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Physician self-disclosure in primary care:

a mixed methods study of GPs' attitudes, skills, and behaviour

Abstract

Background
There is a debate in medicine about the use and value of self-disclosure by the physician as a communication tool. There is little empirical evidence about GPs and self-disclosure.

Aim
To explore what GPs' attitudes, skills, and behaviour are with regard to self-disclosure during a clinical consultation and whether there is a need for the development of training resources.

Design and setting
Mixed methods using open-ended and semi-structured interviews in Auckland, New Zealand, and the surrounding districts.

Method
Sixteen GPs were interviewed on the issue of self-disclosure in clinical practice. A general inductive approach was used for data analysis.

Results
Self-disclosure was common in this group of GPs, contrary to training in some of the groups, and was seen as a potentially positive activity. Family and physical topics were most common, yet psychological and relationship issues were also discussed. Knowing patients made self-disclosure more likely, but a GP's intuition played the main role in determining when to self-disclose, and to whom. GPs have developed their own guidelines, shaped by years of experience; however, there was a consensus that training would be helpful.

Conclusion
Self-disclosure is common and, in general, seen as positive. Major personal issues were acceptable for some GPs to self-disclose, especially to known patients. Although participants had developed their own guidelines, exposure of trainees to the issue of self-disclosure would be of value to prevent future mistakes and to protect both doctor and patient from any unintended harm, for example, developing a dependent relationship.

Keywords
education; general practice; physician–patient relations; self disclosure.

INTRODUCTION

Previous research has identified that self-disclosure is not a rare occurrence in general practice,[1–3] and has demonstrated the potential for it to be either valuable or detrimental to the patient and the physician–patient relationship. What is not known is the attitudes, skills, and behaviours of GPs. Psychologists are generally trained not to self-disclose,[4] likely as a result of the nature of the health issues they encounter in practice.[5] In medicine, there is limited empiric work into physician self-disclosure and it remains a controversial topic.[6] Given that general practice encompasses both psychological and physical health issues, it is believed there is likely a grading of self-disclosure made by GPs; such that the sharing of physical issues and experiences is more likely to be accepted, whereas disclosure of psychological issues or experiences is more controversial.

The current study aimed at ascertaining GPs' attitudes, skills, and behaviour with regard to self-disclosing to patients during a clinical consultation and any associated contextual influences. Also, attempts were made to establish whether GPs feel it would be beneficial to develop training resources around how to handle self-disclosure in clinical practice.

METHOD

Sampling and recruitment

The Healthpoint database (http://www.healthpoint.co.nz/) listing GPs in the greater Auckland area was used to recruit participants. During November and December 2014, 52 GPs were sent letters or faxes inviting them to be in the study or an effort was made to contact them by phone. It was hoped that a range of GPs would respond, with respect to age, sex, ethnic group, and training, whether in New Zealand or overseas.

Study design

Interviews were digitally recorded and fully transcribed. Interviews aimed at exploring GPs' attitudes, skills, and behaviour around the issue of self-disclosing to their patients. A hierarchy of self-disclosure statements was developed to aid in establishing the level at which GPs are comfortable disclosing. To assist in determining what GPs currently think about physician self-disclosure, a list of its potential advantages and disadvantages was produced from a review of existing literature, and GPs were asked to agree or disagree

Analysis

Anonymised transcripts were coded and analysed for recurring themes using a general inductive approach.[7] This was carried out by two independent evaluators, during which core themes emerged that related to the study objectives and were perceived to capture the core messages of the participants. The transcripts were evaluated independently of one another, before comparing results and identifying any discrepancies. Emergent themes were compared between the two evaluators and

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How this fits in

Self-disclosure is common in the group of GPs participating in this study, ranging from self-disclosure regarding physical conditions through to marital discord. Self-disclosure is largely viewed positively by the GPs, who, over years of experience have formed their own guidelines. Some participants described considerable skill in response to direct questions from patients. Previous training undertaken on self-disclosure was not common; however, GPs see value in bringing self-disclosure to the attention of medical trainees to better prepare them for clinical practice.

any disparities were resolved by discussion.

