The provision of medical services to sick doctors

A conspiracy of friendliness?

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Summary

This study examines the provision of medical and other advisory services to possibly sick doctors. How doctors who might require treatment are identified, why they do not use the services that are available, and how services might be improved are the main questions considered. The research was initiated because of concern about the relatively high mortality and morbidity rates of doctors for suicide and conditions such as liver disease, compared to other professional groups. In addition the stresses of medical work and the environment in which it. takes place are increasingly recognised as endangering mental health. It is felt that by improving the way doctors' health is managed, problems will be addressed earlier, risks to patients will be limited and the number of doctors leaving the profession will be reduced.

Eight Health Authority Districts were chosen for the study. Those selected varied in terms of numbers of deaths amongst doctors due to suicide, their geographical location and industrial characteristics, including the presence or not of a university teaching hospital. Four groups of respondents in each district were identified for interview. Senior managers within the health authority and hospital structures, Senior Consultants, GPs and Hospital Juniors, Industrial Relations Officers and representatives of Community Health Councils were included.

Semi-structured interviews were carried out to explore respondents' perceptions of doctors' health concerns, the take-up of services and explanations for lack of use. Postal questionnaires were sent to respondents who were willing but unable to be interviewed. Data was collected from 97 of a possible 112 respondents. Apart from doctors in teaching hospitals, who experienced greater competition and workload pressure, there were no differences in responses between districts. Respondents were aware of colleagues' health problems, both physical and psychological but the sensitivities surrounding them meant discussion was very limited. No overview of the incidence of doctor illness and the need for services across districts was achieved.

Results show that there are major attitudinal and organisational barriers preventing the uptake of services. Doctors do not seek help because of the stigma of illness; peer pressure and professional loyalty; attitudes of denial learned in medical training, and lack of insight into personal illness. As a result their health problems, if addressed at all, are not addressed at an early stage and any support given is informal.

SUMMARY

Lack of knowledge of existing services made it difficult for respondents to comment objectively about their efficacy. Those which are available are insufficiently advertised and do not appear to doctors to offer effective supports. Hospital Juniors have problems accessing them because of their working hours and peripatetic job patterns. Failure to ensure confidentiality, because of links with management, was seen as a major factor in accounting for the failure of services. Absence of a welfare ethos in management philosophy, the ambiguity of management roles, and the ambivalence of managers in addressing doctors' health problems are also factors.

That there is a major need for change was widely recognised and recommendations are proposed in three main areas. Existing provision must be improved and GP registration mandatory for all doctors. Attention to be given to hospital based services and supports, particularly in terms of their accountability and doctors' understanding of them. Confidentiality to be improved in all aspects of the services. Provision must be made in all districts for treatment of doctors outside their locality, and as a back-up to existing services every doctor should be able to access a confidential telephone help-line. There must be better and more effective dissemination of information about all of the supports that are available.

Organisational changes are proposed to develop more effective supports. Those in advisory roles to ensure the adequacy of training for hospital juniors, and together with purchasers of services, that FHSAs and Trusts establish procedures by which doctors' health problems are addressed.

Preventive measures are recommended which require that medical education be developed to foster attitudes and practices which engender greater self-care, and that a proper pastoral structure be established. It is also proposed that further research is undertaken to formally evaluate existing support services/systems and to examine the particular needs of women in medicine.

Introduction

As members of high socio-economic groups, doctors, like other affluent, employed individuals tend to be healthier, with mortality ratios which are generally lower than those for the wider population. However, for certain causes including suicide and accidental poisoning (drugs and other substances) cirrhosis and chronic liver disease, their SMRs are particularly high (Harrington 1990).The OPCS Decenial Supplement on Occupational Mortality (1979-83) shows that male medical practitioners had an SMR of 172 for suicide (182 for injury and poisoning). Among women, it was over twice that of men, at 371 (BMA 1993).

The relatively higher rates of death from road accidents, and of substance abuse and psychiatric illness amongst doctors are also widely acknowledged (Roy 1987, Harrington 1990, Richards 1989). Increasing numbers of doctors are being supervised by GMC Health Screeners following appearances before the Health Committee (GMC 1992). Reliable data on the incidence of health problems and causes of death are, however, difficult to obtain. Given the social connotations of death by suicide, substance abuse etc., it is suggested that there will be reluctance amongst doctors certifying deaths of colleagues, to attribute their deaths to these causes (BMA 1993).

