Doctors' Health and Needs for Services

a study by the
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Summary

This study investigates aspects of the health and illness behaviours of doctors, in order to contribute to current debates about how best to help them to manage their own health. There were two parts to the study, which are outlined below.

PART 1: SURVEY OF DOCTORS AND A COMPARABLE PROFESSIONAL GROUP

The survey

A survey was conducted of general practitioners (GPs) in two Family Health Service Authorities (FHSAs), doctors working in three hospital trusts (HDs) and employees of a multinational accountancy and management consultancy company working throughout the UK (MCs). The aim was to examine the health needs and use of formal services among doctors and a non-medical professional group and to investigate the extent to which problems associated with doctors' health are unique to that profession. Accountants and management consultants were selected as a control group on the assumption that, like doctors, they have generally good health because of their socioeconomic status but are also subject to occupational stress.

Questionnaires were returned from 1279 respondents. Response rates for the participating groups varied from 60 to 85%, with an overall rate of 75.5%.

Sickness absence

Respondents generally reported low levels of sickness absence. However, there were differences in the patterns of sick leave taken by the two professional groups. After adjusting for age and sex, profession was significantly associated with the number of days of sick leave. GPs and HDs took significantly fewer days of sick leave than MCs. Significantly more doctors than MCs reported that their last spell of sickness absence lasted more than 7 days (26% of GPs, 15% of HDs and 3% of MCs).

All respondents reported having 'worked through' illness, but there were variations in the reasons they gave for so doing. MCs most frequently attributed this to 'pressure of work'. GPs most frequently commented that taking sick leave is unfair to colleagues. Junior HDs cited equally this reason and the lack of cover available. Consultants referred most commonly to lack of cover and reluctance to cancel clinics. A hypothetical question was used to test respondents' willingness to take sick leave: doctors seemed more reluctant, or less able, than MCs to take sick leave.

Health and stress

Both groups had broadly similar standards of health, although more doctors reported that their health was 'average' or 'poor' and that they had a chronic medical condition. About one third of GPs, one quarter of MCs and over one fifth of HDs reported that they were 'not very satisfied' or 'not at all satisfied' with their job. Twenty percent of GPs, 11% of consultants and 5% of junior HDs and MCs reported that their job is 'always stressful'. In general, GPs reported higher levels of stress than the other groups, with HDs and MCs reporting similar levels. Consultants were more likely than junior HDs to experience the pressure of time, the impact of work on home life and the impact of changes in working life as stressful.

Services

Almost all GPs, consultants and MCs were registered with a GP; about one fifth of house officers were not. Overall, though, the use of health services was not high, and was lower for the doctors than for MCs. About 60% of the doctors, compared with 38% of MCs, had last had a medical consultation 1 year or more ago. About 60% of HDs reported using occupational health services, mostly for a medical or vaccination.

Almost three quarters of the doctors, but less than half the MCs, stated that there is a need for a special health service for people in their profession. Suggestions about the kind of service envisaged included confidential counselling, occupational health for GPs and a telephone helpline.

PART 2: STUDY OF RECENTLY SICK DOCTORS

The second part of the study investigated the experiences of doctors who have had an illness that resulted in their using services. In-depth interviews were conducted with 64 doctors with a recent experience of illness. These were 36 men and 28 women ranging in age from 27 to 65 years. There were 40 GPs and 23 hospital doctors (11 consultants and 12 juniors), with one doctor a member of the armed forces. Thirty-six interviewees had had a physical illness or disorder; 24 had been ill with a psychiatric disorder; and four had had both a physical and a psychiatric disorder. Issues investigated include the following.

Pathways to care

Doctors accessed services in a variety of ways, via a colleague, GP or direct referral. Self-diagnosis and self-referral led in some cases to delays in treatment and inappropriate treatment.

Mechanisms of support

Doctors were generally supported by family and friends. Colleagues' ability to provide support could be compromised by the burden of extra work that sickness absence placed on them. Doctors need more easily available advice and information (e.g. in organising locum cover and in assessing the implications of illness for one's career). Some doctors also felt that there was a need for more easily available psychological support.

Sick leave

Doctors' ability to take sick leave is compromised by cultural and organisational barriers, including the belief that 'doctors don't get sick' and the lack of provision for cover. This led in some cases to doctors' avoiding taking sick leave, using holiday leave to recuperate and returning to work early.

The professional and personal impact of illness

For most doctors interviewed, the period of illness was a hiatus. In some cases, doctors felt that their career had been slowed down, or more seriously interrupted. Chronic illness was most likely to have an impact on a doctor's career. In some cases, doctors were able to continue part-time training. Most doctors felt that the experience of illness had transformed their professional sympathy towards patients into empathy, improving their ability to communicate with them.

Perceptions of care

Doctors were generally satisfied with the quality of care they received. However, the normal doctor–patient relationship changes when the patient is medically qualified. This can give rise to difficulties in communication. In some cases the quality of care was inferior to that assumed to be given to lay patients: some doctors were left to manage their own treatment, asked to make their own diagnosis and not given adequate information, counselling or follow-up.

CONCLUSION

The report concludes by considering the extent to which the health needs of doctors are different from those of lay people. It is suggested that doctors' attitudes towards health and illness prevent them from using services in the same

way as lay people do. Consideration should be made of both cultural and organisational barriers to the management of doctors' health, including the taking of sick leave and the use of services. To date little attention has been paid formally to the treatment of medically qualified patients, which raises particular problems and requires particular skills.

Introduction

Published studies have long documented reasons for concern for doctors' health. Although doctors generally enjoy the good standards of health associated with their socioeconomic status, two broad areas are problematic: their psychological health and the ways in which they use or fail to use health services.

The mental health of doctors has been the subject of a number of studies. It has been suggested that they may have higher than expected rates of alcoholism and substance abuse (Murray 1976, Brooke et al. 1991). A recent publication lists doctors as among the ten highest risk occupations for suicide, with a proportional mortality ratio of 144 for men and 322 for women for the period 1982–92 (Kelly et al. 1995).

A growing number of studies have investigated the experience of stress as a possible cause of mental ill-health among doctors. Much of this work has focused in particular on junior doctors. Firth-Cozens (Firth 1986, Firth-Cozens 1987, 1990) has documented elevated levels of stress and emotional distress among medical students and junior doctors. She found that about one third of fourth-year students were emotionally distressed, and half of junior house officers were emotionally disturbed. Humphris et al. (1994) found that nearly one in five of their sample of junior doctors were suffering 'burnout', psychological strain caused by job stress. Grainger et al. (1995) found that their sample of pre-registration house officers reported lower job satisfaction and a greater incidence of stress-related problems than a comparative group of junior hospital doctors.

Stress among GPs has also been documented, with one Australian study suggesting that one third of GPs suffered significant levels of job stress (Winefield and Anstey 1991). In a British study about 13% of GPs surveyed reported that they had recently experienced depression (Chambers and Belcher 1993a). There has also been some investigation of the possible effects of the changes in the National Health Service (NHS) on doctors' stress and health. Chambers and Belcher (1992), Sutherland and Cooper (1992) and Kirwan and Armstrong (1995) have reported, respectively, an increase in GPs' self-reported feelings of stress or exhaustion, decreased job satisfaction and poorer mental health, and higher than expected levels of burnout.

One recent study has also found that, as well as GPs, senior doctors and NHS managers also experience high levels of occupational stress (Caplan 1994).

It has been suggested that high levels of stress at work, coupled with low job satisfaction, can lead to absenteeism, defined as absence from work attributed to sickness (Rees and Cooper 1992). In the NHS absenteeism is reported to vary from 1 to 11%, with a mean figure of just under 5% (Seccombe and Patch 1994). Absence at this high overall rate has been estimated to cost the NHS more than £1 billion a year (Cole 1995). Increased efforts and new methods aimed at reducing absence attributed to sickness among NHS employees have recently been reported (Cole 1995).

There is, however, considerable variation in rates according to occupational group. Studies of sickness absence show that manual workers have higher rates of sick leave than non-manual workers, women tend to have higher rates of absence than men, and age affects both frequency and length of absence (McKeown 1989). Importantly, socioeconomic status has also been found to be inversely related to sickness absence, as it is to health status. The Whitehall II study found that civil servants in the lowest grades took significantly more short and long periods of absence than those in the highest grade (North et al. 1993). Because doctors generally have good health, we would expect to find that their levels of sickness absence are low. This is borne out in a number of studies. Pines et al. (1985), Al-Shammari et al. (1994) and Seccombe and Patch (1994) all found that doctors as a group had the lowest rates of sickness absence of all hospital employees. Comparing GPs and teachers, Chambers and Belcher (1993) found that the latter had much higher rates of sickness absence, for short and long periods and across all age groups. In their study of employees of one health authority, Rees and Cooper (1992) found that only general managers took fewer days of sick leave than doctors (mean 0.67 and 1.56 days, respectively).

In addition, studies have also argued that there are difficulties associated with doctors' access to health services (Richards 1989; Silvester et al. 1994). Doctors are generally assumed not to use medical services because, it is suggested, access to such services is impeded by their own status. Thus, when they do require medical care, they tend to treat themselves or rely on informal consultations with colleagues. Allibone et al. (1981) found evidence of inappropriate self-treatment and delays in seeking help. More recently, Chambers and Belcher (1992) investigated GPs' self-reported health care including registration with a GP, self-medication and referrals to a specialist, concluding that most GPs look after their own health rather than use services.

Such studies have been accompanied by calls to address the health needs of medical practitioners. The suggestion that current provision fails to meet the particular needs of doctors is not a new one and has been reiterated by a number of authors (Anonymous 1978, 1980, Allibone et al. 1981, Anonymous 1988, Richards 1989, Harrington 1990, Chambers 1993).

To contribute to the debate about how best to meet the health needs of doctors, this study seeks to address a number of issues that have been identified as requiring further investigation. First, it is clear that, apart from relatively few autobiographical accounts (Hahn 1985), little is known about the experiences of sick doctors who do at some point seek help and thus become users of the system. Enquiry into these experiences is needed to document doctors' pathways into care, their perceptions of the extent to which the services and support provided meet their needs, and the implications of a period of illness for the doctor's career and medical practice.

Second, whereas doctors are generally assumed to have both special health needs and a greater reluctance to use formal services arising from the nature of their work, there are questions of how far their experiences and behaviours are unique or may be shared by other professional groups, especially given the

changes that have taken place throughout society in the organisation of the economy and working life. Very few studies to date have sought to compare doctors' health behaviours and needs with those of other groups.

Third, studies of occupational stress among doctors have tended to focus on medical students and junior doctors (Firth 1986, Firth-Cozens 1987, 1990, Humphris et al. 1994, Grainger et al. 1995). Although studies of GPs document their high levels of stress (Winefield and Anstey 1991, Chambers and Belcher 1993a) and one recent study suggests that senior hospital doctors also experience high levels of stress (Caplan 1994), there is a need to compare levels of stress for all doctors across grades.

Finally, because there has been a tendency in the literature to treat issues such as job stress or service use separately, there is also a need to investigate these as related aspects of health behaviour.

The present study was therefore undertaken to address these issues. There were two parts to the research: a survey of general practitioners, hospital doctors and employees of a multinational accountancy and management consultancy company; and in-depth interviews with 64 doctors with a recent experience of illness. This report presents findings from both parts of the study. A discussion of the results of the study and a list of recommendations are also presented.

Part 1

Survey of doctors and a comparable professional group

AIMS

This part of the project examined the health needs and use of formal services among hospital doctors (HDs), general practitioners (GPs) and a non-medical professional group (management consultants and accountants – MCs). Data were collected on three broad areas: sickness absence, use of services and perceptions of work-related stress.

Although doctors are assumed to have both special health needs and a greater reluctance to use formal services, one aim of the study was to investigate how far these experiences and behaviours are unique or shared by other professional groups. Graduate employees of multinational accountancy firms were selected as a comparable group of professionals because they share with doctors a number of circumstances that may have an impact on health and health behaviour: they have high socioeconomic status, they often undertake lengthy postgraduate training, and they work in an environment and sector which is often described as stressful.

METHODS

Selection of sample

We aimed to recruit to the study participants from contrasting geographical locations throughout England, including urban and non-urban sites. Initially, three Family Health Service Authorities (FHSAs), three hospitals and three multinational accountancy companies were contacted by telephone and letter to explore the possibility of participation in the study. In three cases participation proved not to be possible. GPs in one FHSA had recently received a survey relating to stress and it was felt that it would not be productive to repeat a similar study. After lengthy negotiations, two accountancy firms were unable to agree to participate within the time frame of the study.

The final sample consisted of HDs employed by three hospital trusts (a London teaching hospital, a hospital trust in the south-west of England and a teaching hospital in the north-west of England), GPs in two FHSAs (one in an inner city in the north of

England and the other in the south of England, a mix of urban areas and countryside) and MCs employed by a multinational accountancy company working both in London and in a number of other offices throughout Britain.

The questionnaire

A five-page questionnaire was developed to collect the following information:

- Demographic data.
- Sickness absence, including attitudes towards taking sick leave.
- Use of health services, including GPs and occupational health, and respondents' views on needs for services.
- Stress at work.

The questionnaire was piloted among medical staff at St Thomas' Hospital, London and adjustments subsequently made.

Measuring sickness absence and stress

As Taylor (1979) pointed out, no single index or method is universally used to measure sickness absence. Seccombe and Patch (1994) noted the variation in methods and quality of sickness absence record keeping in NHS provider and purchaser units, which complicates the task of comparing sick-leave data. Initial enquiries made to one hospital medical staffing department revealed that no central records of doctors' sickness absence were kept. Therefore, no recorded figures were collected. Rather, the questionnaire asked respondents to supply their sickness absence data. However, self-reported data have been shown to be reasonably reliable (Rees and Cooper 1990).

Many studies of stress have used measures such as the General Health Questionnaire and the Occupational Stress Index. Such methods require respondents to complete lengthy questionnaires, scoring multiple items. Given the limitations of the study, its broad focus on health and services and the need to maximise response rates, we chose to restrict the number of questions related to stress. The lengthy existing measures were not used. Rather, respondents were first asked to rank their overall levels of job satisfaction and of work stress experienced. Then respondents were asked to rank ten broadly described stressors, which have been identified in the literature.

Distribution and follow-up

The questionnaire was sent to all study subjects with a letter setting out the objectives of the study. To preserve confidentiality, the questionnaire had no identification of respondents. However, those who wished to receive a summary of

the study's findings were invited to supply their contact details at the end of the questionnaire.

