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# The health of doctors

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*Physician heal thyself – but how?*

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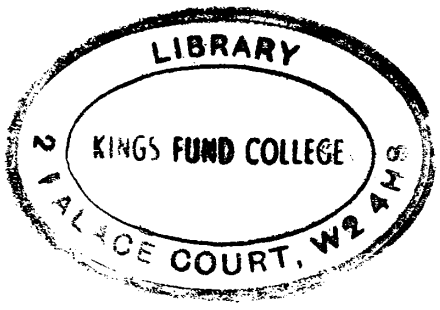
## SUMMARY

Caring for others imposes considerable strains on the carers. It is recognised that those who do care for others often have great difficulty in asking for, and receiving, care for themselves. This seems to be particularly true for the medical profession. Doctors suffer abnormally high levels of alcoholism, drug dependence, marital breakdown, mental illness and suicide.

This paper looks at the attitudes and behaviour in seeking health care of all the general medical practitioners in one family practitioner committee area. The results show that this group of doctors finds difficulty in receiving help from other doctors, particularly for conditions to which doctors are most susceptible.

Some of the reasons for this are discussed. Prevention of some of the difficulties and management of the problem of the 'sick doctor' are considered. Some strategies for improvement are suggested.

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# Introduction

> The attitude of the medical profession to the health of its members has always been one of disinterest which is transiently discarded when disaster overtakes one of its number.

So started one of the few recent papers on the health and health care of doctors in the UK.[1] With this in mind I undertook to study the health care of general practitioners in Avon as part of a Master of Science in Health Care degree at the University of Exeter. This paper presents the findings of the survey. The health of doctors has always received scant attention from their colleagues in spite of considerable and increasing evidence that morbidity is high in the profession.[2,3,4] Doctors have twice as many deaths from road accidents as the general population, a cirrhosis and suicide rate three times higher,[5,6] and a drug addiction rate at least thirty times higher.[7] The dangers of drunkenness to doctors and their patients have been known for many years.[8] In the USA, suicide kills more doctors than automobile and airplane accidents, drowning, and homicides combined.[9]

Many of the difficulties are related to stress. These are too numerous to list in this paper and vary from person to person. They are described with specific reference to the caring professions by Bailey.[10] Particular problems that doctors find stressful include the heavy workload and on-call commitment, high responsibility and insufficient time to do the work or to relax, alienation from families and social networks, and difficult professional relationships. Fatigue, in itself an important stressor, may mask other problems and leave them unacknowledged and unresolved. General practitioners are particularly bothered by the disruptions and anxieties caused by unpredictable emergencies, the behaviour of difficult patients, trivial consultations, unrealistic patient expectations, interruptions to family life, increasing administration, and emotional strain, especially when caring for the dying.[11] To these traditional sources of stress can be added new fears of litigation and of the threat of physical violence.[12] Some women doctors have the additional stresses of reconciling conflicting demands between work and family.

A paradox noted by many observers is that general practitioners seem to feel simultaneously satisfied and extremely stressed by some aspects of their work.[13] This will be discussed later in this paper.

The problems that doctors face in receiving health care are compounded by attitudes they develop during their training. Traditional medical curricula emphasise the concept of illnesses caused by diseases which can be combatted by the skills of medicine. In many medical schools, the students' first contact with a patient is with a dead one – in the anatomy room where they learn to reduce human beings to their component parts. Medical students are rapidly immersed in the suffering of others and exposed to intimate physical and psychological disclosures. A recent working party set up by the Royal College of Psychiatrists to consider recruitment to that specialty reported in these words to the Society of Clinical Psychiatrists.[14]

> It is necessary (for medical students) to block off their emotional reactions to the suffering that they witness. It is necessary to acquire a cold, clinical detachment which deadens them to the emotional impact of the subject matter and to the suffering of the patient. This desensitisation process tends to spread to other things like beauty, music and various forms of creativity and is compounded by the sheer bulk of knowledge required to graduate. . . . Teaching hospitals are pervaded by an atmosphere of sterility, discipline and attention to detail. Students reach the end of their course with their emotions well and truly buttoned up.

The report concluded that medical training avoided the issue of helping students to come to terms with their emotional responses to patients and denied them the chance of becoming more in touch and comfortable with their feelings.

Some of the process of becoming a doctor is that of assuming the mantle. Students start on the wards imitating doctors, going around in white coat and stethoscope. They gradually assume group norms and values. Particular ways of behaving are developed, such as the ways in which doctors communicate with patients. These attitudes are often carried over into doctors' private lives. Many doctors are surprised at being recognised as a doctor without realising that they cannot help behaving like one.

This was echoed by Michael O'Donnell writing in *The Times*[15] who stated that doctors use their power and status to distance themselves, not just from their patients' feelings but also from their own, and from dreaded implications of their own mortality. Young doctors protect themselves with emotional barriers learnt from their elders. But the barriers do not just protect – they isolate. 'Where feeling and empathy are concerned, most doctors have a good deal to learn.'

Once qualified, mature behaviour is demanded of young doctors whose own maturation has often been delayed by their intense commitment to premedical and medical education.[16] This time often coincides with the new and additional responsibilities of marriage and parenthood. The friendships and emotional supports of medical schools will be severed and new relationships will need to be made. The doctors will be working long hours as part of the tradition of internship. The problems will be compounded by the need to make frequent specialty changes which are often accompanied by moves to different hospitals. Fears of inadequate professional performance cause many young doctors to ignore their personal development as they work on their careers. The need to demonstrate membership of an elite profession leads to acceptance of the regimes of the houseman year without question, despite evidence that personal performance deteriorates with lack of sleep.[17] Fatigue adversely affects doctors' abilities to learn, to provide high quality medical care and to respond adequately to urgent problems.

McCue[16] stated that the houseman year was 'not designed to eliminate those unfit for physicianhood by testing for toughness and survival skills'. He wondered whether medical training was actually encouraging young doctors to tolerate and rationalise unnecessary errors and low standards of patient care. This was courageously and poignantly illustrated by West[18] in a description of his house officer year.

> At that time in the morning and after two busy nights, the only thing that I wanted was some sleep. I had developed a one track mind. Truthfully, I did not care about the patient. All I wanted was to get to bed as soon as humanely or inhumanely possible.

Other young doctors have reported being so tired during their house officer posts that they sometimes secretly wished that patients would die in the ambulance before arrival on to their wards. (Anonymous 1988. Personal communication.*) Scheiber[19] reported similar events.

Such a tough initiation ensures adoption of the established corporate identity. Initiates to the profession must either drop out or become moulded into the 'correct' material, a process known as cognitive dissonance. This ensures change by requiring subjects to invest so much time and effort in the task that they cannot afford not to believe in what they are doing. The ordeals of the 100-hour week may not be supportable on educational grounds, but they are highly effective in inducing professional conformity.

During the period of early medical experience, the young doctor encounters the responsibilities and privileges of being a physician, as well as mood changes that include anticipation and excitement, self-doubt, fear, elation and depression. However, the habit of ignoring emotional problems leads doctors into thinking that they are the only ones having difficulty coping with the emotions and stresses of medical practice. They continue to hold self-doubt and guilt inside themselves, and develop dysfunctional coping mechanisms such as denial. McCue wondered whether doctors had become so accustomed to suppressing emotional distress during their early years that they saw it as a necessary part of the training.

