

Original Article

Between the Stethoscope and the Diagnosis: The Experience of Angolan Doctors as Patients

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Abstract: Physicians' experiences as patients expose a distinctive tension between their professional role of caregiver and the lived vulnerability of being cared for. This duality challenges both professional and personal identities. This study investigated perceptions, challenges and emotional consequences of illness among Angolan doctors and examined implications for medical practice and the humanization of care. We conducted a descriptive, cross-sectional, study in Luanda, Angola, between March and May 2024. A total of 139 physicians completed a culturally adapted questionnaire based on Medscape. Quantitative data was analyzed using Epi Info (v.7.2.6.0) and presented as absolute and relative frequencies. Open-ended responses were examined thematically to complement quantitative findings. Most participants were women (64.8%) and worked in the public sector (60.4%). Disclosure of professional identity during consultations occurred "sometimes" for 64.3% of respondents. Almost 70% reported increased fear of illness, though 48.9% reported no career repercussions. While 71.2% did not expect preferential treatment, 46.8% perceived receiving better care because of their status. Importantly, 42.5% indicated that personal illness enhanced empathy towards patients. Illness affects physicians beyond the physical dimension, reshaping professional identity and catalyzing empathy in clinical practice. This pioneering Angolan study underscores the need for institutional policies addressing physicians' health, confidentiality, and psychological support. Facilitating reflective spaces for physicians' illness narratives may strengthen patient-centered, humanized care.

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1. Introduction

Physicians who become patients must reconcile two identities that often feel irreconcilable: the clinically competent caregiver and the vulnerable recipient of care. Although illness is traditionally considered to be the reality of patients, doctors' involvement in their own illness journey challenges this dichotomy and reveal practical and ethical difficulties encountered when they cross to the "other side" of care. Throughout their careers, doctors develop a 'medical self' of greatness, often fueled by the exalted nature of the profession. Paradoxically, this can make it difficult for them to accept the vulnerability inherent in illness [1]. This resistance to becoming ill and asking for help is often driven by factors such as stigmatization, the fear of weakening one's professional image, and the concern of disappointing colleagues, as well as cultural and personal barriers [2-4].



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For doctors particularly, the process of becoming a patient requires a significant change of perspective. For many, this change involves confronting illness physically, as well as undergoing a profound re-evaluation of their role in the world and their professional identity. The movement between medical practice centered on technical competence and the experience of being a patient generates fertile ground for reflection on the impact of illness on doctors' lives. As Charon [5] proposes, medical narrative, or auto-pathography, is a vital tool for exploring this experience. It offers a fresh perspective on the relationship between doctors and patients, enabling a more empathetic and holistic view of illness [5 - 7].

This research aims to investigate the experiences of doctors as patients, highlighting the perceptions and challenges faced by Angolan doctors from various specialties and stages of their careers, with a particular focus on the physical and emotional suffering experienced during illness. By exploring this experience, the research seeks to understand the barriers that doctors face in accessing care and to reflect on the implications of this experience for medical practice and the humanization of care in the context of narrative-based medicine. Through this analysis, the study aims to contribute to a greater understanding of the impact that illness can have on doctors' lives and professional identities.

2. Methods

2.1 Study Design and Setting

We conducted a cross-sectional descriptive study in Luanda, Angola, from March to May 2024. The study was applied to doctors from different hospital units in Luanda using a questionnaire adapted from the Portuguese Medscape [8].

2.2 Participants and eligibility

Eligible participants were practicing physicians registered with the Angolan Medical Association who provided informed consent. Inclusion required $\geq 80\%$ completion of the questionnaire. Five incomplete forms were excluded.

2.3 Sampling and Sample Size

We used non-probability convenience sampling. The final sample comprised 139 physicians, $\sim 1.39\%$ of the estimated 10,000 registered doctors nationally. Given the urban concentration of respondents, external validity to rural provinces is limited.