There is increasing recognition of the occupational related stress experienced by the medical profession, and the vulnerability to psychiatric problems which can result. The nature of medical work and different aspects of the NHS work environment are potentially major causes of stress (BMA 1992-1993). The organisational changes within the NHS, at least so far as GPs are concerned, is causing increases in stress experienced by some doctors (Sutherland & Cooper 1992). In addition, perceptions of risk, from occupational exposure to blood viruses such as HIV and Hepatitis B, increase as medicine advances and becomes more investigative (Buss et al 1991).

That the issue of doctors' health must be addressed is clear. Whilst professional help is rarely sought, friends and family are often looked to for support (King 1972) and the burden of stress tends to fall on them (Bates 1982). There is also the problem of wastage. It is argued that the rigours of medical work select out doctors who are more empathetic and understanding; attributes considered important to the practice of good medicine (BMA 1993). Those who are distressed and unsupported may leave the profession (Hale et al 1992). Doctors who are able to identify and address their own stress symptoms will be better able to help patients with similar problems and overall will provide better standards of care (Foote 1993).

CURRENT PROVISION

The current provision for doctors who are ill and in need of support is of 3 broad types: that stipulated by statutory regulations, work or medical school based supports, and those provided by voluntary agencies. Statutory provision, which includes the procedures of Local Medical Committees (LMCs), the 'Three Wisemen' professional panel procedures, and the GMC Health Committee, may be described as primarily concerned with limiting damage sick doctors cause themselves, their family and their patients (BMA 1992).

Work based provision in the form of occupational health services (OHS), assess employees in terms of fitness to work, and provide health education advice. The emphases of NHS services vary but tend to be essentially preventive and non-treatment in focus (Cox 1981). Advice regarding occupational related hazards, accidents, etc. is also provided, as well as in many cases, treatment of minor injuries and ailments, and immunisation. Occupational health services will advise management on sickness absence and issues relating to the rehabilitation, and return to work, of long-term absentees. Employees may refer themselves or anyone whose health causes concern.

Counselling services have been established in some medical schools (Roy 1987) and are also available for use by staff. Where used it is common for both students and staff to refer themselves. Specialist services are rare, counselling being provided by staff whose main responsibilities typically relate to other aspects of welfare eg. counselling is frequently the part-time role of the Chaplain, an Occupational Health nurse or physician.

Independent agencies, such as the National Counselling Service for Sick Doctors (NCSSD) provide a service which is autonomous and free from any employing, disciplinary or professional controls. Counselling is totally confidential and counsellors are volunteers. Doctors who are sick or those concerned about them, may refer. Medical Council on Alcoholism (including the British Doctors & Dentists Group (BDDG)) provides confidential counselling, and a support network for alcoholic doctors, dentists and their families. Support is given only where a doctor/dentist is agreeable, which in most cases means following self-referral. However, initial referrals are accepted from family members seeking support. (Current details of these agencies can be found in Appendix XX).

The Research

AIMS

To examine the provision of medical and other advisory services to possibly sick doctors.

OBJECTIVES

1. To consider how doctors who might require treatment are identified.

2. To ascertain the extent to which doctors are referred to existing services and why they do not use the services/mechanisms available.

3. To consider how these mechanisms might be improved.

Method

STUDY DISTRICTS

Eight Health Authority Districts out of a possible 190 were chosen for this study. Suicide was used as a possible marker of adequate and inadequate services, and as a method of identifying districts which may have problems in dealing with their sick doctors. Four districts with high suicide figures were matched in terms of geographical location and industrial characteristics, including the presence or not of a university teaching hospital, with four districts with low/nil suicides (Appendices I & II).