The doctors' armour of detachment and confidence is necessary, at least in part, if they are to get on with the job. Firth-Cozens[20] found that junior hospital doctors needed to maintain low levels of empathy with patients and to make external attributions for their problems in order to reduce stress while working. It is difficult for those within the medical culture to admit to weakness or illness in themselves; it is therefore probable that the survivors in medicine, the senior doctors who control the profession, are least likely to accept or admit weakness in themselves or their colleagues. The illusion that doctors are special tends to extend to an immunity

* The doctor who reported this to me was so worried about the disapproval this revelation might incur from her colleagues, and about the consequent effect on her career, that she was unwilling to allow it to be attributed.

from death and from life's problems. Awakening to the realisation that the practice of medicine does not always provide an exciting and challenging meaning to their lives comes as a shock to many physicians.

In 1983, Gerber published an extensive study of health and illness among doctors and medical students at Washington University.[21] He described how much of the physician's training continues to emphasise 'a workaholic mastery of scientific knowledge and gives corresponding lack of attention to personal and family needs'. Fear of failure is an important part of the medical ethos. The exigencies of being a doctor lead to social isolation from other professionals. The difficult working conditions, including long hours on duty, lead to the common fellowship of suffering becoming an important occupational identity. While there is general agreement among doctors on the value of hard work, there is no agreement on how much work is hard enough. There is always more to do than has been done and there is always the fear that what has not been done might cause the doctor to give less than the best to patients. These pressures not only affect working behaviour but also allow doctors less time to work out their interpersonal relationships. In this respect, Gerber found that female doctors fared better than males since they were able to place their family high on their priorities and were less burdened with proving their position as tough and capable physicians.

Doctors have specific needs for health care. They show an increased vulnerability to certain illnesses and a major difficulty in discussing their problems with colleagues. The problems do not only affect the doctor who is sick. The doctor who is required to help a colleague is likely to be confused and distressed by the complex tangle of feelings and distorted communications that follow. Pereira Gray described the problems medical families faced in obtaining care for their doctor members.[22] She pointed out that no other occupation had the same difficulties over obtaining the services for themselves that were provided for others. She highlighted some of the problems. Many doctors treat themselves, which is notoriously hazardous. Some refer themselves to consultants for specific problems, while others try to use the services of a general practitioner, but this is not always easy. She commented that many general practitioners were registered as

patients with their partners in the practice. She suggested that young doctors entering practice did not consider that they might be ill later in life, and were initially keen to bring themselves and their families onto the practice list. This created considerable problems later when illness occurred.

This study attempts to survey the behaviour of a group of general practitioners as patients in relating to other general practitioners as doctors. It is a feature of the National Health Service that every person has access to a named doctor for primary medical care. While there is evidence that doctors suffer from certain stress-related illnesses, and also that their training emphasises the need to deny themselves the human weaknesses they readily accept in their patients, there is little information about the use doctors make of normal medical services.

# The Survey

## METHOD

This study looks at the self-reported behaviour of a group of general medical practitioner principals when seeking health care. It looks only at general practitioners – not because general practitioners are any more or less healthy than their colleagues but because of the ease of identifying them. General practitioners are a relatively stable group of doctors whose addresses are publicly available. Consultants are more difficult to identify. The same problem applies to junior doctors, with the additional difficulty of a high turnover and short tenure of appointments which may be for as little as three months.

The study group comprised all the general practitioner principals in contract with the Avon Family Practitioner Committee at 1 July 1987. This group was selected because the author's own practice is in the area. A pilot survey was first undertaken using general practitioners from outside the area.

The Avon Family Practitioner Committee provided a list of the names and addresses of all the general practitioners in contract with it, who were then sent by post a copy of a questionnaire (see Appendix, page 39) and invited to complete it. The questionnaire, which was printed professionally on green paper to make it distinctive, was sent with an accompanying letter and a stamped and addressed return envelope.

Some features about doctors' personal medical care might be anticipated, such as the following.

1) Most doctors would be expected to be registered with a general practitioner but to consult infrequently.
2) They would probably self-treat to a large degree.
3) They would probably not wish to consult colleagues over matters that showed 'weakness'.
4) They would not accept preventive health care for themselves but would still have needs for caring.

The study attempted to allow respondents to express those needs, anonymously if necessary.

The questionnaires were anonymous, but did contain a code number in the top righthand corner for assessing the sample response. This was explained in the accompanying letter and respondents were advised they might remove it if they wished. The code number was to be used to identify non-responders and, if necessary, send a follow-up letter. However, 431 (86 per cent) questionnaires were returned. Oppenheim[23] considered that a response of over 80 per cent to any postal questionnaire was unlikely, so no follow-up procedures were undertaken.

The doctors were asked for preliminary data about themselves – their ages, the number of years since qualification, and their sex. The questionnaire asked about registration with a general practitioner and the interprofessional relationship with that GP – was the general practitioner a partner, a GP in the same area but not in the same practice, or one from a different area? Respondents were invited to state whether or not they were satisfied with the arrangements, and asked to comment.

It is known that discussing their own health problems with a colleague is difficult for doctors. Question 3 asked about the frequency of consultation and the status of the doctors consulted (that is, consultant or general practitioner).

Self-medication is also known to be a feature of doctors' behaviour. The questionnaire identified two relatively innocuous but different prescription only medications that might be self-administered by doctors (antibiotics and the peptic ulcer remedies Tagamet or Zantac) but also enquired about sleeping tablets, antidepressants, and opiate painkillers. These compounds were placed in the middle of the question since their self-administration might have been regarded as a sensitive issue.

Because doctors are reluctant to seek help for themselves and, when they do, tend to bypass normal channels of medical care, the questionnaire enquired about initial sources of advice for various conditions. For a range of conditions, respondents were invited to choose from a number of different sources of advice, including the option of not seeking advice. A list of conditions was printed, with sensitive problems such as insomnia, sexual difficulty, high alcohol consumption, and dependence on drugs being flanked by more conventional problems such as a suspicious lump, worries about blood pressure, headache, menstrual problems, and glycosuria.

The next question enquired about preventive health care. Respondents were invited to state whether they had ever discussed such factors as their blood pressure, smoking and drinking habits, stress levels, weight and diet with their GP.

The last question asked whether respondents had ever been put off from discussing any problem with a doctor or had felt inhibited because of their profession. Respondents were then invited to comment.

The responses to the questionnaire were entered into an Amstrad PC 1512 microcomputer and analysed using the Statistical Package for Social Sciences program (SPSS Incorporated, Chicago, Michigan, 1986).

## OUTCOME

### Response

A total of 501 questionnaires were distributed and 431 (86 per cent) were returned; 384 replies (76.6 per cent) were received in the first three weeks. A major disadvantage of postal questionnaires is a low response. Oppenheim[23] quotes a typical response of between 40 and 60 per cent, with 80 per cent being seldom exceeded, even in studies of interested groups. The extraordinarily high response from this survey demonstrates a considerable interest. Little difference was found between the questionnaires returned less than four weeks after distribution and those returned after more than four weeks. This indicates that the characteristics of the responders to the survey were similar to the non-responders, and that the results can be extrapolated to generalise about all the GPs in Avon.

Before the survey was undertaken it was thought that doctors accustomed to denying their own illnesses might resent personal questions. However, the high response indicates that this survey was acceptable to most of the respondents. Furthermore, most (404, 93.7 per cent) left their code number on the return. Only 27 (6.3 per cent) sought anonymity by removing the number.

A further observation is the large number of comments – one third of the respondents added remarks. Reading them shows a reservoir of unmet emotional distress and difficult working and

social relationships. One cannot fail to be moved by the feelings exposed. For many doctors, this survey was a unique opportunity to make pressing personal disclosures that do not appear to have been vented elsewhere. For example:

*I cannot discuss the stress of practice life with my GP. I am in a single handed practice and under the constant pressure that I cannot afford to be sick.*

*Eighteen years ago I suffered the slow onset of a progressive illness. I tried to talk to my partners but they did not want to know. I soldiered on for eight years until my vision failed and this gave me a solid symptom to take to the hospital. My brain tumour was removed one year later. The problem was that the onset of symptoms was so slow that I did not realise either the significance or severity for myself and as a result for at least a year, in retrospect, I was not fit for practice. Fortunately only one patient paid the price for my stupidity. The pressure of general practice means staying on the job whatever happens.*

## Replies to questionnaire

Five questionnaires were returned unanswered. Not all the respondents answered all the questions so the total number of replies to each question is not constant. In discussing the results, percentages relate to the denominator of the 431 replies received. Nearly half of the respondents were aged between 36 and 50 (see Table 1).