2.4 Data collection and processing

We adapted a Medscape-based instrument (Portuguese edition) to the Angolan context through (i) linguistic and cultural adjustments, (ii) expert review by three senior physicians, and (iii) pilot testing ($n=5$) to optimise clarity. The final survey contained 14 items (13 closed, one open). Key variables included: demographics (sex, age group), employment sector, area of practice; disclosure of medical identity during consultations; fear of illness following personal illness; perceived career repercussions (e.g., reduced hours, fewer patients, leave, none); expectations of preferential care; perceived differential care (doctor-patients vs non-medical patients); empathy towards patients after illness; preference for care provider (known, unknown, recommended, none); and confidence in colleagues' prescriptions.

The survey was administered via Google Forms and disseminated by email and WhatsApp with a study information sheet and consent statement. Data was exported into Epi Info (v7.2.6.0) for analysis. No personal identifiers were collected; datasets were stored on password-protected devices accessible only to the research team.

2.5 Statistical analysis

Quantitative data were analyzed in Epi Info v.7.2.6.0. We summarized categorical variables using counts and percentages. The open-ended item was analyzed inductively to generate descriptive themes complementing quantitative results. Given the exploratory aim and sampling strategy, no hypothesis testing was performed.

3. Results

3.1 Participant characteristics

A total of 139 physicians participated in the study. There was a predominance of females, who represented 64.8% of the sample. The largest age group was 24–34 years (46.0%), with 64 participants, as shown in Table 1.

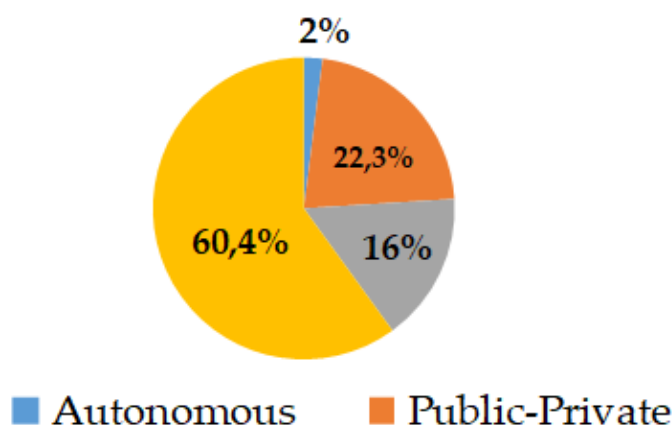
Table 1. Distribution of doctors by age group.

Age Group	Total	
	n	%
24-34	64	46.0
35-44	42	30.2
45-54	19	13.7
55-64	6	4.3
≥ 65	8	5.8
Total	139	100

3.2 Employment and area of practice

Most respondents worked exclusively in the public sector (n=84; 60.4%), while 31 (22.3%) combined public and private practice, as shown in Figure 1. By area of practice, 64 (46.4%) were specialists, 49 (35.3%) residents, and 26 (18.7%) general practitioners, as shown in Figure 2.

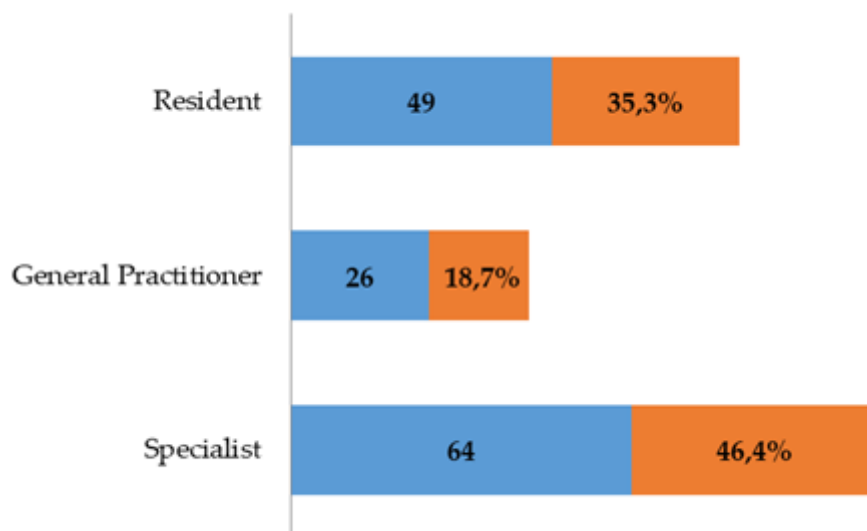
Figure 1. Distribution of doctors by age group.



