

Doctor, heal thyself

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ABSTRACT

This paper will present case studies of rural West Australian (WA) general practitioners (GPs) and their families attitudes and beliefs related to self care.

The aims of the study are to:

- examine the issues related to self care of GPs and their families in rural WA
- discuss the impact of a current program operating in WA to provide a GP and counselling service

Method

Focus groups were used as a method of evaluating a joint general practice screening and counselling service currently in use in rural WA. Both doctors and their partners were involved in this evaluation. Statistical data relevant to the services delivered by the program providers was also collated. In most cases, the focus groups were audiotaped, transcribed verbatim and then analysed using QSR N6 software to identify themes and categories. In other instances a tape player was not used but notes were taken of the discourse.

Results

This paper will present a number of disparate case examples that arose out of the abovementioned evaluation. GPs and their families from large regional centres to isolated remote communities, those who grew up in rural Australia and those who until recently practiced overseas, will be presented. This presentation will discuss how to address the variety of issues that arose.

Conclusions

The figures related to self-prescription of such things as anti-depressants in Australia are startling in themselves. The problems facing GPs in rural areas in respect to accessing confidential general practice care are also becoming more apparent. It is also well known that doctors present a variety of responses to personal ill health, the impact of discussion of these responses to peers in a focus group setting, covers new ground. The impact of research itself assists in moulding ideas and beliefs.

Implications

This study has implications for both rural and urban practice in relation to doctors self care practices and beliefs. It also suggests interventions at the undergraduate and Registrar level.



INTRODUCTION

The Western Australian Centre for Remote and Rural Medicine (WACRRM) co-ordinates the Rural Medical Family Network (RMFN) program in WA. The Care and Co program (formerly called “GPs for GPs”) is a relatively recent component of the RMFN that offers medical screening by a general practitioner (GP) and a counselling service by a trained counsellor to rural doctors and their families.

The program was evaluated during 2002 to determine if it effectively meets the needs of WA rural doctors and their families. This paper will present case studies of rural West Australian GPs and their families attitudes and beliefs related to self care. These will be described in the context of the issues that are relevant to self care of rural GPs and their families as well as looking at the impact of the Care and Co service.

BACKGROUND

A number of studies report that doctors tend to self-diagnose and self medicate, with many seeing this as appropriate behaviour. They are likely to postpone seeking help and more likely to refer themselves to see a medical specialist than to consult a GP. [1]

The literature is generally agreed that the line needs to be drawn for self-prescription of narcotic medications and that self-management of a chronic disease is inappropriate, including self-referral to a medical specialist. The majority of medical practitioners believe that it is reasonable for a doctor to treat an acute, self-limiting illness. However there is some ambivalence reported in regard to the self prescription of antibiotics. [2]

An article by Lawrence [3] about health and the medical profession states that:

- Doctors don't become stressed
- Doctors don't become sick
- If they did, their mates would treat them for free

These myths abound in the medical profession and make it difficult for doctors to see themselves as a person before being seen as a doctor.

There are many barriers to GPs seeking care from another doctor with fears of wasting their colleagues' time and of feeling embarrassed perhaps the most prominent. [4]

It can be difficult for doctors to assume the role of the patient and also difficult for doctors to treat their fellow practitioners. In recognition of this problem, the Northern Rivers Division of General Practice conducts a course for GPs to learn how to be doctors to their colleagues. [5] In other places there are workshops and courses to try and change the culture in general practice and to raise awareness of the need for both counselling and preventive medicine services. [4]

In WA there are around 2,000 GPs, with 450 currently working in regions classified as rural or remote. [6] Resident medical specialists in rural and remote WA number around 90, with half of these residing in the States largest regional centre – Bunbury. The Western Australian Centre for Remote and Rural Medicine (WACRRM) is the



States rural workforce agency whose role is to promote the recruitment, retention and quality improvement of doctors in rural and remote WA.

The “Care and Co” program is just one of a number of innovative projects supported by the RMFN and WACRRM. The program was established in 1999 as “GPs for GPs” in recognition of the fact that in some rural and remote areas of WA it might be difficult for a doctor and their family to access independent medical advice.

The program initially involved two GPs visiting the Kimberley region. From 2000, a husband and wife team of a GP and a trained counsellor have provided the service throughout the State. The medical component of the service is a preventive screening consultation and is not meant to substitute for the doctor and their family having their own GP. Rather, a purpose of the program is to educate and encourage doctors about the need to look after their own health including the need to see a GP regularly.

The program is available to all GPs and medical specialists in rural and remote WA, their partners and their children. The name change in 2001 reflects the fact that the service is not only for GPs and that it is not only a general practice service.



METHOD

The evaluation utilised quantitative and qualitative data collection methods. This included:

- review of the literature
- focus groups
- individual key informant interviews
- demographic data collected by the providers
- feedback survey.

This paper focuses on some of the data obtained from the focus groups. Analysis of this data was conducted using QSR N6 software [7] to develop themes and categories. Main categories were labelled and the themes were then related to each other through further analysis that considered their interrelationships. From this further analysis emerged a number of prominent themes related to self care of rural doctors and their families. An understanding of these themes is essential to the provision of a relevant service although it was not central to the evaluation of the current service. This paper presents that depth of analysis as a separate report on the issues related to self care of rural doctors and their partners in WA.

