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Do GPs practice what they preach?:

A questionnaire study of GP=s treatments for themselves and their patients

Mary Gardner and Jane Ogden

Department of General Practice, Guys Kings and St Thomas=s School of Medicine,
London, UK.

Address for correspondence:

Jane Ogden
Department of General Practice
Guys Kings and St Thomas=s School of Medicine
Kings College London
5 Lambeth Walk
London SE 11 6SP
tel: 020 7840 9417
fax: 020 7735 9232
email: Jane.Ogden@kcl.ac.uk

Abstract

Anecdotal evidence indicates a difference between a doctors= health seeking behaviours for their patients and for themselves. This difference remains untested. This study aimed to assess any differences between the first-line treatment options GPs would accept for themselves and those they would advise their patients. A postal questionnaire was completed by 286 GPs based in two west London Health Authorities (response rate 51.4%) asking them to score the treatment options of 6 common symptoms for both themselves and their patients in terms of over the counter remedies (OTC), prescriptions, referrals and complementary therapies. The results showed that GPs differentiated between themselves and their patients in terms of OTC remedies for indigestion and depression, prescriptions for indigestion, hypertension, depression and >tired all the time= (TATT); referrals for indigestion, hypertension, low back pain and TATT; and complementary therapy for depression. GPs may be prepared to cross the boundary be treated the same as their patients if the symptoms are relatively uncontroversial. Stigmatised problems and those with clinical guidelines, however, seem to result in a >do as I say not as I do= approach to health care.

Key words: doctors, self care, help seeking

1. Introduction

The current political and clinical climates define gold standards of health care for patients with an emphasis on clinical guidelines, evidence based practice and the appropriate use of health care services. However, research exploring doctors' own health care practices indicates that such standards are not always being met. For example, many doctors are not registered with a GP, they self prescribe and self refer and often consult colleagues informally about any health problems (1-5). There is also some evidence that doctors believe that being ill is not an appropriate state for themselves (6) which can result in doctors working through illness and >working when they felt too unwell to carry out their duties to the best of their abilities= (7). This suggests that whilst doctors have one set of rules for their patients they may hold another set for themselves. Some research has indirectly explored this possibility. For example, Chambers (8) indicated that although GPs recommend that other doctors should consult their doctor they would prefer to treat their health problems themselves. Further, Rosvold and Bjertness (9) reported that doctors continue to work for problems for which they would sick list their patients. However, although >double standards= have been alluded to in the above studies and are frequently apparent in anecdotal evidence no double standards between the treatment options a GP accepts for himself and gives to his patients has been described. This has implications for understanding how doctors manage both themselves and their patients. First in terms of patient management, doctors may be offering treatments which they personally do not regard as necessary or effective. Second in terms of self management, doctors may be treating themselves in ways that would be regarded as inappropriate from a medical perspective. Therefore the present study aimed to explore the extent to which doctors differentiate between themselves and their patients for a range of common problems and to examine whether doctors practice what they preach.

2. Methods

All GPs from Kingston and Richmond Health Authority and Ealing, Hammersmith and Hounslow Health Authority were approached for the study (n=556). This is a predominantly suburban area with a few inner city practices. The study consisted of a postal questionnaire with a within subjects design, with ratings for GP and patient as the within subject factor. Approval from the local research ethical committees was obtained.

2.1 Measures

The study was designed to compare what first line treatment options GPs would advise for their patients and what they would find acceptable for themselves. The questionnaire had three sections: questions regarding treatment options for patient, questions regarding treatment options for self, profile characteristics of respondent. As a means to test for an ordering effect the questionnaires were counterbalanced with half of the GPs receiving the patient questions first and half receiving the self questions first.

2.2 Treatment options

In order to select a range of health problems, one problem was taken from each chapter in the British National Formulary (2001) which was relevant to General Practice. Six common problems were identified B indigestion, hypertension, depression, low back pain, tired all the time (TATT) and acute-on-chronic sinusitis. Four general ways of treating these problems were assessed: over the counter (OTC), prescription, referral and complementary therapy. For the patient questions, the GP was asked to >Imagine a patient of your own gender, age, ethnicity and social class presents with a short history of these moderately severe symptoms. How likely are you to do each of the following as a first-line treatment?= For the GP questions, the GP was asked to >Imagine that you have started to suffer from these moderately severe symptoms yourself. How likely are you to accept each of the following as a

first-line treatment?= All the answers were on a 5-point Likert scale from 1 - not at all likely to 5 B very likely. The treatment options were as follows:

Indigestion: advise an OTC antacid, prescribe a PPI (proton pump inhibitor), refer for endoscopy and advise a complementary therapy.