RESULTS

Sixteen replies were received from the 52 contacts, and all 16 (31% response rate) were interviewed. There were no active declines. Descriptions of participants can be found in Table 1. Thirteen semi-structured face-to-face interviews and three phone interviews, lasting 15–30 minutes, were conducted through December 2014 to January 2015.

What do GPs think about self-disclosure?

There was a unanimous agreement that self-disclosure had the capacity to be advantageous to the patient or the doctor–patient relationship. Most also agreed with all potential advantages of physician self-disclosure as listed in Table 2, but there was a wider range of opinions on the disadvantages. In particular, GPs often reported that self-disclosure established empathy and understanding between doctor and patient:

'Oh well it has quite good benefits if you can empathise with the patient's illness, you know, you too may have stumbled across that illness yourself.' (GP6, male, 45–54 years)

An acknowledgment was also made by most GPs (*n* = 14) that self-disclosure could have disadvantages. Fewer GPs were convinced, however, by the list of potential disadvantages given in Table 3. The potential for self-disclosure to shift the doctor–patient relationship from a professional to a more personal or dependent relationship was judged the most likely possible harm:

'There can certainly be harm to the doctor, 'cause there can be a big blurring of boundaries between the professional relationship that you've got with the patient and your personal life. Which is not always a helpful thing.' (GP8, female, 45–54 years)

A few GPs also recognised that some of the benefits of self-disclosure could also be skilfully nuanced by wording the self-disclosure statements in more impersonal or general terms:

'If a mother comes in and she's absolutely worn out from a sleepless night with a kid with an ear infection, you know, I might say "well yes it's really difficult isn't it when kids have ear infections," you know, being a mother.' (GP13, female, 55–64 years)

What GPs are comfortable self-disclosing

Most GPs (*n* = 14) reported one or more instances at which they had used self-disclosure during a clinical consult. The hierarchy of self-disclosure statements given in Table 2 illustrates that all participating GPs are happy to reveal information about their hobbies and activities with patients. Additionally, most GPs (*n* = 14) are comfortable to discuss their families and their own experiences with non-invasive physical issues. Few GPs felt they would divulge more personal information, however, such as their experience with psychological issues or information regarding personal relationships. No GPs would disclose any hypothesised criminal activity to patients. There were no additions by the GPs to the text box, although some did elaborate on their responses within the categories.

The present analysis revealed five core

Table 1. Participant information on self-disclosure

Participant	Sex	Age range, years	Place of training	Perceived ethnic group
#1	M	30–44	Overseas	Latin American
#2	F	30–44	New Zealand	White/European
#3	F	30–44	New Zealand	White/European
#4	M	45–54	Overseas	Asian
#5	F	45–54	New Zealand	Asian
#6	M	45–54	New Zealand	White/European
#7	F	45–54	New Zealand	White/European
#8	F	45–54	Overseas	White/European
#9	M	45–54	New Zealand	White/European
#10	F	45–54	Overseas	Asian
#11	F	55–64	New Zealand	White/European
#12	M	55–64	New Zealand	White/European
#13	F	55–64	New Zealand	White/European
#14	M	>65	Overseas	White/European
#15	M	>65	New Zealand	White/European
#16	M	>65	New Zealand	White/European

Table 2. Hierarchy of self-disclosure statements from written questionnaire

Disclosure type	Example	Level at which GPs are comfortable self-disclosing to patients: (unsure), *n*
1. Physical-activity/hobbies	*'It's about finding exercise you enjoy, I take a class at the gym, it's a great stress reliever and keeps me active'*	16
2. Personal-family	*'I know what you mean, I have three boys myself and they went through the same thing at that age'*	14 (1)
3. Physical-non invasive	*'I broke my ankle a few years back and I also struggled with the crutches at first but you get used to them'*	14
4. Physical-invasive	*'I can see you are worried about this, I have had a colonoscopy myself and it was not a major problem'*	6 (1)
5. Personal-physical illness	*'I had cancer a few years ago. It is an awful thing to have to go through'*	4 (2)
6. Personal-mental illness	*'I also suffer from panic attacks from time to time so I can help you through this'*	2 (2)
7. Personal-relationship	*'Yes it's difficult for everyone involved, when I got divorced I never thought I would find anyone else'*	1
8. Personal-serious mental illness	*'I have had an episode of psychosis and I know what you are going through'*	1
9. Criminal	*'I know what it's like to have a criminal charge so I can understand your situation'*	0

categories of self-disclosures made by GPs (parenting, family, physical health, mental health, and relationships). The most common type described (*n* = 10) was in relation to parenting experiences. Although most of these disclosures were related to physical issues such as nappy rash or allergies, several GPs also felt comfortable sharing their child's experience with a psychological issue:

