

Self-care strategies for GP's

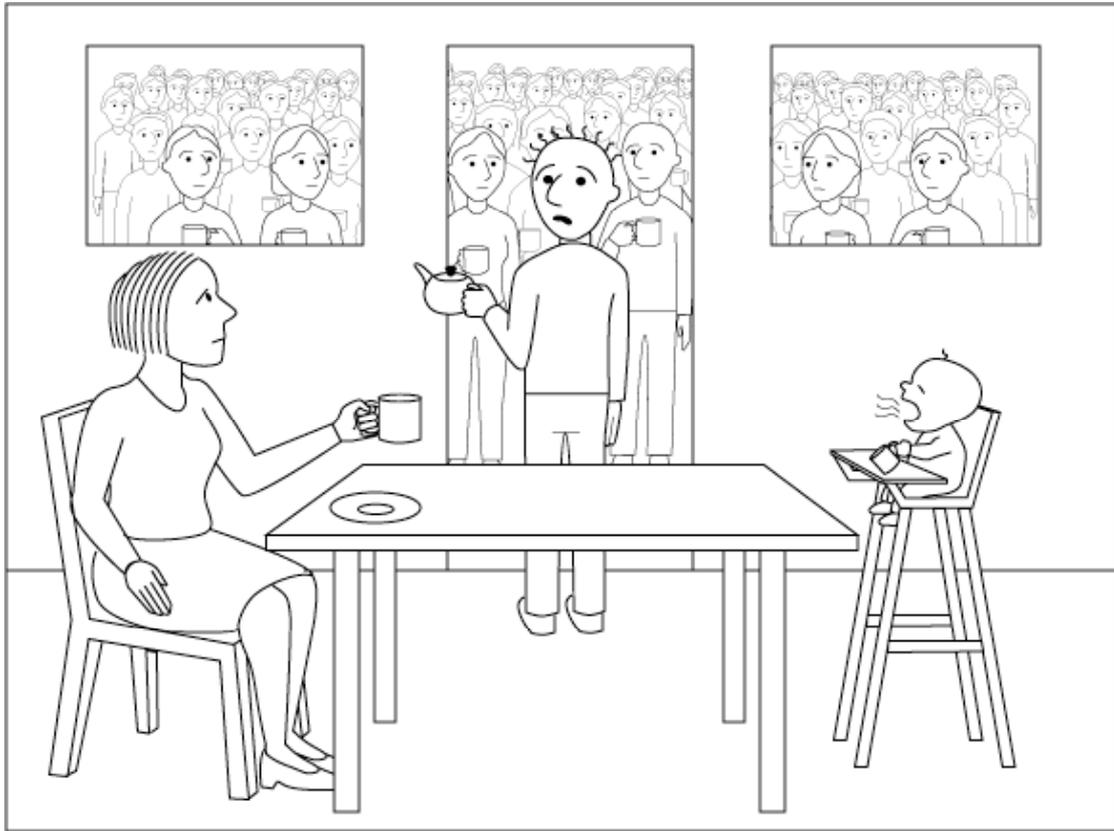
ACT Division of General Practice

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“ We are all teachers; and what we teach is what we learn, and so we teach it over and over again until we learn”^A
Course in Miracles

“ The best doctors are healthy doctors”

**Dr Kerryn Phelps
AMA President**

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Introduction

I suspect you are all very well aware of (in fact, at some profoundly esoteric level you are probably really quite enamoured with) the importance of your own self-care for your own physical, psychological and social well-being. Otherwise, you wouldn't be here tonight. Right? Of course, it has nothing to do with the food and booze, the congenial company, or the "lightweight" content leading to professional development points. Of course not!

Let me suggest to you, that it is one thing to be cognisant of the crucial issues and to have clarity about the multiple reasons for your presence here tonight but on a more sobering note, the evidence suggests that for many service-oriented, caring and conscientious GP's the reality is a bit more like being an expert in motor mechanics and seriously neglecting the regular maintenance of your own car until it is running dangerously close to stalling or more serious breakdown and possibly taking out a few innocent passengers in the process.

I wonder if you really "know" how critical your self-care is for your primary intimate relationships especially your marital and parenting roles. I wonder if you fully appreciate the importance of your self-care for the ultimate quality, consistency and durability of the care you provide to your patients.