One follow-up mailing was carried out 2 weeks after the initial mailing. To achieve a response rate above 60%, a second follow-up was needed for GPs in the two FHSAs and doctors in two of the hospitals.

In the multinational accountancy company, a list of eligible respondents was randomly selected by the company's human resources staff. No follow-up was possible because this list, once used, was not retained. This accounts for the lower response rate of this group.

Analysis

Multiple linear regression was used to test the effect of profession on continuous dependent variables (e.g. number of days of sick leave per year) independent of age and sex.

For dependent variables consisting of two categories (e.g. respondents replying 'yes' or 'no' to questions concerning behavioural stress) chi-squared tests were performed to investigate the association between such variables and profession. This analysis was followed by multiple logistic regression to adjust for age and sex.

All statistical analyses were performed using the SAS statistical package and a P value < 0.05 was considered statistically significant.

Because the questionnaire was answered anonymously, it was not possible to adjust in any way for non-responders.

THE SAMPLE

A total of 1279 questionnaires were returned in time for analysis, representing an overall response rate of 75.5%. However, the response rates of the participating groups ranged from 60 to 85% (Table 1). Overall, respondents comprised 532 GPs (79% response rate), 506 HDs (77% response rate) and 241 MCs (60% response rate).

Table 1 – Response rates by participating group

	n	%
Hospital A	130	78
Hospital B	101	83
Hospital C	275	74
FHSA D	348	85
FHSA E	184	71
Company	241	60
Total	1279	75

Age distribution

The total sample ranged in age from 22 to 68 years, with just over half the sample under 40 years of age (Table 2). A one-way analysis of variance showed that mean age differed significantly across professional groups ($P = 0.001$). Each profession also differed significantly from the other two groups, with MCs being the youngest group and GPs the oldest group (Tukey's multiple comparisons).

Table 2 – Age distribution and mean by profession

Age (years)	GPs		HDs		MCs	
	No.	%	No.	%	No.	%
20–29	8	1.5	144	28.5	50	21.1
30–39	171	32.6	142	28.1	139	58.7
40–49	190	36.2	125	24.8	40	16.9
50–59	120	22.9	75	14.9	8	3.4
60–69	36	6.7	19	3.8	—	—
Mean (SD)	44.5 (9.3)		38.5 (10.9)		43.7 (9.7)	

Sex and marital status

Approximately 34% of doctors and 27% of MCs were women (Table 3). The men in the sample were significantly older than the women ($P = 0.001$) (Table 4). There were also significant differences in the marital status of respondents according to profession, with 31.8% of HDs, 24% of MCs and 8.7% of GPs unmarried ($P < 0.001$).

Table 3 – Percentage of respondents by sex

	GPs	HDs	MCs
Male	66.5	66.4	73.0
Female	33.5	33.6	27.0

Table 4 – Mean age of respondents by sex

	No.	Mean age (years)	SD
Male	862	41.6	10.3
Female	405	37.4	9.7

General practitioners

Less than half the GPs (44.2%) were working in fund-holding practices. There was a significant difference in the geographic location of GPs in fund-holding and non-fund-holding practices ($P < 0.001$) (Table 5).

Table 5 – Fundholders by FHSA

	FHSA D	FHSA E
Fund-holding	55.8	16.4
Non-fund-holding	44.2	83.6

Almost 85% of respondents were full-time principals, and of the part-time principals 74% were women.

Hospital doctors

There were 254 junior hospital doctors and 215 consultants, and 37 HDs gave no information about their grade (Table 6).

Table 6 – Hospital doctors by grade

	No.	%
House officers	149	29.5
Registrars and senior registrars	85	16.8
Clinical assistants	20	3.9
Consultants	215	42.5
Not known	37	7.3

Of the total HD sample, 55% of the juniors and 80.5% of the consultants were men (Table 7). This difference in sex distribution by grade was statistically significant ($P < 0.001$).

Table 7 – Hospital doctors by sex and grade

	Juniors ($n = 254$) %	Consultants ($n = 215$) %
Male	55.0	80.5
Female	45.0	19.5

Management consultants and accountants

All MCs were employed in management posts in different sectors of the company, including accountancy, tax consultancy and management consultancy. Because the reported grade classification varied according to the sector of the respondents, no analysis by grade was carried out for MCs.

The sample consisted of 176 men (73%) and 65 women (27%).

In all, 185 respondents (76%) had a first degree, 23 (10%) had a higher degree and 154 (64%) had a professional qualification.

SICKNESS ABSENCE

Perceived health status

Investigation of reported sickness absence began with questions concerning respondents' perception of their own health. Data were also collected on chronic illness and recent hospital admissions, which may affect individuals' histories of sickness absence.

First, respondents were asked to rate their own overall health on a 4-point scale: excellent, good, average, poor. Most doctors (GPs and HDs) rated their own health as *excellent*, whereas most MCs rated their health as *good*. However, the proportion of doctors who rated their health as only *average* or *poor* was higher than for MCs, with GPs slightly more likely to do so than HDs (Table 8).

Table 8 – Reported health by profession

	GPs (n = 532) %	HDs (n = 506) %	MCs (n = 241) %
Excellent	50.0	57.0	44.5
Good	37.9	34.3	50.2
Average	10.0	7.7	5.9
Poor	2.1	1.0	0.4

Looking at HDs alone, juniors and consultants rated their overall health in similar ways (Table 9).

Table 9 – Reported health of HDs by grade

	Juniors (n = 254) %	Consultants (n = 215) %
Excellent	55.7	60.9
Good	36.4	30.7
Average	7.1	7.5
Poor	0.8	0.9

Respondents were then asked whether they had a chronic medical condition (the examples of asthma and diabetes were given), and whether they had been admitted to hospital in the last 3 years. In reply, 13.1% of HDs and 12.8% of GPs reported that they had a chronic medical condition, compared with 6.6% of MCs. Multiple logistic regression showed that there was a significantly increased risk of having a chronic medical condition for HDs compared with MCs after adjusting for age and sex (P = 0.02). Reported hospital admissions varied only slightly between professions: 15% of GPs, 13.5% of HDs and 11.8% of MCs had experienced a stay in hospital in the previous 3 years.

These differences in the professional groups' responses should perhaps be interpreted with caution. As well as there being a possible age effect, the results could reflect differences in perception and evaluation of health rather than in actual health. Respondents were not asked to supply details of their chronic medical condition, although some added comments to the questionnaire such as 'very mild form of asthma'. That one MC wrote on his questionnaire 'asthma attacks fairly regularly but not chronic' confirms that these differences may indeed reflect a difference in interpretation of the question.

However, the responses to these questions suggest that, as expected, the sample generally had good health.

Days of sick leave taken

Respondents were asked how many days of sick leave they had taken in the last year. In our analysis we assumed that, where no answer was given to this question, no leave had been taken.

For the total sample, responses ranged from 0 to 365 days. However, the distribution of the data was skewed, with more than half the sample reporting that they had taken no sick leave. Almost 30% reported taking 1–3 days in the last year, and small numbers of respondents reported 4–7 days and more than 7 days (Table 10).

Table 10 – Days of sick leave taken in the last year by all respondents

	(*n* = 1279) %
0 days	53.5
1–3 days	29.1
4–7 days	8.8
> 7 days	8.6

Differences by profession

This general picture is altered when we analyse the responses by profession (Table 11). All doctors were significantly more likely than MCs to report not taking any sick leave in the last year. GPs were slightly more likely than either HDs or MCs to report more than 7 days taken in the last year.

Table 11 – Days of sick leave taken in the last year by professional group

	GPs (*n* = 532) %	HDs (*n* = 506) %	MCs (*n* = 241) %
0 days	65.0	53.0	29.0
1–3 days	20.9	30.2	44.8
4–7 days	4.3	9.1	18.3
> 7 days	9.8	7.7	7.9

Multiple linear regression was then carried out to test the effect of profession on sick leave after adjusting for age and sex. Profession was found to be significantly associated with the number of days of sick leave independent of these two variables, with GPs and HDs likely to have taken significantly fewer days than MCs ($P = 0.0001$).

Among hospital doctors, there were significant differences between juniors and consultants in the number of days of sick leave taken in the last year ($P = 0.043$). Consultants were more likely than juniors to report not having taken any sick leave in the previous year (Table 12).

Differences by sex

For the total sample, men reported taking significantly fewer days of sick leave than women ($P = 0.012$). However, looking at the data by profession and sex, there were no significant differences between male and female GPs or between male and female MCs in the number of days of sick leave they reported taking in

the last year. There were differences between male and female HDs in the number of days of sick leave taken in the last year (Table 13), with female doctors reporting significantly higher numbers of days ($P = 0.016$).

Table 12 – Days of sick leave taken by HDs in the last year by grade

	Juniors ($n = 254$) %	Consultants ($n = 215$) %
0 days	48.0	59.5
1–3 days	35.4	24.2
4–7 days	8.3	9.3
> 7 days	8.3	7.0

Table 13 – Days of sick leave taken by HDs in the last year by sex

	Males ($n = 336$) %	Females ($n = 170$) %
0 days	58.0	42.9
1–3 days	27.1	36.5
4–7 days	8.0	11.2
> 7 days	6.9	9.4

Length of last sickness absence

Respondents were asked how many days they had been absent from work on their most recent period of sickness absence. Of the total sample, 960 respondents answered this question: 389 GPs (73% of all GPs), 358 HDs (70%) and 213 MCs (87%). Of the hospital doctors, 167 were juniors, 165 consultants and 26 of unknown grade.

Given the uneven distribution of the data, responses were analysed after being divided into three categories: 1–3 days, 4–7 days and more than 7 days.

Most respondents reported only brief spells of absence, that is of 1–3 days, with smaller numbers reporting 4–7 days. Spells of longer than 7 days were reported by 17% of respondents who had had a period of absence (Table 14).

Table 14 – Length of last period of sick leave as a percentage of respondents reporting a period of sick leave

	(*n* = 960) %
1–3 days	70.3
4–7 days	12.7
> 7 days	17.0

Differences by profession

There were significant differences according to profession (Table 15). Although similar numbers in each profession reported a medium spell (4–7 days), MCs were more likely than doctors to report a short spell of sickness (1–3 days). GPs were significantly more likely than both HDs and MCs to report a spell of more than 7 days ($P < 0.001$).

Table 15 – Length of last sick leave by profession

	GPs (*n* = 389) %	HDs (*n* = 358) %	MCs (*n* = 213) %
1–3 days	60.4	72.3	85.0
4–7 days	13.6	12.3	11.7
> 7 days	26.0	15.4	3.3

After adjusting for age and sex, GPs and HDs were found to report significantly longer spells than MCs ($P = 0.001$ and 0.0187, respectively).

Among HDs, there were also significant differences between juniors and consultants (Table 16). Juniors were more likely than consultants to report an absence of 1–3 days, whereas consultants were much more likely than juniors to report having taken sick leave lasting more than 7 days. This was statistically significant ($P = 0.021$).

Table 16 – Length of last sick leave taken by HDs by grade

	Juniors (*n* = 167) %	Consultants (*n* = 165) %
1–3 days	76.6	67.3
4–7 days	12.0	12.7
> 7 days	11.4	20.0

Differences by sex

After adjusting for age and sex, women in the sample as a whole were found to report significantly longer periods of sick leave than men ($P = 0.0147$).

Looking at the differences by sex for each professional group there were slight differences in the length of the most recent leave taken. As Table 17 shows, female GPs and HDs took longer leave than their male colleagues but these were no longer statistically significant ($P = 0.279$ and 0.548, respectively). Female MCs report taking shorter periods of leave than their male colleagues. Here, however, the numbers are very much smaller.

Table 17 – Length of last sick leave by sex

	GPs		HDs		MCs	
	Male ($n = 262$) %	Female ($n = 127$) %	Male ($n = 231$) %	Female ($n = 127$) %	Male ($n = 154$) %	Female ($n = 59$) %
1–3 days	63.0	55.1	73.2	70.9	83.1	89.8
4–7 days	13.3	14.2	12.1	12.6	13.0	8.5
> 7 days	23.7	30.7	14.7	16.5	3.9	1.7

To summarise, the sick leave data suggest that doctors in general do not have high rates of sickness absence. Comparison with a professional group of similar socioeconomic status confirms that their rates of sickness absence are low, although some caution is needed given the much lower response rate obtained for the comparative group. However, whereas just under 30% of MCs reported taking no sick leave in the last year, 53% of HDs and 65% of GPs reported that they had not taken any.

There are significant differences in the kind of sick leave taken by the two groups. MCs tend to be absent for short periods, and very few for longer than 1 week. Whereas most doctors also report short absences, far greater numbers of doctors than of MCs report long periods of absence: 15% of HDs reported a period of more than 7 days, and for GPs this figure rises to just over one quarter of all those who reported having taken any sick leave. Junior HDs reported taking more days in the previous year than consultants, but when consultants did take sick leave it tended to be longer. These differences remain after adjusting for age and sex.

Reasons for last sick leave taken

Respondents were asked to give the reason for their last sick leave. Responses were then coded into broad categories. The most frequently cited categories are presented in Table 18.

For all groups, most absences were attributed to minor illnesses such as "flu', or 'short-term viral illness'. Depression was cited by a very small proportion of all respondents. There are some variations between professions in the reasons for absence. Doctors tend more than MCs to report back pain and other skeletal or muscular disorders; MCs on the other hand tend to report migraine more frequently than doctors. GPs are less likely than either HDs or MCs to cite flu or illness affecting the respiratory tract as a reason for sick leave.

Table 18 – Reasons for sick leave by profession and illness category

	GPs (n = 389) %	HDs (n = 358) %	MCs (n = 213) %
Flu and respiratory tract infections	36.3	53.0	56.1
Diarrhoea, vomiting and other gastro-intestinal infections	20.7	15.7	14.9
Back pain and other muscular or skeletal disorders	9.1	8.8	3.6
Migraine, disorders of the central nervous system	3.9	3.0	7.2
Accidents	5.3	2.5	3.6
Infectious diseases	2.6	2.5	3.1
Genitourinary disorders	4.3	1.9	0.5
Depression and other psychiatric disorders	2.4	2.2	0.5
Other/no response	15.4	10.4	10.5

Attitudes towards taking sick leave

Given the anticipated low levels of sick leave for both professional groups, we investigated respondents' attitudes towards taking sick leave.

