

Attitudes to healthcare and self-care among junior medical officers: a preliminary report

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THERE IS COMPELLING EVIDENCE that doctors are an at-risk group. Their high rates of mental illness and stress-related illness are of particular concern, and are reflected in tragically high suicide rates, high levels of drug abuse, and decreased job satisfaction and "burnout".^{1,2} All of these are powerful indicators of poor self-care.

Junior medical officers, in particular, are at risk. The New South Wales Medical Board has only incomplete data, but these show an alarming increase in suicides of doctors in recent years, with 21 known doctor suicides occurring between 1992 and 1997 (one in 1992 and eight in 1995).³ The increase is mainly accounted for by junior doctors.

In response to the increasing suicide rates and doctors' high rates of stress-related illness and depression, the NSW Doctors' Mental Health Working Group was formed in May 1997. This was a joint initiative of the NSW Health Department and the NSW Branch of the Australian Medical Association. Its policies and recommendations emphasise that doctors should be aware that they are at risk of stress and mental health problems, and that they have a responsibility to care for themselves and to seek appropriate professional medical care. Further, the Doctors' Mental Health Working Group encourages all doctors to have, and to regularly consult with, their own general practitioner and not to prescribe for themselves or their families.

However, there are considerable barriers to be overcome. A NSW survey found that 26% of doctors who reported suffering from a medical condition warranting a medical consultation had not sought that consultation because they were doctors themselves. Only 42% of doctors surveyed had their own GP, and even fewer usually consulted a GP for health problems.⁴

Why do doctors neglect their own health and self-care? Can we identify barriers and facilitate a process for doctors to seek appropriate care?

Healthcare and junior medical officers

To answer these questions, a project was initiated to determine healthcare behaviours and attitudes to healthcare among junior medical officers (JMOs). The project was supported by the Hornsby Ku-ring-gai Ryde Division of

General Practice, Hornsby Ku-ring-gai Hospital and the Northern Sydney Area Health Service. The project received funding from the Innovative Projects Grants scheme for Divisions of General Practice.

The aims of the project were to identify:

- healthcare behaviours of junior medical officers;
- barriers to the use of general practice services;
- educational needs of GPs to assist them to provide an appropriate service for other doctors as patients; and
- ways in which area health services could facilitate access of JMO staff to GP services.

The project involved focus groups of JMOs and GPs, the development and implementation of a questionnaire survey for JMOs in the area health service, and educational sessions for GPs and JMOs. The questionnaire was developed from issues raised in the focus groups. The General Health Questionnaire (GHQ 28)⁵ was also administered. The survey was issued to 300 junior medical staff across the area health service from postgraduate years 1–4. The response rate was 52%.

Preliminary results

There are high levels of self-prescribing and self-diagnosis, reliance on hospital registrars for advice and referrals, and frequent neglect of preventive health issues. Doctors are prescribing medications, for themselves and others, ranging from contraceptives, antihypertensives and sleeping tablets, up to and including narcotic analgesics and antidepressants (see Box). Doctors are legally able to write prescriptions for themselves, but these prescriptions are, of course, not part of a consultation where ongoing care is considered.

"Corridor consultations" are common, with 22% of respondents admitting to requesting a prescription from a work colleague. Interestingly, more than 50% of respondents said they felt uncomfortable about being asked for a prescription by a colleague.

Half of the respondents indicated that they self-referred to consultants or treated themselves for conditions that warranted a medical consultation; and 30% agreed that they had suffered from a medical condition they would like to have discussed with a doctor, but had not done so because they were doctors themselves.

In focus group discussions, JMOs indicated that young professionals such as themselves should have a medical checkup at least once a year; and 83% of respondents thought that all hospital doctors should have an annual health check. The survey results indicated that 30% of respondents were too busy to have a general health check, 70% could only justify seeing a doctor if they were really ill, 20% indicated that they looked after their own health needs,

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and 39% were overdue for some aspects of their preventive healthcare.

Conclusions and recommendations

Young doctors give their own healthcare a low priority. They feel great pressure not to miss shifts due to ill-health — as if this were not a valid reason. They have to be sure they are really sick enough before they would consider asking for help. This attitude to healthcare means that it is even more difficult for young doctors to seek help for a stress-related illness, a mental health issue or for substance misuse, as these are not seen as “real” illnesses.

Some of the recommendations that have come from this research may help to overcome these barriers to appropriate healthcare. For example, 82% of respondents felt that hospital administrations should allow doctors time to have an annual checkup, while 42% of respondents agreed that it would make it easier for them if the checkup was compulsory. Certainly, the information we have indicates that hospitals should be actively encouraging their medical staff to have regular medical checkups. This would act as a reminder, create an environment in which medical checkups were seen as the norm and not requiring a reason, and perhaps set up life-long patterns of behaviour.

Summary

This short overview of our project does not include the data from the General Health Questionnaire. However, notable links with levels of stress in particular groups of doctors have emerged.

This preliminary research indicates that patterns of inappropriate healthcare behaviours develop very early in doc-

Rates of self-prescribing and prescribing for colleagues among 158 junior medical staff

Drug class	Have prescribed or would prescribe	
	For self	For a colleague
Antibiotics	81%	78%
Sleeping tablets	38%	36%
Antihypertensives	15%	22%
Antidepressants	7%	14%
Narcotic analgesics	7%	18%

tors' careers. We have a responsibility to care for JMOs, who appear to be more vulnerable to stress and its consequences. While we have focused on this group, our results can clearly be extrapolated to the medical profession as a whole. Perhaps the culture of poor self-care that appears to be ingrained in the medical profession comes from within.

Acknowledgement

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The junior doctor in distress: the role of a medical education officer at the systems level

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The training of junior doctors requires a delicate balance between “on the job” experience and quality training. . . . The preregistration year is a time in which training, skills and working role are consolidated under supervision, and it has been suggested that it may be the most stressful period in medical practice.¹

IN SOUTH AUSTRALIAN TEACHING HOSPITALS, the education and training of doctors in their prevocational years is currently the domain of a team comprising a Director of

Clinical Training (DCT) and a Medical Education Officer (MEO), in conjunction with a general clinical training committee. The overarching aim of the DCT–MEO team is to ensure high-quality patient care by guiding and supporting the developing junior doctor. To achieve this, the team works both in and on the system of the public teaching hospital.

The DCT–MEO team

The DCT and the MEO have different, but complementary, roles. The DCT is a senior practising clinician and mentor, whose involvement is of necessity part-time, because of clinical responsibilities within and outside the teaching hospital (Box).² The MEO, on the other hand, can be more

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