Ill doctors

Neil Kessel

Every instance of a doctor's career being impeded by illness represents a tragedy of dashed hopes. Physical illnesses, although their effects may devastate, are not particular occupational hazards. Psychological conditions claim our attention because of the accompanying lack of insight, rendering doctors unaware both of their being ill and needing treatment and of their diminished capacities which can put patients at risk; therefore colleagues must intervene.

Doctors chiefly suffer from: alcoholism (its high prevalence in the profession perhaps stemming from five medical student years); drug dependence, ready availability being the key, prescribable drugs being chosen; and mood disorders, particularly depression.

Helping mechanisms

The profession has a number of structures to help ill members. The conventional route is for doctors to be registered with a general practitioner, although junior doctors should not have to change with each change of location. If doctors go to a trusted specialist the GP should be kept informed.

The 'Three Wise Men' procedure should operate in every Trust hospital. Any one of these senior consultants may be approached in confidence by any doctor, or senior nurse or manager, who is concerned about a doctor. Its chairman may look for other evidence and often asks a psychiatric colleague for advice before talking to the doctor informally, usually to urge the need for treatment. This informal approach generally secures proper care for the doctor. If the doctor refuses, or patient care is compromised, the panel will meet the doctor. In extreme circumstances, where immediate suspension may be contemplated, but not otherwise, the chief executive may be informed.

The Postgraduate Medical Dean may be made aware of ill junior doctors by a consultant or tutor. Sometimes a consultant discusses with the Dean whether to sign that the pre-registration year has been satisfactory and the Dean may suspect illness. A young doctor seeking career guidance may reveal an anxiety state or depressive illness.

The occupational health service, alas, offers little to ill doctors, who do not view it as a reliable or useful resource. For one thing its confidentiality, since it is an employers' agency, is doubted, unfairly. For another, until there are more trained occupational physicians its presence in hospitals is usually a nurse and a visiting GP.

The National Counselling Service for Sick Doctors operates a London telephone line (0171 935 5982) during office hours. It advises doctors concerned about colleagues or themselves. Names are not asked so confidentiality is absolute. The respondent may be a doctor or a layman, each being experienced. The caller, having described the problem, is given the name of a consultant in the same speciality, including general practice, as the ill doctor, reasonably close but not in the same employment area. Names of volunteers willing to help are supplied by Colleges. The Service considers that someone in the same speciality will know of its particular difficulties and is therefore the most appropriate first contact. This is arguable. A doctor with a drinking or drug problem might be better suited by an expert in that field. If the caller directly asks, or if the matter is both grave and urgent, advice may be given about whether to contact the General Medical Council (GMC). The National Counselling Service deals with 400 callers annually. It cannot evaluate either the take-up rate or its effectiveness, but it is a pioneer among help lines and provides a unique and valuable service.

The overarching duty of the GMC is to protect the public. Before 1980 doctors' registration could only be curtailed if they were found guilty of 'serious professional misconduct' by the Disciplinary Committee. It was inhumane and pathetic when manifestly ill doctors appeared before them. Since 1980, under the Health Procedures, the Council may inquire into a doctor's state of health in assessing fitness to practise. If there is serious medical impairment limitations may be imposed on his practice. The Act specifies 'condition' rather than 'illness'; hence personality disorder is included and so violent or aberrant sexual behaviours come to attention.

Under its 'informal procedures' more than 90% of all ill doctors referred never come before any Committee. Their progress is supervised by the Health Screener, a psychiatrist member of Council. Doctors are drawn to his attention in various ways. Chief are: following drunken

https://doi.org/10.1192/pb.20.10.577 Published online by Cambridge University Press

driving conviction (the police always notify these; a very high alcohol level or a second conviction will generally trigger investigation), suspicious prescribing of drugs of dependence, complaints by patients or nurses suggestive of a doctor being ill, or information from concerned medical colleagues. Preliminary investigation of conduct matters may suggest illness or this may be pleaded by the doctor. The Screener acts only when he considers that there may be serious impairment of fitness to practise and that the situation is not being adequately contained by local treatment action. Peripatetic locums pose special problems.

The Health Screener asks the doctor to agree to be examined on behalf of the Council by two psychiatrists, and other specialists if indicated, selected from lists supplied by Colleges. Doctors may also nominate other examiners, usually including anyone involved in their treatment. On the basis of the reports the screener invites the doctor to accept undertakings. These have the dual purpose of ensuring safe practice and securing treatment for the doctor. They require the doctor: to remain under the care of a consultant psychiatrist (the treating psychiatrist if there is one; if not one of the examiners may be asked and the doctor's own wishes are consulted) who becomes the 'medical supervisor'; to attend him when asked; to accept the treatment regime proposed, and not to self-medicate, sometimes not even to possess scheduled drugs; and where appropriate to desist absolutely from alcohol. The supervisor may confer with the GP and with anyone supervising clinical work. The doctor must permit the supervisor to report regularly to the screener – six monthly is usual – and agree to cease practice at once if he or the supervisor so advises. This is rare and temporary. There may also be restrictions on practice, not to prescribe scheduled drugs, not to work unsupervised, not to work in single handed general practice, not to undertake locum work, etc. Most doctors appreciate that the undertakings are framed to help them. Guided by the reports the screener aims progressively to relax the undertakings until the time comes when further monitoring is unnecessary. It is uncommon for a doctor to come to the Council's attention thereafter. Three years is a typical length of monitoring although sometimes much longer is required.