First, in response to the question, *Have you ever continued to work where it might have been better to take sick leave?*, 458 GPs (87%), 429 HDs (86%) and 212 MCs (89%) replied 'yes'.

In response to an open-ended question about reasons for not taking sick leave, most MCs (63%) explained this in terms of 'pressure of work' with smaller numbers of other respondents offering 'no one else to do my work' (20%), 'work ethic' (8%) or 'prior commitments' (5%) as the main reason.

The reasons given by doctors related mainly to the organisation of work (e.g. 'no provision for cover is made', 'too difficult, too expensive to get locums'), concern for the effects of absence on colleagues and patients, and work ethic

(Table 19). Responses coded under the latter category included a range of comments such as 'commitment to the job', 'taking sick leave is disapproved of' and 'workaholism'.

Table 19 – Doctors' main reasons for working through illness

	GPs (n = 458) %	HDs (n = 429) %
Unfair to colleagues	50.3	26.4
Unfair to patients	19.5	19.7
No cover provided	12.4	33.0
No locums available	12.0	2.1
Work ethic	6.9	10.8

Percentages do not total 100 as multiple answers could be given to this question.

Among HDs, 87% of juniors and 85% of consultants reported having worked through illness on occasion. However, there were differences between the two groups in the reason they gave for working through illness (Table 20). Juniors emphasised the impact their absence would have on other colleagues, whereas consultants were more likely to express concern for the possible effect of cancelled sessions on patients.

Table 20 – Hospital doctors' main reasons for working through illness

	Juniors (n = 220) %	Consultants (n = 179) %
Unfair to colleagues	35.2	14.5
Unfair to patients	7.0	31.9
No cover provided	34.7	33.0
No locums available	4.2	0.0
Work ethic	11.3	9.5

Finally, respondents were asked a hypothetical question: *If you woke in the morning with a streaming cold and a headache would you take the day off work?* Four possible answers were offered, ranging from 'yes, definitely' to 'definitely not' (Table 21). There were significant differences between professional groups, with GPs and HDs most likely to respond 'definitely not' ($P < 0.001$); this difference remained after adjusting for age and sex. More than half the HDs reported that they would definitely not take the day off, with consultants slightly more likely

than juniors to report that they would definitely take the day off work (Table 22). However, this was not statistically significant ($P = 0.095$).

Table 21 – Response to hypothetical question by professional group

	GPs ($n = 532$) %	HDs ($n = 506$) %	MCs ($n = 241$) %
Yes, definitely	0.7	1.7	2.9
Probably	1.7	3.7	12.6
Possibly	9.8	38.1	53.3
Definitely not	86.6	56.3	31.9

Table 22 – Response to hypothetical question from HDs by grade

	Juniors ($n = 254$) %	Consultants ($n = 214$) %
Yes, definitely	0.4	3.3
Probably	4.3	3.3
Possibly	39.0	35.7
Definitely not	56.3	57.8

STRESS

Job satisfaction

Respondents were first asked to rank their overall level of satisfaction with their current job on a 5-point scale, from completely satisfied to not at all satisfied.

Most respondents in all three groups were generally satisfied with their job (Table 23). However, over 30% of GPs, 24% of MCs and 22% of HDs reported that they were not very satisfied or not at all satisfied.

When adjusted for age and sex, the difference between GPs and the two other professional groups was not significant ($P = 0.062$). GP responses were further analysed according to respondents' geographical location and work situation (whether full-time or part-time and whether in a fund-holding practice or not). No significant differences were found. Among hospital doctors, levels of satisfaction did not significantly differ according to grade, with 21.8% of juniors and 24% of consultants reporting that they were not very or not at all satisfied with their current job.

Table 23 – Overall job satisfaction by professional group

	GPs (n = 532) %	HDs (n = 506) %	MCs (n = 241) %
Completely satisfied	4.5	4.6	2.9
Very satisfied	21.0	31.9	22.8
Satisfied	40.5	40.6	49.4
Not very satisfied	27.0	19.3	21.6
Not at all satisfied	7.0	3.6	3.3

Perceptions of work-related stress

Respondents ranked their overall level of work-related stress on a 5-point scale from never stressful to always stressful (Table 24). High overall levels of stress were reported, with 72% of GPs, 50% of HDs and 57% of MCs reporting that they found their job often or always stressful. When adjusted for age and sex, profession remained significant: GPs were most likely to report their job as often or always stressful ($P < 0.001$).

Table 24 – Overall job stress by professional group

	GPs (n = 532) %	HDs (n = 506) %	MCs (n = 241) %
Never stressful	0.8	0.4	0.4
Rarely stressful	3.2	8.6	3.7
Sometimes stressful	26.4	40.1	38.2
Often stressful	52.6	42.9	52.7
Always stressful	20.0	8.0	5.0

The effects of geographical location and work situation on overall stress for GPs were investigated. Only work situation was found to be significant, with full-time GPs more likely than part-time GPs to report that their job is often or always stressful: 71% of full-time GPs and 60% of part-time GPs reported that their job is often or always stressful ($P = 0.042$).

HD responses were further tested for the effect of grade on results (Table 25). After adjusting for age and sex, grade was found to be significant, with 62% of consultants and 43% of juniors stating that their job is often or always stressful ($P = 0.001$).

Table 25 – Overall job stress in HDs by grade

	Juniors (n = 254) %	Consultants (n = 215) %
Never stressful	0.0	0.5
Rarely stressful	11.5	5.6
Sometimes stressful	45.6	31.8
Often stressful	38.1	50.9
Always stressful	4.8	11.2

Sources of stress

Respondents were asked to rank on a scale of 1 (very definitely not a source of stress) to 6 (very definitely a source of stress) a list of ten items that might represent sources of stress in the workplace. The 10 items were broad categories of stressors identified in the occupational stress literature that might apply equally to the two professions. They fell into three broad categories: organisational factors, personal and interpersonal factors, and factors related to the job.

Table 26 shows for all respondents the percentage of the sample scoring each item as definitely or very definitely a source of stress. All three groups ranked highest, and in the same order, pressure of time, the impact of work on home life and other people's demands, although the scores given by each group differed. For these three items alone, GPs' totalled score was highest, followed by MCs and then HDs.

Table 26 – Sources of stress in all respondents

	(n = 1279) %
Pressure of time: work exceeds time available	63.0
Other people's demands on me and expectations of me	44.1
Impact of work: interferes with my home life	42.5
The decisions I have to make and the risks I have to take	26.9
Changes in the way I am expected to do my job	21.1
Changes in the organisation I work for	19.1
My rate of pay	14.3
Conflicts with other colleagues, superiors, peers, subordinates	13.3
My job security and promotion prospects	11.9
My ability to do the job	5.7

Other stressors were scored differently by the three groups. Most notably, for MCs job security and promotion prospects ranks as the fourth most important stressor, whereas for HDs this ranks seventh, and for GPs ninth. For GPs, changes in the way I am expected to do my job ranks fourth, whereas for HDs this is eighth and for MCs ninth. Table 27 shows the variations in response by professional group, listing for each the percentage of respondents scoring stress items as definitely or very definitely a source of stress.

Table 27 – Sources of stress by professional group

	GPs (n = 532) %	HDs (n = 506) %	MCs (n = 241) %
Pressure of time: work exceeds time available	69.2	52.8	70.4
Impact of work: interferes with my home life	47.9	37.6	40.8
Conflicts with other colleagues, superiors, peers, subordinates	13.3	14.4	10.9
Other people's demands on me and expectations of me	47.2	26.1	22.5
My job security and promotion prospects	7.0	14.2	17.9
Changes in the way I am expected to do my job	35.6	13.7	4.6
Changes in the organisation I work for	23.5	20.9	5.8
My rate of pay	20.2	12.7	5.0
The decisions I have to make, the risks I have to take	35.0	23.7	15.2
My ability to do the job	6.9	6.3	1.7

Another way of looking at respondents' perception of stressors at work is to calculate the mean scores (on a scale of 1–6) for each item and compare these across professional groups (Table 28). Higher scores indicate greater stress associated with each item. Scores that reach or exceed 4 indicate that high numbers of respondents in that professional group feel that this item is generally, definitely or very definitely a source of stress. From Table 28 it is clear that a number of items are equally viewed as stressors by all three professions. GPs, however, appear to score items highly more frequently than the two other groups. Only where conflicts with other colleagues and job security and promotion prospects are concerned do they score lower than HDs and MCs. MCs, on the other hand, score slightly more highly than HDs on a number of items, including pressure of time, job security, impact of work on home life and conflicts with colleagues.

To test how significant these differences are, and to control for possible confounding effects of factors such as age, the results were again compared across groups after adjusting for age and sex.

Table 28 – Sources of stress at work: mean (SD) scores by professional group

	GPs (n = 532)	HDs (n = 506)	MCs (n = 241)
Pressure of time: work exceeds time available	4.9	4.4	4.9
	(1.19)	(1.41)	(0.99)
Impact of work: interferes with my home life	4.3	3.9	4.1
	(1.28)	(1.39)	(1.34)
Conflicts with other colleagues, superiors, peers, subordinates	2.9	3.0	3.1
	(1.28)	(1.24)	(1.10)
Other people's demands on me and expectations of me	4.3	3.6	3.6
	(1.29)	(1.28)	(1.08)
My job security and promotion prospects	2.0	2.8	3.4
	(1.27)	(1.46)	(1.28)
Changes in the way I am expected to do my job	3.8	3.0	2.7
	(1.40)	(1.24)	(1.04)
Changes in the organisation I work for	3.4	3.3	2.6
	(1.44)	(1.39)	(1.11)
My rate of pay	3.1	2.7	2.4
	(1.47)	(1.38)	(1.10)
The decisions I have to make, the risks I have to take	3.9	3.4	3.2
	(1.34)	(1.34)	(1.16)
My ability to do the job	2.7	2.6	2.5
	(1.14)	(1.82)	(0.99)

Organisational factors were most frequently reported by MCs as sources of stress. They were more likely than HDs (but not GPs) to report the pressure of time as a stressor (P = 0.0001). They were also more likely than all doctors to cite job security as a stressor (P = 0.0001).

GPs alone were more likely than MCs and HDs to report personal and interpersonal factors as stressful: the impact of work on home life (P = 0.037), other people's demands and expectations (P = 0.0001), decisions and risks (P = 0.0001) and ability to do the job (P = 0.0001).

Both GPs and HDs were more likely than MCs to report organisational factors as significant sources of stress: changes in the way I am expected to do my job (P = 0.0001 and 0.0026, respectively), changes in the organisation I work for (P = 0.0001), and rate of pay (P = 0.0001).

Other significant differences found were that married people were more likely than single people to cite the impact of work on home life as a source of stress (P = 0.0018). Women were more likely than men to cite personal ability (P = 0.0001) but less likely than men to report rate of pay (P = 0.0001) as a source of stress.

Hospital doctors

Comparison of the responses of HDs by grade shows that the most frequently cited stressors for both juniors and consultants are pressure of time and impact of work on home life, with consultants scoring both factors higher than juniors (Table 29). Consultants appear to feel the impact of changes in working life more than juniors. Juniors, on the other hand, are more stressed by factors related to career and the job itself, including job security, rate of pay and decision making and risk taking entailed in the work.

Table 29 – Sources of stress at work: mean (SD) scores from HDs by grade

	Juniors (n = 251)	Consultants (n = 212)
Pressure of time: work exceeds time available	4.1	4.8
	(1.43)	(1.25)
Impact of work: interferes with my home life	3.9	4.0
	(1.41)	(1.36)
Conflicts with other colleagues, superiors, peers, subordinates	3.0	3.0
	(1.25)	(1.22)
Other people's demands on me and expectations of me	3.5	3.8
	(1.27)	(1.26)
My job security and promotion prospects	3.2	2.2
	(1.45)	(1.30)
Changes in the way I am expected to do my job	2.9	3.2
	(1.11)	(1.31)
Changes in the organisation I work for	3.0	3.7
	(1.30)	(1.37)
My rate of pay	3.2	2.2
	(1.37)	(1.14)
The decisions I have to make, the risks I have to take	3.7	3.1
	(1.30)	(1.34)
My ability to do the job	2.8	2.3
	(1.20)	(1.07)

General practitioners

For GPs, differences in levels of stress might be anticipated between those who work full-time and those who work part-time. One respondent wrote on her questionnaire, 'I job share two and a half days a week and would find the level of stress in our job intolerable if this were not the case.' The mean scores of full-time

and part-time GPs show very similar patterns, with pressure of time, the impact of work on home life and other people's demands and expectations all reaching a mean score of 4 or above (Table 30). However, except for conflicts with colleagues and ability to do the job, part-time GPs scored consistently lower than full-time GPs, although the differences were small. There were no significant differences in the levels of stress reported by fund-holders and non-fund-holders except that the latter were more likely to cite changes in the way I am expected to do my job as a source of stress.

Table 30 – Sources of stress at work: mean (SD) scores from full-time and part-time GPs

	Full-time GPs (n = 439)	Part-time GPs (n = 80)
Pressure of time: work exceeds time available	4.9	4.8
	(1.19)	(1.22)
Impact of work: interferes with my home life	4.3	4.0
	(1.28)	(1.26)
Conflicts with other colleagues, superiors, peers, subordinates	2.9	3.0
	(1.29)	(1.22)
Other people's demands on me and expectations of me	4.3	4.1
	(1.30)	(1.34)
My job security and promotion prospects	2.0	2.0
	(1.24)	(1.30)
Changes in the way I am expected to do my job	3.8	3.5
	(1.41)	(1.24)
Changes in the organisation I work for	3.4	3.3
	(1.47)	(1.22)
My rate of pay	3.1	2.7
	(1.49)	(1.28)
The decisions I have to make, the risks I have to take	3.9	3.8
	(1.34)	(1.36)
My ability to do the job	2.6	3.0
	(1.13)	(1.11)

Responses to stress

Respondents were asked to indicate whether their experience of stress had led to any of five listed changes in behaviour (Table 31). Over 20% of all respondents

reported that work-related stress had led to an increase in their drinking. Small numbers reported that their experience of stress had led to an increase in smoking, with HDs slightly more likely than the others to do so. Some respondents, especially GPs and younger people, reported that they devoted more time to recreation as a response to stress, and others wrote comments on their questionnaire to the effect that they had too little time to do so.

Over half the MCs and nearly half the GPs reported that they had considered leaving their job; for HDs this figure was almost 40%.

