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Roles ascribed to general practitioners by gay men with depression

Background

This article identifies the roles that gay men with depression ascribe to their chosen general practitioner and considers how they might influence the dynamics of clinical interactions between gay men and their doctors.

Methods

Forty gay identified men with depression (recruited from high HIV caseload general practices in New South Wales and South Australia) took part in semistructured interviews that were analysed using the principles of thematic analysis. Seventeen men (aged 20–73 years) were HIV positive.

Results

Five distinct roles were identified: GP as trusted confidant, gentle guide, provider of services, effective conduit, and community peer.

Discussion

Gay men who have ongoing contact with their GP may expect them to intuitively understand which roles are expected and appropriate to perform in each consultation and over time. General practitioners should consider these changing roles, and take them into account (as appropriate) to achieve open and trusting relationships in the care of their gay male patients.

Keywords: doctor-patient relations; general practitioners; depression; health knowledge, attitudes, practice; patient acceptance of health care

The health concerns of gay identified men have been well documented, including a greater vulnerability to depression, due in no small part to continuing experiences of marginalisation and discrimination. This is certainly true of Australian gay men, including those who are HIV positive.[1–4] However, Australian research also indicates that many gay men have access to open minded and supportive general practitioners, at least in the major cities.[5–11] This is at odds with some reports in international literature which suggest that many gay men avoid disclosing sexual orientation and/or HIV status in health care settings due to fear or evidence of homophobia and stigma,[12–15] which can seriously impact quality of care, including the prevention and treatment of mental illness. This opens up questions about the roles that Australian gay men with depression ascribe to their chosen GP and how this might influence the dynamics of clinical interactions between gay men and their doctors in high HIV caseload general practice settings.

The small amount of research available on the 'role' concept in primary healthcare settings[16,17] provides useful insights into the unspoken assumptions patients can make about the role of the GP, both in terms of clinical care and the more complex issues of verbal and nonverbal communication, social discourse and cultural meaning. A broader body of literature is available on patient expectations of GPs in managing depression, although some of this is contradictory. For example, in two separate British studies, patients with depression were described as having higher expectations of their GP than other patients,[18] and 'low but realistic' expectations of how GPs can help.[19] Other themes are more consistent, including the importance of patients with depression feeling 'understood or listened to'[20,21] and developing a 'special relationship' with their GP,[20,22] and the emotional distress that can be caused by 'structural limitations' in general practice such as time constraints.[23]

No research is available on the range of roles that gay men with depression ascribe to their GPs over time, although we do know this population draws upon particular discourses in describing experiences of depression[24] and may be more than usually engaged with health services because of a relatively high burden of HIV infection. Our analysis aims to redress this lack of knowledge and build upon our 2008 *Australian Family Physician* paper, 'GPs' understanding of how depression affects gay and HIV positive men'.[6]

Methods

The Primary Health Care Project on HIV and depression was funded by the National Health and Medical Research Council as a General Practice Clinical Research Program grant. The methodology has been described elsewhere,[2,3,5,6,9,10] but information relevant to this article is provided here.

Forty interviews were conducted between February 2008 and May 2008 with men recruited from general practices with high HIV caseloads in Sydney (New South Wales) and Adelaide (South Australia). All self identified as gay, homosexual or an alternative description such as 'queer', as 'currently suffering from depression' and measured above '4' on the 9-question Patient Health Questionnaire (PHQ9) self screening

tool for depressive disorders. Seventeen of the men were HIV positive. Ages ranged from 20 to 73 years but almost half were aged in the 40s. Almost all were born in Australia and had an Anglo Celtic background. More than half lived by themselves and nearly three-quarters were single. Most were employed full (21) or part time (7) and earned a wide range of incomes. However, five were unemployed or retired and eight received a disability support pension. Pseudonyms were allocated as appropriate to each participant's age and ethnic background.

Interviews were semistructured and focused on a range of open ended questions about clinical and personal experiences of the diagnosis and management of depression in general practice, with a particular focus on issues relating to HIV and sexuality. Following the principles of thematic analysis,[25] de-identified transcripts were firstly coded broadly by the first author using NVivo software. Potential themes were reviewed in an iterative manner among the project team, so as new themes emerged, earlier transcripts were re-examined and the coding framework refined. For this article, a more focused round of coding was carried out on the themes that related to the 'role of the GP'.