So long as the doctor complies with the undertakings this is all that happens. There is no appearance before any committee; the doctor progresses with treatment and the public remain protected. Applying these informal procedures is immensely satisfying. I note, wryly, that the GMC's commands to stop drinking have more effect than my own similar exhortations when treating alcoholic doctors. This is because doctors know that if they refuse to be examined and to accept the undertakings, or subsequently do not comply with them, the Screener may evoke the sanction of reference to the Health Committee. Of course he exercises sensible judgement. An occasional lapse by an alcoholic may call for no more than an admonition but repeated breaches are not taken lightly.

The Health Committee, one lay and 12 medical GMC members, have the power to order suspension from the Medical Register. Therefore proceedings, conducted in private, must run along strict, and indeed legalistic, rules. Both the Council and the doctor are represented and evidence to the Committee is given in an adversarial manner more proper to courts of law than to medical practice. Advisers are present, experts in the medical condition and also in the doctor's field of practice. They and the members of the Committee may address questions to witnesses and to the doctor. Every effort is made to set the doctor at ease but it is a formidable ordeal, made worse if there is a language barrier, or if psychosis or dementia impair full comprehension of the proceedings. There may be a finding that there is no serious impairment of fitness to practise, but this is uncommon. Usually the Committee places restrictions on the doctor similar to those described and may order a period of retraining. The Committee may suspend the doctor's registration, from 4 months up to 3 years; this may be renewed at a further hearing. Following suspension only the Committee can readmit the doctor to the register.

The GMC's Health Procedures, under which 534 doctors were examined from their inception in August 1980 to the end of September 1994, are rightly regarded as a great success. For most the informal procedures operated from start to finish. Only the Screener's failures, doctors who are disagreeable to what is proposed, for their benefit, and that of the public, or not maintaining compliance come to the Health Committee. They tend to be paranoid, psychotic or demented or those whose dependence on drink or drugs proves obdurate.

Rehabilitation

The Department of Health has provided funding for a number of sheltered supernumerary posts to assist recovering doctors. It can be difficult to construct these posts. Former consultants dislike having to be supervised during rehabilitation. Also, regrettably, colleagues who have long covered up a doctor's deficiencies, particularly with alcoholism, once the condition has declared itself are reluctant to accept him or her back despite recovery. This is, if understandable, ungenerous.

https://doi.org/10.1192/pb.20.10.577 Published online by Cambridge University Press

Prevention

To predict subsequent development of illness by student selection methods is not possible. Nor would illness rates be reduced by requiring Deans to provide a fitness certificate to the GMC at qualification, although this is sometimes mooted. It would, indeed, be counter-productive. Students who consult sympathetic Faculty members about emotional problems, relatively simple to remedy at that stage, would not declare them if they feared that a record might jeopardise future registration. I was frequently consulted by students, but not while I was Dean! Follow-up showed that I could not have predicted the few subsequent illnesses that did develop. Nor, conversely, for those young doctors who did develop serious mental illness could this have been predicted from their student records. There have, however, been several instances when psychotic episodes in students had occurred but had not resulted in their exclusion from the course. The Dean, despite knowing of such occurrences because sick leave had been necessary, did not take effective action to persuade them to withdraw. It is kind, not cruel to do so at a time when they can be helped towards an alternative career.

Mental illness rates rise at times of upheaval and change such as are now rampant in the NHS. Policies replacing caring with financial preoccupation have resulted in doctors becoming so personally harassed that they do attend to the concerns of colleagues, especially junior colleagues. Breakdown of the apprenticeship system has made this more acute. Juniors may no longer relate to a particular consultant, team or ward staff. Anomie results – that condition of society that allows people to exist disconnected from their fellows. In turn this can lead to mental illness and to suicide. Many juniors today regret having taken up medicine and drop out. Also they become ill. It is not having to work hard that oppresses them so much as their working conditions. They complain chiefly of not feeling appreciated, not feeling cherished. Neither Colleges nor Postgraduate Deans have taken effective action to overcome this. The ethos of the NHS is against doing so. Nor are stress and gloom confined to juniors. Senior doctors are equally disaffected. We cannot undo the ruination of the NHS but we must remain sensitive to our colleagues' needs, however pressing seem our own problems and struggles. We must recognise distress in those about us, and do something about it, even to the point of seeming interfering. We often let embarrassment stand in our way but embarrassment has no proper part in the doctor–patient relationship whether or not the patient is a doctor. We may feel guilt about the situation; that should not deter us. We may believe that we have nothing to offer, adequate to the situation, yet we can demonstrate understanding, empathy and support. Sometimes we cannot face a conflict of duty, whether to preserve professional confidence or report an ill and poorly performing doctor to the GMC (whose guidance to do so is too simplistic; if doctors come to believe that their medical attendants may report them they will not disclose their symptoms, and then how will they or the public be well served?). Fortunately such conflicts rarely occur.

Finally, should you be ill yourself, please consult. Do not perversely soldier on, getting worse, out of some macho misconception. 'Physician, heal thyself!' is inappropriate.

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https://doi.org/10.1192/pb.20.10.577 Published online by Cambridge University Press