Over 10% of GPs and slightly lower percentages of HDs and MCs have sought professional help related to their experience of stress.

Table 31 – Responses to stress by all respondents

	GPs		HDs		MCs	
	n	%	*n*	%	*n*	%
Drink more	522	23.4	497	23.5	229	19.7
Smoke more	512	4.5	491	6.3	225	4.9
More time to recreation	521	26.1	494	17.6	231	18.2
Sought professional help	515	10.7	494	4.5	230	7.0
Thought about changing job	512	47.5	488	39.8	226	58.9

As Table 32 shows, similar responses were made by both junior hospital doctors and consultants, except that juniors were significantly more likely than consultants to have increased smoking ($P = 0.003$). Here, however, the numbers were small (29 juniors and 12 consultants).

Table 32 – Responses to stress of HDs by grade

	Juniors		Consultants	
	n	%	*n*	%
Drink more	247	22.3	213	24.4
Smoke more	246	9.7	208	2.9
More time to recreation	246	19.5	212	14.2
Sought professional help	245	5.0	212	3.8
Thought about changing job	242	41.3	209	37.3

Ways to reduce stress

Respondents were asked an open-ended question about ways in which work-related stress might be reduced. Suggestions fell into three broad categories: the need to reduce workloads, changes in working conditions, and calls for

reappraisals of NHS practice and philosophy. There were also a few comments venting respondents' anger with the government and the minister of health. One respondent, for example, suggested that his stress levels would be helped by 'John Major calling an election'; others made direct references to Virginia Bottomley. Another GP commented that his stress might be reduced by 'a basic change in politics/philosophy in the country. I despair at the totally money-driven philosophy in this country.'

Predictably, most of the suggestions related to the most important stressor, work exceeds time available. Responses in this category were expressed in different ways. There were calls for more medical staff to be employed and for more support staff. One GP called for '... actual support services personnel, e.g. CPNs and Macmillan nurses instead of mythical posts not filled or inadequately funded and filled.' Some suggested a reduction in hours, as one GP put it, '... reduce my hours without loss of pay, regain control over my work – I feel powerless as a GP.' Almost 10% of GPs suggested reducing list sizes as a single way of reducing stress, and almost 20% cited the need to reduce or end the out-of-hours commitment as a single way of reducing stress. GPs and hospital doctors both suggested that reducing the amount of administration and paperwork they are required to do would alleviate stress.

The second broad category of responses related to calls for changes in working conditions. These included general calls for more resources to be made available to improve working conditions and facilities. HDs, in particular, were likely to cite the need to improve working conditions, including hours and facilities. One junior, for example, wrote that she would like hers to be 'a 9-to-5 job with guaranteed cover for annual study and sick leave (wishful thinking!)' One senior doctor concluded his list of several suggestions with 'time for lunch'.

Other suggestions in this area were specific to the organisation of work, such as one consultant anaesthetist's call for 'A change in the length of expected time of operating lists. Instead of three and a half hour sessions worked flexibly, there should be fewer but longer sessions of four and a half hours.'

There were also calls from junior HDs for more support and encouragement from senior staff, for example 'more positive attitude from seniors, i.e. encouragement.' Other doctors, including GPs, commented that more support from colleagues would help to reduce stress in the workplace.

A third category of suggestions relates specifically to the NHS. These included, for example, 'more realistic expectations from patients', sometimes with calls for education of patients about how best to use their doctors and calls for the abolition of the Patient's Charter. Other respondents suggested that more realistic expectations on the part of the government would help to reduce their stress. The following GP was not the only one to make the connection: 'Realistic patient expectations. Recognition from government and support from government for work done, rather than unrealistically raising patient expectations.' Some respondents specifically stated that an end to the 'threat of litigation' was needed; others called for less interference from managers and a reduction in the rate of change in the NHS.

USE OF HEALTH SERVICES

We sought to quantify the extent to which doctors use medical services and to compare these with services used by the MCs. We investigated GP registration and private health insurance, the time of last medical consultation, and use of occupational health and other services.

GP registration

Almost all MCs (96.7%) and GPs (97.6%) reported that they are registered with a GP (Table 33). A sizeable proportion of the GPs in the sample (38.5%) are registered with a GP in their own practice. This did not significantly vary according to the respondents' sex or geographical location. Significantly fewer HDs (88.5%) reported that they are registered with a GP ($P < 0.001$). However, among HDs, non-registration with a GP is almost entirely associated with junior doctors (Table 33). The higher the grade, the greater the likelihood of being registered. Over 96% of consultants were registered, whereas about 78% of house officers reported being registered. Of those not registered with a GP, 60% were house officers and 24% were registrars.

Table 33 – Registration with a GP

	%
GPs	97.6
HDs	88.5
House officers	77.9
Registrars	84.7
Consultants	96.2
MCs	96.7

Private medical insurance

Over 90% of MCs in the sample had private medical insurance, but significantly fewer doctors did (Table 34). However, GPs are more likely than HDs to have private medical insurance, and the likelihood of having medical insurance increases with age. The mean age of GPs with insurance was 48.9, whereas the mean age of those without such insurance was 42.6. Among HDs, clinical assistants and consultants are significantly more likely than house officers and registrars to have private medical insurance.

Table 34 – Respondents with private medical insurance

	%
GPs	33.3
HDs	19.7
House officers	5.4
Registrars	8.3
Clinical assistants	35.0
Consultants	33.2
MCs	91.5

Most recent medical consultation

Respondents were asked when they last consulted a doctor. There were significant differences between the professions, with MCs reporting more recent consultations than doctors (Table 35).

Table 35 – Time of most recent medical consultation by all respondents

	GPs (n = 532) %	HDs (n = 506) %	MCs (n = 241) %
In the last month	12.6	9.8	17.2
In the last 3 months	12.2	12.4	22.7
In the last 6 months	10.5	17.8	21.9
1 year or more ago	64.7	60.0	38.3

More than half the GPs and HDs in the sample last consulted a doctor 1 year or more ago. MCs, on the other hand, were more likely to have seen a doctor more recently, with 17% having seen a doctor in the month before completing the questionnaire. Although GPs and HDs reported broadly similar times of last medical consultation, there were significant differences between the sexes (Tables 36 and 37), with female GPs and HDs more likely than their male counterparts to have had a more recent consultation with a doctor (P = 0.004 and $P < 0.001$, respectively).

Table 36 – Time of GPs' most recent last medical consultation by sex

	GPs	
	Male (n = 350) %	Female (n = 174) %
In the last month	9.7	18.4
In the last 3 months	11.1	14.4
In the last 6 months	9.4	12.6
1 year or more ago	69.7	54.6

Table 37 – Time of HDs' most recent medical consultation by sex

	HDs	
	Male (n = 330) %	Female (n = 170) %
In the last month	9.7	10.0
In the last 3 months	9.7	17.7
In the last 6 months	12.4	28.2
1 year or more ago	68.2	44.1

Table 38 brings together data for the time of last medical consultation for the three groups of women in the sample, showing that female MCs are much more likely than female doctors to have had a recent consultation.

Table 38 – Time of most recent medical consultation by women

	GPs (n = 174) %	HDs (n = 170) %	MCs (n = 64) %
In the last month	18.4	10.0	26.6
In the last 3 months	14.4	17.7	29.7
In the last 6 months	12.6	28.2	20.3
1 year or more ago	54.6	44.1	23.4

Doctor seen at last consultation

Respondents were asked whom they had seen at their last medical consultation. For all respondents, their last consultation with a doctor was most likely to have

been with their own GP (Table 39). However, doctors were more likely than MCs to have consulted informally with a colleague or friend (especially among HDs), or to have presented at an accident and emergency department.

Table 39 – Most recent medical consultation by professional group

	GPs (n = 471) %	HDs (n = 467) %	MCs (n = 231) %
Own GP	70.1	69.6	83.5
Private doctor	10.7	3.2	13.4
Informal consultation	14.3	22.7	2.2
Accident and emergency department	4.9	4.5	0.9

Use of services was further investigated by asking respondents whether, during the previous 3 years, they had used any of a list of services in connection with any physical, psychological or stress-related disorder (Table 40). About 60% of GPs and MCs and 55% of HDs indicated that they had used one or more of the health services listed.

HDs' use of occupational health and informal discussion with supervisors clearly reflects the differences in the work structures of hospital medicine and general practice. MCs' use of occupational health services is assumed to relate to use of on-site dental services and uptake of annual medical check-ups offered to the highest grades of employees.

Most of the HDs reporting that they had discussed health problems with a supervisor (4.7% of the HD sample) were junior doctors. Therefore, expressed as a percentage of juniors (n = 254), rather than of all HDs, this figure is slightly higher at 6.7%.

Table 40 – Reported use of health services in the last 3 years by professional group

	GPs (n = 532) %	HDs (n = 506) %	MCs (n = 241) %
Own GP	29.5	28.5	39.0
Another doctor	17.3	16.6	1.0
Occupational health	—	3.8	39.0
Counsellor	4.3	2.4	2.9
Telephone help line	0.6	0.2	1.7
Informal discussion with supervisor	2.1	4.7	2.9

Occupational health services

Hospital doctors were asked specifically about their use of occupational health services (OHS).

All HDs reported having access to an OHS but, whereas before only 3.8% of doctors cited OHS as one of the services they had used in the previous 3 years, 57.9% now reported having used OHS. We assume that the first figure indicates respondents voluntarily using OHS; the second figure may refer to required use of OHS as part of personnel procedures.

Most reported visits to OHS were for vaccination or a medical before taking up a post. Smaller numbers of respondents reported using OHS for injury or acute illness. Use of OHS for any form of advice was negligible (Table 41).

Table 41 – Reasons for use of occupational health services

	(*n* = 506) %
Vaccination	38.1
Medical before taking up a post	28.1
Injury or acute illness while at work	2.6
Advice about work-related stress	0.4
Advice about diet, smoking, drinking	0.2

Percentages do not total 100 as multiple answers could be given to this question.

HDs who replied that they had never used OHS were asked to indicate why not (Table 42). Most who replied to this question indicated that they had never needed to seek medical advice, or that they preferred to see their own GP. Of doctors who have not used OHS, 17% indicated that this is because they have concerns about the confidentiality of the service.

Table 42 – Reasons for non-use of occupational health services

	(*n* = 213) %
It is not convenient	20.9
Concerns about confidentiality	17.6
Prefer to see own GP	54.9
Prefer to see another doctor	15.1
No need for medical advice	68.5

Percentages do not total 100 as multiple answers could be given to this question.

Needs for special services

Respondents were also asked whether they believe that there is a need for special services for people in their profession to deal with health-related problems and stress, and if so what type of service they would like to see. Almost three quarters of the doctors in the sample (77% of GPs and 67% of HDs) indicated that they would like to see such a service, whereas only 43% of MCs thought that there was a need for a special service. In the total sample, women were more likely than men to perceive such a need: 73% of female respondents and 63% of male respondents answered 'yes' to this question.

An open-ended question was asked to investigate what kind of service respondents would like to see. Doctors frequently made reference to some kind of counselling service; smaller numbers made other suggestions, such as a telephone help line, a specialist service for doctors, an occupational health service for GPs and support groups. However, some doctors took this opportunity to express doubts about the utility of simply setting up specific services, arguing that even if services were set up doctors would probably not use them. One commented:

> *I think services are available but it needs to be more 'allowable' to see a GP/counsellor, etc. I told very few people I was seeing a counsellor but the benefits were enormous.*

The barriers to using services and taking sick leave were made explicit by some respondents, as the following comments show:

> *Such a service exists. It is extremely hard for senior psychiatrists to seek help as they would encounter close colleagues or known colleagues from elsewhere. Very hard to envisage effective service given proviso above.*

> *[There should be] lack of stigma in admitting the need for time off.*

The need for confidentiality and the separation of any service from the place of work was reiterated by many respondents:

> *Confidential counselling with no fear of consultants, etc., finding out.*

> *Approach needs to be made to doctors (doctors do not generally seek advice) but by an expert not connected with the organisation.*

Other suggestions were in effect comments about the need for changes in practice as well as attitude:

> *Something to train us to treat ourselves as we would ideally treat patients (i.e. neither over nor under reacting to symptoms, not being our own doctors).*

Still other doctors argued that services would only treat the symptoms, not the causes. Those who answered 'no' to the question sometimes added comments such as:

> *We need more doctors.*

> *More junior doctors' advocacy: treat causes of stress not symptoms.*

Part 2

Study of recently sick doctors

AIMS

The literature related to doctors' health is extensive, but little is known about the experiences of doctors who have been sick. This part of the study documents such experiences by interviewing doctors who have had an episode of illness and thus become users of services. The issues investigated were their pathways into care, mechanisms of support available to them, sick leave, the impact of illness and the return to work, their perceptions of care received and their attitudes towards illness.

RECRUITMENT

Because of the necessity for confidentiality, and the assumed reluctance on the part of doctors to disclose any history of illness, it was decided to invite those who were willing to participate to contact the research team, even though this would result in a self-selected sample.

Two strategies were used to recruit participants:

- A one-page questionnaire was sent to GPs in two FHSAs and HDs in one hospital, inviting doctors who had been ill and would be willing to participate in the study to supply their contact details.
- Small notices were placed in the medical press outlining the study and asking interested doctors to contact the research team.

More than 80 doctors made contact with the research team. Initial telephone discussions were used to clarify the aims of the study and to exclude from the study doctors who did not meet the criteria of being ill or absent from work for 1 month or more at some time in the preceding 3 years.

An assurance of absolute confidentiality was given to all participants in the study.

METHODS

Face-to-face and telephone interviews were carried out. Interview schedules were developed and piloted. (The telephone interview was a slightly shorter version of the face-to-face interview.) Face-to-face interviews generally lasted about an hour, with some taking well in excess of this time. Telephone interviews lasted about 45 minutes. Most interviews were conducted at the doctor's home or place of work. Some doctors preferred to be interviewed at the researchers' place of work. The wives of some male doctors also participated in the interview.

Using a mixture of closed and open-ended questions, the following data were collected:

- Demographic data.
- The illness episode: pathways to care.
- Mechanisms of support.
- Implications of illness and return to work.
- Perceptions of care and attitudes to own illness.

Interviews were audiotaped and transcribed for thematic analysis.

STUDY PARTICIPANTS

Face-to-face interviews were conducted with 32 doctors. Telephone interviews were conducted with 32 doctors. In total, 36 men and 28 women were interviewed, ranging in age from 27 to 65 years. There were 40 GPs and 23 HDs, with one doctor a member of the armed forces. Of the HDs, 11 were consultants and 12 junior grade doctors.