Let me begin by asking you to ask, some not very "lightweight" questions, of yourself:

Questions for GP's to ask themselves (1)

- **How happy am I most of the time? Really?**
- **How do I feel about myself?**
- **Who and what do I love?**
- **How healthy do I feel right now?**
- **Do I seek and accept appropriate help and comfort from others?**
- **How often?**
- **How do I really feel about my work?**
- **What draws me to general practice? Honestly?**
- **What traumatic/stressful experiences have I had?**
- **Have I integrated these experiences?**
- **Is my rest adequate and satisfying?**
- **Do I often feel loved and appreciated?**
- **What are my fears?**
- **What am I angry about?**
- **What are the sources of my greatest emotional pain?**
- **For what do I feel shame?**
- **For what do I feel guilt?**

Questions for GP's to ask themselves (2)

- **What do I do with my feelings?**
- **Do I forgive myself?**
- **What gives meaning or purpose to my life?**
- **What are my hopes and dreams?**
- **Do I often feel lonely?**
- **What do I treasure as joys?**
- **How and when do I have fun?**
- **What don't I talk about with anyone?**
- **What do I feel when I look at myself in the mirror?**
- **With whom can I talk about my inner life?**
- **Do I laugh and cry?**
- **Do I create internal psychological safety for myself?**
- **How do I listen to and take care of my body?**
- **Do I consistently implement clear boundaries with others and myself?**
- **How honest am I with myself?**
- **What form of music and movement do I enjoy?**
- **What are my spiritual needs and comforts?**
- **What could I do to be more self-caring?**

Questions for GP's to ask themselves (3)

If, I changed three things in my life.

What would they be?

Myths

- **GP's don't become "stressed"**
- **GP's don't become sick**
- **GPs will receive the very best of care should they somehow become sick**
- **If GP's are not sick they are healthy (i.e. they are experiencing physical, mental and social health).**

**DHAC report (2001);
Doumani, S. (2001)
Convenor ACT Doctor's
Health Advisory Service
and a Canberra GP)**

Facts (1)

GP's do experience multiple stressors

- **Directly competing demands; GP's in no win situations as follows:**
- **unique aspects of entry and "success' in medical training**
- **the lack of a balanced and healthy lifestyle (physical, mental and social health) well established prior to entry into general practice.**
- **un-informed decision-making in entering general practice.**
- **inadequate preparation and support for the clinical and administrative realities of general practice e.g. large numbers of patients with psychosocial problems that precipitate, aggravate, maintain or co-exist with their physical health problems.**
- **GP's experience work overload and seemingly ever increasing demands and expectations.**
- **inadequate numbers not enough GP's in the ACT (about 50 short); ripple effect in every area of general practice.**
- **constant pressures to take referrals from current patients for prospective patients even when the books are closed.**
- **pressure to keep up professional development points and administrative tasks, often when exhausted and during self and family time .**
- **misconceptions by the general public, the media and politicians about the reality of day-to-day life as a GP.**

Facts (2)

GP's do experience multiple stressors

- GP's often blamed for the woes of the health system (waiting lists, high private health insurance premiums, class divide in health care provision).
- Ethical dilemmas in current health system and being committed to principles of social justice.
- Inability to say no to very needy people in the absence of viable alternatives and working in "an ocean of stress emotions" (Shovholt 2001 p. 86)
- Ambiguous professional loss and lack of clear closure with some patients. Elusive measures of success and failure.
- The confidential and therefore covert nature of the work that can prevent self-disclosure even to those who can really enter the reality of the GP.
- Large number of one-way relationships with huge demands for interpersonal sensitivity and empathy.
- Expectations for record-keeping (eg keeping government statistics) and other paperwork
- Other after hours work eg programs Like Practice Incentive Payments (PIP) encourage after hours work that can have a negative impact on health (physical, psychological & social)
- Women GP's often criticised for working part-time (implicitly or sometimes explicitly considered wasted education and financial investment).
- Unfair remuneration (GP's feeling powerless to increase incomes to offset increases in administration, staffing and other overheads)
- Lack of structured career pathway and little time for outside intellectual or emotional stimulation.

