THE HEALTH OF THE FAMILY DOCTOR

ANTHONY PAUL AZZOPARDI

Doctors tend to have better physical health but poorer mental health than others. Their poor mental health may inevitably affect their care of patients and the epitaph of an Athenian physician reads:

"These are the duties of a physician: First to heal his mind and to give help to himself before giving help to anyone else."

However a survey amongst doctors showed that:

Almost 20% of doctors had not consulted a doctor when they would have liked to because they were doctors themselves. In addition,

- 30% would not seek advice from anybody for excessive tiredness;
- 20% for excessive alcohol consumption;
- 17% for dependence on drugs;
- 40% would not see anybody about sexual difficulties.

These are circumstances when one would strongly advise a patient to seek advice.

- Over 75% had treated themselves with antibiotics;
- 25% were not sleeping well and treated themselves with hypnotics;
- 5% treated themselves with anti-depressants;
- 3% treated themselves with opiate pain-killers.

Self-medication is common among doctors.

In addition many did not seek out preventative care:

- 75% had not talked to their GP about BP;
- 43% had not discussed their dietary habits;
- 84% had not talked about stress and their lifestyles.

Mortality and morbidity statistics show that GP's may be at considerable risk from diseases and other illness related to stress. For example, figures from the Registrar General (1978) have shown:

"...Medical practitioners have a higher risk than the general population of dying from three causes frequently linked to stress namely:

•Suicide;
•Cirrhosis;
•Accidental poisoning..."

A US study has shown that there the suicide risk for doctors was twice that of the general population with a higher proportion being psychiatrists. Most early studies were made on male doctors but recent evidence suggests that the rate among women doctors is just as high.

A letter in the British Medical Journal noted that in the United Kingdom the rate was three times that in the general population and the rate for women doctors was six times that of women who were not doctors.

A twenty year follow-up of college students (NEJM 1970) found that, compared with other professions, doctors were more likely to have poor marriages, to abuse alcohol, and to use sleeping pills, amphetamines or tranquillisers.

There are various hypotheses:

- Medical Associations do not act as support groups and leave their members to deal alone with ever-increasing demands — possibly predisposing to depression and suicide.
- Difficulty with diagnoses and treatment, death of children, impact of work on family life.
- Achievement-oriented compulsive people are attracted to medicine and this pre-selection of vulnerable individuals may contribute to the high incidence of mental illness, stress and drug dependence.

The main physical problems identified in the local scene would include:

- Long hours. Ours is not a 9 to 5 job.
- Poor working environment. Some surgeries are conducted from small pokey back rooms in a pharmacy. In this regard there might be subtle pressure from the pharmacist to over-prescribe or to prescribe particular brands. There might be sharing of the same consulting room with other GP's so that one cannot leave letters, prescription pads or instruments and be constrained by time-limits. Having said this this, one also has to acknowledge that over the years a personal friendship does develop with the pharmacist who also acts as a receptionist, telephone operator and, at times, an assistant.
- Weather conditions in Malta cannot be described as extremely adverse but carrying out house visits in the early afternoon in mid-summer is by no means easy.
- Poor communications system. The telephone system is in the throes of renewal and in the meantime you can easily spend fifteen minutes trying to get through to a single number with many wrong numbers, incorrect connections and simply no connection at all.
- Poor roads and driving standards — which are deteriorating by the day — with bumpy roads, dug-up roads, frequent inexplicable deviations, large volume of traffic on the inadequate roads.
- Working single-handed means that one is continuously on

call and this, apart from the stress it engenders, is physically exhausting.

- Large numbers of house visits expected by the Maltese patients even for minor complaints. The chart shows the proportion of house visits to surgery consultations in my practice during 1990. As you can see the winter months are worse. Three explanations come to mind:
  1. There is more illness in winter;
  2. People are less ready to leave their warm homes in winter and therefore expect the doctor to visit;
  3. The extreme heat of summer makes me use all my powers of persuasion to convince patients to call themselves.

  Overall the figure is 37.1% which is extremely high by any standard.