Ethics approval was granted by The Royal Australian College of General Practitioners and ratified by the Human Research Ethics Committees of participating universities.

Results

We identified five distinct 'roles' that these men ascribed to their GPs in relation to the diagnosis and management of depression.

GP as trusted confidant

The GP was firstly described as a central figure in the emotional lives of these men, requiring a willingness to listen on the part of the GP and a significant degree of trust on the part of the patient:

'Some days I'd go in there and I was a bloody mess. And I'd be in there going, 'I can't fucking cope anymore!' and 'I want to kill myself'. And I felt like I was going crazy... she really understood why I was going through this depression and why I felt the way I felt. And, you know, the care was always there. And she let me know that any time I needed to ring up and ask anything, or if I wanted, if I needed to come in and see her, 'don't hesitate'. It didn't matter, there was always time to see you.' (Nate 48, HIV positive)

Time was identified as the most common barrier to the GP always being able to play that role:

'Just be patient and let the person talk. You know? And if it means they've got to call through to reception and alter those bloody appointments, do it. Because at that moment... if they've come to the doctor, they've come because they want help. And they don't know where to start. And their mind is a mess. There's just so much going on. And they need someone to calm it all down. And they need to feel safe.' (Brad 40, HIV positive)

Additional characteristics were also necessary for the GP to demonstrate in order to be recognised a trusted confidant including empathy, honesty, caring, humour, safety and judgment. Some men described these characteristics as important for both doctors and patients:

'They really, you know, redefine the philosophy behind medical care. Because I know there's so many people coming in with complaints now, and sick, and wanting a part of the scheme to help them with some pills or this or that. And I know that doctors, people in the medical profession, have their stresses. I empathise with them. But still somehow they're able to keep it separate and come and smile and ask you genuinely how you are. And treat you as a person. It's amazing!' (Lucian 44, HIV positive)

The inevitable outcome of this level of investment however, is a greater sensitivity to evidence of these characteristics, with potentially serious consequences if they are not apparent. This is the case even if the patient simply doubts a GP's sincerity, as in the following example:

'If he asks me if I've had unsafe sex, I wouldn't tell him where I've been. I'd just say, 'yeah'. I wouldn't tell him because I don't want to, I feel like, I feel embarrassed. In the sense that he did, like he's done a lot to help me and that's like shitting in someone's face... most people are [judgmental]. But that's human nature, I think... And look, I don't want to burden [my GP] with having to like freeze warts off my behind! [laughs] I'm sure there's other things he'd rather be doing... I try and not be as, not be a hassle to him. But he'll see me at any time. If he's booked out, he's just like, 'come in, whatever.' [Phillip 31, HIV negative]

GP as gentle guide

In the second role, the GP is expected to be able to 'guide' their patients until they are open to accepting a 'label' of depression and the therapeutic options that can then flow from that:

'[When I'd first gone to see [my current GP], she'd asked me about depression and that. And I said to her, 'Yeah, I get the blues, what I call the blues.' And I said, you know, 'but everybody gets them'... But this time when I really hit the wall... I was just a mess... and I went to the doctor. And she said, 'Well, you must see someone'... [She] got frustrated with me saying it's not depression. And she said, 'Well, what do you think it is?' [laughs]... I thought, 'ooh, she's going to get upset! And I don't want to upset her.' So I went and I started on the treatment and it helped.' (Lucian 44, HIV positive)

The GP is expected to stay engaged with the patient after the initial diagnosis, but to not commit unthinkingly to a particular treatment or management pathway:

'Whether it's the GP directly or they have someone in their practice who makes the call [to follow up with a patient who has been diagnosed with depression]. And says, you know, 'Brad, how did you go? How did you find that? That experience in going there or doing this? Was it good for you? Okay, right, get back in here now. Let's try something else.' They just need to know that something's happening. To be left with a prescription and then to go back into the world when you're already in the trench, you know, in that dark place, that's frightening. A doctor leaving someone who is suicidal or in a dark place, giving them the responsibility to pick the phone up and call is not smart. Because they'll never do it. They need to be proactive.' (Brad 40, HIV positive)

