Doing a PhD

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When you say it quickly it sounds like a dance, "Doing the PhD", like the Locomotion by Kylie. Well, nothing could be further from the truth. Did I enjoy it? Well that depends. I can just see the sun coming up over the hill so am a little more relaxed about its inevitability but it wasn't always that way. There have been times in the six years when I thought it will be amazing if I see this thing out. I still won't be completely settled until I have that scroll in my hand, being congratulated by my supervisors.

As much as the PhD is a journey in itself, my journey had started long before I got to the starting line. I had graduated from medical school at age 23, spent one year training as an RMO before being sent bush. I owed the government a year's indenture for short funding scholarship to finance me through graduation. I had been academically-minded at school and fair at medical school. My only claim to fame is never failing an exam, except the grade 4 altar boy exam. My father, who expected success in nearly all aspects of life, was not phased by this. So, I didn't become an altar boy.

Back to being a doctor, I wished to pick up my school studies in Japanese while I was a resident doctor at the Mater Hospital. As the drinking age was 21 when I went to university, grog was not an overwhelming part of my life. I continued attending night classes once or twice a week during that year. Simultaneously, I tried to assemble the skills I thought necessary to survive as a bush doctor. All of us on a government scholarship knew we would be sent rurally and often to towns who could not attract non-indentured doctors. My hospital teachers, senior doctors, were variable in teaching practical skills essential for rural survival. A few thought I was too pushy to get my hand on the scalpel, thinking I overestimated the rural challenge. If anything I had underestimated what I would face.

Being the medical superintendent with right of private practice, I was working during the day seeing a slow trickle of private patients at my small clinic, and public patients at the hospital. While it was not overly busy it was constant, with the only relief coming from a similar second year doctor giving me five days off every thirty. The relieving doctor did this in five rural hospitals then had five days off herself. The blessing was the slowness of people seeking my opinion. People were cautious about attending as the previous medical superintendent had been controversially sacked. I could see a patient with a chronic disease like hypertension, read up on their case in the intervening week and have decided on which anti-hypertensive to give them

when they returned. I read and learned book knowledge, while the patients taught me real world knowledge.

I could see it would be easy to become deskilled quickly in the bush and I hadn't become sufficiently skilled to be deskilled. In the first couple of years I sought out education that would help me treat my new community. Starting simply with learning how to do a curette to treat women who suffered a miscarriage locally, not having to travel 220kms to Toowoomba. I was very cautious about what I treated electively. I had some cowboy skills such as competent horse riding, but I did not want to be a cowboy in medicine practicing on people. As I identified needs of the community, I would seek a teacher in the big smoke to mature my skills to practice safe medicine. Probably the most important skill was the crash course in doing a caesarian section in a month's placement at the Royal Brisbane and Women's Hospital facilitated by the superintendent John Campbell. A very generous act as I had never worked as a doctor at the RBWH, although I had done curette training there two years previously. Now I could truly practice safe obstetrics in Miles. Perhaps John was amazed that I had remained in the bush now four years, non-indentured for three.

I had become fairly skilled with the procedures. Another rural doctor had instructed me on how to do an appendectomy. Getting me to draw the proposed incision with a pen on the anaesthetized patient's abdomen. It was deep end stuff but it was learning in its rawist form. I also realized that the medical needs of patients such as the treatment of asthma, hypertension and diabetes needed attention. Continuing education was now formalized so I enrolled with RACGP with a view to doing the fellowship exam. In those days the qualification was not necessary to practice as a GP. However, I was specially using the study to progress my skills in the treatment of my community.

After six years I was a fairly competent doctor in acute medicine, then I recognized the need to treat chronic painful aging conditions such as osteoarthritis. The only treatment available besides Paracetamol were the NSAIDs. These had the nasty side-effects of causing stomach ulcers with the occasional patient bleeding to death, not a great outcome. Two elderly women in 1984 used to drive to Toowoomba for a weekly acupuncture treatment, being unable to tolerate NSAIDs. That seemed like a good clinical trial to me. I decided there must be something in acupuncture and anything was better than the current treatment. I also learnt from my mother, who managed to get off the 1970's treatment for menopause, Valium, often the cause of long term addiction. With the help of a chiropractor she used herbal medicines to do this. Without realizing from an early age I was learning to be inquisitive, looking at all ways of improving peoples' health.

By now I'm guessing the reader knows the next move. Yes, I went to China and worked with a traditional Chinese doctor learning acupuncture. It was helpful that I had also finished the language degree with majors in Japanese and Chinese. I was by no means fluent but I could easily get myself around and converse with the Chinese patients. This is one of the best skills I have learnt developing a busy acupuncture clinic alongside western medicine. What a joy to be able to use non-drug medicine for some conditions.