Hypertension: give dietary and lifestyle advice only, prescribe a diuretic, refer to a cardiologist and advise a complementary therapy.

Depression: advise counselling, prescribe antidepressants, refer to a psychiatrist and advise St John=s Wort.

Low back pain: advise OTC analgesia/ NSAID, give prescription- only analgesia/ NSAID, refer to a hospital specialist and advise a complementary therapy.

TATT: advise OTC >pick me up=, prescribe multivitamins, arrange routine blood tests and advise a complementary therapy.

Acute-on-chronic sinusitis: advise OTC decongestants, prescribe antibiotics, refer to an ENT surgeon and advise a complementary therapy.

The order of the treatment option (OTC, prescription etc.) was different for each symptom category. To hinder comparison of the answers for GP with patient, the order of the treatment options for patient was different to the order for GP, and the patient and GP questions were on different sides of the questionnaire.

Profile characteristics: GPs rated their age, gender, ethnic group (white / black / asian / other) and length of time in General Practice.

The questionnaire was initially completed by 15 GPs who commented on the ease of completion and the language used and minor changes to the structure and wording were subsequently made.

2.3 Data analysis

The data was analysed to describe the profile characteristics of the respondents using descriptive statistics and to assess differences in mean scores between the treatment options for patient and GP using paired t-tests.

3.0 Results

Completed questionnaires were received from 286 GPs (response rate of 51.4%). There were no significant differences between the profile characteristics between those GPs that returned >patient first= questionnaires and those that returned >GP first= ones. However, unfortunately due to the anonymous nature of the questionnaire it was not possible to make comparisons between the responders and non responders.

3.1 Profile characteristics

The profile characteristics (see Table 1) show that the average age of the respondents was 45 years old. Half were male, half female and almost two thirds of the participants were white. This sample seems representative of GPs in the UK.

-insert table 1 about here -

3.2 Differences in treatment options for patient and GP.

The differences between the mean scores for the treatment options for patient and GP are shown in Table 2.

-insert table 2 about here-.

For indigestion, the GP was more likely to accept both an over the counter antacid and a prescription for a PPI for himself and less likely to accept referral for endoscopy. No difference between GP and patient was found for complementary therapy.

For hypertension, the GP was less likely to accept a prescription for a diuretic and more likely to accept referral to a cardiologist. No differences were found for either lifestyle changes or complementary therapy.

For depression, the GP was less likely to accept counselling, a prescription for antidepressants and St John's Wort than to advise them. No difference was found for referral to a psychiatrist.

For low back pain, the GP was more likely to accept referral to a hospital specialist than to advise it (although the scores for both are low). Otherwise, no differences were found for over the counter and prescription-only analgesia or a complementary therapy.

For 'tired all the time', the GP was more likely to accept prescribed multivitamins than to advise them (although again, both scores are low), but less likely to accept a routine blood test. No differences were found for an over the counter 'pick me up' and complementary therapy.

For acute-on-chronic sinusitis, there were no significant differences between what the GP would accept and what he would advise his patient.

4 Discussion and conclusion

The present study explored the extent to which doctors differentiate between themselves and their patients when considering a range of treatment options for six problems common to General Practice. The results showed that GPs consistently show differences for the care they find acceptable for themselves compared to that they would offer to their patients.

These results provide insights into when doctors are prepared to cross the boundary and become a patient and what kinds of diagnosis and treatment option are deemed appropriate for a doctor to have. In particular, when considering acute-on chronic sinusitis and low back pain which are comparatively neutral problems the doctors were prepared to cross the boundary and be treated the same as, or 'become', a patient for most treatment options. In

contrast, depression and tired all the time are not neutral problems but are embedded with adverse social meaning. For the most part, the GPs were not prepared to become patients when suffering these stigmatised problems and consistently reported that they would manage these symptoms differently if suffered by themselves than by their patients. GPs also differentiated between themselves and their patients for indigestion and hypertension. Both these problems often have both national and local guidelines that most GPs would be aware of. GP=s have been shown to have a positive attitude to guidelines (10), but to implement them in a complex, fluid and adaptive way (11). The results from the present study indicate that this fluidity of interpretation is also apparent in their application of guidelines for themselves compared to their patients. This is evident in the difference in their prescribing and referral habits for both indigestion symptoms and hypertension.

4.1 Conclusion

To conclude, anecdotal evidence suggests that doctors may not practice what they preach. The present study empirically tested this possibility and indicates that doctors consistently report that they would accept different treatment options for themselves than they would offer to their patients. In particular, whilst GPs may be prepared to cross the boundary and be treated the same as their patients if the symptoms are relatively uncontroversial, stigmatised problems and those with clinical guidelines may result in a >do as I say not as I do= approach to health care.