'I've sort of spoken to GPs who – about depression – and they've just kind of gone, you know, 'Here, give SSRIs a try! Come back later.' They try and talk about what's wrong, dah-dah-dah. But if you only sit there for half an hour or something, it's not... [my] experience with GPs has been rather kind of short and kind of, I mean, not 'cold', that's the wrong word... It's almost kind of, I don't know, I suppose I just found it almost formulaic. It's sort of like, 'Oh, someone's got depression! Here, give him [antidepressant medication]!' You know? It was just kind of like working from the script.' (Oliver 29, HIV negative)

GP as provider of services

The third role ascribed to the GP imagines the patient-doctor relationship as purely pragmatic:

'[I] view the GP as pretty much a mechanic. I can go and see any mechanic and that's not an issue... I think when a GP starts out they're all very altruistic and they want to do the best thing, etc. I think now for my GP, it's pretty much a business. And it is 15, you get 15 minutes per person. You know, come in, state the problems. And he gives you a response based on that. So that's that. It's, yeah, I think it's pretty much a business transaction.' (Ian 40, HIV positive)

In this model, the patient is represented as an active 'consumer' with the capacity to think with critical and informed objectivity about the medical knowledge being shared with them:

'I mean [my GP] and I had a pretty frank conversation one day. I said to him, 'You're here, you can give me your advice,' but I said, 'You're not the one that's going to make the decision about my care. I will.' [laughs] And he looked at me, 'Oh okay. That's fair enough.' So I'm not one of those old school, 'the doctor's god', not at all.' (Brad 40, HIV positive)

Time constraints were responsible for some quite critical views of the GP as service provider. Yet others developed deliberate strategies to make the best use of the time they had with their doctor:

'I find most GPs these days are very high volume. So he's very... I'm sort of a fairly organised person so I have my dot points ready when I go and see my GP. And usually in the first 30 seconds I tell him all the dot points he has to deal with. And then he goes, he responds in the same way... And it's just, 'all right, we're doing this, this, this, this'. And, you know, occasionally if there's something a little bit serious, he'll kind of ask me some probing questions. But we're very efficient, my doctor and I!' [laughs] (Keith 47, HIV negative)

GP as effective conduit

In the fourth example, the issue of time restrictions in general practice is seen to require the role for GPs in relation to depression management to be limited:

'The reason he's not a very good mental health practitioner, essentially, and this is the case with many GPs, I think, is they just don't have the time. And to do proper mental health work is very, very, very time consuming and expensive... And your 20 minute GP consultation, standard consultation, is just simply not long enough. I think really the best a GP can do is refer on, if there's an issue. So just pick up a few key bits, and refer them on to specialists.' (Nicholas 46, HIV positive)

'I'm not anti-GP. I think they care a lot [and]... most of them are very, very sympathetic people. But you know, in a busy practice where you've got lots and lots of people who are either chronically or acutely ill in so many ways, it's, what can you do?' (Alan 63, HIV negative)

In this role, GPs are expected to act as an 'effective conduit' in organising appropriate referrals both because of their limited time but also because of perceived limitations in their skills and experience:

'The way I see it is that my GP doesn't have the time nor the skills to be able to, to deal with say, my emotional state or depression. He pretty much, based on what I tell him, tries to direct me to somebody who can provide a better service than he can. So he, it's pretty much a matter of fact, 'this is what I'm feeling, this is how it is.' And he will suggest a course of action.' (Ian 40, HIV positive)

'I don't trust them to deal with [my depression], really! [laughs]... I just think that, as well intentioned as they are... most GPs just don't have the sort of degree of experience in dealing with a kind of rather complicated subject... it was, actually, that's one good thing about my GP. He does tend to sort of pick out, you know, the decent specialists.' (Oliver 29, HIV negative)

GP as community peer

Finally, the GP is also expected to be identifiably connected to gay community, either through their physical location in a 'gay identified' practice or through their choice to disclose their own sexual preference or political support for minority sexualities:

'I chose the practice because I wanted to go to a gay practice. I believe in it, you know. I think that's fair enough... [most] GPs these days are quite accepting of a gay lifestyle. I mean you wouldn't find many that weren't... but nonetheless, I support the gay oriented practice because I know they do a lot of work for sexual health and for people who do have HIV at various stages... I pay my bill, I don't go for bulk bill, so you know. And I think that's right and proper.' (Alan 63, HIV negative)

'The GP I see myself is not gay but I know that he's fully au fait with HIV and all of those things. And I think, 'Well, why go anywhere else?' (Charles 67, HIV positive)