Table 1 *Age of respondents*

| Age band | numbers | per cent |
|---|---|---|
| 35 or under | 118 | 27.4 |
| 36–50 | 206 | 47.8 |
| 51 and over | 102 | 23.7 |
| Unanswered | 5 | 1.2 |

There was a wide spread of years since qualification but no particular pattern emerged (see Table 2).

Table 2 *Years since qualification*

| Number of years qualified | numbers | per cent |
|---|---|---|
| 0– 4 | 1 | 0.2 |
| 5– 9 | 79 | 18.3 |
| 10–14 | 98 | 22.7 |
| 15–19 | 82 | 19.0 |
| 20–24 | 47 | 10.9 |
| 25–29 | 43 | 10.0 |
| 30–34 | 38 | 8.8 |
| 35–39 | 28 | 6.5 |
| 40+ | 6 | 1.4 |

Three quarters of the respondents (308, 71.5 per cent) were male and one quarter (115, 26.7 per cent) female. No attempt was made to define full or part time working for either sex.

During subsequent analysis of the replies no differences were noted between male and female respondents, apart from a tendency for men to self-prescribe peptic ulcer remedies. This may be explained by the increased prevalence of this condition in men. There is no firm evidence about whether women doctors adapt differently to the pressures of medical life. Cartwright[24] suggested that this provocative question could only be answered impressionistically, since there is no data for a definitive answer. She commented on the tension between occupational and traditional gender roles and suggested that the woman who chooses to be mother, spouse and physician would suffer more than one who has relinquished all obligations but physician. Certainly some problems arise from trying to combine those roles. However, Gerber[21] found that female doctors often coped better than male doctors with the stresses of medical life, since culturally they may place their families before their careers.

*I felt I should have been able to cope with problems of breast feeding my first baby – I was given the feeling that the GP was not really happy to get involved.*

*I find it enormously stressful working part-time in a busy practice with three small children and became acutely anxious last year about it.*

Gender issues in medicine require further study. Although this study showed no significant difference between male and female respondents, it is probably naive to assume that sources of stress are the same for men and women doctors, or that the times in their careers when stress occurs are the same. Similar consideration must be given to asking whether coping strategies are different.

**Question 1 Registration with a general practitioner and professional relationship to that general practitioner** Most of the respondents (414, 96.1 per cent) were registered with a GP. Nine respondents were not registered and eight did not answer the question.

When asked about the interprofessional relationship with their GP, it seemed that three doctors were registered, quite legally, with themselves. Nearly one third (119, 27.6 per cent) were registered with their partners. Two thirds of the respondents (293, 68 per cent) were registered with a GP outside their own practice. There are obvious problems in being registered with one's partner – for example, confidentiality, embarrassment at discussing personal details, difficulty of admitting to problems with the job to doctors who are also business partners, and a conflict of interest over sick leave. Compared with Allibone's survey[1] where 70 per cent of the doctors were registered with their partners, it is to be hoped that the marked decrease in the proportion of doctors registered with their own partners represents an increased awareness of the potential problems. Many of the comments on interprofessional relationships referred to this.

*I actually chose my ex-trainer as my doctor as I thought I would find it easier to discuss psychological problems with him from our previous relationship. Now I am not so sure, but have not had to put it to the test.*

*I suffered a severe depression following the death of my parents. I did not see myself as ill, just that my life had become pointless and hopeless and that it was all my fault. I took to drinking, despising pills. I only got help when my wife intervened and called in a doctor. I had treatment and fortunately recovered. I had difficulty in seeking the help of my partners. I did not want them to be burdened by my problems and I knew that if I went sick they would have to carry the load. I had seen*

*this problem with another partner and knew that pressure had been put on him to return to work before he was fully well to ease the load on others. There are no passengers in general practice. The most difficult problem was that in depression I lost all objectivity and did not see what was happening to me. Neither, it appears, did my partners. I was in retrospect quite 'potty' at times and must have been working way below my normal self, besides any evidence of my drinking, but nothing was said or done.*

*It is easily possible to see where partner and doctor roles overlap, for example, depression due to various pressures at work. However, we are registered with our own practice as a vote of confidence, really.*

**Question 2 Changing general practitioners** Most respondents (88.6 per cent) were satisfied with their registration with a particular GP and 82.7 per cent would not change their general practitioner even if they could easily do so.

However, 54 respondents (12.6 per cent) stated that they would prefer to change to a doctor in another practice and two doctors would change to register with themselves.

*Professional etiquette and loyalty to one's colleagues does make a change of GP extremely restricting and inhibiting – if not impossible.*

*Generally satisfied, but as she is a friend, we talk about her and her family sometimes to the exclusion of my problem.*

*I would feel intimidated to approach my partner with whom I am registered. Ideally I would like to register in a neighbouring village where I am not known and could keep my occupation secret. I cannot really do this now as I might offend my partner. I would feel intimidated to approach my partner. Oh well! Fortunately I'm never ill.*

It is interesting to note that some of the problems which doctors experience when consulting their colleagues are also those felt by their patients.

*The appointment system is sluggish and the premises in need of updating.*

*I have to make appointments and wait in the queue sometimes – the hours coincide with my own practice hours. I would much prefer to see a consultant informally.*

*I would not consider consulting my GP. This is partly because the time I tried to get an appointment with her I was told the next appointment was two weeks away.*

*He refused to come out to see me when my wife and I thought I had meningitis. I have been with the practice for over thirty years.*

*It is very difficult to get a time to see another GP.*

**Question 3 Frequency of consulting doctors and type of doctor consulted** One quarter of the respondents had consulted a doctor in the past year. Of those, approximately half (42.2 per cent) had consulted their GP. In this survey, many doctors bypassed the usual channels of referral, sometimes for preference and sometimes for reasons of necessity.

*Stress and lifestyle problems are discussed on a friend to friend basis – not doctor to patient basis – and this is something I regret but can see no way out of unless I attend my doctor at his surgery. If I had a major problem, I would see the partner in the practice with whom I have the least social contact.*

*Have wanted psychiatric counselling in the past year over marriage breakup and sexual difficulties. Am receiving therapy after self-referral to a London psychiatrist. Have trusted in professional colleague and friend, but not my GP, who remains unaware of treatment.*

*I suffered from anorexia for many years and eventually referred myself to a psychiatrist as I felt inhibited from discussing psychological problems with my GP. I had a recent health insurance medical and felt disapproval of my psychiatric history from the older general practitioner who did the examination.*

Some of the respondents shunned orthodox medical practitioners altogether, preferring to take their problems, if not outside the profession, certainly to doctors who allowed alternative approaches.

*I have significant back trouble so I registered with a part-time GP who is also a specialist in manipulative medicine.*

*It is difficult to admit that one has 'psychological' problems to another doctor. It would have been easier to discuss this sort of problem with a counsellor/therapist.*

*I experienced a certain amount of work-related stress and mildly disturbed sleep pattern for which I attended an acupuncturist. I find the acupuncture helpful and probably her personality as a therapist helps also.*

**Question 4 Self-medication** The questionnaire enquired about self-medication. It asked whether any of the survey population had initiated treatment for themselves with prescription only medicines. A few medicines were selected for specific enquiry and the results are shown in Table 3.

