

Self-treatment and self-medication by Swiss primary care physicians: a cause for concern?

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Why should a carpenter not make his own furniture? At first glance, the idea of physicians looking after their own health appears natural. At second glance, however, questions arise. If we consider severe, chronic and mental conditions, where do we set the limits to self-treatment? Does self-treatment and self-medication have a measurable impact, positive or negative, on a physician's well-being? Do physicians differ from the general population, or from comparable subgroups in the population, in terms of their subjective or objective health status, use of health care resources, or use of screening and preventive services? If the answer to any of these questions is yes, what causal mechanisms are active in the background? Is there a need for corrective action, and if so, what form might this take? Physicians are far from forming a negligible fraction of the entire population, and so this set of topics is clearly relevant from the perspective of occupational medicine and public health. Taking the public health argument further, we may even need to enquire whether impaired health among physicians may have a negative impact on the quality of the health services provided to the population as a whole.

However, before these questions can be appropriately addressed a sound, empirically-based description of the underlying facts is indispensable. To date, no such data has been available for Switzerland. In the present issue of SMW this gap is partly filled by Schneider and colleagues, who report findings from a mailed survey on medical care and pharmaceutical drug use among Swiss primary care physicians. With its focus on self-treatment, self-medication and potential over-medication, the article raises a number of questions.

The findings that physician self-treatment and self-medication are very frequent, and that many physicians avoid seeking the help of other physicians when health problems arise, are in line with expectations and reports from several countries [1–4]. They can hardly be questioned. However, the authors' conclusion regarding increased use of medication among Swiss physicians appears only partly meaningful, and the connotation of increased use of "problematic" drugs such as anal-

gesics and tranquillisers I find a matter for concern. Data from the Swiss Health Survey representative of the Swiss population aged 15 or over (with no upper limit), were used as the comparator when these points were established. Would it not have been more appropriate to compare the physician sample with a subpopulation showing a more closely matched age distribution and perhaps also more closely matched levels of education and job-related stress? Considering that the drug categories compared were not entirely equivalent and that some of the differences in observed use of medication were rather moderate, any relevant conclusions should be drawn with great caution, even though similar findings have been published for France and Norway [5, 6].

As the authors report, the use of analgesics, benzodiazepines and antidepressants was more, not less, frequent among those physicians who sought help from other physicians, which contradicts the notion of overuse induced by self-medication. (Why was consultation of other health care providers not used as a potential predictor in the multivariate regression analysis of medication use? And, as an aside, how would the regression results have looked if clearly non-significant predictors had been eliminated?)

A link between the observed level of drug consumption and "psychological distress in an ever more complex health system environment" is established, but the regression results do not show increased use of analgesics, tranquillisers or antidepressants in physicians with lower work-related satisfaction or higher perceived stress (although there is a relatively clear association between medication use and lower self-perceived mental health). Those with higher perceived stress and lower self-perceived mental health were less, not more, likely to use self-medication.

Some of the reported regression-based findings can even be interpreted as confirmation of rational behaviour: many female physicians saw a gynaecologist; older physicians were more likely to visit any health professional; physicians living alone were more likely to see a mental health specialist, etc.

The descriptive data presented by the authors are highly important and make clear that the situation in Switzerland is roughly similar to what we know from other Western countries. Further studies would be needed to confirm negative effects from physician self-treatment and self-medication. While the authors fully acknowledge this lack of evidence, a negative picture of self-medication nevertheless emerges, partly based on commonsense or normative arguments.

In consequence, should we, or should we not, now be concerned about Swiss physicians looking after their own health? As a non-physician perhaps viewing the matter at some remove, my position is that we should not be concerned about physicians self-treating trivial conditions. This may indeed be highly cost-effective from the viewpoint of health economics. On the other hand, we must of course be concerned where more serious conditions are involved. Some of the commonsense and normative arguments put forward by Schneider and colleagues are judicious, e.g. that lack of distance may be a substantial barrier to effective self-treatment and that there are clear (but not easily definable) limits where severe illness and mental health problems are involved. It is consistent with these arguments that studies from other countries have found inappropriate self-referral behaviour [1], different perceptions (partly depending on the physician's speciality) of acceptable limits to self-treatment [3], and barriers to rational health behaviour due to physicians' high expectations concerning their own effectiveness (partly acquired during training) and culture-specific perceptions and connotations of the physician's role [7–9]. The notion that work-related stress has increased in recent decades is commonplace but nevertheless true, for physicians as well as other professionals. Within the medical profession, primary care

physicians may be most affected by situations of effort-reward imbalance.

In the light of these arguments we should interpret the points brought out by Schneider and colleagues as important questions which are admittedly difficult to answer empirically. Long-term prospective cohort or case-cohort designs measuring attitudes and resource use patterns as well as health outcomes would perhaps be a suitable means of addressing the impact of self-treatment. However, apart from the financial and administrative effort involved, the participants' behaviour may be influenced by the study situation. Moreover, the results may only be valid for a single generation of physicians and not for future generations with different attitudes. At the other end of the spectrum, retrospective study designs would require much less time and effort but would be likely to suffer from limited data availability, recall bias and related problems. Given these difficulties, creative approaches are required. Would it be thinkable to base careful, tentative corrective action on current knowledge and commonsense arguments, and to accompany it by appropriate, controlled evaluation studies? It might be easier to measure the impact of intervention than to measure the impact of physician self-treatment and self-medication considered in isolation.

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