Although the sample of doctors we interviewed was self-selected, a broad spread has been captured, with variations in geographical location, disease category and medical specialisation. Some respondents volunteered to be interviewed because they wished to speak about the poor treatment they believed they had received. Others explained that they had come forward because they had not had particular difficulties and wished to ensure that the researchers heard also from those who had experienced good service from their colleagues.

In all, 36 doctors had had a physical illness or disorder. These included, for example, cancer, glandular fever, multiple sclerosis and a sports injury. Twenty-four doctors had been ill with a psychiatric disorder, mostly depression but also two cases of addiction. The remaining four doctors had had both a physical and a psychiatric disorder. Of the doctors with a psychiatric illness, five were female and ten were male GPs, four female and four male junior HDs, and two female and three male consultants. Illness had led to four doctors retiring on the grounds of ill health. Nine doctors still had an illness at the time of interview.

PATHWAYS TO CARE: ACCESS TO SERVICES

The doctors accessed services in a variety of ways. Some went to their own GP, whereas others consulted a colleague or friend informally. In some cases a self-diagnosis was made, followed by a self-referral to a specialist who might be known in a professional capacity. In some cases, this was successful and non-problematic:

> *I noticed a change in the skin of one of my breasts, made the diagnosis myself as women do, and had a word with my partner who is my GP which is not a desirable state of affairs although it hasn't caused us any bother. And he said, 'Well who do you want to see?' and so I told him and we set up the appointment and I went off to see the surgeon the following week which I arranged personally because he's someone I know and we send lots of our patients to him.*
>
> **Interview 31**

In other cases, self-diagnosis and referral was problematic. After a year of feeling unwell, a 59-year-old male GP believed that he had bowel cancer and referred himself to a surgeon. The surgeon arranged for a colonoscopy to be carried out. No abnormality was found. Almost 6 months later he felt so unwell that he referred himself to a consultant physician and was admitted to hospital where auto-immune Addison's disease was eventually diagnosed and treatment began.

Another GP explained how his lack of insight led to a delay in appropriate treatment:

> *I had a psychotic illness with bipolar depressive features... The first thing I did about it was – I had no insight whatsoever – I went to a priest because I thought I might be being possessed or I thought the devil might be interfering with me. I'd been brought up a churchgoer, but this was new to me to think anything like that. I didn't normally have a particularly religious outlook. Then I did nothing at all for about 6 months: I just lived with odd ideas, carrying on at work, didn't seek any medical help until I noticed that I was having inappropriate sexual thoughts about patients. Again I had no insight about it. I thought that I was criminally insane and went to my GP, and my GP said he didn't know very much about psychiatry and I had suggested to my GP that he refer me to a forensic psychiatrist who specialised in extreme mental conditions and he did. And he sent me off to a forensic psychiatrist out of the area who suggested that I put a rubber band around my wrist and twang it in an effort to get rid of intrusive thoughts. He also suggested that I try a drug treatment which was flupenthixol in small doses.*
>
> **Interview 21**

This account is untypically dramatic, but it is noteworthy that lack of insight led to a long delay in the GP's receiving effective treatment. A year later, he began re-

ceiving regular psychiatric treatment, having been given the name of a consultant by a therapist acquaintance.

In a very few cases, treatment followed the intervention of another person. A 34-year-old senior registrar who has a history of depression described his access to services:

> *In 1987 I was sent by my consultant to see a clinical psychologist. There were rumours that I was taking drugs and I think perhaps I was behaving a bit oddly and I was summoned to see him, and one condition of me carrying on working there – and this wasn't punitive, I don't think – was that I went to see a psychologist.*
>
> **Interview 55**

A 47-year-old male GP was told by a community psychiatric nurse colleague that she thought he might be depressed; she also spoke to the GP's partners. This GP had been unwell for 6 months, losing weight and not sleeping. Until his depression was suggested by the colleague, he believed that he was simply tired by overwork.

When doctors need to access medical services their insider status and knowledge can be both advantageous and disadvantageous. On the one hand, familiarity with the system, having contacts and the professional courtesy of colleagues all mean that doctors can gain easier and quicker access to services than lay people. For instance, those who presented at casualty were often seen more quickly than other patients. Doctors who consulted specialists were often seen outside normal hours, sometimes in their own home.

On the other hand, problems in accessing services were often associated with concerns for confidentiality. This might be fear of the implications for work should colleagues learn that a doctor has a stigmatised illness such as depression, or a chronic condition such as multiple sclerosis. Insider knowledge might also lead a doctor to believe that there is no one available locally to whom she or he can turn.

Although all the doctors we interviewed were registered with a GP, not all chose to consult their GP. In some cases this was because doctors felt that it was simply more convenient to refer themselves to a consultant or to discuss the matter with a colleague. In other cases, such as depression, the doctor felt embarrassment because of the nature of the illness. Some GPs felt that there was little value in consulting another GP whom they believed to be of the same level of competence and knowledge as themselves.

Eleven of the GPs we interviewed were registered within their own practice. As some of the doctors suggested, this could lead to a conflict of interest – with the needs of the practice and colleagues taking precedence over the health needs of the individual doctor. The case of the doctor who had no GP and consulted a partner when he realised that he was becoming depressed illustrates this. The difficulties that would be created for the practice should the doctor take sick leave were made plain. The partners discussed the case with a psychiatrist, who later

saw the doctor in question. The psychiatrist's judgement was that the GP was not depressed but fit for work. The GP, initially relieved to find that he was 'not depressed' soon found himself unable to cope and 6 weeks later took sick leave, sought psychiatric help and resigned from the practice.

MECHANISMS OF SUPPORT

We asked doctors about the support they had received during their illness. In some cases there were no particular support needs aside from medical intervention. Other doctors needed practical help and information about finding locums, advice about the implications of illness for the doctor's career, or psychological support. This was sought from a range of sources.

Most doctors were supported during their illness primarily by their own family and friends.

> *Well, my wife's a nurse and that's very useful. She certainly believes that I have too much tendency to go in to work when I shouldn't. Always encouraging me just not to answer the phone, not to go in, saying things like, 'if you'd broken your leg or got run over by a bus, they'd have to do without you so they can do without you today'. Yes, she looked after me very well, you know, on top of looking after the three children, so she was a great support.*
>
> **Interview 57**

Those who provide support to the patient may themselves also need support. One GP, ill with depression, described how his wife looked for support.

> *[My wife] was given a lot of support because Dr C. gave her access to ring him at any time. She could have rung my partners at any time so she had that kind of support. She wrote to the BMA asking what facilities were available for sick doctors and got a fairly bland letter back saying that they hoped that I would get well and hoped that she would be able to contact somebody. We were given the name of a doctor ... who would be prepared to come and see us confidentially and just talk through the problem and see if there was anything that he could do to help with medical structuring, in other words to see if my partners were being reasonable.*
>
> **Interview 20**

Colleagues were extremely supportive in some cases and less so in others. The degree of personal support and sympathy depended on the nature of the relationship between colleagues. It could also be limited by the others' understanding and perception, as the following comments, both from GPs, illustrate:

> *My partners were very annoyed that I was ill. To begin with they didn't realise.*
>
> **Interview 3**

> *My colleagues occasionally came round to see me ... but I didn't get a great deal of support from them. I think nobody had any perception, no understanding of the depths that you plummet to.*
>
> **Interview 15**

But, as both GPs and HDs explained, the support that colleagues are able to offer might be coloured by the implications for them of the sick doctor's absence.

A consultant who had had glandular fever described his colleagues' reaction:

> *A lot of my colleagues were very friendly and they sent flowers or cards or get well messages.*

Yet, when the implications of his having glandular fever became clearer, there was a shift in attitude:

> *There was a fairly sort of comprehensive lack of understanding on behalf of my colleagues and actually what made the situation worse was the communication to me that I was going to have to pay back all my on-call while I was off sick. Now the trouble with glandular fever is it can leave you debilitated for a whole year so you accrue a year's worth of on-call ... And then to compound it was a rumour that I was fit enough to do some private practice but I wasn't doing NHS, which was totally untrue and unfounded. Really that's when I got particularly fed up with my colleagues.*
>
> **Interview 19**

A GP, who eventually retired through ill health, understood her partners' reaction as related to concern for their own practice:

> *When I was in hospital I got shouted at on the phone by one partner ... I know they were very worried whether patients would leave the practice.*
>
> **Interview 3**

For some juniors the situation was more difficult. The support of peers might be tempered by the burden of extra work that the sick doctor's absence placed on them. Concern for their future career might dissuade juniors from seeking support from senior colleagues. A 27-year-old senior house officer who has subsequently left medicine was diagnosed with depression and off work for 4 weeks. On returning to the rotation she was told that she was lazy.

> *I said that I wasn't very well. They told that me that I shouldn't be in anaesthetics if I couldn't cope. I said 'Look, would you be saying that if I had a broken arm?' ... I asked one of the consultants who I thought had been a bit more understanding than others if he would write me a reference. He said he couldn't because he felt he would have to refer to my depression. His advice was 'You'll*

have to learn to cope with these things' and he gave me the phone number of the National Counselling Service for Sick Doctors.

Interview 63

The wife of another junior doctor with depression discussed her husband's illness with his consultant. The response was sympathetic but not particularly helpful.

He was supportive but he felt it was in the nature of the job: the patients we see are very sick. And he said there were other juniors who are depressed as well.

Interview 33

In other cases, colleagues did not provide support because the doctor concerned was careful to ensure that they did not get to know of the illness. One junior doctor with multiple sclerosis has told only one trusted colleague in her new job since previously having been asked to resign by a clinical director who learned of her condition. Another junior, with depression, asked during the interview if colleagues were any source of support, replied, 'My God, I hope none of them know!'

Official structures were little used by the doctors we interviewed. Two HDs used occupational health services, one because she experienced a severe attack of panic while at work. Another HD with a chronic condition was given useful advice by a local BMA officer. In general, though, doctors were not supported by official structures. Some GPs were critical of what they perceived to be lack of interest on the part of the FHSA:

It would have been quite nice if somebody could have just shown interest in the fact that a doctor who's been with the FHSA for 26 years has actually got a serious enough illness to be in hospital but there was little response at all ... This independent contractor status is a bit pernicious because you're left to cover everything ... then when you fail because of illness the only thing they're interested in is applying the rules and talking about sanctions.

Interview 11

A male HD was adamant that he could never seek support from either OHS or 'anyone connected with the Royal College':

Occupational health is related to my employers. I regard trusts and employers as my enemies. They are there to control, not to support. To save money, not to help me out. I am not their priority. Anything to do with employers is very frightening. The Royal College – no! They control exams, accreditation, everything. They are the last people I'd go to for help.

Interview 33

Some doctors we interviewed mentioned support groups, such as those for diabetics. Although they acknowledged that these are useful for lay patients, they

suggested that it would be problematic for a doctor to participate in such a group. One doctor who did have contact with a self-help group explained:

> *Self-help groups: they're not much help really. I didn't want to go to their groups because all they wanted to talk about was their steroid doses ... When I rang up I wanted to know if there was anyone else who was working and they said 'I wouldn't dream of working with this condition!' They were so negative, but belonging to it is helpful because you get this newsletter ... I suppose it is helpful knowing there are other people out there with it.*
>
> **Interview 14**

There is also a fear that other patients will attempt to use the doctor with the same condition as a medical resource rather than view him or her as a patient. Additionally, the wife of a diabetic doctor pointed out another potential problem envisaged by her husband:

> *It is very difficult for someone like him to go to [a support group] because they may end up being his patients. It puts him in a difficult position.*
>
> **Interview 45**

What support is needed?

Practical advice and information, and psychological support, are the two main areas cited as lacking.

Advice and information was sometimes needed about practical issues, such as entitlement to locum payments from the FHSA. Assistance in the process of locating and paying for locums was also cited. Acute need for a locum caused by an unplanned event such as illness was seen to be especially problematic.

In other cases, illness led to a need for career reappraisal, but there seemed to be few sources of help available here, either for juniors considering leaving medicine or for those considering retirement:

> *I feel possibly that I've been sick enough to retire through ill-health and yet there is nobody around to give me the sort of advice I need, whether I can retire on ill-health grounds or not ... There is no occupational health doctor I can go and see and say, 'Look, I've got that and I've had this and I've had that. Should I retire?'*
>
> **Interview 30**

Some doctors also described the shock of suddenly discovering themselves to be ill and described a need for some type of psychological support:

> *I think the other thing is there is a feeling of aloneness as well. I'm not suggesting a club for knackered doctors or those who've been ill or psychiatrically distressed*

> *... but there has to be something – I suppose that's why patients have self-help organisations. They feel less alone. I don't know of any other doctor who has been ill, who has been involved in an accident that almost killed him or whose wife died of cancer or something ... we are very private as doctors.*
>
> **Interview 15**

The junior doctor whose consultant remarked that he was not the only depressed junior around commented that it would have been helpful

> *... knowing others who've run into similarly stigmatising problems, talking might have been better. I wouldn't know if any of my colleagues are undergoing similar problems because you can't talk about it.*
>
> **Interview 33**

SICK LEAVE

As we suggested in Part 1, doctors very commonly work through illness and feel pressure not to take sick leave. A number of strategies were used by the doctors we interviewed to avoid or to minimise the sick leave they took, and some took no sick leave. One junior with depression, for example, has never taken time off work but has worked through his illness, at times helped by psychotherapy, at other times by drugs. He commented:

> *I've never taken time off work. The form of illness that I've had has meant that I've been a bit unpredictable, up and down a bit.*
>
> **Interview 55**

Others used holiday leave rather than take sick leave. Two women with chronic conditions decided to continue their training on flexible training schemes, partly as a way of managing their health better and reducing the numbers of days of sick leave they took.