RESEARCH APPROACH

A pluralistic evaluative approach was adopted, in which the viewpoints and opinions of a broad group of participants are collected to assess services (Smith & Cantley 1985). A series of key people in each district were identified for interview. Those identified were considered to be 'senior persons' within the health authority and hospital structure, who would know about doctors' health concerns and be aware of current practice. In addition, a number of junior hospital doctors and GPs were interviewed, as well as BMA IROs and CHC representatives in each district (Appendix III). Prospective interviewees received a letter detailing the aims and nature of the study and a request for an interview (Appendices IV). Arrangements for interview were confirmed in writing, and all respondents received a copy of the study outline (Appendix V).

INTERVIEWS

A series of schedules was designed to provide the basis of semi-structured interviews with the different groups of respondents (Appendices VI–VIII). This approach gives respondents control over the discussion and at the same time allows them freedom to develop issues they deem pertinent. This was considered essential to the achievement of valid data, given the potentially very sensitive nature of the subject to be studied. A postal questionnaire was drawn up and sent with an accompanying letter to those GPs and hospital juniors who, whilst agreeable were unable to take time to be interviewed (Appendix IX). Pre-paid envelopes, marked 'CONFIDENTIAL' were enclosed for the return of the questionnaires.

Responses

Our overall response rate of 87% (97/112) suggests that a very high level of cooperation was achieved. 96 people were interviewed, and a further 6 expressed a willingness to be interviewed although only one returned a questionnaire. Five people chose not to participate in the research and five potential respondents could not be identified due to lack of information. Responses varied across districts and amongst different groups of personnel. The highest response rate of 93% was achieved in 3 districts; the lowest – 79% was recorded in 2 districts (Appendix X). A response rate of 100% was achieved in half of the 14 groups of respondents interviewed – DPHs, FHSA Managers, Senior Consultants, OHDs, IROs, LMCs, and CHCs. The lowest response rate – 38% – was recorded for Wisemen, who could not be identified in 3 areas, and who refused to be interviewed in 2 areas (Appendix XI).

Generally, the opportunity to be interviewed was well received by interviewees. Several commented how, as preparation they were able to give thought to issues not normally considered, and in some areas it was evident that the research had provoked widespread discussion. However, the high overall response rate masks resistance experienced by the researchers during interviews on some occasions. Whilst it seems respondents generally were reluctant to refuse to be interviewed, a number were reticent about answering the questions put to them (Appendix XII). Interviews lasted on average for about one hour, with the briefest being 20 minutes and the longest lasting over 2 hours. Following the interview, each respondent received a letter of thanks detailing our intention to inform them of our initial findings (Appendix XIII).

ANALYSIS

The analysis of the interview data was completed in two stages:

1. Interviews from each group of personnel were collated across all districts to establish to what extent attitudes were dependent on position held.

2. Data was analysed by district to examine whether perceptions and attitudes were dependent on geographical location, etc.

Apart from doctors in teaching hospitals, who are subject to greater pressure and increased competition due to workloads which include teaching, research, etc., no differences in perceptions were discernible between districts. Few respondents remarked on the particular needs of women doctors, although, they were not questioned directly about them.

Results

The findings of the study are presented below. Discussion of the contextual issues relating to doctors' health concerns, known cases of illness, roles, responsibilities and aims of respondents is followed by consideration of the reasons why doctors do not refer themselves or seek help for others, how they come to the attention of services, and why services are seen to fail.

DOCTORS' HEALTH CONCERNS

Only a very small number of respondents (2 Chief Executives and a DHR) considered doctors' health concerns as no different to those of other workers, or at least those working in the NHS. Where stress is experienced, argued one Chief Executive, it is probably no greater than that faced by other professionals, for example, those in management.

There was widespread agreement that the major risk to doctors' health is stress, and the related problems of drug and alcohol abuse. The other major risk cited was blood borne virus infections, but compared to stress these appeared to be of minor concern (Appendix XIV). Failure to admit to being stressed and to show signs that one is not coping is seen to be a stressor in itself and compounds the problem. This obligation to 'not weaken or show any need for support' may mean that physical symptoms are also ignored. Stress related and psychiatric problems in particular, are seen to damage career prospects and mean that problems are denied: "Unless you're bleeding, there's nothing wrong with you type of attitude" (IRO (G)). Not being able "to admit to actually being ill" was commonly cited by GPs, as well as small number of Chief Executives and IMAs, as a major health concern in itself. This denial and failure to report illness means that, since it is unrecorded, from an employers point of view at least, ordinary sickness amongst doctors does not exist: "...... the perfect of all staff .... they're in the best of health it seems" (CE (H)).