3.3 Professional Identity and emotional impact

Regarding disclosure of professional identity during consultations, 89 (64.3%) reported doing so “sometimes”, 33 (23.7%) “never”, and 17 (12.2%) “always”. Following their own illness, 97 (69.8%) reported increased fear, while 42 (30.2%) reported decreased fear (Table 2).

Figure 2. Prevalence of adequate DVT prophylaxis in 2020.



3.4 Career repercussions

Overall, 68 (48.9%) reported no significant career repercussions. Among those reporting an impact, 34 (24.5%) took leave, 32 (23.0%) reduced working hours, and 5 (3.6%) saw fewer patients (Table 2).

Table 2. Distribution of doctors according to whether they claim to be doctors during consultations, their fear of the disease, and the repercussions of the disease on their careers.

Declares to be a Doctor in Consultation	Total (N=139)	
	N	%
Always	17	12.2
Sometimes	89	64.0
Never	33	23.7
Fear of the Disease		
Increased	97	69.8
Decreased	42	30.2
Repercussions of Illness on Career		
Decrease in Working Hours	32	23.0
Decrease in Number of Patients	5	3.6
Holidays	34	24.5
No Repercussions	68	48.9

3.4 Perceptions of care and empathy

While 90 (71.2%) did not expect preferential treatment, 40 (28.8%) did. When comparing care quality for doctor-patients versus non-medical patients, 65 (46.8%) perceived doctors received better care, 59 (42.4%) perceived the same, and 15 (10.8%) perceived worse care for doctors. Personal illness was reported to enhance empathy in 59 physicians (42.5%); 37 (26.6%) reported “a little” impact and 43 (30.9%) reported no impact (Table 3).

Table 3. Distribution of doctors according to privileged care: medical versus non-medical patient care.

Privileged Service	Total (N= 139)	
	N	%
No	99	71.2
Yes	40	28.8
Medical Vs. Non-Medical Patient		
Same	59	42.4
Better	65	46.8
Worse	15	10.8
Empathy		
Very	59	42.5
No	43	30.9
A Little	37	26.6

3.5 Preferences for provider and trust in colleagues

Twenty participants (14.4%) preferred consultation with an unknown doctor, 31 (22.3%) with a known doctor, 33 (23.7%) with a recommended doctor, and 55 (39.6%) had no preference. Confidence in prescriptions by colleagues was high (n=125; 89.9%), with 5 (3.6%) reporting lack of confidence and 9 (6.5%) selecting “other” (Table 4).

Table 4. Distribution of doctors according to their involvement in medical care and the safety of prescribed medication.

Preference in Medical Care	Total (N=139)	
	n	%
Known doctor	31	22.3
Unknown doctor	20	14.4
Recommended doctor	33	23.7
No preference	55	39.6
Safety in Prescribed Medication		
Yes	125	89.9
No	5	3.6
Other	9	6.5

4. Discussion

This study sought to understand the experience of doctors as patients in Luanda, a topic that has been little explored in African literature. The results revealed multiple personal, professional, and institutional dimensions, in line with international evidence, but also raised issues specific to the Angolan context.

4.1 Sociodemographic Profile and Feminisation of Medicine

The study population was predominantly young (24–34 years old) and female (64.8%). This data confirms the global trend of feminisation in medicine, already documented in different countries [9-11] and evidenced in studies conducted in Angola, where most medical students are female. This phenomenon may influence the experience of illness, for example, due to stigma during pregnancy and additional difficulties in balancing personal and professional life [12].

4.1.2 Employment Status and Area of Practice

Most participants (60.4%) worked in public administration, while 22.3% worked in the public-private sector, confirming the predominance of the state sector as the main sphere of professional integration. Regarding the area of practice, 46% were specialists and 18.7% were general practitioners, a distribution similar to that found in the study by Fawibe et al. in Nigeria [1], but divergent from that found by McKevitt & Morgan in the United Kingdom, where general practitioners predominated [12].