Facts (3)

GP's do experience multiple stressors

- **Unrealistic expectations from patients. Patients may have unsolvable problems that need to be solved. Most of them are not honours students. They may have strong motivational conflicts and want to be rescued. When the GP's can't do that, they are likely to bear the brunt of negative and sometimes quite hostile feelings.**
- **Uncertainty about making mistakes and litigation.**
- **Risk of violence and problems in ensuring GP safety (a survey of rural GPs cited verbal insults, threats, physical assaults, sexual abuse, property damage and harassment with 20% of respondents being physically attacked).**
- **GP registrars (job versus family conflict, exam pressures, and unrealistic patient expectations).**
- **Concerns about medical indemnity insurance.**
- **Government financial reward (in the form of rebate) tied to quantity rather than quality of work.**
- **After hours coverage in the ACT- Principals having to do after hours locum work on a regular basis.**
- **Daily exposure to the worst of pain , suffering, grief and loss within the context of meaningful relationships with the patient and their family.**
- **High risk of direct and vicarious traumatisation because of dose-response effects, psychological proximity of trauma and the lack of a favourable recovery environment.**

DHAC report (2001) Doumani (2001), Phelps (2002) Higgins, 2000; 2001; Personal communications with GP colleagues; (Shovholt 2000).

**GP's do become sick and distressed and they are often not healthy (physical, mental and social health)
(1)**

- GP's severely underreport illness or distress of any kind, especially if they can be personally identified.
- This reality would suggest calling upon research data but empirical literature on GP well being is really in its infancy (DHAC 2001).

There are methodological constraints in any epidemiological data that generalises across occupational groups because of two major issues:

1. Oversimplified and largely irrelevant controversy concerning whether being a doctor results in more illness and distress than other occupations. Severe restraints in focusing on occupation as the only explanatory variable when there are so many other variables that contribute to illness and distress.
2. Conceptual confusion concerning the relative primacy and influence of particular life events as opposed to the perceived influence by individual GP's (Higgins, 1995; 1997).

Within these constraints the research suggests that, GP's wellbeing exists along a continuum i.e.

- satisfaction; to poor morale and dissatisfaction but " coping with work"; to significantly stressed and at high risk for burnout; to impaired (physical, psychologically, socially) and in need of professional treatment. (DHAC 2001).

Some overseas studies indicate male doctors are up to 3 times and female doctors are up to 5.5 times more likely to commit suicide than the general population. (Doumani 2001).

Aasaland et al (2001) in a study of Norwegian physicians (n=73) showed suicide rates controlled for age and time period were significantly higher for physicians than for people with other or no university education. The strongest predictors of suicide among male physicians were depression, alcoholism, other drug dependence and being single. The sample of female physicians was too small to allow for any meaningful statistical analysis.

GP's do become sick and distressed and they are often not healthy (physical, mental and social health)

(2)

- Australian GP's prone to psychological conditions especially depression and substance abuse and they seem to have inadequate coping skills in a high demand environment (DHAC 2001).
- There is no systematic recent Australian data on pre-morbid vulnerability to psychological distress, suicide rates, alcohol abuse, or relationship distress amongst GP's (DHAC 2001).
- Australian GP's are reported to be generally in better physical shape than the rest the population (DHAC 2001).
- In an Australian doctor survey in June 1999, half of Australian GP's would not choose general practice again, 66% were concerned about the effect of their work on their health. 41% of GP's were working longer hours than they were 5 years ago and 43% reported that their income was lower over the same time (Ayres 2001).
- 11 year British study of medical practitioners, Firth-Cozen (1998) found that self-criticism (rather than empathy, early stress or depression levels or current job factors) strongest predictor of subsequent stress and depression levels, especially in men. Alcohol abuse begins in medical school but 65% of senior doctors used alcohol as a coping strategy, with 11% using it frequently.
- Stress Management courses to 22 hospitals reduced the rate of malpractice claims from 31 in the previous year to 9 after the intervention; compared to 22 hospitals acting as controls (matched on bed numbers, frequency of claims and whether urban or rural), malpractice claims remained unchanged, 36 in the previous year and 35 in the year following. Medication errors in a single hospital fell from 10.3 to 5.1 following the intervention (Jones et al 1988).
- Complaints against doctors increased significantly in the past year; concerns about misdiagnosis, treatment, over prescription of drugs, and professional standards. Weekend Australian (January 2001).
- Harris (2001) found in SA that complaints about doctors had risen by 50%.