DOCTORS WHO ARE ILL - KNOWN CASES

There was widespread agreement amongst those interviewed that it is very rare for doctors with illness to come to the attention of services. There was little discussion of known cases of illness and apart from comments made by JHDs and CHCs, it was not possible to establish whether respondents were unaware of problems, or simply unwilling to discuss them. One CE (H) said that he would not discuss the cases he knew, in any terms whatsoever, and when asked when he last addressed the case of a doctor who was ill, an OHD(E) remarked that such information was 'confidential'. As a result accurate calculations of numbers of

known cases could not be made. The mean number of cases cited across all districts was 2 but some respondents were not aware of any. The greatest number of cases cited by an individual was 8 (FHSA(C)) (Appendix XV).

Most of the hospital juniors interviewed (5/7) said they were aware, or had been aware, of a variety of psychological and physical problems amongst their colleagues. Most knew of juniors continuing to work with acute physical problems; a doctor with pneumonia "treating patients less ill than he was"; one who, following an accident "worked a full weekend with a freshly casted leg"; another who, with a chest infection, "worked until she collapsed". The most serious examples of illness recounted by those interviewed were of colleagues who had eventually committed suicide. Others knew of abusers of drugs and alcohol, problems so apparent they were "too obvious to ignore" (JHD (H)). None of those interviewed had been involved in any way in supporting the doctors they described. There had been "no obvious signs" of the suicide, and the substance abuse was addressed by senior consultants.

ROLES AND RESPONSIBILITIES

Respondents, apart from GPs and hospital doctors were asked about their roles and to what extent they are formally involved with health problems of doctors. Whilst concern for doctors' health problems is an element of various roles throughout the HA and hospital structure, there are few doctors/managers who have a specific, active responsibility. Those directly involved in health issues, that is occupational health physicians, do not have a formal responsibility for the health of doctors, nor indeed for any other employees. Responsibilities for health issues vary with doctors of different status (the majority of those with a formal role being within the hospital setting, and concerned with senior doctors), and only become formalised when management procedures relating to absenteeism or disciplinary action come into play. Should a doctor be ill but continue to work, it is unlikely, at least in the early stages that this will be seen to be the concern of a manager or senior doctor. Where responsibility for hospital juniors and GPs is held, and what happens in practice, is unclear (Appendix XVI).

AIMS IN ADDRESSING THE CASE OF THE DOCTOR WHO IS ILL

Patient safety was a major concern of all groups of respondents involved with such cases, but willingness to give it primacy varied to some degree according to role and responsibility. DPHs, IMAs, OHDs, and two of the the four LMCs who commented, discussed the need first, for appropriate treatment for the doctor,

with careful consideration also to maintenance of patient safety. IMAs also stated that the priority is to make the doctor well; ability to return to work thereafter being a bonus.

DHRs, FHSAs, Consultants and Wisemen were more likely to make patient safety the priority. However, this does not mean that doctors, like other employees are not dealt with humanely. Consultants and Wisemen acknowledged the importance of ensuring doctor safety, that in some cases a doctor will need 'protecting from himself', as well as support and rehabilitation. However, it was clear that their view largely focused on organisational interests, and the organisation "is about delivering health care to others" (DHR (C)). It was also observed that following risks to patients, effects on colleagues must be considered: "there is nothing more stressful than for highly competent staff, who ever they are, than having to cover up incompetence, that is assuming illness is affecting performance" (DHR (B)).

Whilst OHDs largely agreed that safety and welfare of patients and assessing suitability for work were main aims, two pointed out that their aims in addressing the case of an ill doctor will largely depend on how the doctor in question had come to their attention. A doctor who had been referred by personnel management procedures would be treated slightly differently to one who had presented him/herself for treatment, but in both cases would be treated as an individual, "independently and impartially" (OHD(D)). Concerns of the doctor are addressed by the FHSA if the doctor who is unwell is a GP working alone. However, intervention is mainly limited, at least in the first instance, to ensuring that patient safety is maintained.

