Challenge of culture, conscience, and contract to general practitioners' care of their own health: qualitative study

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BMJ 2001;323:728–31

Abstract

Objective To explore general practitioners' perceptions of the effects of their profession and training on their attitudes to illness in themselves and colleagues.
Design Qualitative study using focus groups and indepth interviews.
Setting Primary care in Northern Ireland.
Participants 27 general practitioners, including six recently appointed principals and six who also practised occupational medicine part time.
Main outcome measures Participants' views about their own and colleagues' health.
Results Participants were concerned about the current level of illness within the profession. They described their need to portray a healthy image to both patients and colleagues. This hindered acknowledgement of personal illness and engaging in health screening. Embarrassment in adopting the role of a patient and concerns about confidentiality also influenced their reactions to personal illness. Doctors' attitudes can impede their access to appropriate health care for themselves, their families, and their colleagues. A sense of conscience towards patients and colleagues and the working arrangements of the practice were cited as reasons for working through illness and expecting colleagues to do likewise.
Conclusions General practitioners perceive that their professional position and training adversely influence their attitudes to illness in themselves and their colleagues. Organisational changes within general practice, including revalidation, must take account of barriers experienced by general practitioners in accessing health care. Medical education and culture should strive to promote appropriate self care among doctors.

Introduction

The health of the medical profession is causing some concern.[1–7] Doctors are reluctant to seek health care through usual mechanisms[3 7–10] and find it difficult to adopt the role of patient.[9] The consequences include self prescription, working through illness, self referral,[2 6–13] and late presentations with serious problems.[8] This inappropriate self care occurs in a profession that reports high levels of stress[1 2 12 14] and psychological distress[2 15 16] and comparatively high suicide rates.[17]

Questionnaire surveys of the extent of distress and illness in doctors have been reported.[3 10–16] However, questionnaires may impede analysis of reasons why doctors respond in particular ways to illness in themselves. This study aimed to explore, qualitatively, general practitioners' perceptions of the effects of their profession and training on their attitudes to illness in themselves and colleagues.

Participants and methods

We sent a letter inviting a purposeful sample of 141 general practitioners representing both sexes, different lengths of experience, and urban and rural locations to attend focus groups on occupational health issues relevant to general practice. We also invited 13 general practitioners who were part time occupational physicians and 18 recently appointed principals. This sample was selected from a list of all general practitioners in Northern Ireland. Our experience of general practitioners' low response rates to invitations to attend focus groups on other subjects suggested we needed to contact a large number of doctors to get a representative sample. Doctors known personally to the research fieldworkers were not invited.

Grounded theory acknowledges that researchers do not approach reality without some preconceived ideas.[18] We used concept mapping to explore preconceptions. From this map, we generated the primary questions for the focus groups. The map was considered provisional, to be modified or discarded in view of emerging findings that were explored by secondary questions. We audiotaped focus groups and interviews with the participants' permission and transcribed the tapes. The groups provided the range and social context and interviews allowed exploration of emerging findings in depth. This represents a synthesis of approaches used in qualitative research.[19] We treated details of participants with sensitivity and confidentiality throughout.

Two researchers independently analysed transcripts and notes of verbal and non-verbal communication using the grounded theory approach. Emerging themes and links were identified and coded. The categories into which the data were placed were modified to accommodate new data until "saturation" was reached.[20] Themes emerging from analysis of early

Number of years since registration and practice location of participants

Years since registration	No of participants	No from urban practice	No from rural practice
>30	4	3	1
20-29	7	6	1
10-19	10	7	3
<10	6	6	0
Total	27	22	5

groups were presented to later focus groups and interviews to ensure they agreed with their experience.

Results

Twenty seven general practitioners participated (22 in one of five groups; five in individual interviews). Six participants were part time occupational physicians and six were recently appointed principals. Twenty one were men and six were women. The table shows their numbers of years since registration and practice location.

Health of the profession

Participants were reluctant to declare themselves ill but readily shared anxieties about the health of the profession:

We are seeing … increasing illness in doctors and that's quite scary. It used to be 50 year olds with MIs … also seen recently is a number of younger doctors in their 30s with various stress related illnesses.

Several said that self employment made it difficult for general practitioners to look after their own health.

Attitudes to acknowledging personal illness

General practitioners talked about the pressure to appear physically well. One said, "Nobody wants to go and see a doctor who is sick," reflecting the perception that patients believed a doctor's health reflected his or her medical competence. This attitude affected their approach to screening.

We have a number of doctors in my practice and the number of cholesterol checks is very unimpressive. They make sure that their patients have their cholesterol checked … but will they go to their doctor and be screened themselves? They might … take it themselves, but it won't go into their chart.

Many agreed that they were poor at looking after themselves. Almost all reported working through, and expecting colleagues to work through, illnesses that they would not have expected patients to work through.

I broke my leg … and went into the surgery … because I couldn't get a locum at short notice.

Unless you're unable to get out of bed you'll crawl in and work.