Many doctors commented on the dominant attitudes that shape doctors' reluctance to take sick leave. For example, one consultant said:

> *You're not allowed to be ill. That's a holiday. I can tell you up until about 5 years ago you felt guilty about taking your annual leave. It was only when I became a consultant that I ever took my entire entitlement for annual leave.*
>
> **Interview 19**

Another amplified this:

> *There is definitely, you know, a macho perception that illness does not affect doctors as badly as it affects other people, and we should work on. I'm very aware*

> *of that when I've seen other people become ill; they've come into work and one has almost expected them to. I mean, a number of occasions I've seen doctors coming into work very, very ill and it can be difficult to convince them that they ought to go home, and they ought to take time off work. So it is part of the culture I think. I suspect if I was not a doctor I would have been told to take time off work. I was struggling on and certainly no one suggested that I should do anything else.*
>
> **Interview 57**

This consultant described how his GP in effect colluded with his not taking time off, where this possibility might have been suggested to a lay patient:

> *I realise that I could have said, 'Well I need two weeks off' and he would have signed the certificate, but I didn't ask for that, although I might have wanted it, I didn't feel that I could take it because of the work to be done here.*
>
> **Interview 57**

Another registrar, at the early stages of a chronic illness not yet diagnosed, was seen by a locum at her normal family practice:

> *She said, 'Oh doctors never take enough time off. You shouldn't work' and she gave me a week's certificate.*
>
> **Interview 14**

The pressure to avoid taking sick leave also resulted in some doctors returning to work before they were fully recovered. One junior HD explained that she was very keen to get back to work after an episode of depression for which she had been hospitalised:

> *I remember ringing up the consultant and saying 'I'm coming back to work' and he said 'Oh it's a bit soon!' And I just wanted to be back at work to prove that I was all right ... I was terrified that if I didn't make it back to work I would just be written off. I thought I was OK to carry on. I wasn't well – I remember trying to do a journal club and someone gave me something on anorexia nervosa to do and I just couldn't. I couldn't present a paper. The facts – I couldn't get hold of them – spinning round the room and I just had to stop half way through, which was totally embarrassing, and I said I'm sorry I can't do this. Those sorts of things happened.*
>
> **Interview 37**

Among GPs, in particular, there might be financial constraints on the amount of sick leave one could take. Some GPs found that their insurance did not adequately cover the locums and deputising services that were required during their illness. Where payable, FHSA contributions were not always sufficient to meet these costs.

THE IMPACT OF ILLNESS

The experience of serious illness often causes people to change their lives and to reappraise them. This was also the case for many of the doctors we interviewed. Here three issues are discussed: the impact of illness on career, attitudes towards work, and the benefits of the patient experience.

Implications for the doctor's career

For many doctors in the study, their illness represented little more than a hiatus in their career. Some were even able to see the enforced time off as an opportunity to relax, to catch up on reading, or to follow a course. For others, though, the impact was more serious. Most drastic was the case of the junior HD who left at senior house officer stage during a depressive illness. For some, having a chronic illness enforced a change of pace along the career path. One HD, a senior registrar, suggested that having to deal with depression over a long period of time may have resulted in his appearing to be 'eccentric' and that this slowed his career. As we have already seen, others opted to join the flexible training scheme as a way of continuing in their career on a part-time basis. Some GPs also decided to work part time. Illness in some cases led to a change in specialisation, for example from general practice to research. For several older doctors, having an illness forced early retirement. Another doctor, who has insulin-dependent diabetes, works as a locum, being unable to find permanent employment because of his history of ill-health. Having a chronic illness, he believed, debarred him from employment in permanent posts. Three doctors were in a state of limbo at the time of interview, unsure when or whether they would be able to return to work. One of these doctors had suffered memory loss as the result of encephalitis and was unable to find guidance on how her fitness to practice was to be assessed.

As we have seen above, where the impact of an illness is such that it forces the reappraisal of one's career, there is usually little help available in doing this. One doctor was fortunate in having career counselling paid for by the FHSA and provided by Medical Forum, a private careers counselling service for doctors. Another who began part-time training found that she was very well supported by the local scheme organiser. Others were supported by sympathetic colleagues. In general, however, finding guidance and support is fortuitous, depending on the presence of individuals with the necessary skills and abilities to offer such support and whom the doctor concerned feels able to approach. Not all the doctors we interviewed and who needed support were able to find individuals capable of providing it.

Changes in attitude

The experience of illness also led in some cases to a change in attitude towards work. In general, this has been a re-evaluation of the relative importance of work as part of life.

Above, we quoted a consultant who encountered scepticism on the part of his colleagues about the impact of his glandular fever on his ability to work. This led to a change of attitude on the part of the consultant.

> *... that sort of naive belief that I was working for a team with a team goal at the end of it was completely shattered and one realised that if you don't look after yourself ... then there is absolutely nobody who is going to step in to give you a hand ... any sort of offer that I might make from time to time – I'll take on that, I'll be happy to do that, sit on that committee, run this course – all of that has completely gone out the window. I wouldn't remotely consider doing any of those things now.*
>
> **Interview 19**

A junior HD who suffered from depression learned from this to alter her attitudes towards taking sick leave.

> *If I think I'm unwell I take time off now, what's called mental health days. I don't take many. I don't misuse the system, but if I feel I'm getting stressed out I just take the time off. I don't say it's for mental illness, quite often it's just a day here and a day there which you don't have to certificate ... I do work with heavy colds but not flu. And these days I'm much more likely to take a full 2 weeks for flu because you need it. Not because I'm being soft on myself whereas in the past I'd think I'm being naughty, it's necessary to take that time off to recover and get back to work properly ... at last being a bit more responsible for myself, never mind what other people think.*

When asked if she was concerned that this would gain her a reputation as a doctor who takes time off, she replied

> *No, because people know that when I'm at work I give all I've got. I suppose I can say that because I've worked on this rotation for a good number of years. I know that people that have met me and know me know that I work well. It might be different if I was in a hospital that I didn't know. I would have to think twice but I think now with my experience that if I don't look after myself, it doesn't pay me. I become more unwell.*

However, this doctor also admitted that, in the process of revising her attitudes towards work, she had also been forced to revise her career ambitions.

I don't really go for pressurised jobs any more. I just go for something that sounds quite nice.

Interview 37

Another consultant was able to review the impact of work on his family life as a result of having to work through a debilitating illness.

It certainly made me stop and think about why I had carried on for so long providing a one-in-two on-call without having made plans about what would happen if I became ill, so it's made me think about the sort of work I want to do in the future ... the pace of work and the amount of night work I was doing and the pressures on my family too, because it's only when you sit down to talk to your family, you realise that the kids weren't seeing much of you and your wife wasn't being able to do piano lessons in the evening because she wasn't sure when I'd be home or if I'd be home ... I hope that after this I will change the way I work, my job structure, and I'll be doing less on-call.

Interview 57

Another consultant physician also described his change in attitude to hard work.

I've had to become a lot more rigorous in diary control and time allocation, so perhaps I practice better because of that because I'm more rigorous with myself. I try very hard not to let workloads mount up, and I make sure I get home each evening by half 6, 7 at the latest.

Interview 26

In a job that relies on culturally validated and maintained attitudes towards working hard, minimising one's own health needs and not imposing extra work on colleagues, it is striking that for some individuals – those with relative job security at least – the experience of illness has led them to call into question, and reject, such values.

The benefits of the patient experience

Almost all the doctors suggested that, although they would not have chosen to be ill, the experience of being a patient was instructive. Often this was expressed in terms of learning from the experience what illness means to the patient.

I wouldn't wish it on myself again, but I think it is actually terribly good for you to be a patient sometimes ... I came back to work with a far greater sort of sensitivity and empathy. All of a sudden, you remember what it's like to be on the other side of the fence, and that patients need to be handled carefully. Because, I mean, what we're doing here is we're spending our time telling women they've got cancer and that is a very big emotional experience for them and it's devastating,

> *and it's very easy in a way when you're doing it day in and day out to at some point get a little bit blasé about it all, but experiences like that occasionally bring you up short and remind you what that is all about.*
>
> **Interview H3**

Other doctors expressed this as a transformation of their professional sympathy into empathy. For some, being ill had awakened in them a greater sense of tolerance towards patients.

> *It's made me more tolerant and more understanding, not just in my own psychiatric problems, but psychiatric illness on the whole ... it's not just depression. Maybe thinking about things like care in the community for patients with psychiatric disorders. Yes it occupies a large slice of my consciousness.*
>
> **Interview 26**

In other cases it was the practicalities of being a patient and being hospitalised that the doctor learned. For example, one GP, who spent 3 months on crutches, described how this gave him insight into the basic problems of mobility and limited independence experienced by those with any form of disability. A consultant psychiatrist took more care to explain the possible side-effects of anti-depressants, having experienced them for himself. Another GP, whose breast cancer was treated with surgery and then radiotherapy, realised with some surprise initially that she did not know what to expect.

> *I've been trained. I know what radiotherapy is given for, that's about it. I didn't know the reality of what it actually involves and very few doctors do. Very few doctors have been inside a radiotherapy department. Very few have been to a simulation room to see how they get the whole thing drawn out and mapped out, and very few have experienced it.*
>
> **Interview 31**

Having now experienced it first hand, she felt that this made her better placed to explain to patients the implications of having such treatment.

> *I know the practicalities. Some of these things we're expected to explain and we don't necessarily know all about them and, as medical science advances and new techniques and new investigations come up, those of us who were trained a while ago don't necessarily have the information that we need to explain everything and the hospitals don't often have the time. We don't have much time either but we know the patients better so we're best placed to do that if we know about what we're talking about.*
>
> **Interview 31**

However, this also raised the issue of self-disclosure to patients with the same condition. Different doctors had different views. One doctor was in favour where

this seemed to be useful.

> *I have told quite a few patients since – patients with depression who are not responding very well or who are not taking their tablets and are ill enough. I tell them that I've been ill myself and that the tablets work if you do take them, and I've found that a very interesting thing – empathising with the patients like that makes a big difference to how you manage depression. Not only knowing what it's like, but telling them you know what it's like helps an awful lot, and I think that's changed how people view me as a GP – but I don't know – that would be more difficult to prove.*
>
> **Interview 20**

Another doctor, a consultant psychiatrist, was more cautious:

> *I was trained never to say 'I know how you feel' but I find it very hard to not say ... It's always a very dodgy area, self-disclosure, with patients but there have been perhaps two or three clinical situations where I have felt that it was sensible and safe and appropriate to self-disclose to a patient that yes, I know how you feel because I've been there, and you have got to be extremely careful in doing that but that has proved therapeutic on those occasions when I've done it. The patients have not been shocked it was well thanks doc, yes that helps me to know that you know some of how I feel because you've been there. Self-disclosure in psychiatry is a potentially very dangerous thing.*
>
> **Interview 51**

The doctors in the study therefore felt that the practical experience they gained as patients could enhance their theoretical knowledge and could also revitalise their professional sympathy. Although no one would choose to be ill, these doctors' reflections on their experience suggest clear areas in which medical practice may need to be improved.

PERCEPTIONS OF CARE

Just as lay patients' experience of health care varies, so too the doctors we interviewed had different perceptions of the quality of care they received. There were instances of poor care, including lack of competence, poor management, and a breach of confidentiality in a small town where 'all the doctors know each other'. However, many doctors reported that they received excellent care during their illness. Professional courtesies were frequently extended, such as arranging for immediate consultations, seeing the patient out of hours and consultants carrying out home visits and making themselves available for telephone consultations at any time. Such professional courtesies were not always offered, though. Doctors who had to wait hours to be seen in outpatients or accident and emergency

departments were as annoyed as anyone might be. In general, though, this GP's view was common to many:

> *Overall the service was excellent and for the major illnesses the NHS still functions very well and the NHS with the bonus of being in the trade functions extremely well.*
>
> **Interview 31**

Doctors who were hospitalised were frequently put in side rooms. This was welcomed by many, especially where patients of the sick doctor were coincidentally hospitalised at the same time. However, in some cases, being put in a side room led to a sense of isolation as the doctor-patient tended to be left alone, even neglected. One doctor, admitted to hospital, complained 'No one ever came to see me. My drip never got changed. I never got washed for 3 days'. She acknowledged that this was probably because the overworked nursing staff assumed that because she was a medically qualified she was able to monitor herself. She also felt that because she was known to some of the staff they might have felt embarrassed treating her.

Some older doctors also complained that the standard of nursing care in hospitals had deteriorated. The ward seemed to be a noisier place than they remembered; one doctor complained that he was not visited by the ward sister, which was a courtesy he would have expected; another found it disconcerting to be called by his first name by a very junior nurse.

The doctor–patient relationship

Even where doctors' access to care is straightforward there may be problems in the consultation because of particular issues that arise when the patient is medically qualified. The relationship between patient and doctor is generally not an equal one. Where doctor and patient are both medically qualified, the power relationship is unclear and this can affect communication, management and decision making.

Some doctor-patients interviewed complained that they were not given information about their illness or appropriately counselled because it was assumed that they were already adequately informed. For example, a female GP being treated for epilepsy after an acute encephalitis was not counselled about the drugs she was prescribed.

> *I was seriously allergic to one of the drugs they gave me and I think that was probably an assumption that myself and [my] GP knew how it should be – the dose should be gradually increased and not so rapidly and that's how the allergy started. That was an assumption, I think, on the consultant's part.*
>
> **Interview 35**

Some doctor-patients interviewed commented that their doctor seemed to be embarrassed to treat them. A number of possible reasons have been suggested for this embarrassment. It may arise where the treating doctor is of a lower grade or younger than the patient. This is exemplified by the case of a 53-year-old GP who wished to change his current GP, who is a member of his own practice. However, because he has been a local trainer for the past 15 years, many of the principals in the area are ex-trainees of his. He explained that he would feel awkward going to one of them, and he knows that they would find it difficult to swap roles to become his treating GP.

Some of those we interviewed who have themselves treated colleagues suggested that treating another medically qualified person is difficult because it is like sitting an examination. The treating doctor may be embarrassed because he or she feels that his or her competence is being tested.

> *I think it's very difficult to be a GP to another doctor, or another doctor to another doctor. There is always the feeling that you know full well that anything you say is clicking through their computer.*
>
> **Interview 51**

The very commonly held idea that doctors should not get sick means that those who do are in a sense anomalous. They confuse the normal boundaries between doctor and patient and call into question the balance of power in the doctor–patient relationship.

> *I think part of the problem is that mostly doctors don't like to feel that they have to rely on anybody else to solve their problems for them. There is no doubt that a doctor-patient relationship is one of somebody who is definitely subservient to the other. I don't think there are any doctors who like to be subservient to anybody so actually to go to a colleague and say look I am feeling broken and miserable is an enormously difficult task, and certainly within a department where you know people I think would be impossible. They have to be your GP who you're not an intimate friend of or almost a complete stranger who you could say I'm despairing at the moment.*
>
> **Interview 51**

The issue of management is also problematic. In some cases, the treating doctor was unable to take control of the consultation, asking the patient what the diagnosis was, inviting him or her to interpret test results and suggest what treatment they would like.