FAILURE TO REFER

Doctors fail to use the supports available to them because they have little knowledge of their existence and purpose, they are reluctant to use them, and because the mechanisms themselves are not seen to be effective.

KNOWLEDGE AND AWARENESS OF MECHANISMS

Overall, there is little known about the services and supports available, and only limited information is provided to both those in need of the mechanisms and those who administer them. Amongst both junior doctors and GPs there was little awareness of the supports available. Two of the six JHDs interviewed admitted to knowing nothing of any system of support available either locally or nationally.

None mentioned Wisemen procedures, or any of the services either within the hospital or at district level, in terms of providing support. Just over half of the juniors and GPs interviewed (11 out of 20) knew or had experience of voluntary or independent services. The three who knew of NCSSD did not know how to access it. Amongst hospital doctors, apart from OHS, the general perception is that there are no services or supports for doctors (and for JHDs this included senior colleagues), or at least none are "advertised as available". The knowledge of senior HA and hospital personnel of services and mechanisms to support doctors when ill is very partial and fragmented. The knowledge of those who are most informed tends to be limited to those aspects of the services/mechanisms in which they are involved. Taking the mean number of mechanisms named, IROs (mean 4.6) have the most extensive knowledge of the supports available followed by DHRs (mean 3.0). Those with least knowledge are HA Chief Executives (mean 1.5) and FHSA managers (mean 2.0), both of whom have least direct involvement with doctors (Appendix XVII).

In five areas detailed information is provided by OHS about health services, supports, etc., in two it is provided as part of an induction programme for juniors. Apart from OHDs and DHRs few of those in senior positions knew what information about health procedures new appointees to the hospital or district received. Half of the Directors of Public Health knew of the information being provided to staff new to the district in the form of an induction pack, but there was confusion as to who receives it. If induction materials are provided then it is usually to juniors but not to seniors. It was observed that the amount of information given may mean that it is not used, or that information on health supports is ignored, a view which was borne out by juniors. For those commenting on GPs, the consensus was that little information is provided to doctors about how to deal with illness or the support services available. Information about the enactment of Wisemen procedures is provided on an ad hoc basis. Having not yet convened a disciplinary committee one newly appointed Wiseman had no information on how to implement the procedures or the exact nature of his role.

THE RELUCTANCE OF DOCTORS TO REFER OR TO SEEK HELP

Apart from lack of awareness of mechanisms, it is clear from the responses from all groups interviewed (apart from Chief Executives) that doctors' reluctance to access services is a product of the attitudes they and their colleagues hold about illness. There is widespread recognition that such attitudes create barriers to seeking help for both those who need it and those who recognise the need for it in others.

TABLE I

BARRIERS TO HELP-SEEKING

– Stigma of Illness
  – Professional Loyalty
  – Medical Training
  – Perceived Irrelevance of Services
  – Tradition of Self-treatment and Informal Consultation
  – Lack of Insight

THE STIGMA OF ILLNESS

The idea that illness amongst doctors is stigmatising was the most frequently made observation by all groups of doctors interviewed, apart from hospital juniors. Most GPs agreed that doctors are not prepared to admit that they are ill, and are stoical about continuing to work. Most other groups of respondents commented on the expectations that doctors be "superhuman, invincible, immortal". Illness is perceived as weakness and failure and, as such, is a threat to their livelihood. The stigma means that the needs illness presents are denied by doctors, they are reluctant to protect themselves against stress, and to seek help. As a result, they tend to dismiss their own illnesses and to ignore it amongst their colleagues.

PROFESSIONAL LOYALTY

This tendency to ignore and conceal problems from others is seen to arise from professional loyalty, again recognised by most of the respondents interviewed. Hospital seniors described this "misguided professional loyalty", together with a number of DPHs, FHSA managers, CHCs and IROs, as preventing doctors from being honest about their problems, and taking responsibility for themselves and colleagues. As a result, it becomes very difficult for those outside the profession and those new to it (ie. hospital juniors) to draw attention to problems, "to report up through the system". Some, aware of doctors' tendencies to "cover up poor practice by colleagues to avoid publicity" (CHC (D)), felt it unlikely that patients would notice the health problems ignored by, and concealed from, colleagues. Such loyalty was described by one DPH as "a conspiracy of friendliness", or as an IMA suggested, a "collusion of silence".

