians, revealed that the self-medication taken prior to observation by a specialist was inappropriate in about 78% of cases.[5,13-14,18-19]

As explained above, informal consultations are another practice widely accepted by physicians, and the literature indicates that more than one-third of doctors have resorted to this type of practice to solve their health problems, with musculoskeletal complaints being the main cause of this self-reference.[5,20]

In the clinical case presented, the first informal consultation was characterized by an evaluation conducted under the interference of expectations management. Thus, the patient's follow-up was nonexistent, despite corresponding to the doctor-patient's expectations, reinforcing the triviality of the symptoms and denial of the problem, ensuring her compliance. This informal assessment, aggravated by the non-exploration of the patient-doctor's fears and concerns, did not respond to her real needs as a patient, due to the non-resolution of the condition and the doctor-patient needed a formal evaluation six months later. The doctor-patient shared that the anamnesis was not complete, a proper physical examination was not performed, or a formal treatment plan was established. As she herself states: "Since the corridor evaluations end up being disorganized, I decided to resort to a formal consultation" *(sic)*. The result of a doctor consulting a colleague as the patient led to an unsuitable consultation, with the setting and direction being defined by the doctor-patient and not her doctor. In the formal evaluation, the orthopedics colleague was faced with the challenge of a doctor-patient who trivialized her symptoms and denied one of the most likely diagnostic hypotheses – disc herniation. In order to manage this clinical case dominated by socio-psychological factors, it was necessary to perform a formal evaluation and engage in fruitful clinical communication. A properly structured consultation allowed the healthcare provider to understand the clinical picture and its temporal evolution in a rational way and without interference from psychosociological factors, achieving greater efficiency. Without the presence of this interference, it was possible for the healthcare provider to assume an assertive attitude for the correct course of the clinical case.

Denial is a conscious or unconscious refusal, defined by the inability to recognize some painful aspects of reality or triggered emotions. Denial can be classified as adaptive or maladaptive, depending on the long-term sustained response. Adaptive denial is a protective coping mechanism in the face of an event perceived as a threat.[8] In view of this reaction, there must be efficient clinical communication, providing a space free of judgment, guided by active listening and recognition of the degree of emotional vulnerability.[6] In order to

take this assertive approach and ensure the correct involvement of the doctor-patient in the consultation, it was essential to validate her feelings and concerns, increasing her insight. Once the barrier created by denial had been overcome, closer contact and communication became possible, establishing a common ground for sharing thoughts and knowledge and, through shared decisions, creating a plan that met the patient's needs and expectations. In this complex clinical case, the key was undoubtedly adequate clinical communication; using good clinical communication techniques, it was possible to establish a diagnosis and design a plan to improve the symptoms and, consequently, the doctor-patient's quality of life.

Health professionals tend to undervalue their signals and symptoms, always envisaging them as acute and transient situations with simple solutions. They often resort to asking colleagues for informal consultations to try to resolve their clinical situation, without ever taking the opportunity for a formal clinical assessment. Contrary to what they do in consultations with patients, in which they detail the clinical history and do an objective examination, explain the importance of complementary means of diagnosis to clarify some clinical conditions, and jointly decide the therapeutic plan, when the health problem is their own, they always try to get 'just' well enough to keep on working. The logic behind this rationalization is fallacious, based on a subjective feeling that a doctor has a real notion of what goes on in their own body, that they cannot fail patients and colleagues, and that it makes no sense to overload services and colleagues, wasting resources on what they "are perfectly equipped" to resolve on their own.

Following what is described in the literature, if health professionals regularly sought medical appointments with their family physicians, most of their health issues would be tackled in formal consultations, with structured interviews, physical examination, and a proper discussion of the treatment plan, always considering the doctor-patient's feelings and fears regarding their own health. This clinical report effectively highlights the need for physicians to avoid self-treatment except in emergency situations, particularly due to the difficulty in maintaining the level of objectivity and professionalism that must prevail in any medical evaluation.

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ABSTRACT

CONSULTAS INFORMAIS: RELATO DE CASO DE UMA JOVEM MÉDICA COMO PACIENTE

Introdução: As consultas informais são atos médicos caracterizados pela autorreferenciação a um médico, sem registo clínico ou seguimento adequado. Apesar de controversa, esta prática assume-se como parte integrante da cultura médica. Este caso clínico mostra a importância de compreender as consequências das consultas informais e as vantagens de uma atitude preventiva em relação à saúde do próprio.

Descrição do caso: Profissional de saúde do sexo feminino, de 28 anos, com lombalgia com dois meses de evolução recorre a uma consulta informal, na qual foram discutidos um diagnóstico presuntivo e um plano de tratamento a ser implementado. Devido ao agravamento sintomatológico recorreu a uma consulta formal de ortotraumatologia, na qual se estabeleceu um diagnóstico definitivo de hérnia lombar e foi discutido e implementado um plano de tratamento de forma partilhada, que teve bons resultados.

Comentário: Este caso revela a complexidade da relação clínica e contexto psicossocial das consultas informais. Os profissionais de saúde estão particularmente suscetíveis à trivialização dos sinais e sintomas, recorrendo a consultas informais para uma rápida resolução da condição clínica, de forma a conseguirem manter-se a trabalhar, mas sem aprofundar a etiologia e causa do problema.

Palavras-chave: Consulta de corredor; Consulta informal; Comunicação; Médicos; Relato de caso.