Those GPs perceived as supportive were also represented as providing a culturally safe environment in which to talk about practices that may be difficult to raise in other contexts. The final extract presented here points to the health implications of having a doctor who is not seen as a 'peer':

'It is nice to have a doctor who's up with the lingo and doesn't call it a 'penis' or whatever... [and] I actually think this particular doctor's one of the 'go-tos' for when there's a sexual health story. He's like a, fairly up there on that sort of thing.' (Thomas 29, HIV negative)

'I think it's really important to have an open, verbal relationship with your GP. And as a gay man, be able to talk about sex and gay sex and anal sex and diseases and blow-jobs and everything, in great detail, without any fear of getting looked down upon. And I definitely wouldn't talk to random doctors like that.' (Dominic 33, HIV negative)

'I had a different relationship with [the HIV home care nurse] than I had with my doctor. Because we had that, a) he was gay, my doctor's not gay, b) he was dealing with plenty of other gay men that were starting treatment, ending treatment, coping with, balancing it with depression. At the time I did use recreational drugs. I felt I could be honest with him about it. I didn't feel I could be honest with my doctor about it.' (Jake 32, HIV positive)

Discussion

These accounts were provided by a particular group of men recruited from general practice clinics known for providing care to gay and HIV positive men, and because of their own experiences of depression, both of which are likely to have shaped the way they talk about their doctors. There is also a large number of interview extracts from the HIV positive participants, which could suggest those men have more developed opinions about the role of their GP as a result of a higher frequency of general practice attendances.

Despite these limitations, a number of important conclusions can be drawn.

This group of gay men with depression voiced clear expectations that their GP demonstrate the characteristics required for being a trusted confidant (despite time limitations and a high level of scrutiny), guide patients to accept diagnosis and treatment (but not be unthinkingly committed to those pathways), maintain high standards as a provider of services (and support the efforts of patients to become an expert consumer in turn), act as an effective conduit to specialist clinicians (while recognising their own limitations in time and skills/experience), and stand up and be recognised as a community peer (using identity politics to achieve health outcomes).

While these men did not describe these role expectations as either difficult to achieve or potentially contradictory, it is clear that some of these roles would be challenging to perform either at a single consultation or over time. For example, the role of effective conduit is conceptually incompatible with the role of trusted confidant, since one requires immediate referral onward and the other a long term and consistent building of rapport. And the role of community peer may be particularly challenging to fulfil in that it requires the declaration (even if subtle) of personal and political values; not a standard expectation of doctors in Australia. The consistency of these themes suggests that this particular group of men has high expectations of the role that a GP can play in depression diagnosis and management, and even higher expectations of how well a GP can intuitively understand the role that a patient is expecting them to play. Thus, it could be helpful for GPs to take into account (and potentially even ask for clarification of) the roles that gay men with depression are ascribing to them, in order to consider how changing the roles they perform in each consultation and over time might support the development of more open and trusting relationships in the care of gay men.

There are additional reasons to support communication and trust between doctors and patients in the healthcare settings of gay men. One is that gay men with depression face the prospect of a 'double' stigmatisation in relation to mental illness and homosexuality. Therefore, treating their depression requires a nuanced understanding of how marginalisation and discrimination continues to impact on the lives of gay men in Australia. The other is that if general practice services for gay men are provided in an environment of cultural safety and understanding, then the everyday realities of their lives – which can in some instances include the generally stigmatised practices of unprotected anal intercourse and illicit drug use – are more likely to be shared openly with GPs. In this regard, the GP can play a direct role in contributing to the broader goal of reducing the burden of depression and other mental health issues among homosexually active men in this country, in addition to HIV prevention and harm reduction outcomes.

Implications for general practice

Gay identified men have a greater vulnerability to depression, due in no small part to continuing experiences of marginalisation and discrimination. Therefore, many gay men appreciate the openness and understanding of gay friendly medical practice settings. However, gay men with depression who have ongoing contact with their GPs may have particularly high expectations of their capacity to intuitively understand when to perform the roles of trusted confidant, gentle guide, provider of services, effective conduit and community peer.

If GPs can take account of how patients ascribe roles to their GP in relation to the diagnosis and management of depression, they may be more able to understand when and how to change roles accordingly. This can build more open and trusting relationships and contribute to reducing the burden of depression and other mental health issues among homosexually active men.

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