Table 3 *Responses to the question 'Have you ever initiated treatment with any of the following drugs?'*

| | Yes | No |
|---|---|---|
| Antibiotics | 354 (82.1%) | 66 (15.3%) |
| Sleeping pills | 103 (23.9%) | 312 (72.4%) |
| Antidepressants | 18 ( 4.2%) | 398 (92.3%) |
| Opiate painkillers | 12 ( 2.8%) | 404 (93.7%) |
| Tagamet or Zantac | 31 ( 7.2%) | 385 (89.3%) |
| Others | 144 (33.4%) | 264 (61.3%) |

Other drugs used are shown in Table 4 (some respondents had used more than one drug).

Self-medication is common among doctors. In this study, four fifths of the respondents (82.1 per cent) had treated themselves with prescription only medications, particularly antibiotics. One quarter (23.9 per cent) had initiated treatment for themselves with sleeping tablets. Smaller but significant numbers (30, 7 per cent) had initiated treatment for themselves with antidepressants and with opiate analgesics. One third of the respondents (33.4 per cent) had also used other drugs which included analgesics, anti-emetics, hormone treatments and various topical medications. In view of the high incidence of alcohol and drug abuse in the

profession these findings are potentially alarming, although it is difficult to define a point at which self-medication is unacceptable. Doctors have easy access to medications that they commonly prescribe to their patients.

Table 4 *Other drugs used*

| Drug | Numbers |
|---|---|
| Antihistamines | 17 |
| Antidiarrhoeals and antiemetics | 16 |
| Non-opiate analgesics | 15 |
| Non-steroidal anti-inflammatory agents | 26 |
| Antacids | 17 |
| Migraine treatments | 11 |
| Hormones (replacement and contraception) | 14 |
| Salbutamol inhaler | 7 |
| Topical steroids, antifungals, and other creams | 20 |
| Miscellaneous, including eye drops, diuretics, wart treatments, antiviral agents | 26 |

*I get very frequent migraine and have done so since childhood. I have been worried that I would be labelled as a complainer. However, I feel that although my headaches were eventually investigated by my GP there has never been any real understanding as to how disruptive they are to me. I self-treat, get to the end of the day and then rehabilitate at home. I should be on prophylactic treatment which I offer to others but I have never been offered it.*

Although most doctors appear to self-medicate with antibiotics, the abuse of drugs and chemical addiction is still confined to a minority. However, any self-prescribing of antidepressants or opiate drugs may be thought to be unacceptable, particularly since there is no indication that the doctors concerned received any counselling or follow-up.

*From time to time I have had complaints and have soldiered on, analysing myself and self-treating, when some weight would have been taken from my concern if I had discussed things with another doctor. Fortunately, my health has been*

*good, but if a problem arose, I would feel that I was an inadequate medical practitioner (either for not being able to cope for myself or for bothering a colleague).*

**Question 5 First source of medical advice for common complaints**
Following the question about self-medication the questionnaire asked about the initial source of advice for common conditions. Respondents were given four options for each question – not to seek outside medical advice at all, to seek advice from their GP, from a consultant, or from a non-medical source such as a counsellor or therapist. The results are summarised in Table 5.

Table 5 *Percentages of respondents choosing sources of advice for specific conditions*

| | Would not seek advice | GP | Consultant | Non-medical advice |
|---|---|---|---|---|
| A suspicious lump | 0.5 | 71.7 | 25.3 | 0 |
| Blood pressure worries | 15.1 | 71.5 | 6.5 | 4.2 |
| Headache | 59.4 | 34.1 | 2.6 | 0.5 |
| Insomnia | 67.5 | 23.4 | 0.9 | 3.9 |
| Sexual difficulty | 39.2 | 19.3 | 11.6 | 24.8 |
| High alcohol consumption | 20.4 | 40.4 | 12.8 | 20.9 |
| Dependence on drugs | 15.8 | 45.7 | 17.2 | 14.8 |
| Excessive tiredness | 33.9 | 53.4 | 4.6 | 4.6 |
| Menstrual problems (115 female respondents) | 13.0 | 64.3 | 17.4 | 0 |
| Glycosuria | 2.8 | 79.1 | 14.8 | 0.2 |

The answers show that when treatment is sought, it is likely to be from the GP. For common, well-defined and 'respectable' medical problems such as a suspicious lump or the finding of glycosuria, 97 per cent of respondents would seek independent medical advice. The pattern changes when considering those conditions that are not directly medical but for which patients often consult doctors. The medical profession has an increased risk from suicide, and from drug and alcohol abuse. Headache, insomnia and excessive tiredness might be indicators of stress and mental illness, and

can be important symptoms of these conditions. Two thirds of respondents would not seek advice about headache or insomnia. One third would not seek advice about excessive tiredness. The possible 'improvement' about consulting for excessive tiredness might relate to the association of this with anaemia or other respectable organic disease. This is illustrated by some of the comments.

*When a little depressed felt unable to seek help from local colleagues because of 'stigma'.*

*I did not feel that I would be able to discuss problems that made me appear 'weak'. As a doctor I felt that others would expect me to cope – I did but in isolation and so it was harder. I feel we are a very vulnerable group. We spend our lives dealing with others and leave no time for ourselves. We have to be tough – the problems we have to deal with can be desperate. Too much of what we do leaves us in isolation – particularly in general practice, but we need the back-up and support of other human beings – very often a spouse, and even that can throw other problems in if it puts a strain on the marriage. I don't know what the answer is – perhaps support groups would help, but only those of us who would find help anyway when it was needed would take it up.*

*It is very difficult to go to another GP with complaints like tiredness. I know what I should do with my various psychosomatic problems, but I find it difficult to find somebody I can open up to.*

For sexual difficulty, the pattern remains. Forty per cent of respondents would not seek advice despite the obvious association of this to marital problems to which doctors are notoriously susceptible. Of those doctors who would seek advice, the majority would prefer to consult a non-medical counsellor. This may reflect a realistic view of medical limitations in this field or it may reflect a reluctance to admit to these problems to colleagues.

*I saw my GP in order to discuss marital difficulties. I have never been happy about that consultation. This is because I see the doctor socially and feel uncomfortable that it may have altered his view of my character.*

*My doctor/partner is too close to my problems of domestic stress and not objective. I am reluctant to consult outside agencies as one feels one ought to be able to cope as a professional. If we can't cope how can we help others?*

Drug abuse and high alcohol consumption are problems for which a higher proportion of doctors would seek professional advice. Nonetheless, a significant minority – 20.4 per cent for high alcohol consumption and 15.8 per cent for dependence on drugs – would not seek advice.

*Alcoholism is something I did not see my own doctor for. I was in denial for many years but because of a friend in Alcoholics Anonymous was eventually persuaded to consult my GP. I attend the doctors and dentists groups of AA.*

*I think I might be too embarrassed to seek a GP's advice for very personal or frowned upon conditions such as alcohol, drug dependency, sexual problems, or psychiatric problems.*

The situation seems to be that doctors are reluctant to seek independent advice for the very conditions from which they, and their colleagues, are most at risk.

*I think minor depression is not uncommon in GPs and yet it is a subject that I find difficult to talk about.*

**Question 6 Discussion of preventive health measures with a general practitioner** This question asked whether any of several aspects of preventive health care had been discussed with the respondent's general practitioner. Table 6 shows the results.