JHDs were particularly aware of others' expectations as to how they should perceive and respond to their own illness. There was strong recognition of the peer influence which prevents many from taking sick leave or time to address

personal health problems. As some juniors commented: "doctors expect other doctors to be in perfect health, it is seen very negatively if you are not..............you are expected to be able to cope". As one hospital junior put it, "the macho nature of medicine means that you soldier on.... if you don't you dump on colleagues ... there is a lot of peer pressure not to stop working" (JHD (E)). Where there is concern about colleagues' health, it is unlikely to be raised with seniors. Bringing such problems to the attention of others it was agreed, is 'difficult', and has an element of 'whistle blowing' about it. Juniors are aware of their tendencies to deny the existence of problems, especially those relating to mental illness, and drug and alcohol abuse. As one observed about the behaviour of his peers, "they know it happens but it happens elsewhere" (JHD (H)). GPs were also aware of 'difficulties' in addressing colleagues' health problems because of the questions it would raise about competence: "It is difficult .... involves workloads and performance" (GP (H)). Since problems of colleagues are not identified, the unwell doctor goes unsupported. All were aware of doctors' discomfort in dealing with such problems, although some hospital Seniors expressed a need to be more effective in identifying sick doctors.

MEDICAL TRAINING

Four groups of the doctors interviewed described how these attitudes are fostered in medical training, a major element of training being that it denies students the potential to exhibit weakness. "Not admitting it (illness), being strong" is, said one, "an arrogance which is learned in medical school". Both juniors and GPs described how medical school training teaches the young doctor who is ill to "tough it through". The idea of being able to work for long hours, over a number of days or weeks, is seen as an achievement, as being "made of the right stuff", and there is the development of a "self-induced pride" in not needing to ask consultants for help. Seniors are viewed, in some cases, as unsympathetic, and often sceptical of the need to take sick leave.

THE APPARENT IRRELEVANCE OF SERVICES

In failing to recognise their needs, hospital doctors particularly, tend to perceive the existing health services available to them as irrelevant. A number of occupational health physicians commented that doctors do not recognise the value of occupational health services to them: "doctors view occupational health as an intrusion into their lives", said one junior (JHD (C)). Most OHDs experienced difficulties getting doctors to attend for vaccination renewal or for any general health screening, and they also observed that the relevance of GP services is not recognised. The fact that they can self-medicate in the first instance, and then consult hospital specialists, means that the GP system is

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bypassed by hospital doctors. Although there was widespread awareness amongst those interviewed that it is bad practice, it was agreed that most juniors do not register with GPs. The main reason given for this was the lack of time to consult; the peripatetic working patterns of junior hospital doctors means that it is easier to follow the tradition of seeking the opinions of colleagues than going through the normal channels. This was confirmed by a number of juniors themselves and GPs, who agreed that they were unlikely to seek medical consultations given that there "is nothing another doctor can do for you" (GP(D)). One junior expressed particularly starkly how the GP has little to offer the hospital doctor: ".....everyone is supposed to be registered with a GP. Most people probably don't. You can deal with it more effectively by treating yourself or going to a colleague, or asking a consultant. The purpose of a GP is to sort out the trivial from the serious and refer on. Well, you can do that yourself" (JHD (E)). Another, one of the very few to do so, aware that "you cannot always be objective", described how juniors also treat themselves. It was not uncommon he said, in the hospital where he worked, to use the physicians' samples provided by drugs companies, on the basis that: "if you want to see if something works, who better to try it on than yourself" (JHD (H)).

INSIGHT

A small number of respondents (across four groups of personnel) discussed doctors' failure to seek medical consultations as resulting from insufficient insight into their condition. IROs, as well as some of the IMAs, saw lack of insight as a product of the denial, inherent in the profession's reaction to illness amongst its own members: "....knowing is the real issue of illness. Physical illnesses are recognised. It's drug, alcohol abuse and mental illness which cause the biggest problems ... lack of insight", which, argued LMCs, cause particular difficulties where the doctor is a lone GP. With insufficient insight doctors appear either over anxious about their medical problems on the one hand, or to underestimate them on the other. The possession of medical knowledge can lead to fears that (minor) symptoms indicate serious problems. These fears are not necessarily allayed once treatment is sought. An IMA, together with a number of GPs, observed that because doctors tend to make only informal approaches when they need to consult, they are either over or under investigated, and neither approach is necessarily appropriate.