'My eldest daughter had depression ... and I think [self-disclosure] *really helps the parents, and it helps the teenager to feel a lot more comfortable.'* (GP2, female, 30–44 years)

In addition to their children, a few of the GPs interviewed (*n* = 3) reported sharing the experiences of other family members with their patients. Again this was not limited to issues physical in nature but also incorporated their family members' experiences with more psychological or emotional matters:

'If perhaps an older woman has got something like atrial fibrillation, needs some warfarin, is very uncertain about it. I say look, my mother's been taking it for 5 years, you know what she's like. They know my mother.' (GP9, male 45–54 years)

'I lived with a grandmother when I was growing up who had, who was bipolar. And had every kind of therapy under the sun including ECT, so I know a little bit about what all of that's like. And I had an uncle who had schizophrenia who ultimately committed suicide so I know a lot about that, as, so those two circumstances in my life I have shared over and over again.' (GP8, female, 45–54 years)

Another category of self-disclosures commonly made by GPs were disclosures of their own physical health issues (*n* = 7). Disclosures of musculoskeletal problems, dermatological issues, diabetes, and weight management were the most commonly described:

'A patient of mine has been very distressed with her allergy, you know dermatitis, contact dermatitis from here down and what not and she keeps itching and scratching ... Then I just told her that, you know, I have just recently realised that for over a year I have developed new allergy to the pigment red or magenta.' (GP10, female, 45–54 years)

Surprisingly, a number of the GPs interviewed (*n* = 7) revealed that they have shared their own struggles with mental health, such as depression and anxiety. Additionally, a few GPs (*n* = 3) have disclosed

Table 3. Participant viewpoints from questionnaire on the potential advantages and disadvantages of self-disclosure from existing literature

Potential advantages of self-disclosure	Agree	Neither agree nor disagree	Disagree
• Enhances patient support and empathy	16	–	–
• Creates sense of closeness	11	3	2
• Increases patient motivation and adherence	15	1	–
• Makes it easier for patient to share their experiences with physician	16	–	–
• Develops trust and mutuality	16	–	–
• Helps reduce any power imbalance in the relationship	15	–	1
Potential disadvantages of self-disclosure	**Agree**	**Neither agree nor disagree**	**Disagree**
• Skews the doctor–patient relationship	7	2	7
• Burdens the patient	9	–	7
• Takes focus away from patient's needs	8	2	6
• Risk of expanding professional relationship into a more personal/intimate one	12	1	3
• Creates patient curiosity and dependency	8	4	4
• Reduces the credibility of the doctor	4	1	11

their own relationship difficulties to their patients. Marriage breakdown monopolised disclosures of this type:

'General practice is dominated a lot of the time by stress, anxiety, especially the pre-Christmas run. Every second patient comes in with stress and anxiety and you can relate back to times of stress and anxiety in general practice … I don't mind doing that, self-disclosure, at times where I have felt stress and anxiety.' (GP6, male, 45–54)

'On an odd occasion I've told people that at one point in my life after a marriage failure that I was depressed for 6 months. And basically took a long time to get better. And so, that everybody's vulnerable. It doesn't matter who you are.' (GP15, male, >65 years)

GPs were, on the whole, comfortable and well prepared when self-disclosure was prompted by patients asking them personal questions. Answers were skilfully kept superficial and brief to satisfy the patient's need for information without taking too much time and focus away from the patient and their issues. Even GPs unwilling to answer certain personal questions raised by patients expressed no trouble in deflecting the questions and bringing the attention back to the patient:

