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Where do GPs seek help for their illnesses?

SHORT REPORT

HOGNE SANDVIK

hogne.sandvik@outlook.com
National Centre for Emergency Primary Health Care
NORCE Norwegian Research Centre
Bergen
Author contribution: idea, study design, data analysis, data interpretation, preparation of the manuscript and approval of the submitted version.
Hogne Sandvik, MD PhD, specialist in general practice and researcher.
The author has completed the ICMJE form and declares no conflicts of interest.

ØYSTEIN HETLEVIK

Department of Global Public Health and Primary Care
University of Bergen
Author contribution: design, data interpretation, preparation of the manuscript and approval of the submitted version.
Øystein Hetlevik, PhD, specialist in general practice and community medicine, general practitioner and professor of general practice.
The author has completed the ICMJE form and declares no conflicts of interest.

JESPER BLINKENBERG

National Centre for Emergency Primary Health Care
NORCE Norwegian Research Centre
Bergen
Author contribution: data retrieval, data interpretation, preparation of the manuscript and approval of the submitted version.
Jesper Blinkenberg, PhD, specialist in general practice and head of the National Centre for Emergency Primary Health Care.
The author has completed the ICMJE form and declares no conflicts of interest.

STEINAR HUNSKÅR

National Centre for Emergency Primary Health Care
NORCE Norwegian Research Centre
Bergen
and
Department of Global Public Health and Primary Care
University of Bergen
Author contribution: data retrieval, data interpretation, preparation of the manuscript and approval of the submitted version.
Steinar Hunskår, MD PhD, specialist in general practice, senior researcher, general practitioner and professor emeritus in general practice.
The author has completed the ICMJE form and declares no conflicts of interest.

Background

Doctors generally enjoy good health, but often refrain from seeking help when they are ill. Self-treatment is widespread, and this can be an inappropriate and risky practice.

Material and method

This is a registry study that compares GPs' own use of the primary and specialist health services in 2018 with a control group consisting of all others in the same age group with the same sex, level of education and health as the GPs. Morbidity in both groups was surveyed with the aid of two validated morbidity indexes in the period 2015–17. Only those who scored zero on both indexes were included.

Results

While only 21.7 % of the GPs had sought help from a GP and 3.3 % had attended the emergency department, the corresponding figures for the control group were 61.6 % and 11.8 %. Of the GPs, 17.5 % consulted a contract specialist, compared to 15.5 % of the control group. Measured as a proportion of all specialist consultations, consultations with a psychiatrist constituted 35 % for GPs and 13 % for others. There were small differences in the use of somatic outpatient clinics (25.9 % of GPs and 25.7 % of the control group) and acute admission in somatic hospitals (3.8 % of GPs and 3.3 % of the control group).

Interpretation

This study indicates that GPs receive medical assistance from other than their own GP.

Main findings

A total of 21.7 % of general practitioners (GPs) had consulted their own GP and 3.3 % had attended the emergency department, compared to 61.6 % and 11.8 % in the control group.

GPs were overrepresented in terms of consultations with contract specialists (17.5 % compared to 15.5 %), and consulted contract psychiatrists 2.7 times as frequently as the control group.

It is generally assumed that doctors enjoy good somatic health, at least on a par with their peers with the same socioeconomic status. However, mental problems, primarily depression and suicide, are somewhat more common among doctors (1–3). The social media campaign #legermåleve (doctors must live) has focused attention on doctors' working environment as a cause of poor mental health (4).

When doctors fall ill, they do not behave like other people. They refrain from seeking help, but to a large extent turn to self-treatment and continue to go to work (5, 6). This is a risky practice. In a study of English GPs' self-treatment of illness, assessment, treatment and referral were of poorer quality than if these had been entrusted to a colleague (7).

Previous studies are based on questionnaires and interviews, with varying response rates and representativity. Published Norwegian data is moreover old, mainly from the 1990s (1, 2, 5). The purpose of this study was therefore to present new, updated and more complete data.

Material and method

This is a registry study based on data from 2018, supplemented by morbidity data from the years 2015–17. The material consists of GPs, and a control group comprising all others in the same age group of the same sex, level of education and health as the GPs.

The study is part of the project 'Use of health services in Norway', which is a collaborative project between the National Centre for Emergency Primary Health Care (NORCE) and the Department of Global Public Health and Primary Care, University of Bergen.

