Hilton Koppe

Two HEADSSS are better than one

A biopsychosocial screening tool for use when treating other doctors

Background

This is the fourth article in a series exploring issues involved in treating other doctors. The first article discussed potential barriers faced by doctors when seeking medical care for themselves. The second article looked at strategies for minimising these barriers before the consultation takes place, and the third explored strategies for use during a consultation when the patient is another doctor.

Objective

In this article, a model for a biopsychosocial screening tool for use as a prompt when treating other doctors is discussed.

Discussion

Many of the challenges involved in doctors treating other doctors revolve around communication, not only what is said, but also what remains unsaid. It can be tempting for the treating doctor to collude with the patient doctor resulting in less than ideal medical care. Use of a biopsychosocial screening tool and normalising the process of asking questions on potentially sensitive topics can reduce the risk of collusion.

Keywords: doctor (physician) health status; doctor-patient relations

As discussed in previous articles, there are many challenges involved doctors in treating other doctors. Many of these challenges revolve around communication, not only what is said, but also what remains unsaid. It can be tempting for the treating doctor to collude with the patient doctor resulting in less than ideal medical care. Examples of such collusion are outlined in *Table 1*.

Although possibly well intentioned, any of these actions could have the potential to result in less than an ideal outcome for the patient doctor.

The solution

To assist treating doctors to avoid colluding with their patient doctors, especially with regard to history taking, the 'Two HEADSSS are better than one' biopsychosocial screening tool has been developed. It is based on the HEADSS screen,[1] which was initially developed as a guide for clinicians to use when treating young people and includes criteria from the initial HEADSS screen in the left column *(Table 2*). HEADSS is a mnemonic representing the important factors in a young person's life, from least threatening to most threatening. These can also be important factors in a doctor's life.

Items in the right column of *Table 2* have been developed specifically for the new model. They are based on both the author's experience from working in this field for the past 13 years, as well as the excellent literature review of doctors' health conducted by The Royal Australian College of General Practitioners in the 'The conspiracy of silence'.[2] However, this model has not been validated in the clinical setting.

The rationale for naming the model 'Two HEADSSS are better than one' comes from the belief that when a doctor seeks medical attention from a colleague, there are two people thinking about one person's problems. It is a reminder for the treating doctor to be aware that the patient doctor will almost certainly have given a lot of thought to the issues they are bringing to the consultation.

Home

'Who is living at home with you? How are things going there?'

For many doctors their primary support person is their spouse. This is particularly the

Table 1. Potential points of collusion between treating doctor and patient doctor

Point of collusion	Discussion
Location of consultation	The treating doctor may agree to a request from the patient doctor for a medical opinion in the corridor or outside of the normal consulting room setting
Timing of consultation	The treating doctor may agree to a request from the patient doctor for a medical opinion without an appointment
Content of history	The patient doctor may omit important aspects of history as a result of fear or embarrassment. The treating doctor may omit important aspects of history as a result of not wanting to ask potentially embarrassing questions
Content of examination	The treating doctor may omit more personal aspects of examination as a result of not wanting to embarrass a colleague
Content of management plan	The treating doctor may agree to requests for management strategies which would vary from usual best practice (eg. follow up of results, prescribing ongoing treatment)
Content of medical records	The treating doctor may agree to leave out important but sensitive information from the medical record

case for male doctors. If things are not going well on the homefront, it can mean that doctor is not getting much in the way of personal support.

Like other members of the community, sometimes doctors' children have difficulties. It can be embarrassing for a doctor to acknowledge that their children are having problems, and that this is causing them considerable stress. A visit to a caring general practitioner may be the only opportunity a doctor has to share these concerns.

A nonmedical spouse of a doctor may feel similarly hesitant about admitting difficulties with their children. There can be a belief within doctors' families that they need to be publicly seen to be doing well, as both individuals and as a unit.

Health (general)

'How is your health in general, apart from the reason for coming in today?' 'What other concerns to you have about your general health?'

Patient doctors need general health care just as much as anyone else in the community. This can be overlooked by doctors who refer themselves directly to specialists for management of conditions usually treated by competent GPs. If a specialist sees a doctor under these circumstances, it would be in the best interests of the patient to advise them to see a GP for a general health review, if they are not able to do this themselves.

When GPs refer themselves directly to specialists for advice regarding management of conditions that they usually feel comfortable treating in their own patients, they are in effect denigrating their own craft group within medicine, and devaluing the work they do themselves. It may result in not only a lost opportunity for a general health assessment, but also a more subtle loss of self worth.

Education

'How are things going with your CPD program?' 'What steps do you take to keep up-to-date with advances in medical practice?'

Difficulty in completing continuing professional development requirements may be an indication of deeper difficulties such as stress, burnout or depression. Of course, this is not always the case, but simple questions such as those above may give a clue to the treating doctor to probe more deeply into psychological issues for the patient doctor.

Engagement

'What do you do at the end of the day to help you unwind?'

The work of a doctor can be mentally exhausting. Many doctors go home feeling drained at the end of the day. For some, the attempt to solve the problem of exhaustion is to withdraw into a quiet place. This place may be found at the bottom of a wine glass, or in the pages of the newspaper, or on the screen of a television. These strategies may not be the most effective way of unwinding and may result in further isolation from family and friends.