The selected themes are:

- But I am a doctor
- As a doctor, I cant also be a patient
- Can my colleague be my doctor?
- I need a GP who is not my partner



But I am a doctor

Would a motor mechanic send his beloved car to another mechanic for repair? If he did, what would that suggest about his skills in car repair? What would be the issues you would expect to see in relation to his interactions with the other mechanic? Perhaps he would be checking what was said and what was being done, he might also be lacking trust in the other mechanics ability. What is certain is that no one would suggest that he himself should not do the repairs. For one thing it would be cheaper and more convenient. For another, no one could know his car as well as he does and he couldn't blame anyone else if anything went wrong.

Some doctors think that medicine is synonymous with the above example. As a doctor they know their own body and self treatment is free and convenient. To suggest they see someone else might imply that they were not competent to make their own diagnosis or suggest their own treatment. However, the two examples are not similar and we know that even following evidence-based guidelines is not enough – we need to call upon clinical expertise and objective knowledge of the patient. This knowledge can never be objective if the patient is yourself or someone close to you, such as your partner or your child.

Its very important to understand that you cant look after yourself and that being a doctor does not mean that you can solve your own medical problems. The old belief that doctors are heroes, and are infallible, is a myth.

A quote from one of the focus groups:

The egocentric nature of doctors prevents them from seeking the required medical attention. We tend to be neurotic, high achievers, with OCD.

And another one:

... It is hard as a rural GP to look after your health, there are confidentiality and privacy issues if you go to see one of your colleagues. Prior to the visit by Care and Co, I had not had my blood pressure checked since in Medical school.

Not everyone agrees that they should seek advice externally however:

I don't have one (a doctor), I don't want one, and I'm sick of people telling me I should have one.

And:

The perception that we are not competent to manage our own health is insulting.

As a doctor, I cant also be a patient

The second theme is that it is difficult for a doctor to take on the role of a patient, even with the best of intentions. Part of this is related to the culture that says that a doctor shouldn't be unwell, and this is especially true if the illness is psychosocial or psychiatric in nature. It is also about trust in the other person to assist them in managing their health. This topic was discussed in a number of the groups and some participants challenged their peers.



A few doctors talked about doctors they had seen as patients. There was a feeling that they had not been used as a GP in the way that other patients used them. For example there was very limited interaction and their role as a GP for colleagues was minor.

Another participant said:

There is a distinct role change from being the doctor to being the patient and this can be difficult for both parties in the consultation.

This leads into the next theme of the doctor being a doctor to a colleague.

Can my colleague be my doctor?

This section begins with the case study from one of the groups when a GP and his wife shared their story.

Some doctors said that if they had a mental health issue they would be reserved in what was said to other doctors. Part of this concern relates to fears of confidentiality as well as a belief that their peers might not be empathic.

The fear with mental illness is that GPs will self medicate. Some felt that this issue was less of a concern if you had colleagues around you than if you were solo in a town. Others felt that their colleagues wouldn't necessarily notice or else they wouldn't say anything. One doctor said:

If I was sick I'd like to think that one of my colleagues could look after me. It is an insult to my peers to think otherwise.

I need a GP who is not my partner

The final theme looks at the way in which doctors might treat their partner or their children. In the groups, most said that they believed it was difficult to be objective about your own family. Often it was pressure from the family on the doctor, where the partner had an expectation that there was no need to see another doctor.

CONCLUSIONS

The four case studies presented here help to highlight the complexities of doctors caring for themselves and their families. Education continues to be needed for doctors and their families. This needs not only to be about appropriate health seeking behaviour but also about caring for your colleagues. The Northern Rivers Division of General Practice conducts courses for doctors to learn how to be better doctors to their peers. Maybe we should look at something like the AMA's "youth friendly doctor" program as a "GP friendly doctor" program? We also need to encourage doctors to be "better" patients.

A number of places including WA run GPs for GPs type programs and these are highly valued in rural areas especially. But they cannot replace the traditional relationship that a GP has with a patient and this needs to exist for doctors also.



One participant said:

Hopefully one day this service will be irrelevant as we will all have our own GP.

The figures related to self-prescription of such things as anti-depressants and the incidence of suicide amongst doctors in Australia are startling in themselves. Whilst a stigma still exists for people in the general population with a mental health condition, this is much greater for doctors with these problems. Government initiatives have begun to address this issue in the community but more input is needed into the way in which this is perceived amongst health professionals. Part of this is the responsibility of the medical community and they should be encouraged to share their stories with their colleagues to help break down these barriers.

Education needs to be addressed not only at practicing doctors but also to medical students and GP Registrars. Most of the participants in these focus groups were GPs and their partners – it would be useful to know how well medical specialists manage their health, especially in rural areas.

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PRESENTER

Sally Roach completed a Doctorate in Sexology through Curtin University, in WA in 2001. For the past four years she has worked in general practice research, initially with the RACGP. Sally is now employed by WACRRM in a newly created position as the Associate Director Research.