With the aid of pseudonymous sequential numbers, the data from four registries were linked together: The Norwegian GP Registry, the Norwegian Patient Registry (NPR), Norwegian Control and Payment of Health Reimbursements Database (KUHR) and Statistics Norway (SSB).

Two validated indexes were used to identify persons whose health was essentially comparable. The Charlson score is based on diagnoses from ICD-10 (International Classification of Diseases) from the specialist health service, while the ICPC (International Classification of Primary Care) morbidity index is based

on ICPC-2 diagnoses from the primary health service (8, 9). Data were retrieved from NPR and KUHR for the three-year period 2015–17. To obtain sufficiently large, comparable groups, we included all who have scored zero on both indexes. This means that most individuals with serious or chronic illnesses were excluded.

Use of health services in 2018 was surveyed using KUHR and NPR. We recorded all who had at least one consultation with a GP (not necessarily their own GP), emergency department, contract specialist, somatic outpatient clinic, or who had been acutely admitted to a somatic hospital (births were not included). We had no data on use of psychiatric institutions.

Since the material is complete and does not represent a sample, the differences that were determined are real and not encumbered by statistical uncertainty. The data is therefore presented without confidence intervals and no statistical testing was carried out.

Ethics

The project is approved by the Norwegian Data Protection Authority (reference number 14/0322 - 9/CGN) and the Regional Ethics Committee has given it exemption from the duty of confidentiality (reference number 2013/2344/REK vest).

Results

The material included a total of 4 747 GPs; the average age was 47.6 (standard deviation 11.3; age range 26–76 years), of whom 43.5 % were women. Of these, 4 271 scored zero on both morbidity indexes and were included in further analyses. The proportion of persons who registered zero on the morbidity indexes decreased uniformly with age, but to a smaller degree for the GPs than for the control group (Table 1).

Table 1

GPs and control group with corresponding educational level: Proportion (%) who are 'healthy' assessed using two morbidity scales (2015–17). ICPC (International Classification of Primary Care).

			Charlson Index = 0		ICPC index = 0	
	GP (*N*)	Control group (*N*)	GP	Control group	GP	Control group
Men						
26–35 years	354	192 005	96.3	97.5	96.3	97.0
36–45 years	799	180 525	95.0	96.2	96.7	95.7
46–55 years	544	146 237	93.4	92.6	95.2	92.0
56–65 years	741	100 124	87.0	84.1	90.4	84.0
66–76 years	243	81 082	81.9	69.4	85.2	70.6

			Charlson Index = 0		ICPC index = 0	
	GP (*N*)	Control group (*N*)	GP	Control group	GP	Control group
Women						
26–35 years	371	246 690	96.0	96.8	98.4	96.6
36–45 years	824	210 641	95.0	94.7	96.1	95.0
46–55 years	463	165 937	94.0	91.0	95.5	91.4
56–65 years	367	107 973	89.6	84.8	93.2	85.6
66–76 years	41	70 234	87.8	75.9	95.1	77.7
All	4 747	1 501 448	92.5	91.3	94.6	91.4

GPs consulted a GP and attended an emergency department less than the control group (Table 2). While the control group consulted a GP more with increasing age, there was no such tendency for GPs. Young women GPs were those who consulted a GP most. Measured as a proportion of all consultations with the youngest women (26–35 years), pregnancy-related diagnoses constituted 67 % for GPs and 22 % for the control group.

Table 2

'Healthy' GPs (as defined with the Charlson Morbidity Score and the ICPC Morbidity Index) and 'healthy' control group with corresponding educational level: Proportion (%) who have had at least one consultation with a GP, emergency department, contract specialist, somatic hospital outpatient clinic, or have been acutely admitted to a somatic hospital in 2018.