4.1.3 Professional Identity and Vulnerability

The results reveal the difficulty physicians have in assuming the role of patients, a phenomenon already described in the literature [6,13]. Many resort to self-medication, self-diagnosis, or postponing appointments. In the present study, 64.3% revealed their medical identity during consultations, a strategy that can facilitate communication but also compromise the therapeutic relationship.

4.1.4 Fear, Knowledge, and Illness

Almost 70% of doctors reported increased fear of the disease, in line with international studies [14]. Medical knowledge, rather than providing reassurance, exacerbated anxiety. This finding suggests the need to prepare doctors to deal with their own vulnerability and reduce the stigma associated with illness.

These data suggest that doctors in Angola, despite being very knowledgeable about diseases, may also internalise high levels of anxiety about their own health. This fear may be amplified by weaknesses in the Angolan health system, including limited access to advanced diagnostic and therapeutic resources, financial constraints, and cultural stigmas associated with certain diseases. Unlike higher-income countries, where physician health programmes offer structured support, in Angola doctors often face illness with little institutional assistance.

In addition, the reported professional repercussions, such as a reduction in the number of patients or changes in responsibilities underscore physicians' vulnerability in reconciling personal illness with professional activity. These findings highlight the need for organisational policies that protect physician well-being, including occupational health programmes, psychological support, and clear guidelines for reintegration after illness.

4.1.5 Perceptions of Care and Equity

Perceptions of care were ambivalent: 46.8% felt they received differentiated treatment, while others reported equality or even neglect. Reports described both excessive zeal and neglect after the disclosure of medical identity, a situation also observed in Portugal [8] and Brazil [14]. This finding is consistent with international literature describing the "doctor-patient privilege" in different contexts [13,18]. However, in Angola, this perception may be shaped by systemic and cultural dynamics. The relatively small size and interconnectedness of the medical community, coupled with hierarchical professional relationships, may foster a culture in which colleagues, consciously or unconsciously, extend preferential treatment to peers.

Limited access to specialised services in the public sector may further exacerbate this perception, as doctors often know where and how to mobilise resources more effectively than laypeople. While this may reflect solidarity within the profession, it may also indicate inequalities in access to healthcare, where professional status influences the quality of care. Addressing these dynamics requires reflection on equity in the Angolan healthcare system, ensuring that all patients, regardless of their background or profession, receive the same level of care.

4.1.6 Empathy and Clinical Practice

Although 42.5% of physicians reported increased empathy after experiencing illness, most did not show significant change. This result, also reported in other contexts [17,18], suggests that the experience of vulnerability can be transformative for some, but is not universal. This result is consistent with studies from other countries showing that experiencing illness can sensitise doctors to their patients' vulnerabilities. However, it is equally significant that the majority did not report increased empathy. In the Angolan context, systemic pressures, such as high patient volumes, scarce resources, and limited institutional support for physician well-being, may constrain the ability to translate personal experiences into greater empathy. In addition, cultural expectations of resilience among physicians may discourage explicit acknowledgement of vulnerability, limiting the potential impact of personal illness on clinical practice. This duality suggests that while some physicians deepen their patient-centred approach after becoming ill, systemic barriers may prevent broader changes in empathy. Medical training and continuing professional development in Angola could integrate practices of structured reflection on personal experiences of illness, promoting empathy as a professional competency.

4.1.7 Professional repercussions

Most did not report a significant impact on their careers, but some participants reduced their working hours or took early leave, a finding similar to that of Henderson et al. [6] and Tarantino [8]. This presenteeism is worrying in Angola, given the shortage of human resources, as it can increase the risk of errors and compromise the health of the professionals themselves.

4.1.8 Preferences for Care and Confidentiality

The absence of preference for the attending physician predominated (39.6%), differing from findings in Brazil and Portugal [8,14]. This pattern may reflect fears related to breaches of confidentiality, a recurring theme in the reports, indicating ethical weaknesses in the Angolan health system.