One such experience persuaded a married couple who currently act as GP to each other that it was not worth consulting the GP with whom they were registered.

> *We did have Dr A. for a bit, and that was hopeless because he couldn't really manage us ... when [my wife] was pregnant with the last child ... she got very dyspnoeic so Dr A. came along and he got the portable X-rays to come to the*

> *house and he did an X-ray. Then he just left the X-rays for us to look at and decide what to do. So I thought, 'Well!' ... in the end we thought, 'Well, we'll have to carry on ourselves.'*
>
> **Interview 11**

Another GP was treated for a torn Achilles tendon, the result of a sports injury.

> *I was consulted at every stage and asked what I wanted. That put me a bit on the spot as I didn't really know what to ask for. I felt I had to stand back and say 'I'm leaving this to you chaps.' They seemed to want me to make a decision but I refused.*
>
> **Interview 10**

The experience of another GP illustrates why it may be important for the treating doctor to take control of the management of the illness. This doctor had acute encephalitis but went into work the following day nevertheless. He found that he was still vomiting between seeing patients. He spoke to his partner, who acts as his GP, and was sent home. After a week of illness he was referred to a consultant physician who diagnosed viral encephalitis. He commented that he would have been happier if his GP had 'taken charge'. When asked why the GP was unable to do this he replied:

> *Well, he was dealing with an experienced GP, but what he didn't realise was that I had no insight at the time. I was in severe pain but I didn't really realise what was going on. If it had happened to a patient of mine I would have tried to have him admitted. I suppose there was a bit of collusion on my part because I didn't want to have a lumbar puncture. I thought the headache I'd get from that would be even worse than the one I had. I felt I just wanted to curl up and hide.*
>
> **Interview G2**

In this case, then, there was clearly an element of collusion between doctor and patient, the treating doctor unwilling to intrude on what appeared to be a colleague's clinical judgement, the patient unwilling or unable to present all the facts of the case to his GP.

This doctor's wish that his GP had taken charge was also expressed by many other doctors we interviewed. Many doctors said, 'I just wanted to be treated like an ordinary patient.' The advantages of this, it was assumed, were that the doctor-patient would not be asked to make decisions about his or her own diagnosis and treatment. Of course a certain degree of involvement is appropriate. Often, however, doctors felt the level of involvement offered to them as patients was too great, especially where their illness was in a clinical area where they were not experienced.

Doctors also felt that being treated as an 'ordinary patient' would ensure that adequate counselling and standard follow-up would be offered. A 44-year-old male GP treated for atrial fibrillation found it distressing that the consultant physician

> *... didn't really explain what was going on. I felt left out on a limb. They imagined I knew what to do but I could have done with more guidance.*
>
> **Interview G10**

One doctor treated for alcoholism was not offered follow-up after the rehabilitation. He believed that this would have been offered to an 'ordinary patient' but felt that this was lacking in his case because it was assumed that he as a GP 'knows the score' and so 'was left to get on with it'. He asked for antabuse to be prescribed and arranged for his own supervision by an alcohol dependence counsellor.

As we have already seen, the status of the doctors involved clearly has an impact on the doctor–patient relationship. There was a general feeling that it was difficult for juniors to treat someone more senior to themselves, whereas some GPs felt that there was little point in being seen by another GP.

> *I ... think there is a lot of value in doctors seeing a consultant-status person early on because as doctors we have quite a lot of factual knowledge and it's unlikely that a GP is actually going to have the time or maybe even the expertise to put a doctor's mind at rest and to answer all the questions that they might want to ask. If I had chest pains and went to my own GP he'd probably listen to my heart and say 'Oh it's probably nothing take some pain killers' or he might have an ECG in his surgery but even if I were ECG'd and he looked at the strip I might still be worried. What I'd really want was a cardiologist to tell me no, my heart was OK. Doctors take more convincing and more reassuring and that's another advantage of seeing the specialist early.*
>
> **Interview 21**

However, the desire to be treated as an ordinary patient led one doctor to challenge the view that a consultant should properly treat a medical colleague.

> *... they get senior people to do things to you which they are not used to doing to people, when you would be better off having a junior person do it. There is a standard medical gag about, if you have appendicitis it's best not to let anyone know you're a doctor in case they get the consultant to take your appendix out. The person who is best at taking your appendix out is the surgical registrar. And you should let him do it. I have certainly seen the same with ... a rather senior lady who is a doctor. The consultant surgeon felt obliged to put her under the impression he was going to do the operation. He actually, sensibly, once I had got her off to sleep, got his junior to do it because he was far more used to fixing them. There is this feeling that we owe our colleagues consultant input. Yet in practical terms consultants aren't always best at some of the more mundane duties.*
>
> **Interview 57**

The desire to be treated as an ordinary patient begs a number of questions about the doctor–patient relationship in general. How is the level of patient

involvement in treatment negotiated? What assumptions are being made about standards of counselling and provision for follow-up? Nevertheless, it is clear that treating a medical colleague is problematic and requires particular skills. A number of respondents were fortunate in being treated by doctors who had expertise in providing care to colleagues. However, it is worth noting that they had happened across such doctors either by word of mouth or by chance.

ATTITUDES TOWARDS ILLNESS

The issues raised so far suggest that doctors have particular attitudes towards illness, which can complicate its management. As has already been documented (Silvester et al. 1994), a stigma attaches to doctors who are ill, which can make it difficult for them to seek help. One important way in which this is manifested is, as we have seen above, in doctors' reluctance to take sick leave. Aside from consideration for one's colleagues and financial concerns, this reluctance stems from a prior unwillingness to see oneself as susceptible to illness, let alone sick.

The unwillingness to be seen to be sick reveals something of doctors' attitudes to illness in general. This is illustrated by the comments of one registrar in psychiatry, who herself was hospitalised with a psychiatric illness.

> *I do know now that in line with the guidelines of the college they do make sure that you know that you can go and apply for counselling outside of the service and that it is confidential ... but people, I think, are so worried about what that means. There's a lot of stigma to having problems whatever they are. I suppose it betrays a sort of attitude to one's patients – you've got it not me, thank God – quite deep down. Because one is so appalled to have the problem oneself.*
>
> **Interview 31**

This is reinforced by early training and by peer expectations. Patients, and sometimes family and friends, may collude with this view that doctors do not or may not get sick. Although many doctors remarked that their patients were supportive and kind during their illness, they also noted surprise that doctors could get sick.

One consequence of this unwillingness to adopt the patient role is that doctors often delay in seeking advice, sometimes with deleterious effects. For example, a 46-year-old male GP eventually diagnosed and treated for depression commented:

> *It started over the summer. I was working extremely hard, getting more and more knackered ... my wife left me ... by October I was still coming into work, working just as hard, but I didn't know what I was doing. I wasn't sleeping. I lost a stone in weight. I couldn't concentrate. I just thought I was tired.*
>
> **Interview G7**

This may also affect the way they view illness in colleagues. A 42-year-old female GP experienced spasmodic sensations and stiffness in the tongue off and on over a period of 3 years.

> *I thought it might be due to stress. I asked one of my partners about it and he agreed it was probably due to stress and nothing to worry about. I did think about going to my own GP but I was afraid he would dismiss it as trivial. Eventually one day I noticed that my tongue was deviating noticeably to one side. I rang a medical friend who recommended an acquaintance at Queen's Square.*
>
> **Interview 2**

She was eventually referred through a letter from the senior partner in her practice and operated on for a neuroma.

Doctors, it seems, are not 'allowed' to be sick. One male GP, whose episode of depression had significant consequences for his career, reflected:

> *Illness doesn't belong to us; it belongs to them, the patients. Doctors need to be taught to be ill. We need permission to be ill and to acknowledge that we are not superhuman.*
>
> **Interview 52**

NEEDS FOR CHANGE: THE DOCTORS' VIEWS

The qualitative interviews have provided an opportunity to investigate in more detail doctors' views about the kinds of change needed to assist them to manage their own health better and about the kinds of services they would like to see. These include proposals for specific health services, suggestions about how to facilitate taking sick leave and how to improve the return to work, and ideas about the need for cultural changes.

Suggestions for services

The doctors made a number of suggestions concerning services they would like to see, including:

- An occupational health service for GPs, staffed by doctors with experience in treating other doctors.
- Local nominated consultants for key specialist areas.
- Support groups for stressed doctors.
- Improvement of existing facilities, for example transforming the National Counselling Service for Sick Doctors from a referral service to an intervention service.

Sick leave

There were also suggestions about how taking sick leave could be facilitated. These included:

- Providing more guidance about how to go about recruiting locums, and making funds more easily available to recruit them.
- Improving the provision of locum doctors, for example by organising a bank of locums who can be called in at short notice like supply teachers.
- Ensuring that HD juniors in particular are aware of their sick leave entitlement.
- Ensuring that juniors are able to discuss confidentially with a senior colleague the career implications of a period of illness.
- Clarifying the position concerning 'paying back' on-call for a doctor who has an extended period of sick leave.

The return to work

A number of suggestions were made about facilitating a doctor's return to work after a period of illness. These included:

- Structures for supervising the return to practice of doctors with an addiction.
- Making it easier for doctors to return to work on a part-time basis, which might necessitate devising ways of covering the doctor's on-call duties.
- Making provision for careers advice where a change of career seems advisable.

Cultural changes

Many doctors suggested that 'cultural' changes were needed to encourage members of the profession to deal better with their health. It was generally recognised that such changes might be more difficult to achieve.

> *I think what's needed are shifts in the way people think rather than specific services. It would be much easier if it was more accepted to admit that you have problems. But I feel too vulnerable to do that: I'm only a registrar. The way doctors perceive you as someone with MS – they expect you not to cope. The way doctors perceive illness has to change.*
>
> **Interview 41**

However, one doctor suggested that a starting point might be

> *... a change in the whole medical school education – start to teach doctors more about themselves. You start out reckoning you can save the world – you can't.*
>
> **Interview 48**

A simple way of improving morale among juniors was attempted by one of the doctors we interviewed.

> *... when I went back a bit higher up the ladder I sought to be available, to make a bit more of a network of friendship amongst the juniors in the hospital, just to make it friendly, to make a better atmosphere so that at work you're not so lonely.*
>
> **Interview 31**

The doctors in our sample generally believed that improving doctors' health depends not only on providing services but also on changing attitudes to allow them to overcome existing barriers to service use.

Discussion

This study was conducted in two parts. In the following discussion we first highlight the main findings from the survey. Then we draw on these, as well as the findings from the interviews with doctors who have had an experience of ill-health, to address a more general issue: to what extent are the health behaviours and needs of doctors unique to that professional group?

SICKNESS ABSENCE

Through the survey, we compared sick leave taken by doctors with that taken by another professional group of similar socioeconomic status assumed to have similar standards of health.

Our self-reported data on sickness absence confirm the findings of other studies that doctors tend to have low rates of sickness absence (Pines et al. 1985, Hall et al. 1991, Chambers and Belcher 1992). More than twice the number of GPs than of MCs reported taking no days of sick leave for the previous year. The data also suggest that doctors do not take short periods of sickness leave. Again, the difference between GPs and MCs is most striking: a quarter of GPs but only 3% of MCs reported that their last spell of sick leave lasted more than 7 days. This difference remained significant after adjustment for age and sex. The lower response rate obtained for MCs must be taken into account here, especially as it was not possible to control for non-responders. Nevertheless, the data obtained for doctors confirm the findings of Pines et al. (1985), who also reported that doctors do not take short periods of sick leave. Because our data rely on self-reporting, rather than certificated data (as in the study of Pines et al.) we can be more confident about asserting that this is not a case of doctors failing to record short absences but rather indicates that doctors do not stay off work for relatively minor illnesses.

Both doctors and MCs report working through illness and cite similar reasons for doing so, including work ethic, peer expectations not to submit to illness, and absence of anyone else to take over their work. Doctors were much more likely than MCs to cite pressure not to be seen to be ill as a reason for not taking sick leave. Nevertheless, the MCs in our sample are also subject to such pressures, working in a competitive environment where admission of illness is regarded as weakness (interview with a human resources manager).

It is worth noting the very low proportion of respondents whose last sickness absence was for depression or another psychiatric illness. This does not, we believe, reflect the prevalence of such illnesses but suggests that doctors with depression continue to work.

When presented with a hypothetical question that tested respondents' willing-

ness to take sick leave for a given set of symptoms, doctors appeared more reluctant than MCs to take time off work. This, and the fact that MCs take more days and that these periods are more likely to be of very short duration, all suggest that there are qualitative differences that allow MCs to be absent from work more easily than doctors. It is sometimes possible for MCs, for example, to work at home if ill. Because they often work to specific deadlines they may also be able to postpone taking sick leave if necessary. Such flexibility is not available to doctors.

The frequency with which lack of locum cover was cited by both GPs and HDs suggests that there are organisational changes which might facilitate doctors' management of their own health. Certainly, easier access to locums would help single-handed GPs to take unplanned leave. But GPs in multiple-partner practices and junior doctors in firms are clearly well aware that an absence on their part will result in already overworked colleagues having to work even harder.

Our data show that, whereas studies of sickness absence have generally focused on the problem of absenteeism, in the case of doctors at least the issue is the opposite: how to facilitate their taking sick leave when it is needed. The interviews with recently sick doctors revealed that taking sick leave is commonly regarded as compromising one's professional integrity, a desertion of duty, and a failure towards colleagues and possibly patients. The doctor who is ill may be forced to review these cultural values, realising the necessity or inevitability of taking sick leave, but such notions may force him or her to delay taking sick leave, to feel guilty about taking it and to return to work prematurely. We have not been able to demonstrate the extent to which the difficulties they experience and the unwillingness they are required to exhibit in taking sick leave puts doctors' health at risk, but there are undoubtedly instances where this is the case. A number of doctors we interviewed who continued to work while unwell expressed concerns about the quality of care they were able to offer at that time.

The problem is clearly both a cultural one and an organisational one. Any attempt to reform current practice must take into account both dimensions.

STRESS

Although most respondents reported being generally satisfied with their job, a significant proportion – over 30% of GPs and over 20% of HDs – stated that they were not satisfied. This is slightly higher than reported by Allen (1994) for 1986 qualifiers (around 15%). The association with increasing age was an unexpected finding given that other studies have reported a positive relation between age and job satisfaction (Linn et al. 1985).