Table 6 *Preventive health measures discussed with GP*

| | Yes | No |
|---|---|---|
| Blood pressure | 98 (22.7%) | 324 (75.2%) |
| Smoking habits (whether or not the respondent smoked) | 45 (10.4%) | 376 (87.2%) |
| Drinking habits | 18 ( 4.2%) | 403 (93.5%) |
| Stress and lifestyle | 59 (13.7%) | 364 (84.5%) |
| Weight and diet | 37 ( 8.6%) | 386 (89.6%) |

The question is topical in view of current concerns about health promotion and illness prevention and increasing emphasis on exercise, diet, and a healthy lifestyle. One quarter (22.7 per cent) of the respondents had discussed their blood pressure, but only 10.4 per cent had discussed smoking habits, and 4.2 per cent drinking habits.

*I take my own BP 2-monthly. I have had well-controlled hypertension for 15 years.*

*It is a stressful job and the pint of beer when I get home in the evenings is becoming a habit which I will have to watch.*

There were no sex differences in discussing preventive health. Female doctors might have been more likely to have had their blood pressure measured routinely during the course of antenatal care but this was not demonstrated. It seems ironic, but in keeping with the medical profession's self-image, that a high preoccupation with preventive care for patients is not matched by similar concerns for colleagues.

**Question 7 Had status as a doctor prevented discussion of a problem?** The final question asked whether respondents had ever been concerned about any problem that they would have liked to discuss with a doctor but felt put off because of their profession. Nearly one quarter (98, 22.7 per cent) replied 'yes'.

## Comments

Question 7 was followed by space for comments: 144 respondents (33.4 per cent) took the opportunity to make remarks that were sometimes very revealing about the health of doctors. Many have been used to illustrate this paper. A few comments describe positive feelings about access to medical care.

*It was actually quite pleasant recently to have a medical for insurance purposes and to be asked questions about my own health.*

*My GP is a personal friend and I think this helps greatly as I feel I can discuss all matters with her.*

*I have been able to discuss personal problems and illnesses easily and adequately with my helpful GP.*

The majority of the comments refer to problems and concerns. Common themes emerge which in themselves merit further study. A picture develops about some of the other reasons why doctors chose not to seek medical help for themselves.

Emphasis on self sufficiency

*. . . should be able to cope . . .*
*. . . having to cope regardless . . .*
*. . . no time to be ill, letting colleagues down . . .*
*. . . don't want to waste colleagues' time . . .*

Embarrassment at being wrong or in complaining about trivial ailments

*Worried about trivial condition which I logically know is not serious but still wanted reassurance. I am never certain whether to consult a GP or treat myself.*

*Episode of eczema which I was uncertain about but felt that my GP would expect me to be able to diagnose – rashes look different on yourself than on other people.*

*Anxiety about suspicious skin lesion – eventually consulted GP after some delay because of worry that the GP might consider it trivial.*

Fears about confidentiality and about records being read by unauthorised persons

*My GP was a partner in another practice which shared a health centre with my practice. I felt I was suffering from stress/anxiety/depression but did not discuss it because of the staff in the health centre sharing the notes.*

*While I was in hospital correspondence about my condition came to my surgery and was opened as usual by the secretary. It should have been marked confidential, but was not. It was all*

*very embarrassing. I knew that my insurance against sickness carried specific exclusion clauses and that drinking had been a contributory cause. So even in hospital having ECT and therapy, I could not get locum cover except by paying directly. It was very expensive to be sick that long and in that way.*

Fears about illness being put on the record with consequences for sickness insurance and life assurance

*Recent depression – I felt unable to consult my GP as I knew it could adversely affect my insurance claims if I needed to take time off work. My sickness insurance policy excludes 'anxiety and depression' as I have been affected by these in the past.*

*I consult my own partner rather than the doctor with whom I am registered over matters like blood pressure in case I am mistaken and I get a life assurance loading.*

*Whilst working as a clinical assistant, I took a four-week break for exhaustion following a custody battle for my children after my marriage broke down. I subsequently found that my sickness insurance has a special condition excluding anything from anxiety to mental breakdown for the next five years.*

*I had two grand mal fits recently and the second time I waited five days before seeing my doctor as I was worried about the driving implications.*

Concern about doctors' families

*You should include doctors' spouses in your survey. They don't necessarily obtain objective advice from their husbands/ wives and yet they suffer many of the inhibitions of the doctors.*

*I wonder how often ill health presenting in the spouse is a reflection of the state of mind of their partner. I sought help when my own wife became seriously depressed and was unable to care for our children. In the course of therapy it became clear that I was the one generating a great deal of the domestic stress and disharmony. The problems are the difficulties of combining a demanding job which often intrudes into a normal family life.*

Lack of confidence in colleagues

*I think there is an unexplained reluctance to use the GP service like our patients.*

*It is very difficult to deal with someone of equal understanding and medical knowledge – the GP tends to act only as a referral agency.*

*Ten years ago I had a recurrent illness for which I sought a lot of help, but I believe that none of the doctors who saw me ever realized that I needed help and counselling as a patient. They were unable to relate to me other than as another doctor. This attitude made the illness doubly difficult to bear and added considerably to my distress and anxiety.*

Denial of any problem

*Stress symptoms are not viewed very sympathetically by many doctors who are subject to the same pressures but may deal with them in other ways – or not at all.*

*It is inconceivable that I shall suffer from sexual difficulty, high alcohol consumption, or dependence on drugs, but if I did, I do not know what I would do. I do suffer from a recurrent ulcer for which I have seen a consultant a few times. I now just buy the necessary drugs and although it is constantly painful, I just put up with it. It is not all that difficult to learn to live with pain especially if you have a lot to do. I do suffer from excessive tiredness, which is due to too many hours work without adequate rest. However, if you mean excess tiredness as a pathological entity when adequately rested, then I would consult my appropriate colleagues, such as a consultant.*

# Discussion

There is much more that can be asked about doctors' health. In the preparation of the survey, the known reluctance of doctors to admit to their problems led to anxiety that the questionnaire might be rejected as too intrusive into personal matters. That this fear is unfounded is shown by the very high response. More work is possible on the investigation of doctors' attitudes to their own health, since it is clear that many respondents welcomed the opportunity to make personal disclosures of feelings that had not found outlets elsewhere. Whether the relative anonymity of a questionnaire is more acceptable than personal consultation with a colleague or a counsellor is in itself an interesting question.

There is also scope for further work to extend the scale of the survey. The population of 501 GPs in Avon is barely adequate to confirm or refute some hypotheses about doctors' medical care. For example, it would be expected that doctors who were registered as patients with their partners would be more likely to be dissatisfied than those who were registered with a doctor outside the practice. Furthermore, this might only be relevant for doctors in certain age groups. The numbers in this survey are inadequate to confirm or refute this. Other branches of the profession, including consultants and junior doctors warrant investigation. Many surveys have shown that newly-qualified doctors have considerable unmet health problems that are compounded by social isolation and job mobility.[19,20] Medical students too, are an at-risk group who appear to acquire an occupational identity as physicians early in their training, and suffer many of the problems that afflict their more senior colleagues.[21,25]

Many of the profession's difficulties stem from its perception of itself. Those who care for others, out of vocation or compulsion, often have great difficulty in caring for themselves. Much of medical training can be seen as a depersonalising initiation into a privileged profession. 'Being crucial and decisive for patients, doctors' licensed tools and protocols are correspondingly powerful and dangerous. In consequence doctors can only use them legitimately if they are, or seem to be, strong, unselfish, responsible, and undemanding for themselves when others are in need. They

cannot be seen to be unable to face what is there, or to be self-indulgent or weak.'[26]

This was emphasised in many of the comments explaining the difficulties in asking doctors for care.

*I cannot talk to my doctor about stress – probably because I feel embarrassed as it is supposed to be part of the job.*

*I am very aware of time wasting. One should be able to solve most of one's own problems but feel isolated at times.*

Strategies for improving this situation and for reducing the profession's vulnerability to stress-related illnesses fall into the categories of prevention, coping and, finally, dealing with the problems of the obviously sick doctor.