'It happens a lot. And people like to open that up. And that's pretty easy to manage and deflect. Just make a joke or just go sideways, go lateral. I mean, it's easy to deflect that.' (GP15, male, >65 years)

Limits to self-disclosure

In support of the findings above, only two GPs reported during the interview that they would reveal their own mental or psychological health issues to their patients:

'Basically unless you sort of say something like I had a nervous breakdown last year … There are some things you would never discuss.' (GP12, male, 55–64 years)

In contrast with the few GPs (*n* = 3) previously mentioned who felt comfortable disclosing their relationship issues, half of the GPs (*n* = 8) would not self-disclose on issues relating to their own or their families' personal or intimate relationships:

'Someone will come in with relationship issues and, you know, you might, they're going through some things in their relationship that you've recently been through. And you think there's a possibility of relating there and then I think it's actually too personal.' (GP2, female, 30–44 years)

Although the most common self-disclosure type made and the most common topic asked by patients, several GPs (*n* = 4) expressed a need to safeguard their family's privacy. Therefore they felt that revealing information about their children or other family members was only appropriate when they had gained permission from their family to do so:

'Personally I wouldn't really want to disclose anything about my family because I haven't got their consent. But it's me, that's got my consent, but my family I mean I haven't got their consent.' (GP5, female, 45–54 years)

The time constraints that exist in general practice also prevented some GPs from self-disclosing too often or too much for fear that it would take up the limited time the patient had to talk about their presenting issues:

'And in fact with the constraints of the consultation we do have to deflect because we use up the time for the patient otherwise.' (GP13, female 55–64 years)

The purpose and the outcomes of self-disclosure

The reasons fuelling GP self-disclosures described above were reported by all participants as being in some way beneficial to the patient. No GPs described self-disclosing for personal motives or without a preconceived intent. GPs felt that there was a huge therapeutic benefit in using self-disclosure as a means to express their genuine empathy and understanding of a patient's illness or experience:

'It's about whether you've experienced the thing or felt similar … there's an obvious expression of relief that they've, they've found somebody that's hearing them. It's about being heard I think. I think that's a hugely therapeutic and valuable thing.' (GP2, female, 30–44 years)

'There are all kinds of reasons to know that you understand, you care, you have some idea of what's really happening and not just what you learned out of a book.' (GP16, male, >65 years)

Self-disclosure was also seen as a way to instil hope and provide motivation to patients, and enabled them to see a solution where otherwise they could not. Similarly, GPs described self-disclosure as a method to

guide patients down a particular therapeutic path by offering real-life examples of success with a certain therapy:

'If somebody's feeling hopeless and I just can't seem to get on top of this problem, you know. It's about hope and instilling hope. There are good treatments available they just have to, just have to work out a regime that's going to help them.' (GP3, female, 30–44 years)

'Talking about the journey for adapting lifestyle and changing the way you think and what I learnt out of that. And there's some patients who I may say "yeah I'm actually pre-diabetic and I really, I get the difficulty, the cravings you get and having to look at, you know" ... this is what I did when I got say they've been talking about these cravings which sabotage them, I relate, this is my experience as well and this is what I found worked.' (GP7, female, 45–54 years)

By revealing something about their life and their own experiences, GPs felt they could appear more human and approachable by the patient. The advantage of this is that the patient feels comfortable enough to share:

'And then they feel like they can just come in here and say g'day. And make it a more equal type of interaction ... I think it's a much more equal interaction if you offer people maybe a glimpse of you as a person.' (GP15, male, >65 years)

Several of the GPs also reported using self-disclosure as a way to reassure patients and help diminish fear or worry:

'Often it's, like I said before, it's a reassurance. What you're feeling is normal. Especially if they're distressed or confused you can, you can draw parallels that I felt the same way or my family felt the same way.' GP8, female, 45–54 years)

Although GPs acknowledged the potential for self-disclosure to be detrimental to the patient or the physician–patient relationship, none of the GPs interviewed had experienced an adverse reaction. Interestingly, the perception of the outcome of self-disclosures was profoundly positive, with several GPs reporting patients being more forthcoming with information as well as more receptive to advice:

'Often there's that oh okay, or that it will allow the person, the other person then opens up and starts talking about oh okay and then blah, blah, blah and they talk, talk, talk, talk so you've obviously pushed something which has opened a door and facilitated them to talk further.' (GP7, female, 45–54 years)

Is self-disclosure altered by the nature of the patient to whom the disclosure is made?