My story is about life-long learning, helping people along the way if I could. I have tried to stay faithful to the ethos of fairness, egalitarianism and provision of health services on a basis of disease not wealth. For most of my career I have had the privilege of working in both the public and private sectors simultaneously, allowing me to treat all. The learning has been in traditional western medicine at Queensland and Monash University, also in medicine at the fringes in acupuncture and osteopathy, even in what some people call quackery in Homoeopathy. The drive has always been to not only educate myself but to help my patients safely.

Part of my responsibilities in the bush was my role as a Government Medical Officer or a police doctor. This meant being involved in assessing impaired drivers clinically and taking blood for alcohol and drug assessment. I was also expected to perform forensic examination of deceased motor vehicle crash victims. Whilst this was a legal responsibility, I also considered it a good opportunity to revise my anatomy knowledge as I learnt in a similar way on the generously donated cadavers at the UQ medical school.

Fast forward to 28 years completed in the bush, it was time to move on to a different challenge Palliative Care. I will not bore the reader with how this came about, I was just someone who needed a new challenge in helping others every so often. This is where a kindly health librarian, enters the picture.

I was working as a Senior Medical Officer in Palliative Care at Toowoomba Base Hospital. This was a new medical specialty in which I could see my various skills such as Acupuncture, Homoeopathy and Osteopathy being used alongside my traditional skills of western medicine. The three year specialist training program was fairly unorganized at the time (2007). I had to source my own education and educators. For two days a week I worked at St Vincent's Hospital in Brisbane, going down on a Wednesday morning doing on-call overnight and returning on Thursday evening. With the TBH job, St Vincents job and three children at school, life was busy. Not much time for study. This is when my librarian colleague entered my world. I explained my problem ie I had to be educated in Palliative Medicine and no time to do it in. In a calm way the librarian listened to my story, took a few notes, saying "I'll be in touch". He did ask one salient question "Do you have a CD player in the car?"

Within a few days a couple of CDs were delivered to my office with a note "Try these". What a brilliant idea. Each CD lasted 1 hour, finishing just on the outskirts of Brisbane when I would have to concentrate on city traffic. Two CDs a trip for a year. For a really interesting topic I would listen to the CD twice. What amazed me was the focus of the CDs. Despite a wide focus including hospital talk-back radio in the US, Telomeres, Anesthesiology and Pain control to name a few, all were relevant to Palliative Care. I was taught that the role of the librarian had changed, embracing the new digital world with much greater access to knowledge. I realized that a good librarian was now a keeper on knowledge with skills to link relevant knowledge to the researcher.

Somehow with help from a few other colleagues my training fell into place. Firstly there was the preliminary dissertation on the role of diuretics in ascites (Abdominal Fluid Collection). This involved a literature search on all articles pertaining to the subject, with assistance from the ever-helpful library. Additionally, should any new articles be published on the topic, library staff would have them to my in tray pronto. The librarian was also an experienced teacher on the use of end-note to reference the study. The final product in retrospect could have been published as a comment piece, however we were not into publishing at that time. It was just submitted to the RACP.

Three years passed and it was time to write an article for an international medical journal in order to receive my fellowship. Once again enters library help with literature reviews and brushing up my end note skills. This was more challenging being on Complimentary Medicine as the grey literature had to also be accessed. With the help of my supervisor, Dr Jarad Martin, and the library, I was awarded the best registrar research prize at the 2009 RACP Conference in Auckland. My quest for knowledge was getting explorative, having graduated from course work degrees with proscribed reading lists.

While I was working in Palliative Medicine, I was confronted by a social issue: "Could Palliative Care Cancer Patients drive safely while medicated on opioids?" This raised issues for me as I had spent a lot of my life as a bush GP assessing driving privileges and assessing impaired driving due to alcohol and drugs. The impairing drug in this case wase the opioid class of drugs providing necessary pain relief for quality of life. The issue was that opioids can impair driving through cognitive side effects. Palliative Care promises maximizing QoL for the patient and family. Can both these QoL improvements co-exist together whilst maintain safely for both patient and wider community.

This subject of the safety of opioids and driving had rolled around my head for some years. When palliative cancer patients entered the mix, I had to find an answer in order to see this marginalized group of patients treated fairly. I could see

investigating the issue would take some work. From my background I believed the attitudes of GPs and Pharmacists to driving on opioids would have to be explored as GPs prescribed the opioids and Pharmacists dispensed the opioids. These two professions were likely to be advising the cancer opioid medicated patients on driving. Then there was the question of which palliative cancer patients to study. There were more questions, like should it be one cancer or a number of cancers.