## PREVENTION

This is aimed at anticipating some of the problems and dealing with them early on in a doctor's career.

Counselling is one solution, but unfortunately, despite evidence that undue stress is prevalent among medical students and young doctors, it is only in the USA that provision of effective student counsellors has been made. Students and young doctors can be encouraged to discuss matters of emotional importance without bearing the stigma of being unable to cope.

Such a programme at the University College of Los Angeles (UCLA) was described by Borenstein and Cook.[27] It offered psychiatric help and short-term psychotherapy to UCLA medical students and interns, and sought to foster greater sensitivity among young physicians by educating them about the importance of their own psychological needs. It also sought to promote a sense of community in the medical profession by demonstrating the concern of mature practitioners for their younger colleagues. No formal records were kept so no data was available on numbers or outcomes. Quite apart from the humanising aspects of this programme, it was regarded as cost-effective in reducing the dropout rate for medical students. The authors concluded that 'a medical school does not have to be psychiatrically orientated to encourage therapy for its students since it is clearly cost-effective to do so'.

McCue[16] stated that those responsible for supervising young doctors should be aware that these doctors have to display mature coping skills very early in their careers. These older colleagues should recognise that emotional and physical fatigue lead to mistakes and dysphoric experiences, and that intellectual successes do not balance out emotional distress. He called for greater attention to the matter of enabling doctors to accept their humanity and to anticipate the conflicts of work, home, and personal development. Further, their idealistic expectations of life as a doctor may not match the reality. Porter[11] quotes the story of the young doctor who had just entered general practice and who then returned to his medical school to demand his money back, as he had been so inadequately prepared for the job.

An alternative, but quite serious strategy has been proposed by those who argue that medical students should initially be selected for their coping ability, and that those who are likely to show distress should be weeded out before arrival. This attitude is exemplified by a notorious quote from the dean of a medical school[28] which also demonstrates some of the sexism inherent in the profession.

> Medicine is a demanding mistress – any doctor who is unable to make the commitment necessary for the patient whenever he is needed is better off in some other field of endeavour.

However, since there is evidence[20] that those students and doctors who show significant stress levels during their training and the early years of qualification are also those with appreciably higher levels of empathy with patients, there seems to be a logical flaw in a caring profession selecting its members for their ability to be uncaring.

This also emphasises denial of problems as a means of coping with them, as was considered in quite another context by Jonathan Swift in his 'Treatise on Various Subjects', 1711.

> The stoical scheme of supplying our wants by lopping off our desires, is like cutting off our feet when we want shoes.

In this survey, several doctors quite obviously felt that they were unable to acknowledge or discuss their own needs.

*I had anxiety and depression following a miscarriage. I did not discuss this with the doctor because I felt that the information was already available in journals and therefore nothing the doctor could say would help.*

*My general practitioner, who is normally very good, effectively said everyone has problems and they will get better.*

## COPING

Despite the obvious attraction of trying to prevent problems before they occur, this is a process that takes time. In the case of medical education, the altering of attitudes that have evolved over decades, if not centuries, is a slow process. Awareness of the problems and of the vulnerability of the profession to certain types of dysfunctional coping behaviour such as inappropriate denial is important, especially when accompanied by the realisation that the sufferer is not alone. Sharing concerns with family and colleagues is a valuable method of coping with stress. Ironically, doctors' family and emotional relationships are often neglected, despite the need for close emotional support.[21] The particular stresses in medical marriages are caused by lack of time for the partnership. Unfortunately the period of intense commitment to a medical career that follows graduation is also the crucial time for the development of personal identity and an important time for the establishment of permanent relationships.

Gerber[21] described the reactions of a spouse to the constant demands of a medical career as being akin to a process of grief, with the familiar stages of protest and denial, anger, despair, and finally, detachment. He commented that this would be quite natural when it became clear that the pressures on the doctor to concentrate on career development were causing neglect of interpersonal relationships. The spouse in a medical marriage often feels left out and resentful while the medical partner becomes bored with the lack of parallel career development. A career interest for the spouse seems vital to the relationship. At the same time, the subjugation of personal development to career development in the doctor leaves the spouse becoming more socially skilled and advanced, while taking a role in the marriage that is subordinate to long hours spent on patient care and study. There is

the inevitable fatigue, emotional exhaustion, and withdrawal in the medical partner. A recent study of medical marriages[29] showed that the greatest conflicts occurred over lack of time spent on 'self, family, and fun'. The doctors and their spouses blamed each other for not listening. It appears that maladaptive patterns are adopted early in the marriage.

Many comments expressed concern about doctors' families. As Pereira Gray has written:

> The teacher can be taught, the bus driver can be driven, and the dustman have his own dustbin emptied without emotions eroding efficiency. It is the doctor who cannot easily reverse his role and become a patient, and his family who may suffer as patients through having a doctor in the house.[22]

> *We need to be more tuned in to our colleagues instead of switching off the 'radar' when the patients are no longer around. Doctors are only too well aware of health education, they just don't think it applies to them. There are a vast number of doctors treating their families.*

Professional peer groups for doctors such as trainee groups, trainer workshops, and young practitioner groups are currently evolving and will influence the reduction of professional isolation. The wonder is not that peer support groups are expanding, but that doctors, alone among all the other caring professions, have been so slow to accept and use them. Doctors are now the only occupational group within the caring professions not to schedule time into their normal work for these activities. Many of the respondents in the survey referred to help from support groups.

> *In my view and that of so many experienced people, this job cannot be done without a spiritual basis of faith, and needs the support and fellowship of others.*

> *I feel that there should be more support functions and more open discussion of the stresses of the job. During a recent episode of anxiety I was lucky to have been able to rely on sufficiently strong support network to have been able to get through it. I really feel for those doctors who have neither the time nor the inclination to set up such support networks.*

## DISCUSSION

There is much evidence from industry that occupational stress is not primarily an illness, but a management problem.[30] It was recognised by Field Marshall Slim that it is the quality of leadership, not of medical care, that determines the health of an organisation. This was shown in practice by General Montgomery whose ability to inspire his troops and raise morale was such that only six in every 10,000 of his men reported sick during fierce battles. Unfortunately, much medical management is in the hands of the profession itself. Managers know that, in relation to executive stress, excessive hours mean inefficiency.

> It has been known for 70 years that no one can put in more than 60 hours work a week without performance suffering. In 1917, both the quantity and the quality of munitions production was shown to fall off rapidly when workers exceeded that limit. Yet many people work those hours.[30]

Especially doctors.

These attitudes persist throughout the profession. The British Medical Association and the Department of Health and Social Security carried out a nationwide survey in 1987 into the workload of general practitioners and found that the average general practitioner is on duty for 73 hours per week. The effect of such a system on doctors' performance in delivering sophisticated personal medical care has yet to be evaluated, but it appears that doctors themselves may provide the greatest resistance to changing this. Mawardi[12] found that being needed was the single most important source of satisfaction to physicians, despite the excessive workload and the lack of leisure time, and that pressures of work are the biggest sources of stress. She stated that 'the physician's narcissism keeps him from ever saying "No", and from believing that his patients can get along without him'. Many schemes have been devised for reducing the excessive hours worked by doctors, fatigue having often been identified as a major, if not the major, cause of occupational stress. Yet it is the doctors themselves who have opposed schemes to rationalise their working day when this has been tried.[31]

A recent editorial in the *British Medical Journal* marshalled some of the evidence about the effects of fatigue on performance.[32] It concluded that a reduction in the working hours of doctors was

essential. Yet in the same issue other doctors, particularly senior registrars in the hospital service, were quoted as expressing fears about patient care and about losing income if working hours were reduced.[33] Another article[34] in the same edition describing personal experiences of fatigue suggested that it was 'time to organise, to fight, and perhaps even to strike' against overwork, without appreciating that the pressure to maintain these practices comes from within the profession rather than without.