Table 2. The HEADSSS mnemonic

Home	Health (general)
Education	Engagement
Activities	Alcohol
Drugs	Depression
Sexuality	Support
Suicide	Spirituality
	Safety

A more helpful strategy can be to 'engage with' rather than 'withdraw from' at the end of the day. Exercising, cooking, and playing with one's children are examples of 'engaging with' activities that can be more helpful end of the day strategies, particularly if they are done in a mindful, focused manner.

This type of information can be helpful for the treating doctor if they get a sense that there will be a need for discussing burnout prevention strategies. Knowing what a person engages with is important to allow the practitioner to be able to work effectively with the strengths of their patient.

Activities

'What type of activities are you involved with outside of medicine?' 'What do you have to look forward to each week?'

Medicine can be all consuming. To have a balanced life it is important to have interests outside of medicine. Part of a general wellbeing screen includes asking questions of this nature.

Alcohol

'Doctors can run into problems with alcohol, especially if they are feeling stressed in any way. Has this ever been an issue for you?' 'How often do you drink alcohol?' 'Do you have any concerns about your alcohol consumption?' 'Has anyone else expressed concern about your alcohol consumption?'

These are all fairly standard questions used in the assessment of alcohol consumption. It can be difficult to ask a colleague these

questions, especially if the patient doctor is perceived in some way to be more senior than the treating doctor. However, because doctors are at risk of alcohol dependence, and because the consumption of alcohol is culturally acceptable at medical gatherings, it is important for the treating doctor not to collude with the patient doctor by minimising the potential impact of alcohol on their health and wellbeing, as well as their ability to competently practise medicine.

Drugs

'It is not uncommon for doctors to use prescription or illicit drugs as a way of coping with some of the stressors of the job. Have you ever been tempted to use any drugs in this way?'

Doctors have easy access to narcotics and benzodiazepines. A stressed doctor may turn in this direction in an attempt to ease their distress. While not all patient doctors need to be asked this question, treating doctors should satisfy themselves that questions of this nature can be omitted.

Depression

'Doctors are known to have higher levels of depression than the general population. This can be quite difficult to detect at times. I would like to ask you some questions to assess your mood. Would that be alright with you?'

A treating doctor may not want to discuss depression with a colleague, but to not do so when depression is present would be doing a disservice to someone who has trusted them with their care.

Sexuality

'Are you engaging in any sexual activities which may put your health at risk?'

Like many of the other sensitive issues, it can be challenging and potentially embarrassing to ask a colleague questions of this nature, but treating doctors should consider taking a sexual history if they feel it is in the best long term interests of their patient.

Support

'Many doctors can feel quite isolated and alone at times. From whom do you get personal support when you need it? How effective do you find this support?'

It is especially important to find out where a patient doctor gets personal support if things are not going well in their personal relationships. Having this knowledge can be helpful in determining a management plan, particularly for psychological or lifestyle issues.

Suicide

'I am sure you are aware that doctors have increased rates of suicide compared to the general population. Have things ever got so hard for you that you have thought about harming yourself in some way?'

Asking questions of this nature can be challenging for any doctor. Prefacing the question with a 'normalising' statement such as the one above can make it a little easier.

Spirituality

'Do you have a faith or belief system which you find helpful, in particular at times of difficulty?'

Working as a doctor brings us face-to-face with life in all its richness, from birth to death and everything in between. Many of our patients find comfort and strength in spiritual beliefs at important or challenging times in their lives. So too, for doctors, a sense of spirit can be helpful. Spirituality is not often part of the medical dialogue, but if used in the appropriate context, it can greatly help a colleague to manage life's transitions.

Safety

The treating doctor needs to make an assessment that the patient doctor is safe, both from self harm and from the perspective of being safe to practise medicine. Making such an assessment can be difficult. State based Doctor's Health Advisory services can offer support and advice for treating doctors in this situation. Requirements for reporting an impaired colleague to the relevant medical board vary between states and information regarding these requirements is available directly from each medical board. With the advent of national registration in mid 2010 these requirements will become uniform.

Summary

It can be tempting for the treating doctor to collude with the patient doctor to avoid embarrassment or confrontation. This may result in a less than ideal long term outcome for the patient doctor. The biopsychosocial screening tool outlined in this article can act as a guide to some of the more challenging aspects of the consultation to assist the treating doctor in offering the best possible care for their doctor patients.

Author

Hilton Koppe MBBS, MFM(Clin), FRACGP, is Senior Medical Educator, North Coast GP Training, and a general practitioner, Lennox Head, New South Wales. hiltonkoppe@optusnet.com.au.

Conflict of interest: none declared.

References

1. Goldenring JM, Cohen E. Getting into adolescents heads. Contemp Pediatr 1988;7:75–90.
2. Clode D. The conspiracy of silence. Emotional health among medical practitioners. The RACGP, 2004. Available at www.racgp.org.au/Content/NavigationMenu/PracticeSupport/peersupport/20060106conspiracy_of_silence.pdf.

correspondence **afp@racgp.org.au**