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The health of general practitioners: a cause for concern?

THERE has been much interest recently in the long hours worked by junior hospital doctors and the effect of their consequent stress and fatigue on safety and efficiency.[1-3] Junior hospital doctors may indeed spend years with excessively tiring on-call rotas, but they usually ascend the scale towards consultant posts which are in general shielded from the regular nocturnal and weekend demands of patients. Junior hospital doctors carry their high out-of-hour loads when in the prime of their lives.

In contrast, most general practitioners spend the whole of their working lives of 40 years with regular and inescapable weekend and night-time commitments. They frequently have to cope with 'shifts' of 33 hours or more, continuous weekend duty and seldom take days off in lieu. The ageing process makes all this more difficult to manage because of increased fatiguability and likelihood of physical ailments.

The British Medical Association reports than an 'average' general practitioner spends 73 hours working per week, 38 providing general services and 54 hours on call. This is in contrast to the 'average' consultant who spends 41 hours working per week.[4]

The debate about the use of deputizing services and how much a general practitioner may utilize them has turned the limelight away from those who do not use a deputizing service either because of personal principles or geographic inaccessibility.

Doctors have an increased risk of death from cirrhosis, accidental poisoning and suicide.[5] The National Counselling and Welfare Service for Sick Doctors was set up to address this problem in 1985,[6] but at best it can only be a crisis intervention service. The health committee of the General Medical Council also caters for extreme ill health and corresponding inadequate professional performance. What is needed is a preventive approach, offering a service that can be used in the earliest stages of physical or mental illness.

Research has shown that job stress is common in general practice.[7-9] However, only a few studies have looked at the amount and type of stress[7-9] and even fewer have considered the physical health of general practitioners.[10,11] Allibone[10] compared the health of older general practitioners and older hospital doctors. He found a high incidence of self-treatment, delay in seeking medical care and inadequate follow up of chronic diseases. In a second survey Richards[11] looked at the attitudes and behaviour of 500 general practitioners. This revealed much personal distress with 33% of the respondents making comments about and personal disclosures of emotional difficulties.

The Home Secretary has announced that a psychology unit is to be set up to help the police cope with the daily tensions of their jobs (Home Office press release, 27 October 1988). In commerce and industry senior executives often have private medical screening arranged and paid for by their companies on a regular basis. Airline pilots

have strict medical examinations and specific limitations on their hours of work and rest time enforced by law.[12]

What of the National Health Service? An occupational health service for nurses, doctors and other employees working in hospitals has at last been established and its work is expanding. However, there are no special provisions for the health care of general practitioners, who are independent contractors. Many general practitioners feel that consulting their own doctor, who is likely to be a partner or close friend, might be construed as a weakness especially if the problem is about ordinary human failings. They also worry that the consultation may result in loss of their own professional credibility or even their livelihood.[10,11,13,14]

An independent, confidential counselling and consultation service available to all general practitioners would appear to be long overdue. It could be staffed by experienced general practitioners with direct access to hospital specialties and investigations and incorporate a full range of support services. Accessibility, confidentiality and clinical competence are the three essential features of such a service.

The need for time for mental recuperation to enable efficient and safe working practices has been described for airline pilots[12] and drivers of heavy goods vehicles.[15] Doctors require respite time in the same way. The problem of the long working hours of hospital doctors and general practitioners will not go away. Tired doctors make errors, take short cuts, are forgetful and perform at less than their best. There is no other job with potentially unlimited working hours where the effects of fatigue can have such disastrous consequences for others.

The health care of most general practitioners is sketchy at best and dangerous at worst, and in no way a credit to what is supposed to be an intelligent, responsible and caring profession. The need for reform must be recognized and instituted without delay.

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Breast self examination: should we discourage it?

FEW general practitioners have been involved in the current debate about breast self examination although all have patients who practise it, and some doctors actively promote it. Until the advent of mammography, the medical profession had little else to offer in the quest for early detection of breast cancer, and breast self examination was generally accepted to be a good thing, offering women the possibility of self determination and self awareness as well as protection against death from breast cancer. Mammography changed the situation both by offering an alternative method of early diagnosis of proven value and by encouraging critical appraisal of all methods of screening. The most cogent challenge to the self evident goodness of breast self examination came from Frank and Mai writing in the *Lancet* in 1985, who pointed out that the evidence for its effectiveness was minimal, whereas its cost (in terms of false positive results) was high.[1] They suggested that, particularly in young women, breast self examination was not an acceptable screening test and should no longer be promoted. Although the academic debate this paper engendered had little impact on medical practice at the time, it did impinge on advisory bodies, both here and in the United States of America. In 1987 the Forrest report on breast cancer screening in the United Kingdom was equivocal in its support for breast self examination, and once again pointed to the lack of evidence for its effectiveness.[2] Similarly, the US Preventive Services Task Force and the World Health Organization have both concluded that there is insufficient evidence to support it as a public health policy.[3] However, no government agency has felt sufficiently sure of its ground to recommend that breast self examination should be abandoned.

The evidence for the value of breast self examination is derived from retrospective studies comparing the stage at diagnosis of breast cancer in women practising or not practising the technique. The 12 major studies carried out between 1978 and 1986 are summarized in a meta analysis by Hill and colleagues.[4] Six studies reported on the basis of pre-morbid practice of breast self examination, that is whether or not the woman practised breast self examination before the cancer was discovered irrespective of its mode of detection, while the other studies reported the circumstances of detection. The former method of analysis is to be preferred, and when the results of the six studies were combined, the proportion of women with lymph node involvement at diagnosis was 50% in the no breast self examination group and 39% in the breast self examination group. This provides reasonably compelling evidence that the method does lead to earlier diagnosis. The one study of this type reported since 1986, from the department of community medicine and general practice at Oxford, confirms these findings, but suggests that the improvement of stage in diagnosis may be restricted to women who have been taught breast self examination.[5]

It must be stressed that earlier diagnosis does not in itself