Part of the problem is that the causes of stress are often also the sources of stimulation. For example, surgeons suffer from chronically elevated levels of serum cortisol and experience problems with physical demands, long hours and fatigue, and are under pressure to avoid failure. Yet they also report being able to enjoy the challenge of responding to difficult cases. This enhanced job satisfaction might explain why surgeons have a lower standardised mortality rate than general practitioners.[35] Major causes of stress for GPs (which might not affect surgeons to the same degree) include elements of frustration at the restricted nature of the work, the trivial nature of many of the complaints that they are called upon to solve, under-utilisation of skills, and the loss of respect from patients.[13] Other factors are fatigue and the disruption of sleep continuing into the middle years.

There is an element, too, of circular argument in the discussions on the nature of GPs' frustrations. Cartwright and Anderson[36] felt that the apparent tedium and triviality of complaints were of the GPs' own making because the doctors who felt that way tended to be those who did not carry out many procedures on behalf of their patients. The unspoken criticism is that it is only doctors who are not good enough who feel stressed. However, if doctors are not coping with their stress, they may become irritable with patients, give them less time, appear less interested in them, listen and explain less, and prescribe more. Lack of involvement is in itself a protection from pressure and stress. Which comes first?

Certainly it seems that the teaching of stress management skills to medical students and doctors would be more useful than learning about obscure diseases.

Finally, schemes for reducing occupational stress are not supported by many doctors who have attained senior positions and are able to control the profession. As survivors of an environment

which has many of the features of a jungle culture, they tend to perpetuate the system on the assumption that what was expected for themselves is satisfactory for their successors. A psychotherapist responsible for making a training video on counselling for management training put it succinctly.[37]

> Usually those most responsible for clawing their way to the top, with one or two notable exceptions, are disastrous human beings: they are the last people who would favour counselling for junior colleagues because it would call into question their whole set of values.

There is the whole concept of medical training as an initiation rite into a select society or tribe. It is well known that persons who have suffered initiation into a society are keen to inflict the same rites on newcomers. The concept of professional identity taking on some of the features of tribalism explains not only the solidarity of the profession against outsiders but also the severity with which doctors who have transgressed the moral code are punished and expelled.

## THE SICK DOCTOR

At present much concern is expended on limiting the damage that is caused by sick doctors to themselves, their families and their patients. There are recognised processes, many with statutory powers. General practitioners who, in the view of the local medical committee, are incapable of working properly through physical or mental disability may be suspended by the family practitioner committee. NHS doctors and community physicians likewise may be suspended by their employing authority, sometimes following an intervention by the 'Three wise men' procedure. The General Medical Council's health procedures may have the effect of compelling a doctor to accept treatment, and may ultimately lead to suspension from the Medical Register.

The practical difficulties of this were outlined by Roy.[38] Borenstein and Cook[27] commented on the problems of doctors receiving help in the early stages of illness, and on the ineffectiveness of colleagues. 'The reluctance of mature physicians to intervene on behalf of their impaired colleagues is the predictable fallout from a lifelong neglect of their own emotional needs.'

In 1985, the National Counselling and Welfare Service for Sick Doctors was set up by the medical Royal Colleges, the British Medical Association and other professional bodies. It is controlled by a management committee which is autonomous and independent from any employing, disciplinary or professional controls. The service was established because it recognised some of the problems doctors face when seeking personal medical help.[39] A doctor concerned about the effect of illness on the fitness to practise of a colleague may telephone a national contact number (01–580 3160) and will be given the name of an adviser who will be a senior doctor in the same branch of the profession as the doctor-patient but from outside the district. The adviser may approach the sick doctor personally to offer help or may arrange for another colleague to do so. The offer will be made in strict confidence and will be entirely informal. Self-referrals to the scheme are acceptable – and common.

## AND WHERE NOW?

This survey has confirmed earlier studies that identify a significant problem faced by doctors in obtaining care for themselves. Some of the problems are attitudinal, stemming from doctors' traditional neglect of their own needs. These include such prohibitions as not bothering the doctor with trivia, not wanting to show weakness and needing to know it all.

> *When I had a change in bowel habit I presumed it was the irritable bowel syndrome but felt I could not approach my partners or the local physician as it seemed a bit 'neurotic'. I feel there should be a separate service for general practitioners which would be run by somebody who would understand that we feel embarrassed at wasting a GP's time.*
>
> *I do not consult my GP because of the need to appear professional, efficient, and able to cope with life's stresses.*
>
> *An interest in similar problems amongst patients makes me feel I should not need to seek advice.*

These can only slowly be dealt with by education and by changing attitudes within the profession.

Other problems concern specific difficulties over access to health care. Is it adequate for family doctors to use the same family doctor service as their patients? This survey emphasises the fact that many doctors feel inhibited about approaching their colleagues. Matters of confidentiality, of knowing the doctor socially, or being involved with the doctor as a business partner all conspire to intrude into the doctor/patient relationship in a way that they do not with other patients. There are also the difficulties doctors face when consulted about their colleagues' problems since this also disrupts the normal doctor/patient relationship.

*The only time I tried to talk to my own GP about an emotional problem I got very short shrift and I have never tried since.*

*I have always tried to be a normal patient but find that my GP will not treat me as one because he self-refers himself and therefore does not understand why I do not. This ends up causing considerable problems.*

*I needed counselling four years ago and approached my GP who was embarrassed. I cannot ask him again.*

*I could not consult my doctor about stress related to work – I felt likely to be rebuffed as has happened before. GPs seem to think I should be able to cope just because I am a doctor.*

Many of the replies called for a special family doctor service for family doctors. Since doctors do have particular needs for care and for an understanding of their specific problems in obtaining it, it seems reasonable that a specialist service should exist to cater for their needs.

*Surely a health service for GPs is a necessity? I cannot avoid being registered with my partners. At the moment, if medical advice be sought, one's partners are terrified that more work will come their way and this entirely warps their clinical judgement. Yet to change doctors would hurt terribly. I feel quite strongly that what happened to me could have been noted much earlier and that it could have been treated more quickly in other circumstances. I am not sure how one can change the attitudes of doctors who deny they are ill for fear of showing weakness, and colleagues who turn a blind eye to abnormal behaviour.*

Much attention is paid to the effect of sick doctors on their work, but little is paid to the effects of work on sick doctors. If establishing a health service for doctors only reduced some of the excess stress-related morbidity in the profession it would be cost-effective – to say nothing of the benefits patients in general might reap from the humanising effects. Part of the function of a doctors' health service would be the development of support groups for doctors. Loneliness and isolation do not have to be inevitable features of doctors' professional identity. An awareness that colleagues were affected similarly by similar problems and that it was not unacceptable to cry and rejoice, to acknowledge anger and sadness, would help us all come to terms with ourselves in a positive way.

# Conclusions

> It is one of the most beautiful compensations of this life, that no man can sincerely try to help another without helping himself.

This survey outlines some of the difficulties doctors have in looking at their own health, and some of the problems they face when they need to receive care. Despite the high response rate, the limited number in the survey population makes it difficult to draw firm statistically-based conclusions. However, several trends are shown.