Acknowledging psychological illness was extremely difficult. General practitioners regarded psychiatric illness in themselves as a weakness. Paradoxically, they reassured patients that "it's just another illness." Concerns about confidentiality emerged as another factor affecting their use of psychiatric services.

Doctors feel they shouldn't be sick … you don't want to go and see your local psychiatrist in case one of your patients is sitting beside you.

Embarrassment was also a barrier to consulting other general practitioners and specialists about illness in themselves or their families.

Responses to personal illness

Comments indicated a perception of "us/doctors" and "them/patients," with a reluctance to accept treatment and an underlying assumption that the roles of patient and doctor were incompatible: "We think we're superhuman and that we don't get ill, or if we do, we can cope with it."

Professional culture appeared to discourage discussion of personal health with colleagues. When asked about discussing personal health, one responded, "You keep quiet about it." This generated laughter in the group, which was confirmed with participants to mean a shared experience of embarrassment.

Some reported that in medical school and hospital "illness was not really tolerated and you were expected to do the job." Recently appointed principals reported that self care was not taught adequately at either undergraduate or postgraduate level. One general practitioner illustrated the process of self diagnosis.

Take a change in bowel habit and colonic carcinoma … if you are a GP … at what point do you declare yourself as having a change in bowel habit? Do you under-react or over-react? … we don't know how to apply the protocols we work with every day to ourselves.

Several reported that their medical knowledge made them prone to swing between panic and denial when they experienced symptoms: "One minute you think it's just a headache, next minute you're sure it's a brain tumour." Similar stresses were described regarding illness in their family.

Influences of general practice organisation on support

A sense of obligation to partners emerged in an interchange in one of the focus groups.

You don't stay off work because you're not going to earn money, you continue to work because of your partners.

Your partners are working twice as hard to carry you.

It's a conscience thing.

This view was supported in an indepth interview and in another focus group:

A terrible sense of duty of letting your partners down if you don't go in.

The real quandary arises when that person decides to come back. You might not think they are ready … but they are feeling guilty because the locums can't cover everything.

Fragile partnerships seemed to influence general practitioners' reluctance to acknowledge and manage personal illness appropriately. Several reported knowledge of difficult relationships between partners: partners are not necessarily friends.

They maybe try to cover each other equally at work … but they don't … socialise together.… They work in the surgery and that's it.

Most agreed that they did not take an active interest in their partners' health and played down evidence of colleagues being unwell. The reasons given illuminate difficulties experienced when doctoring doctors:

You didn't want to be made wrong … to be told "I wouldn't do that, that is stupid" … You are not sure whether they want you to interfere.

Some did not want their colleagues to comment on their health, but others wanted and needed muted cries for help to be acted on.

He made a few statements to his partners that he really couldn't cope but it wasn't really taken very seriously because he didn't make it very serious. He was registered with the practice and it went on for quite a while till he just cracked.

Informal shadow contract

We used a synthesis of the elements described above to construct an informal shadow contract (box). The terms in the contract were not stated explicitly but were communicated through anecdotes and black humour. At times participants questioned their compliance with this contract, recognising its destructiveness. Some identified themselves as its cocreators but felt helpless to change it. The contract was subsequently presented to four additional small groups of general practitioners, who confirmed that it agreed with their experience.

What is already known on this topic

High levels of stress, psychological distress, and suicide have been reported among doctors

Doctors are reluctant to seek help in the normal way when they become stressed or ill

What this study adds

The perceived need to portray an unrealistically healthy image is stressful and a barrier to appropriate self care

The emotional response to personal illness can produce an oscillation between panic and denial

The working arrangements of general practitioners reinforce a culture in which their own and colleagues' distress is overlooked

Discussion

Our findings confirm previous reports that embarrassment and unease with the role of patient influence how doctors approach illness in themselves.[3 8–11 21] Within the professional culture and working arrangements of general practice, these influences contribute to the potential for self and mutual neglect as described in the informal shadow contract.

The number of participants was sufficient to confirm saturation in responses.[20] The fact that feedback showed that the findings agreed with the experiences of other general practitioners also supports the validity of our results.

Pressure to appear healthy

General practitioners perceive that patients and colleagues link good health in doctors with medical competence. Thus doctors feel compelled to portray a healthy exterior while being aware of their vulnerability. Their concerns about confidentiality were linked to this, particularly in relation to psychological illness.

Unease with personal illness and with being a patient influenced doctors' interpretation of symptoms in themselves and their relatives. General practitioners described oscillating between panic and denial when experiencing potentially serious symptoms. Their sense of shame about personal illness influences how they access health care for themselves, deal with distress in colleagues, consider personal sickness absence, and participate in screening.

Reluctance to admit to illness and the impact of absence on colleagues' work are among the reasons doctors give for working through illness.[9 12] We found that sense of duty towards both patients and partners was an important reason why doctors continued working when they would not expect their patients to work. Doctors seem to take less sick leave than other self employed people,[9] but it is difficult to obtain information about attitudes to sickness from these occupational groupings.