REFERRAL TO SERVICES

Very little data was collected on referrals to services/mechanisms, largely because they are so little used. Where used it is likely that problems are advanced. Prior to that, if help is provided at all, it is on an informal basis and not via more formal procedures.

IROs frequently advise senior managers about difficult situations which arise with staff, and hospital seniors often contact IROs for impartial advice and information about the most appropriate courses of action. The cases discussed are most likely to be those "heading towards disciplinary procedures", and are relatively rare given that, "In a hospital there needs to be something spectacular going wrong before formal procedures are implemented" (IRO (D)). OHDs rarely see doctors, those with profound problems being highly unlikely to reach them in OHS. Where they are referred, it will be generally as a result of colleagues' concerns, probably because of sickness absence or a decline in performance. Self-referrals are not common, and when they do occur this is usually because of anxieties arising from accidents, such as needlestick injuries.

Whilst no definite pattern was observed, DHRs noted that attention may be drawn to doctors' problems as a result of complaints from patients and nursing staff, but given their peripatetic working patterns it is unlikely that the problems of juniors are noticed or addressed (IRO (A)).

There was widespread agreement again amongst those involved with GPs (FHSA Managers, IROs, LMCs, IMAs and CHCs) that the problems experienced by GPs are also most likely to be dealt with informally, be they raised by patients or colleagues. Initially, concerns about a GP which are brought to the attention of the FHSA by doctors appear to be less about a doctor's health and more to do with payments for sickness absence and locum cover, or in the words an FHSA manager, "issues relating to maintaining the service".

FHSA managers and IROs were aware that problems of illness tend to be passed to them by "concerned" colleagues/partners because they fear them becoming serious, but are reluctant to personally intervene. One manager explained: "I have known doctors phone and say they think their colleague or partner is behaving oddly, but they have not tried to do anything about it themselves, they just wanted to offload it on to us." (IRO (B)) They were also aware of mischief reporting, apparently not uncommon in partnership disputes. Three IROs discussed cases brought to them where the intention was, they felt, "to get someone out". "You can have your suspicions .... some are trying it on. They will speak to me in the hope that I could speak to the doctor concerned and perhaps persuade him to resign or something." (IRO (B)) The few which are reported tend to be well established problems. Respondents (LMC, CHC) gave accounts of patients noticing that doctors smelled of alcohol, or who had been taken ill during surgery, (in one case during a home visit). Two LMCs had

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received reports from local pharmacists about irregularities in doctors' prescribing/use of drugs. Two FHSA managers had experience of cases following police proceedings for, for example, drinking and driving. Like IROs' comments about hospital doctors, one manager described them as "end of the road situations": "GPs are highly unlikely to contact us and say they want help in the early days. Typically we hear of crisis..........or just before it becomes a crisis. Would be a major advantage to hear of it sooner for all parties involved, for the FHSA, for the patients for the practitioner" (FHSA Manager).

The four doctors who discussed their own experiences of being ill and accessing services were all GPs. Only two discussed their experiences at any length, but even so the discussion generally was brief. One described his experience of an acute physical illness, the other of several episodes of "serious mental illness". Both had sought the support of their own GPs. Neither expressed criticisms of the care received. Generally it was agreed that the number of cases of GPs with illness which come to the attention of anyone, be it the FHSA, LMC or the IRO, are only a very small number of those which probably exist.

USE OF NON NHS MECHANISMS

The use of support outside of the NHS was hardly discussed, largely because there was limited awareness of schemes such as those provided by the NCSSD and the MCA. When non NHS supports were referred to, this was mainly the use of private psychiatric clinics and therapies. Two OHDs saw little need to refer on to mechanisms outside the main stream NHS services, since: "to use other mechanisms would be to admit that nothing could be offered" (OHP (G)).