4.1.9 Confidence in Prescriptions

Despite the frequent practice of self-medication, 89.9% stated that they trusted their colleagues' prescriptions, in line with Portuguese and Brazilian studies [8,14]. However, situations of unquestioned inappropriate prescriptions were also identified, revealing hierarchical and vulnerability dilemmas that could compromise clinical safety.

4.1.10 Ethical and Systemic Dimensions

Reports pointed to breaches of confidentiality, excessive or insufficient care, and a lack of humanisation, confirming previous findings [1,6,16]. These results reinforce the urgency of specific policies focused on doctors' health, including psychological support, confidentiality programmes, and institutional measures that promote greater equity and ethical sensitivity. In the Angolan context, marked by structural weaknesses, such measures could mitigate risks to physicians' health and the care provided to the population.

4.1.11 Implications for the Health Context in Angola

Taken together, these findings suggest that doctor-patients in Angola face a complex intersection of privilege, vulnerability, and systemic constraints. Preferential care reflects both solidarity and inequality. Increased empathy, while significant, is limited by systemic barriers. The heightened fear of illness underscores the fragility of physician well-being in a resource-constrained health system.

These findings have broader implications. They point to the need to integrate physician well-being into health policy agendas, promoting equity in access to care and in-

corporating reflective practices into medical training. Strengthening institutional support for physicians, through occupational health programmes, mentoring, and safe spaces for dialogue, can mitigate the negative consequences of illness while reinforcing empathy and professional solidarity.

Ultimately, this study not only documents experiences but also reveals structural and cultural challenges in healthcare in Angola. Addressing these challenges requires coordinated action in the areas of education, professional regulation, and health policy.

4.1.12 Limitations of the study

This pioneering research has some important limitations that should be considered when interpreting the results. Firstly, the sampling was not probabilistic and was based on voluntary participation through an online questionnaire (Google Forms) distributed by email and WhatsApp groups. This approach may have introduced selection bias, as respondents may not be representative of doctors in Luanda province or Angola as a whole, which limits the generalisability of the results. Second, the use of a self-administered questionnaire may have resulted in social desirability bias and underreporting of sensitive information, particularly regarding issues of vulnerability, mental health, and personal experiences with illness. As a result, some results may have been underestimated or presented in a more favourable light.

Thirdly, the study design did not allow for stratified analyses by medical specialty, workplace, or years of professional experience. Such analyses could have provided a more nuanced understanding of the differences between subgroups of doctors, which may limit the depth of interpretation of the results. Finally, as this is a cross-sectional and descriptive study, the results capture perceptions at a single point in time. Consequently, it is not possible to establish causal inferences or assess how experiences and perceptions may change over time. Despite these limitations, the study offers original and valuable insights into doctors' experiences as patients in Angola and highlights areas that merit further, more comprehensive, and representative investigations.

5. Conclusion

This study sheds light on an under-explored dimension in Angolan literature: the experience of doctors as patients. The results demonstrate that falling ill significantly impacts not only the physical sphere, but also the professional and emotional identity of the doctor. The main findings include the predominance of female participants and a high proportion of young doctors (aged 24–34), reflecting the growing feminization and generational renewal of medicine in Angola. It was also observed that most doctors do not expect preferential treatment, although a significant proportion recognize differences in treatment when they reveal their professional identity.

The fear of illness increased for almost 70% of participants, which reinforces the idea that technical knowledge can amplify anxiety about becoming ill. However, the majority said they had suffered no direct repercussions on their careers. Nevertheless, the experience of fragility reported by many contributed to greater empathy, with 42.5% reporting positive changes in how they treat patients. Another relevant point was the high level of trust (89.9%) in prescriptions from other professionals, indicating a growing openness to shared care and an increased appreciation of teamwork.

These findings demonstrate that experiencing the disease first-hand enables doctors to rethink their approach and develop a deeper understanding of others' experiences. Creating spaces for reflection on these experiences could lead to a more humane, empathetic and patient-centered approach to medicine, even when the patient is the doctor themselves.

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Conflicts of Interest: The authors declare no conflict of interest.

Supplementary Materials: None.

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