Informal shadow contract

I undertake to protect my partners from the consequences of my being ill. These include having to cover for me and paying locums. I will protect my partners by working through any illness up to the point where I am unable to walk. If I have to take time off, I will return at the earliest possible opportunity. I expect my partners to do the same and reserve the right to make them feel uncomfortable if they violate this contract.

In order to keep to the contract I will act on the assumption that all my partners are healthy enough to work at all times. This may mean that from time to time it is appropriate to ignore evidence of their physical and mental distress and to disregard threats to their wellbeing. I will also expect my partners not to remind me of my own distress when I am working while sick.

Managing illness

Training in recognition and management of doctors' own health problems and those of their colleagues has been advocated.[22] However, participants were not aware of this having been included in their training.

Securing appropriate personal health care might be regarded as essential for self employed general practitioners working within partnerships in which liability is shared. In reality, influences such as a sense of conscience to provide a service for patients, loyalty to partners, difficult relationships within partnerships, precarious sickness insurance arrangements, and poor locum availability may contribute to neglect of self and partners. One manifestation of this is ignoring illness in partners. Primary care groups with salaried general practitioners may ease the difficulties of locum arrangements. Occupational health services could also be an important resource for health care.[8 11 12 13 15] Such services for general practitioners and their staff are currently being discussed by the government.

The General Medical Council recognises that ill health can affect professional judgment and performance.[23] Doctors may be required to provide information on their health for revalidation.[24] The list of a doctor's duties begins with "make the care of your patient your first concern."[23] We suggest that the duty of self knowledge and self care should underpin this.

We acknowledge the contribution of Tim Carter in planning this project and thank the steering committee (Denis Todd, Tony Stevens, and David Courtney) for its advice and guidance. We also thank Jean O'Connor, medical librarian, for support and Rosemary Kilpatrick for advice on the design of the project and for support and encouragement during the field work and writing up stages.

Contributors: DIS was responsible for initiating and coordinating the project. WTT and CHS were responsible for initiating the design, organising and facilitating the focus groups and interviews, and collecting and analysing the data. All authors were involved in reviewing literature, planning and designing the study, interpreting the results, and writing and editing the paper. WTT is the guarantor.

Funding: This work forms part of a study of general practitioners' occupational health needs funded by the Health and Safety Executive for Northern Ireland.

Competing interests: None declared.

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(Accepted 29 June 2001)

More on pre-mortal provision

In his article on pre-mortal provision in the *BMJ* of 2 June, Douglas Black shows his customary wisdom when he points out that, in making a living will, it is not possible to be sure that convictions will remain unchanged.[1] How right he is, as I now know to my own satisfaction and happiness.

At noon on January 12 this year I began to experience pain in the right iliac fossa, which quickly crescendoed. I lay on the sofa and applied the 13 questions required for the elucidation of any pain of unclear origin.[2] On examination there was tenderness on release. Appendicitis and Meckel's diverticulitis could be excluded because both had been operated on in 1970. The pain had none of the characteristics of renal disease, nor could I relate it to previous coronary artery problems, which had been dealt with most successfully by bypass surgery in 1992.

However, I knew that I had an abdominal aortic aneurysm, which had been diagnosed by chance during a barium enema for a change in bowel habit in 1994. The aneurysm was then 8 cm long and 4.5 cm wide. At that time, it was generally considered that surgical intervention should not be sought until the aneurysm was 5 or 6 cm wide. At 84 years of age in 2001, I took the view that rupture of the aneurysm might well be my best exit and far preferable to a stroke that might put me in an old people's home, obtunded and a burden to my wife and family. In December 2000 I had consulted a professor of medicine at a London teaching hospital in connection with my adrenal insufficiency caused by disseminated histoplasmosis contracted in the United States in 1996 and first clinically manifest in the autumn of 1998 when there was pulmonary, hepatic, splenic, and adrenal involvement. This responded well to treatment with intravenous Ambisome followed by oral ketoconazole. The professor asked me about my aneurysm, and I told him I thought it was best left alone; I had to die of something, and this seemed a good way out. "I quite agree with you," he said and banged his desk with conviction.

I did not make a living will but discussed the matter with my wife, and we agreed that if I ruptured my aneurysm I should be left to die from it. In the event this conviction went out of the window. I telephoned my general practitioner, and when he called within half an hour I made no mention of my wish to die from the condition, perhaps because all I wanted was relief from the pain. This he gave me, and later that day I was admitted to a postgraduate teaching hospital in north London and successfully operated on at midnight. My course was complicated by dehiscence of the wound and later by infection with a methicillin resistant staphylococcus, which persisted for two months, but I am delighted that I did not hold to my original negative decision.

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2 Bayliss RIS. Pain narratives. In: Greenhalgh T, Hurwitz BS, eds. *Narrative based medicine*. London: BMJ Books, 1998.

We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.