GP's do become sick and distressed and they are often not healthy (physical, mental and social health)
(3)

- **The General Practice Strategy Review Group (GPSRG) 1998 reported that GP's, especially urban GP's may have limited opportunity to practice the full range of skills learnt in training.**
- **Calnan et al (2001) in a UK study explored the level of stress among workers in a random sample of 81 general practices in Southern England. GHQ-12 classified 23% as suffering from mental distress with practice managers the highest and clerical and administrative staff the lowest. The rate of distress amongst GP's was lower than hospital practitioners (27%); but higher than general population surveys that range from 14 to 18%. Non-responders (30%) may be sick and/or distressed but not participate in the study.**
- **Dunstone & Reames (2001) study on 19 US physicians. The research participants said their medical practice has increased in complexity and the public's expectations were greater. The physicians sense of control and autonomy had diminished (more employed, more technology, more stakeholders in patient care, more pharmaceuticals, hospital stays are shorter, hospitalised patients are sicker, more care given in ambulatory settings).**
- **Anecdotally, too many ACT GP's are reporting a sense of personal exhaustion and powerlessness to effect meaningful change in health behaviours, financial pressures and strains. Few, if any, real holidays, problems in finding suitable locums, unrelenting work pressures, marital and family strain, a sense of hopelessness in being able to change their circumstances and emotional disconnection and cynicism.**

GP's do not receive the best Health Care

- **GP's disregard the health advice they would give their own patients. Relatively, few Australian GP's have their own GP and the majority diagnose and treat their own illnesses. GP's receive inferior care when they are ill (in one study 26% of doctors suffered a condition warranting a medical consultation but reported being inhibited about consulting a GP –this was truer for females. Self-treatment often involves prescribing medications, including opiates DHAC report (2001).**
- **A study by Bosch (2000) in Barcelona involving 262 doctors demonstrated that they do not pay due attention to own health and prefer to use self-treatment when they are ill.**
- **The Medical culture tends to views ill-health (especially psychological distress or addictive behaviour) as a weakness DHAC report (2001).**

Systemic Strategies (1)

- **Recruitment of more people into general practice.**
- **Interventions directed at better and more informed selection and preparation of medical trainees (Gerrity 2001) and then ongoing training and feedback on the implementation of effective self-care methods including those addressing verbal and physical forms of self-defence, direct and vicarious traumatisations.**
- **Political lobbying (e. g. AMA safe hours campaign for junior doctors, quality rather than quantity of care rewarded).**
- **Creative options for ongoing training eg professionally refereed multi-media training that can be individualised and self-paced and still earn professional development points and facilitate the GP's sense of competence to assess, offer effective preliminary treatment and where appropriate suitably refer patients with complex biopsychosocial problems.**
- **Professional bodies to effectively educate the media, the community and governments about the day to day life of GP's and for clearer legal distinctions between a mistake in an inexact world, and negligence.**
- **More social justice in our health care systems.**

Systemic Strategies (2)

- **Fairer financial rewards and incentives for quality rather than quantity of service provision, to facilitate working only part-time in direct clinical work with a view to diversify workloads and to better look after important intimate relationships that can help positively moderate to the negative impact of multiple stressors.**
- **Ongoing support for Health initiatives by professional bodies for GP's (24 hr confidential telephone service, GP's for GP's list, screened mental health practitioners for GP's list (both supervision and treatment options).**

Personal Strategies (1)

With everything else being equal, the strongest predictor of health and vocational outcomes for GP's is individual coping ability and so you have far more power to change your circumstances that you may have previously thought possible.

Physiological

- **Proactively and reactively lower baseline level of physiological arousal. Learn to connect bodily sensations to feelings, thinking and behaviour e.g. emotional awareness track down, progressive muscular relaxation, visualisation, meditation, self-hypnosis, regular physical exercise, regular therapeutic massage, laughter and satisfying sex.**
- **Regular independent audits of all aspects of well being (physical, psychological and social).**