			GP		Emergency department		Contract specialist		Outpatient clinic		Urgent admission	
	GP (*N*)	Control group (*N*)	GP	Control group	GP	Control group	GP	Control group	GP	Control group	GP	Control group
Men												
26–35 years	334	183 304	12.0	44.5	3.9	11.6	4.8	6.6	15.9	16.5	1.8	2.0
36–45 years	747	168 825	12.3	45.8	2.4	10.4	7.9	7.4	16.6	16.7	3.1	2.2
46–55 years	497	129 110	15.9	51.7	3.2	9.9	13.9	10.2	23.1	19.9	4.8	3.1
56–65 years	615	77 524	15.1	59.6	3.1	10.0	19.3	16.1	24.4	25.9	4.7	4.5
66–76 years	185	48 449	21.6	72.6	3.8	11.3	23.2	28.6	33.5	36.6	8.6	7.0

			GP		Emergency department		Contract specialist		Outpatient clinic		Urgent admission	
	GP (*N*)	Control group (*N*)	GP	Control group	GP	Control group	GP	Control group	GP	Control group	GP	Control group
Women												
26–35 years	352	232 764	52.8	68.9	6.0	14.7	19.3	15.3	45.7	31.9	5.7	3.7
36–45 years	765	193 081	30.7	69.4	3.3	12.0	21.3	17.5	29.5	27.6	2.6	2.9
46–55 years	425	143 694	21.2	72.1	2.8	11.3	26.4	21.0	25.2	28.0	2.6	3.0
56–65 years	316	84 801	21.2	74.8	3.5	11.7	28.2	26.0	29.7	32.7	4.1	3.9
66–76 years	35	47 356	14.3	79.4	2.9	12.4	25.7	36.5	37.1	39.6	5.7	6.1
All	4 271	1 308 908	21.7	61.6	3.3	11.8	17.5	15.5	25.9	25.7	3.8	3.3

Apart from the youngest men (26–35 years) and the oldest age group (66–76 years), GPs consulted contract specialists more than the control group (Table 2).

Altogether 1.6 % of the GPs had consulted a psychiatrist, compared to 0.6 % of the control group. Measured as a proportion of all specialist consultations, consultations with a contract specialist in psychiatry constituted 35 % for GPs and 13 % for the control group.

The youngest women GPs had many consultations at somatic outpatient clinics, of which 61 % were pregnancy related, compared to 47 % for other women in the same age group. There were otherwise only small differences between the groups with regard to outpatient consultations. There were no obvious group differences in acute admissions to somatic hospitals (Table 2).

Discussion

This study shows that few GPs seek help from the primary health service when they are ill. However, they are overrepresented in terms of consultations with contract specialists.

Older GPs apparently enjoyed better health than their peers with the same level of education, but this might be bias due to the so-called healthy worker effect (10). Both the ICPC morbidity index (the primary health service) and the Charlson score (the specialist health service) surveys chronic and serious illness (8, 9), but it is possible that illness among GPs is underestimated as they tend not to consult their own GP.

We had no access to more recent data than from 2018, and the health survey was performed with data from 2015–17. The results are consistent with many previous studies (5, 6, 11), but we do not know the degree to which they are still valid.

Doctors often tend to ignore their own symptoms, and to go to work even when they are ill (5, 11). Many studies have shown that self-treatment is widespread (1, 5). Primary care providers and GPs have wide-ranging competence and can therefore administer self-treatment for many different conditions. Although this can be a sensible, resource-saving approach when it comes to uncomplicated conditions, it increases the risk of incomplete investigation and delayed diagnosis of serious illness. It may also entail breaches of the Norwegian Medical Association's code of ethics for doctors (12): 'A doctor should take care of his own health and seek help if it fails.'

GPs identify strongly with the role of helper, and it can therefore be difficult to switch roles and ask for help. In most Norwegian municipalities, your GP will be a colleague whom you also know socially, and there may be concerns about confidentiality (6). Some may find it embarrassing to talk about their own problems with a colleague. On a busy workday, doctors may not take the time to make an appointment with their GP but may in passing ask a colleague at their place of work, usually an informal contact that is not entered in the medical records, nor is it recorded in any other way. There may also be some underreporting of genuine consultations if no patient user fee is required. This applies for example to the collegial support scheme for doctors (13).

This study indicates a higher use of contract specialists by GPs than by other groups. This may be due to the fact that GPs can refer themselves to a specialist, but it is also possible that doctors have a lower threshold for referring a colleague to a specialist.

It is well known that doctors more often struggle with work stress and mental problems (1–4), and it is therefore to be expected that they have a greater need for help from specialists in psychiatry than other people. That is also confirmed in this study, which shows that GPs consult contract psychiatrists almost three times as much as others. It can be particularly difficult to consult a GP colleague in order to be referred to a psychiatrist, so the opportunity to refer oneself may act as a safety valve.

This article has been peer-reviewed.

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