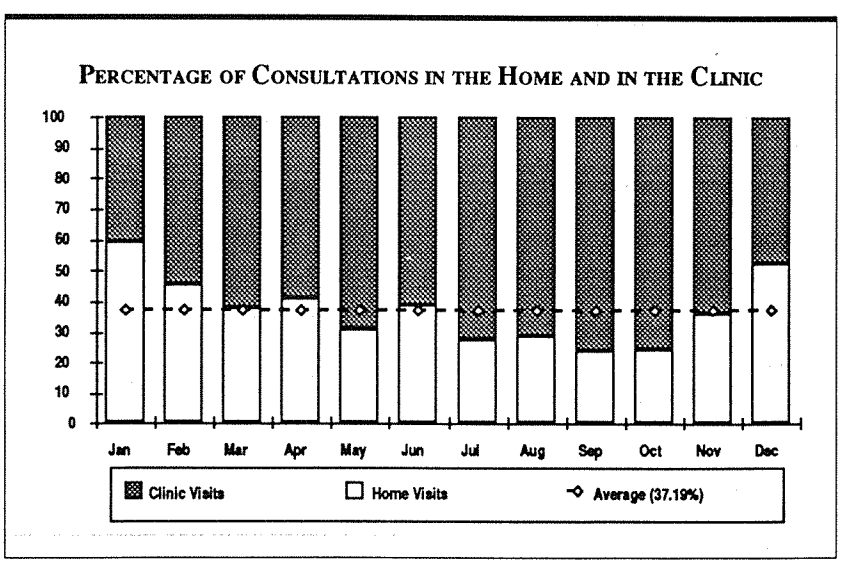
Increasingly we shall encounter problems with AIDS and drugs. The AIDS-mentality (i.e. consider every blood sample as potentially infected and every patient at risk as potentially a person with AIDS) has not yet crept into the local scene, but no doubt this varies from one practice to another and if not, eventually it will. Drugs seem to have by-passed the GP. Being a small country, every drug patient is taken, sent or goes to the central Detoxification Centre. The introduction of the Control Card and the green prescription form have severely limited our freedom to prescribe drugs of dependence so we are not approached by addicts for prescriptions. We are however called in by the drug addict's family in a panic when he is newly-discovered.

Psychological problems

These would include:

- Worrying about patients' complaints. Allied to this is the fear that you might have missed something important. This is, of course, worse when one has a large number of patients to see.
- Unrealistically high expectations by others of your role.
- Coping with phone calls during the night and early morning. Allied to this is the pre-call tension. This comes on when the patient has already phoned once and you have given advice but lie there expecting him to call again.
- Night calls. This is the single most important source of stress experienced by GP's in their work.
- Dealing with problem patients. Here I would include the requests for unjustified certification to avoid school, work or to avoid attending court. The latter are frequently sent by their lawyer, another professional! Here we have the constant struggle to convince the patients without losing them. Another source of stress is when an unnecessary visit is requested. These unreasonable requests make the doctor angry because he cannot accept, and even angrier because the patient should not have put the doctor in a position of having to refuse.
- Daily contact with dying or chronically-ill patients and, in their bereavement, sometimes being blamed by the relatives for the patient's death.
- Dealing with relatives and friends as patients. If something goes wrong, you lose both a friend and a patient. Conversely, very often, patients end up as your friends.
- Inadequacy. A GP is by no means a specialist in all fields. One tries to be a good all-rounder, but there are instances when one is found lacking. One might note that as medicine becomes more effective, so what one misses or doesn't do becomes more critical.
- 24-hour responsibility for patients' lives, especially in our solo-practice set-up.
- Rankin et al (1987) have suggested that general practitioners derive pleasure from exercising their technical skills. However Mechanic (1968) has observed that: *"... the average doctor to his growing practice and increasing demands on his time ... by practising at a different pace and style. Such a pattern of work requires doctors to practise on an assembly line basis, which diminishes the unique satisfaction possible in general practice."*

The large number of patients waiting in a crowded waiting room has been described by one GP as a head of steam so



that the more patients there are, the faster one is forced to work.

- Another powerful source of anxiety/stress is the "Report of the Working Committee on the GP Scheme in the Maltese Islands". The "Charter for the Family Doctor Service" worked out by Sir James Cameron at Brighton in 1965 stated:
"That general practice must remain a family doctor service; that the GP must have adequate time for each patient; be able to keep up to date; must have complete clinical freedom; have adequate well-equipped premises; have all the diagnostic, social service and ancillary aids he needs; be encouraged to acquire additional skills in special fields; be adequately paid by a method acceptable to him and which encourages him to do his best for his patients; have a working day which leaves him some leisure."
Shall *we* have this? Our anxiety stems from our justified mistrust of our politicians, but it is also partly the fault of our Medical Unions who do not keep the rest of the profession informed of what is going on.