Back to the library for a search on driving on opioids in Palliative Care. Only one study done but not relating to opioids. We then knew this was a novel topic worthy of research. With the library's help I broke the topic into its component parts to see if any studies related to my area of interest. Searches were performed on:
1. Opioids and driving (in non-cancer pain patients or healthy volunteers).
2. Opioids in Society (including illicit use and policing in other countries).
3. Doctors and driving (history, road safety, EMST and Mandatory Medical Examinations).
4. Palliative Care (what is it, what promises, research to date).
5. The Car (from T Model, choices, Personalised Plates, relationship, bucket list).
6. Articles were also read on Qualitative Analysis before deciding on an analytical approach.

In the following six years over 1,500 articles have been broadly canvassed during the course of this project.

I now had a fair idea about what I wanted to study but no idea what to do with it. I had spoken to one drug rep who manufactured opioid medication but they showed no interest. I went to Queensland University of Technology as I knew the car accident research unit was there. I went to QUT unannounced to discuss my idea. I had no contacts there but thought I would knock on the door. While wandering from office to office to find the right person, I was lucky to bump into an old colleague from the bush I had not seen for 20 years. She was now the professor of paramedicine. She organised introductions for me and I was on my way. With the funding pressure on academic institutions, my original supervisors have moved on. I am now under a different school with different supervisors for the last two years, who I am well settled with.

I had to decide the exact cancer cohort to study and how to recruit them. Interviewing the GPs and Pharmacists I thought would be relatively easy as these were my professional equals. Ethics approval for interviewing these two groups was quite straight forward, being considered negligible or low risk studies. When it came to interviewing advanced cancer patients ethics to study this group were considered high risk, taking many meetings and a full year to obtain ethics approval. I had considered my profession of medical practitioners as being very ethical so was surprised by the length of time to get approval.

The next issue was whether to study part-time or full-time. I did consider studying full-time and thinking I had an important idea applied for an NHMRC scholarship. Heard nothing, not even an indication of whether my idea was worthy of research. Fortunately QUT were happy with my research proposal and have funded the course fees and a small stipend to cover interview transcription. So part-time it is.

Quantitative or Qualitative, that is the question. As driving on opioids in Palliative Care is sparsely researched, this being exploratory research, it had to be qualitative to see what was happening in this space. Then which qualitative analysis system to use, RTA, TA, GT or CGT? I have made a fist of using CGT and RTA however in retrospect wish I had read about them a little more prior to the research. One must have a solid view about these analytic systems and how to use them. Some of the literature can be confusing when describing these analytical methods. Once again the hospital library came to the fore, getting me books on these topics.

There are two ways to climb the final mountain of writing up a PhD thesis ie by monograph or by publication. I initially thought I would do it by monograph but in doing basically three studies on GPs, Pharmacists and Cancer patients I had not realised how much data I had to analyse. Somehow I had to reign the task in by analysing each study as I went. This resulted in writing a paper on each study and submitting for publication. It made sense to do a last minute change (at the 5.5 year mark) to thesis by publication.

Once again my trusty librarian came to the rescue helping me select which journals to submit to. The quality of the journal had to be high to satisfy the university and for me the journal audience had to be appropriate. I do not want the reader to think my university team of Julie-Anne, Melanie and Mark, previously Vivienne, Lisa and Mark were not advising me. Mark deserves a special mention for continuing on the team even though the uni did not extend his contract. They were. However, when you are researching and studying part-time while still working, it is invaluable to have a colleague locally who can advise, proof read and be a counsellor when one receives the occasional journal knock back or harsh criticism. Having an on-site advisor complemented the fortnightly meetings with the uni advisory team.

Now with two articles published and one about to be submitted to publication I am confident that the end is in sight. Some advice to other non-academic clinicians who wish to attempt a PhD at the end of their careers:

1. Make sure it is a topic you are passionate about researching. This should not be an issue for a senior clinicians.
2. If you can, sort out your supervision properly, in a more formalised way than I did.
3. If you are doing it part-time try to have some local support. In my case it was the librarian. I was lucky as he has also become a good friend.

4. If you are doing qualitative research for the first time read about it. Braun and Clarke, Charmaz etc.
5. Get ready to learn a new language spoken in academia like heuristic, ontology and epistemology.
6. Enjoy trying to do good for others.
7. Buy your wife flowers regularly.

I did think doing a PhD would be my swansong into a slipper and pipe retirement, but already I am having thoughts about the next project (in confidence… don't tell my wife).
John Gillett (28/07/2025, or about 20 years since I walked into a small hospital library and met staff who would go on a journey with me).