This was a decision frequently made on a case-by-case basis, which was largely driven by the intuition of the experienced GP. Therefore, many of the GPs found it difficult to identify characteristics of patients to whom they would be more or less inclined to self-disclose. Patient age, culture, and sex did not seem to significantly alter the likelihood or nature of doctor self-disclosure. A longer, more established relationship between the doctor and patient, however, did appear to increase the likelihood that self-disclosure would occur. Similarly, the probability of self-disclosure increased if the doctor perceived a connection or rapport with the patient:

'I think we all have our patients whom we have known over a number of years and sometimes we, well of course it's not a social relationship it's a professional relationship, but you are a little bit more relaxed around them and you understand each other better and you're more likely to drop things.' (GP5, female, 45–54 years)

Given that self-disclosures around parenting are most common, it is not surprising that the GPs who are also parents were more likely to self-disclose to patients with children, particularly new mothers, whom they believed would benefit more from a parent's perspective than a medical one:

'Definitely the mums with the new babies, I disclose a lot more too because they're at such a topsy-turvey time in their lives and it really helps them to know that they're not the only person on the planet that's ever gone through this.' (GP3, female, 30–44 years)

Patients with mental health issues appeared to be the only patient characteristic that discouraged self-disclosure by a few of the GPs ($n = 3$):

'Some of the psychiatric patients you need to be extremely careful about self-disclosure.' (GP14, male, >65 years)

Is anything taught or should anything be taught about self-disclosure?

Five GPs recalled being taught about the

issues of self-disclosure. Two of the GPs remembered discussions around its possible benefits and harms, emphasising caution with crossing professional boundaries. One of the GPs was shown a videotape of a psychologist incorporating self-disclosure into a clinical consultation. Interestingly, two of the GPs were taught not to self-disclose. However, both these GPs now use self-disclosure openly in clinical practice:

'I did my training in the US and over there we're actually encouraged not to self-disclose … to patients. For these reasons I told you, "cause it's about the patient not about ourselves".' (GP1, male, 30–44 years)

All agreed that self-disclosure should be included in medical training. Experience has allowed GPs to gradually discover their own limitations to self-disclosure as well as what is, and is not, beneficial to patients and thus form their own guidelines for the use of self-disclosure. Therefore, it was suggested that by incorporating lessons on self-disclosure into the medical school curriculum or registrar training, these guidelines would be shaped earlier and more efficiently:

'I think we all develop our own … personal guidelines over the years but even now I would be prepared to go along and see what other people think about things … But I think definitely if I was starting out now I would like to have some guidelines.' (GP5, female, 45–54 years)

'Unless you teach them they don't necessarily learn. Unless they make a mistake … I think, therefore, it's important to teach round this topic cause it just saves young doctors wading into mistakes and finding out the hard way.' (GP3, female, 30–44 years)

As doctors and patients are all individuals, and because self-disclosure is largely context-dependent, GPs felt that it would be difficult developing a rigid structure into the 'dos' and 'don'ts' of self-disclosure. Instead they proposed that teachings should focus on creating awareness of the advantages and disadvantages of sharing personal information with patients:

'Every consultation is quite different and every doctor and every patient [is] *quite different. So it would have to be guide lined and maybe this document here … on the advantages and disadvantages is quite useful really … it's just about pointing out the risks, it's just about opening, expanding the mind of the reader.'* (GP3, female, 30–44 years)

'[Teaching should not focus so much on] *the rules around it just creating an awareness. Because I think, because we can bowl in and I think just creating an awareness around it so that, you know, we've got these little red flags that go up in our own head what's happening here, how, am I applying my own reality to this situation.'* (GP2, female, 30–44 years)

DISCUSSION

Summary

This is the first study to interview GPs about their attitudes, skills, and behaviour around clinical self-disclosure. Most GPs self-disclosed during clinical consultations and participants thought that self-disclosure has the potential to enhance support for the patient and create empathy.