Social problems

1. Demands of the job on the family.
2. Dividing time between spouse and patients.
3. Demands of the job on social life.

Women who marry doctors may think it is going to be a glamorous life. This is possibly more so in the case of couples who marry soon after the husband graduates so that they do not really know what to expect. Then they find it a bit humdrum, the telephone is always ringing and they find it's a bit irksome. The children need you for their homework and you're still doing your surgery at 7.30 at night. You can't commute your children to school because you have a long list of patients to visit.

A DHSS study in 1980 that many men and women doctors were deeply unhappy in their chosen profession. Marriage and children were seen as obstacles to their career plans by both sexes. On the other hand many, including men, resented the way a medical career may diminish family life. The statement "I preferred to be at home playing with the baby than looking after somebody else's" was made by a man. All the family, especially the wife, frequently share in the patients' problems. All our children are trained from an early age to take intelligible and intelligent messages. The wife is expected to be able to give advice. It is not just the doctor that is part of the village life: the wife is always the doctor's wife, not Mrs. A., an entity in herself. This can cause problems in the beginning, especially when the wife is professionally qualified in her own right, and who used to work.

Welfare Issues

There is in Malta tremendous cohesion in the profession and even between doctors and paramedics. In the case of medical necessity one can within hours fix an appointment with a consultant most of whom we know personally. Special investigations, physiotherapy, hospital appointments and treatment for ourselves and for our families pose no problems.

Obtaining medication from Drug Reps again most of whom we know well is also easy.

Our patients are fortunately not yet given to litigation with us but the Medical Associations are ready with their experience to help the doctor concerned should this occur. Here one might remark that it is time the Profession as a whole started to think of Medical Defense Insurance because what is happening abroad is sure to happen here eventually.

Our College ought to work as a support group: For example in 1985, the British Medical Association announced a new service — a National Counselling and Welfare Service for Sick Doctors — where a concerned colleague may contact the centre and a National Adviser is appointed who can approach the sick doctor who, very often through lack of insight as a result of their illness or through embarrassment, may not have approached somebody "local".

Earlier On

Realistic advice must be given at schools so that pupils have some idea what a career in Medicine will mean.

Personal assessment and career advice should be offered throughout Medical School and before.

Women who have had a break in their career should have retraining.

In 1988, the World Federation of Medical Training recommended that:

"Medical Schools should use selective methods for medical students which go beyond intellectual ability and academic achievement to include the evaluation of personal qualities."

This might therefore help provide effective primary prevention, help reduce long-term unhappiness, stress and mental illness in the profession.

By providing CPD, journals, advice on the upgrading of our

surgeries, record-keeping and computerisation, the practice of medicine would become more efficient and the job easier.

On a psychological plane, the provision of CPD, opportunities to serve on committees, for research, for meeting with other professionals with interests other than medicine — for ourselves and for our spouses — this would provide the support which most of us who work in isolation badly need.

It is unfortunate that as self-employed professionals we have never been helped in any way by the State. We have instead been made the target of punitive taxation with unfair best of judgement assessments. We have been excluded from all forms of sickness or injury benefits. Whilst the employed category was entitled to a full pension at age 61, we had in many cases to wait until age 65 to get our due. To date this is still the case until the proposed new legislation is enacted. We have had legislation enacted prohibiting us from working in our traditional surgeries – the pharmacies, from working in any private clinics or hospitals and now we are faced with a great unknown – the proposed FD Scheme which we know very little about (and which we like less). Being such a vulnerable group I might lastly mention the various insurance options open to a self-employed GP in Malta.

We have BUPA with which the MAM has negotiated a very favourable rate. PPP also provides medical cover.

Then we have the Income Protection Insurances which will pay out a sum of money for the duration of periods of illness when we cannot work. We lastly have the Life Insurances.

Once the local Government Legislation is about to be changed to permit self-employed professionals to qualify for benefit, I might here point out too the importance of paying the correct National Insurance contribution. Furthermore, a recent amendment to the Law which has come into effect in 1988 lays down that if one pays at a lower rate than one should, currently one-sixth of the annual income up to a maximum of LM 13.60 per week, one might be asked to pay the underpaid contributions in arrears and still not qualify for the right pension. ◆