1 Doctors suffer excessive morbidity and mortality from certain illnesses, particularly mental disorder, alcoholism, marital breakup, and suicide. All of these can be linked to stress.
2 Doctors do not readily present themselves as unwell to their colleagues.
3 Despite the reluctance of doctors to discuss their emotional problems openly, these are a major feature of perceptions about their own health.
4 Doctors need an acceptable outlet for their emotional problems. Many respondents took advantage of the anonymous nature of the questionnaire to make personal disclosures that they had been unable to express elsewhere.
5 Doctors will readily present 'medical' problems such as a suspicious lump or the finding of glycosuria to a colleague for advice, but are much more reluctant to present illnesses that have implications of weakness or of being unable to cope, such as headache, insomnia, sexual problems, or alcohol and drug dependence. These are common symptoms of the disorders to which the profession is particularly vulnerable and for which doctors have the most difficulty in seeking help.
6 Doctors commonly treat themselves with prescription only medications. In this survey they ranged from 82 per cent of respondents who treated themselves with antibiotics to 3 per cent who had used opiate analgesics.
7 Despite considerable contemporary emphasis on preventive health care for patients, this is not something that doctors seek

for themselves. Only a quarter of doctors had discussed their blood pressure with their general practitioner and few had discussed smoking and drinking habits.

8 Consideration should be given to the establishment of a special family doctor service for family doctors. Many doctors in this survey demonstrated a need and a willingness to discuss pressing emotional and personal problems with sympathetic colleagues.

Following this survey, it seems that there is much more that should be asked about doctors' health. The high response rate indicates that more work is possible on the investigation of doctors' attitudes to their own health, since it is clear that many respondents welcomed the chance to talk about their feelings.

This study has concentrated on the problems of doctors and on the difficulties they face in being ill. The discussion has focused on many of the features of medical training that make these problems worse. Yet it must not be forgotten that medicine is also a profession with the potential for great satisfaction for its members. Doctors can help others, and are needed and valued by society. There are distinct occupational hazards and distinct occupational satisfactions. There is the paradox that the profession's ability to deny its own emotions can be its strength when helping others to cope with serious illness, and its weakness when coping with its own. For many years the emphasis has rested entirely on the former. Only now are doctors realising that admitting their own humanity may not be so bad after all.

*Quis custodiet ipsos Custodes?*
Juvenal

# APPENDIX

Dr D. Green
Dr C. W. Richards
Dr G. C. How
Dr P. A. Horry

Tel: Clevedon 876097

THE HEALTH CENTRE
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CLEVEDON
BS21 6DG

Dr R. D. Bullock
Dr D. K. S. Irving
Dr M. C. Hime
Dr C. I. F. Russell

Tel: Clevedon 871454

Friday 31st July 1987

Dear

For the past few years I have become increasingly concerned at the higher than average incidence of mental illness, suicide, alcoholism and marital breakdown amongst doctors. There are many hypotheses why our profession should be particularly vulnerable to these complaints. One contributing factor is that doctors are reluctant or unable to seek help for conditions in themselves that they take quite seriously when they occur in patients.

As part of some work I am undertaking at the Department of General Practice at Exeter University, I am looking at the access to primary health care for general practitioners in my own area - that covered by the Avon Family Practitioner Committee. This survey has the approval of the Avon Local Medical Committee.

I would be grateful for your help with the project. I enclose a short questionnaire which I hope you will be able to complete as fully as possible, together with a reply paid envelope. Please do not write your name on the questionnaire. There is a code number on the questionnaire which is for checking the sample response and which will be removed before analysis. You may remove it yourself if you wish. All questionnaires will be destroyed at the completion of the project. Any information obtained will be held in absolute confidence and results will be published only in statistical form.

If you feel unable or unwilling to answer the questions, please return the blank questionnaire in the enclosed envelope. It is important to me to know whether doctors have felt unable to reply.

With many thanks for your cooperation.

Yours sincerely,

**Clive Richards**

# THE HEALTH OF DOCTORS

Code

You may remove this sample check code if you wish

DO NOT WRITE YOUR NAME ON THIS FORM

Please return this questionnaire in the enclosed stamped addressed envelope whether or not you have answered it.

## SURVEY

## DOCTORS AS PATIENTS OF DOCTORS

Please indicate the correct response by ticking the boxes or by marking the appropriate answer.

Do comment freely on any matters arising from this questionnaire.

Age: 35 or under ☐ 1
36 – 50 ☐ 2
51 and over ☐ 3

Number of years qualified ☐

Sex M ☐ 1 F ☐ 2

1. Are you registered with a general practitioner? Yes ☐ 1 No ☐ 2

If yes, is your general practitioner
- a Yourself? ☐ 1
- b Your partner? ☐ 2
- c A doctor in another practice in your practice area? ☐ 3
- d A doctor in a practice outside your practice area? ☐ 4

Are you satisfied with this arrangement? Yes ☐ 1 No ☐ 2
Please comment.

2. If you could change your general practitioner without difficulty, would you
- a Stay with your present GP (i.e. no change)? ☐ 1
- b Change to yourself? ☐ 2
- c Change to your partner? ☐ 3
- d Change to a doctor in another practice in your practice area? ☐ 4
- e Change to a doctor in a practice outside your practice area? ☐ 5

3. (i) How frequently do you consult a doctor (not necessarily your GP)?
- a More than once a week. ☐ 1
- b More than once a month but less than once a week. ☐ 2
- c More than once a year but less than once a month. ☐ 3
- d Once a year. ☐ 4
- e Less often than once a year. ☐ 5

3. (ii) Are these doctors
- a Your general practitioner? ☐ 1
- b A consultant to whom you have been referred by your GP? ☐ 2
- c A consultant to whom you have directly referred yourself? ☐ 3
- d Both a consultant and your GP? ☐ 4
- d A colleague (GP or consultant) whom you consult informally? ☐ 5
- e Other? [please specify] ☐ 6

# APPENDIX

4. It is well known that doctors often treat themselves. Have you ever INITIATED treatment for yourself with any of the following prescription only medicines?

| | Yes | No |
|---|---|---|
| a Antibiotics | ☐ 1 | ☐ 2 |
| b Sleeping pills. | ☐ 1 | ☐ 2 |
| c Antidepressants. | ☐ 1 | ☐ 2 |
| d Opiate painkillers. | ☐ 1 | ☐ 2 |
| e Tagamet or Zantac. | ☐ 1 | ☐ 2 |
| f Others. [please specify] | ☐ 1 | ☐ 2 |

5. If you suspected you were suffering from any of the following common conditions, whom would you turn to FIRST for advice? For each condition, please tick one box.

| | Would not need to seek advice | GP | Other doctor (e.g. consultant) | Non medical help (e.g. therapist, counsellor) |
|---|---|---|---|---|
| a A suspicious lump. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| b Worry that your blood pressure is high. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| c Headache. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| d Insomnia. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| e Sexual difficulty. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| f High alcohol consumption. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| g Dependence on drugs. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| h Excessive tiredness. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| i Menstrual problems. Not applicable ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| j Glycosuria. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

6. Have you ever discussed any of the following preventive health matters with your general practitioner.

| | Yes | No |
|---|---|---|
| a Your blood pressure? | ☐ 1 | ☐ 2 |
| b Your smoking habits (whether or not you do smoke)? | ☐ 1 | ☐ 2 |
| c Your drinking habits? | ☐ 1 | ☐ 2 |
| d Stress and your life style? | ☐ 1 | ☐ 2 |
| e Your weight and diet? | ☐ 1 | ☐ 2 |

7. Have you ever suffered from any condition or become concerned about any problem that you would have liked to discuss with a doctor but felt put off because of your profession?

Please give reasons Yes ☐ 1 No ☐ 2

Space for comments.

Many thanks for your help. Please return the forms to:
Dr. Clive Richards, 'The View', 2 Castle Road, Clevedon, Avon BS21 7BX.

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Caring for others imposes a considerable strain on the carers. It is recognised that they often have great difficulty in asking for, and receiving, care for themselves. This seems to be particularly true for the medical profession. Doctors suffer abnormally high levels of alcoholism, drug dependence, marital breakdown, mental illness and suicide.

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