It was found that GPs have varying comfort-zone levels regarding self-disclosure. Although the participants agreed that self-disclosures surrounding family, hobbies, and experiences with physical illness were more often and freely shared, self-disclosure of experiences with mental health and relationship issues were seen as acceptable by some. Lack of family consent was an issue for some whether they did or did not disclose family information.

There appeared to be no threshold beyond which, at least a few participants, would self-disclose other than a hypothetical criminal situation. Some felt that it was wiser and more skilful to use impersonal or general language to lessen the personal focus of a self-disclosure. The participants reported only positive outcomes from their self-disclosures. When self-disclosure occurred, it was more likely to be with an established patient, while caution was expressed about self-disclosure with patients with psychiatric issues.

The issue of consuming patient time and changing the focus of the consultation was a cautious note expressed by some GP participants.

There was a strong sense that GPs had developed their own guidelines since graduation and, in spite of some prohibitions instilled during training, commenced the process of self-disclosure with patients.

There was a strong consensus that training would have better equipped them for dealing with self-disclosure issues. The study needs to be repeated in other countries and with different ethnic groups, and using a larger study pool of participants.

Strengths and limitations

This study used a qualitative study design incorporating open-ended questions in an

attempt to encourage GPs to communicate their opinions and behaviours on self-disclosure. Additionally, there was also a quantitative section through the use of questionnaires. The study was small and achieved data saturation with 16 participants, with a well-varied spread of GPs by age and sex. The response rate was 31%, which is reasonable in current experience of unsolicited requests for information from GPs and better than was expected. It is possible that those who participated were more sympathetic to use of self-disclosure. Patient response was also judged as being positive by the GPs, and thus it is not certain that this accurately represents patient satisfaction. Both authors are generally in favour of self-disclosure, but do not feel that this was communicated to the participants.

Comparison with existing literature

The results of this study provide support to existing literature that highlights the complexity and variability of self-disclosure as a communication strategy.[2,3] Self-disclosure is influenced by the nature of the doctor, the patient, the dynamics of their relationship, and also by the content and context of the disclosure made. Contrary to two other studies, which concluded that self-disclosure can be unhelpful and unwanted,[1,8] the present results have given no indication that this is the case.

One of the other studies used external assessors to judge the value of self-disclosure and was, in the current authors' opinion, consistently critical and did not seek the views of the patients or physicians.[1] The other study was an opinion piece that did not report any original data.[8]

Implications for research and practice

Future research should explore the patient perspective, through means such as questionnaires aimed at assessing the patient experience. These may help to develop more informed guidelines into the use of self-disclosure. The Medical Council of New Zealand does not have a policy on self-disclosure, therefore, guidelines would need to be clinician-driven. Investigation into whether self-disclosure differs depending on physician characteristics such as ethnic group, sex, and medical discipline would also be welcome, as this was outside the scope of this study. In the current study, two female doctors stated that they would be cautious self-disclosing to male patients. Physician discipline is of particular interest and a previous study indicated that patient satisfaction was higher after self-disclosure from surgeons but lower after self-disclosure from family physicians.[2]

A patient-centred consultation, with foundations of good communication and doctor–patient partnership, are strongly desired and appreciated by patients.[9] To achieve this in practice, doctors must be equipped with a multitude of communication skills. The present findings suggest that there is a gap in medical training and that inclusion of information on self-disclosure would be of significant benefit to medical students and graduate trainees given the modern focus on communication. Rather than a rigid framework, it is suggested that discussion be encouraged around the topic including forewarning about benefits and harms, with the ultimate goal of better preparing future doctors for clinical practice. The present study could inform a training framework for undergraduate and postgraduate students.

Discussion around self-disclosure will inspire self-reflection and encourage careful thought before self-disclosures are made. Examples of successful use of self-disclosure in a clinical setting incorporated into practical communication training would be highly beneficial.[10]

By educating doctors in training, future mistakes can be prevented, thus protecting both doctor and patient from any unintended harm, such as developing a dependent relationship.

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Provenance

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Competing interests

The authors have declared no competing interests.

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