Cognitive

- **Non-hostile sense of humour especially helpful in keeping things in perspective**
- **Very important to remember that GP's are people first and medical practitioner's second.**
- **Finding your own inherent value and meaning in the work e.g. constantly satisfying your curiosity about how people function, realistic sense of helping people to help themselves and thereby contributing to the community.**
- **Moving away from narrow paternalistic, materialistic and hierarchical definitions of occupational success to incorporate notions of personal health and well being. Look to boundaried service to patients as a source and a predictor of current job satisfaction. (Dunstone & Reames 2001).**
- **Choose criteria of occupational success over which you have some real control e.g. professional expertise and presence with any particular patient, rather than patient adherence to medical advice or ultimate health outcomes. Operate within your circle of influence rather than your circle of concern (Covey 1990; Skovholt 2001).**

Personal Strategies (2)

Cognitive cnt'd

- entering the moment (whether work or play) and learning to being fully in the present
- learning and implementing effective interventions in self-critical and discouraging ways of speaking to self and internally becoming your own most encouraging, safe and supportive friend
- design own professional and personal development program

Affective

- Modulate and check emotional barometer.
- Learn to identify and constructively express a full range of feelings including those associated with multiple stressors, governments, patients, insurance companies, other health professionals and workplace relationships e.g. journal writing, safe physical release of anger, drawing, music, dance.

Behavioural

- Recognise the reality of dose/response stressor issues in general practice and choose to stop behaving like a superhero.
- Use proactive and integrated sensitivity and responsiveness to own physical, emotional, interpersonal, behavioural and spiritual needs.
- Implement own professional and personal development program
- Recognise the need for more self-care at times of personal vulnerability and increased strain.
- Stop or organise proper help for all self-destructive behaviours, immediately.
- Monitoring of caseload and other duties.
- Regular breaks (holidays, half days off). Consciously discriminate in your use of personal energy. Life and work are a marathon not a sprint. Pace yourself.

Personal Strategies (3)

Behavioural cont'd

- **Capture specified and separate time for self-care, creative and fun behaviours. Do administrative tasks during reasonable working hours (or delegate).**
- **Model health (physical, psychological and social) behaviours to your children, your staff, your patients and the general public.**
- **Choose your own GP and be a responsible, informed and congruent patient.**
- **Clear knock off times and have some real evenings and weekends (sex, rivers, beach, mountains, life).**
- **Please do not re-enact patterns of personal, emotional , social and physical self-neglect (possibly unconsciously informed for many of us by unmet emotional needs in childhood; before the age of psychological parenting eg lack of close emotional tracking; experience of worth being conditional on external achievement or service to other people. Please do not emotionally disconnect from yourself or your feelings. Your uncomfortable feelings and bodily reactions are trying to tell you something very important.**

Interpersonal

- **Selective personal self-disclosure.**
- **Recognise and set limits. Stop being innocent about the assertive need for self-care. Challenge unrealistic and sometimes manipulative expectations of patients and some other people. Enact appropriate boundaries, conflict resolution skills, listening and assertion skills.**
- **Organise and pay for regular quality professional supervision (for an hour at least once a month) (Wilson 2000).**
- **Regular involvement in GP or community networks to overcome sense of professional isolation.**

Personal Strategies (4)

Please make a real commitment to yourself to do at least three things to enhance your self-care before you leave tonight and I will have used my precious time wisely.

Tell your immediate dining neighbour and later on, someone who loves you (unless it is now the same person) about your plans for action

Resources

Medical Registration Board- Impaired Doctors Programme 02 62051599

The Doctors' Health Advisory Service (NSW) 02 9437 6552 - available 24 hours per day independent of all professional organisation and registration authorities and confidential (calls associated with alcoholism, other drug addiction (especially narcotics), clinical competence issues, financial difficulties, legal and ethical issues, marital breakdown, physical and psychological disorder.

Doctors Health Program Heidi Hodges Monday to Wednesday Ph 6552 65 32 Fax 6552 5703 Email: heidi@hrdgp.org.au. This includes GP for GP's list and resource folder

Understanding Depression. Evans, B. J., Burrows G. D. & Norman, T. R. Mental Health Promotion Unit. University of Melbourne. Austin & Repatriation Medical Centre. Email: bevans@alphalink.com.au Phone: 03 949 645 37.

Your Guide to Understanding and Managing Stress (Revised Edition). Evans, B. J., Coman, G. J. & Burrows G. D. Mental Health Foundation of Victoria. The Options Project. Email: bevans@alphalink.com.au Phone: 03 949 645 37.

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