4.2 Practice implications

These results have implications for understanding how GPs manage both their patients and themselves. First, in terms of patient management, the results from this study indicate that GPs may offer patients treatment options which they personally believe are ineffective or unnecessary. They may follow clinical guidelines for problems such as indigestion and

hypertension because they believe they should, not because they believe the guidelines reflect best practice. This lack of conviction could be communicated to the patient resulting in either a lack of trust in the doctor or a belief that compliance with the doctor's recommendation is not really necessary. Second the results have implications for how GPs manage themselves. In particular, if they avoid treatment for stigmatised problems such as depression they may be denying that a problem exists when acknowledging and managing the problem may be more beneficial to their health in the longer term.

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Table 1. Profile characteristics of respondents.

Characteristic	Mean $\forall$ SD / n (%)	
Age*	45.0 yrs $\forall$ 9.8	
Length of time in general practice*	13.9 yrs $\forall$ 9.2	
Sex*	Male Female	142 (50.7%) 138 (49.3%)
Ethnicity*	White Black Asian Other	182 (64.5%) 1 (0.4%) 89 (31.6%) 10 (3.5%)

*missing data

Table 2. Differences between treatment options for patient and GP

Treatment option	Mean score for patient	Mean score for GP	t	p	CI	CI
Indigestion						
OTC **	3.80 ∨ 1.35	4.09 ∨ 1.28	-3.94	0.01	-0.44	-0.15
Prescription **	2.81 ∨ 1.30	3.13 ∨ 1.41	-3.867	0.01	-0.48	-0.16
Referral **	2.37 ∨ 1.37	2.09 ∨ 1.22	3.717	0.01	0.13	0.44
Comp Therapy	1.42 ∨ 0.84	1.43 ∨ 0.92	-0.264	0.792	-0.13	0.10
Hypertension						
OTC	3.74 ∨ 1.41	3.75 ∨ 1.42	-0.153	0.879	-0.16	0.14
Prescription **	3.48 ∨ 1.43	3.27 ∨ 1.48	2.888	0.01	6.73E-02	0.36
Referral **	1.97 ∨ 1.20	2.20 ∨ 1.37	-3.424	0.01	-0.37	-9.96E-02
Comp Therapy	1.42 ∨ 0.91	1.50 ∨ 0.98	-1.307	0.192	-0.02	4.13E-02
Depression						
OTC **	3.87 ∨ 1.10	3.37 ∨ 1.44	5.909	0.01	0.33	0.66
Prescription **	3.85 ∨ 1.07	3.42 ∨ 1.38	5.784	0.01	0.29	0.58
Referral	1.88 ∨ 0.98	1.87 ∨ 1.12	0.113	0.91	-0.13	0.14
Comp Ther **	1.92 ∨ 1.08	2.08 ∨ 1.31	-2.711	0.01	-0.29	-4.52E-02
Low Back Pain						
OTC	3.96 ∨ 1.10	3.80 ∨ 1.37	1.92	0.056	-4.14E-03	0.32
Prescription	3.63 ∨ 1.11	3.48 ∨ 1.36	1.901	0.058	-5.48E-03	0.31
Referral **	1.75 ∨ 0.89	2.07 ∨ 1.20	-4.768	0.01	-0.45	-0.19
Comp Therapy	2.73 ∨ 1.44	2.78 ∨ 1.59	-0.685	0.494	-0.18	8.82E-02
TATT (Tired all the time)						
OTC	1.69 ∨ 1.13	1.60 ∨ 1.11	1.277	0.203	-4.59E-02	0.22
Prescription **	1.49 ∨ 0.88	1.66 ∨ 1.07	-2.674	0.01	-0.30	-4.55E-02
Referral **	3.98 ∨ 1.09	3.59 ∨ 1.44	4.761	0.01	0.23	0.55
Comp Therapy	1.94 ∨ 1.14	1.99 ∨ 1.31	-0.618	0.537	-0.20	0.11
Acute-on-chronic sinusitis						
OTC	3.07 ∨ 1.40	3.19 ∨ 1.46	-1.794	0.074	-0.25	1.17E-02
Prescription	3.98 ∨ 1.07	3.90 ∨ 1.19	1.322	0.187	-3.57E-02	0.18
Referral	2.24 ∨ 1.16	2.31 ∨ 1.34	-0.949	0.344	-0.20	7.06E-02
Comp Therapy	1.67 ∨ 1.03	1.71 ∨ 1.13	-0.659	0.511	-0.15	7.71E-02

** significant difference between patient and GP