Overall, stress levels appeared to be high, with GPs in particular likely to report that their jobs are often or always stressful. It is striking that consultants were more likely to report high levels of stress than juniors. This finding is interesting given that the focus of much research into occupational stress experienced by doctors has been on medical students and junior doctors. However, it confirms

recent work by Caplan (1994), which shows that consultants also appear to be experiencing high levels of stress and that there are unexpected levels of anxiety and depression which could be clinically defined. Given this finding, the association between age and job dissatisfaction also becomes more plausible.

Comparing doctors with MCs, it is clear that the latter experience similar kinds of stress. All three groups ranked three sources of stress in the same order: these were related to the volume of work they have to do, the pressure they experience from other people's expectations of them and demands on them, and the impact work has on their personal lives. None of these sources of stress is related to the nature of the job itself, but rather to the organisation of work and the demands it places on the individual. Only when we consider junior HDs does a stressor related to the job itself rank in the first three: junior HDs ranked as the third most stressful item decision making and risk taking associated with the job.

It is interesting to compare part-time and full-time GPs, because we might expect those in full-time employment to experience reduced levels of stress. The mean scores of the part-time GPs were generally slightly lower, and the item globally scored as second most stressful – the impact on home life – for part-timers ranked as third most stressful suggesting that part-time work may, however slightly, improve the impact of work on home life.

Change as a source of stress appeared to be more significant for GPs than for HDs and for consultants than for junior HDs. Sutherland and Cooper (1992) found an increase in GPs' stress and decrease in their job satisfaction measured before and after the introduction of the new contract. That well over a third of the GPs in our sample rated changes in the way they are expected to do their job as definitely or very definitely a source of stress also suggests that radical changes in the NHS may be having an impact on the stress they experience.

SERVICES

Registration with a GP was very high in our sample. Only junior hospital doctors continue to show lower rates of registration and, as is well known, this is assumed to be associated with their frequent change of job. There have been calls for doctors' registration with a GP to be mandatory. Our data suggest that generally doctors are already registered – GPs even more so than MCs. Making registration mandatory would not necessarily make it easier for juniors whose non-registration is likely to be related to their long working hours and frequent moves. Nor would mandatory registration of itself necessarily encourage doctors to consult their GP or facilitate consultations.

Concern has been expressed about the continued tendency of doctors to treat themselves, rather than to use services. Chambers and Belcher (1992) found that GPs in their sample generally managed their own health problems. Self-prescribing was high, and three quarters of them had not consulted their own GP in the preceding 12 months. Our survey collected data on time and type of medical

consultations. Well over half the doctors last consulted a doctor 1 year or more before completing the questionnaire. Although we cannot say whether this result reflects low levels of need or unwillingness to use services, we can compare it with the use made of services by MCs whom we assume to have similar (or perhaps better) standards of health. MCs reported much more recent medical consultations than doctors which, if we assume similar levels of need, suggests greater willingness to use services.

It is also interesting to note that the generally observed pattern that women use services more than men also holds in the case of the medical profession. Female GPs and HDs reported more recent consultations than their male colleagues. Nevertheless, female MCs reported more recent consultations than all female doctors.

Chambers and Belcher (1992) and King (1985) have remarked on the dangers attached to 'kerbside consultations'. A sizeable proportion of our survey (14% of GPs and 22% of HDs) reported that their last medical consultation was an informal one with a colleague. This confirms that some doctors at least may be continuing to deal with their health problems in a manner that is inappropriate, or at worst potentially dangerous. The interviews with recently sick doctors illustrate the ambivalent attitudes doctors can show to colleagues' health, and the poorer care which can result from informal consultations and being registered with a GP in one's own practice.

Our data confirm the finding of Silvester et al. (1994) that use of occupational health services by doctors is limited. Although nearly 60% of HDs reported having used OHS, in most cases this was for immunisation or a routine medical screening before taking up a post. Most of those who had never used OHS stated that this was because they had never needed to do so, and half indicated that they prefer to see their own GP. Yet relatively high proportions indicated that they chose not to use OHS either because it is not convenient or because they have concerns about the service's observation of confidentiality. Whatever the role of OHS is or should be, it is clear that at present they do not provide doctors with a specialised medical service.

A high proportion of doctors surveyed indicated that they believe there is a need for special health services for medical practitioners, with many respondents identifying the barriers to their using existing services.

CONCLUSIONS: ARE DOCTORS A SPECIAL CASE?

This study sought to compare aspects of the health behaviour of doctors with those of another professional group to investigate the extent to which doctors represent a special case with special needs for the management of their health.

Assuming that the two professional groups are socioeconomically similar, we would expect to find that they enjoy similar standards of living and health. However, our study suggests that there are some differences in the ways the two groups manage their health.

On the whole, doctors seemed to be more reluctant, or less able, to take sick leave. In both groups high percentages of respondents reported having worked through illness. However, when presented with a hypothetical situation, doctors were more likely than MCs to say that they would not take time off work for the given set of symptoms. More doctors than MCs reported taking no sick leave in the previous year, whereas similar numbers reported taking spells of more than 7 days (around 8–10%). In both groups, the majority of respondents reported that their most recent spell of sick leave lasted only 1–3 days, but doctors were much more likely than MCs to report having had a period of sick leave lasting more than 7 days.

Although registration with a GP was high for the total sample, MCs were more likely than doctors to report having consulted their GP. Assuming similar standards of health for both groups, and therefore similar potential use of services, we may conclude (as other studies have found) that the doctors in this study tend to treat themselves and consult with colleagues.

Doctors, as providers of health care services, ought to be well placed to get the most from these when they need to. Many of those we interviewed did indeed receive excellent care from their colleagues. However, as has long been recognised, doctors' access to services is frequently problematic. Our research has shown that, in addition, management of illness and ability to adopt an appropriate patient role are problematic. Access to services is made particularly difficult in psychiatric illness and other conditions where the concern for confidentiality is heightened because of the nature of the disease, and where the patient's future employability may be called into question. Confidentiality may also present greater problems in areas where choice of doctor is limited.

Management of illness is complicated by the way in which the patient's medical status affects the balance of the standard doctor–patient relationship. The boundaries between expert and lay person are dissolved, leaving both patient and treating doctor unclear as to how to proceed. Both parties need to renegotiate the relationship, which requires patience and communication skills.

Ability to adopt the patient role is limited by the ways in which doctors are trained to perceive themselves and lay people, and, we suggest, by their disease-focused view of health. It is also limited by attitudes towards taking sick leave and by practical circumstances that may make it more difficult to take sick leave.

Many doctors felt that they had gained insight from their illness, such as the GP with atrial fibrillation who remarked

> *My approach to life has altered. I no longer regard good health as a right. I take more exercise. I'm more aware of health now.*
>
> **Interview G10**

It is perhaps not surprising, although it is telling, that a doctor, who is trained to treat disease, should be made 'more aware of health' – or at least the importance of preventive measures – only when his or her own health fails. The way in which doctors conceive of health has not been fully investigated and yet

this is an issue which clearly has implications, not only for the management of their own health, but also for medical practice in general.

Doctors' management of their own health and use of services differs, therefore, from that of the comparative group. These differences arise both from medical culture and the attitudes to health, the profession and patients that this engenders and from the organisation of medical work, which may make it apparently simpler and quicker to treat oneself or consult informally yet more difficult to take sick leave when this is needed. Attempts to improve the management of doctors' health will require attention to both cultural and organisational factors.

Finally, it is likely that increasing disenchantment with the National Health Service and the documented high rates of occupational stress at all levels of the profession will only exacerbate the situation. A common response of doctors who had been ill was to return to work with very clear ideas about the need to limit their commitment to the job, not in terms of their commitment to patients, but in terms of the extra hours they are willing to put in, the extra tasks they are willing to perform and an increased concern for their own health needs.

Recommendations

1. A number of suggestions related to ways of providing specialist health care to medical practitioners have been collected. These include counselling services, occupational health services for GPs and the enhancement of existing services. The feasibility and acceptability of the different models of service delivery should be investigated through consultation with doctors.
2. The particular issues related to the treating of medically qualified patients must be recognised more widely, and attention paid to the special skills needed to treat such patients. Opportunities to develop awareness and skills should be developed.
3. In general practice, access to and availability of locum doctors must be improved, in particular where locums are required at short notice.
4. In hospitals, the provision of cover, and practices related to colleagues covering the on-call duties of doctors who have been absent from work for an extended period, must be improved.
5. Ways of providing guidance and support to doctors whose careers may be jeopardised through ill-health must be improved.
6. The return to work of doctors who have been absent for extended periods must be improved through, for example, facilitating return on a part-time basis.
7. The cultural and attitudinal barriers to doctors' appropriate management of their own health must be acknowledged and attention should be paid at all levels of medical training to the health needs of doctors and the importance of appropriate use of existing services.
8. The present study has relied on retrospective data. A prospective study of doctors' morbidity, sickness absence and use of health services should be undertaken in order to compare actual patterns of morbidity with sickness absence, including the thresholds at which doctors decide to take sick leave and their use of medical services.

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Appendix: Questionnaires to hospital doctors, general practitioners, and management consultants and accountants

CONFIDENTIAL

DOCTORS' HEALTH AND NEEDS FOR SERVICES

Please fill in this questionnaire by ticking the appropriate box , or completing in numbers or words as necessary.

1. Demographic data

1. Sex ☐ male ☐ female

2. Age ☐☐ years old

3. Are you ☐ single ☐ married/ living with partner?

4. Which of the following qualifications do you have?
(please tick one or more boxes)

first degree ☐ higher degree ☐ post-graduate professional qualification ☐

5. What is your present job? _____
(Job title and grade)

6. How long have you had this job?

☐☐ years ☐☐ months

2. Sickness absence

1. In general, how would you rate own health?

excellent ☐ 1
good ☐ 2
average ☐ 3
poor ☐ 4

2. Do you have a chronic medical condition, eg asthma , diabetes?

yes ☐
no ☐

3. In the last three years have you had any illness which required hospital admission?

yes ☐
no ☐

4. How many days sick leave have you taken in the last year?

☐☐☐

5. On the last occasion you took sick leave, how many days were you absent from work?

☐☐☐

6. What was the reason for your last sick leave? _____

_____

7. Have you ever continued to work even where it might have been better to take sick leave?

yes ☐ no ☐

8. If so, why did you continue to work? _____

_____

_____

9. If you woke in the morning with a streaming cold and headache would you take the day off work?

yes, definitely	☐ 1
probably	☐ 2
possibly	☐ 3
definitely not	☐ 4

3. Your use of health services

1. Are you registered with a GP ☐ YES ☐ NO

2. Do you have private medical insurance? ☐ YES ☐ NO

3. When did you last consult a doctor?

In the last month	☐ 1
in the last 3 months	☐ 2
in the last 6 months	☐ 3
one year or more ago	☐ 4

4. Was this

- your own GP ☐ 1
- private doctor ☐ 2
- informal consultation with a doctor friend/colleague ☐ 3
- A&E ☐ 4

5. For what reason? _____

6. Is there an Occupational Health Service on site? ☐ YES ☐ NO

7. Have you ever used it? ☐ YES ☐ NO

8. If so, for what reasons? *(please tick one or more boxes)*

- medical before taking up post ☐ 1
- injury or sudden illness while at work ☐ 2
- advice about diet, smoking, drinking ☐ 3
- advice about work related stress ☐ 4
- vaccination ☐ 5
- other ☐ 6

(please specify) _____

9. If not, why not? *(please tick one or more boxes)*

- It is not convenient ☐ 1
- I have doubts about confidentiality observed by the service ☐ 2
- I prefer to see my own GP ☐ 3
- I prefer to see another doctor (though not my GP) ☐ 4
- I have never needed to seek medical advice ☐ 5

10. In the last 3 years have you used any of the following services in relation to any physical, psychological or stress related disorder?

- My own GP ☐ 1
- Another doctor ☐ 2
- Occupational Health Service ☐ 3
- A private counsellor ☐ 4
- A telephone help line ☐ 5
- An informal discussion with my supervisor ☐ 6
- None/not applicable ☐ 7
- Other ☐ 8

(Please specify) _____

4. Stress at work

1. Overall, how satisfied would you say your are with your present job?
(please circle one)

completely satisfied	1
very satisfied	2
satisfied	3
not very satisfied	4
not at all satisfied	5

2. Overall, how stressful do you find your present job?
(please circle one)

never stressful	1
rarely stressful	2
sometimes stressful	3
often stressful	4
always stressful	5

3. Below is a list of possible sources of **stress at work.** Please indicate how significant these are for you in your present job by circling the appropriate number for each item.

***very definitely not** a source of stress*	1
***definitely not** a source of stress*	2
***generally not** a source of stress*	3
***generally** a source of stress*	4
***definitely** a source of stress*	5
***very definitely** a source of stress*	6

a. Pressure of time: work exceeds time available	1	2	3	4	5	6
b. Impact of work interferes on my home life	1	2	3	4	5	6
c.Conflicts with other colleagues, superiors, peers, subordinates	1	2	3	4	5	6
d. Other people's demands on me and expectations of me	1	2	3	4	5	6
e. My job security and promotion prospects	1	2	3	4	5	6
f. Changes in the way I am expected to do my job	1	2	3	4	5	6
g. Changes in the organisation I work for	1	2	3	4	5	6
h. My rate of pay	1	2	3	4	5	6
i. The decisions I have to make, the risks I have to take	1	2	3	4	5	6
j. My ability to do the job	1	2	3	4	5	6
k. Other (please specify) _____	1	2	3	4	5	6

4. Has the level of work related stress you currently experience led to any of the following:
(please tick one or more boxes)

a. I drink more than I used to ☐ YES ☐ NO

b. I smoke more than I used to ☐ YES ☐ NO

c. I devote more time to recreation ☐ YES ☐ NO

d. I have sought professional help, eg doctor, counsellor ☐ YES ☐ NO

e. I have thought about changing my job ☐ YES ☐ NO

f. other _____ ☐ YES ☐ NO

5. Can you suggest any changes which would reduce the work related stress you experience?

_____

_____

6. Do you think there is a need for a specific service to help people in your profession deal with health related problems or stress?

☐ YES ☐ NO

7. If so, what kind of service would you like to see? _____

_____

If you wish to receive a summary of the findings of this study, please supply your contact details here:

_____

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

PLEASE RETURN IN THE PRE-PAID ENVELOPE PROVIDED