TABLE II

REASONS FOR THE FAILURE OF EXISTING MECHANISMS
– Perceptions of Services
– Poor Interaction and Feedback
– Problems of Treating other Doctors
– Poor Accessibility
– Absence of Confidentiality
– Ambiguity and Ambivalence of Management

PERCEPTIONS OF EXISTING SERVICES

Perceptions held are limited by involvement with particular groups of doctors and aspects of the services. IROs had the widest all round knowledge of how the existing services function given that they work with doctors at all levels, in both GP and hospital settings. They agreed, along with LMCs and OHDs, that whilst the existing system has the potential to meet doctors needs, it fails to do so because doctors do not access this support; where it is accessed it is not accessed early enough. Inadequate knowledge of the system is itself a failing of the system, and leaves managers unable to tell to what extent problems are dealt with well, if indeed they are dealt with at all. OHDs observed that it is difficult to say how effective the system is or what the gaps are in terms of doctors' health since by failing to use the system, they do not test it. The structure, they said, is not at fault, the problem is that doctors don't know about it, and don't want to use it. The greatest problems of the mechanisms, believe IROs, are at the outset, the nomination process, which fails because of problems of professional loyalty, but also because the system is so difficult to negotiate: "I always feel lost, it is all very awkward and ad hoc. It is difficult to get a handle on... not sure how to access what there is. Is no formal mechanisms to maximise support – may do informally – it's shrouded in secrecy and informality" (IRO (G)).

GMC

It is unlikely that doctors with health problems will seek the support/advice of the GMC because of its association with maintenance of standards and litigation against doctors (FHSA managers, IROs). Several GPs discussed the GMC which they tended to perceive as an organisation which was "big brotherish", "paternalistic", and "unfriendly".

From the point of view of patients, concern was expressed amongst FHSA managers, IMAs, and IROs particularly about the slowness and "cumbersome" nature of the GMC procedures which mean they are unlikely to be used and how, as a result, patients may be placed at risk. They observed that there is a problem, particularly with GPs who, because they are outside other management structures, may continue to practice during the long periods taken to reach a conclusion.

FHSA

Similar observations were made about the role of FHSA. Amongst GPs the FHSA tends to be perceived as "disorganised, management-oriented and sometimes confrontational". It is unlikely that the GPs would seek the support of the FHSA at times of crisis.

Both FHSA managers and IROs voiced anxieties about existing regulations which mean that the FHSA must defer to the judgement and the proceedings of the LMC, there being a need for earlier intervention where there is evidence that patients are at risk. Four FHSA managers felt that the LMC procedures do not always work to the benefit of the doctor with illness, or his/her patients, since doctors are sometimes allowed to continue to practice even when, in the view of FHSA, it would seem that his/her interests would be better served in taking sickness absence: "Have known of a case where a FHSA wanted to terminate the contract of doctor. He was the subject of many complaints from patients and other health professionals over a number of years, many of whom were jolly worried. The LMC wanted the softly, softly approach: protects their right to practice" (FHSA (E)). One manager suggested that failure to address the interests of both patients and the needs of the doctor related to LMCS' professional concerns: "there are vested interests" (FHSA (E)).

For GPs, LMCs are considered to be useful for advice and as an intermediary for dealing with patients' complaints, but again are not perceived as a source of support. The problems of finding locum cover, and also having to pay staff and overheads of the practice whilst on sick pay allowances, was discussed by LMCs and GPs. IMAs felt GPs were reluctant to take sick leave because the limited availability of locum cover meant that they would be a burden to partners.

THREE WISEMEN

Comments on Wisemen procedures were limited and came mainly from IROs, Senior Consultants, a number of DPH, DHRs and OHDs. Consultants commented that little is known about, how in practice, this committee works. This was supported by the fieldwork experience which demonstrated the difficulty in identifying members of the panels (Appendix III & XI). One Wiseman admitted to being unclear about his role, given the infrequency with which the committee meets. DPHs suggested that the procedures are inadequate because they depend on a colleague showing concern and being prepared to act, which given the issues of professional loyalty is unlikely, particularly since "Wisemen procedures are seen as an admonishing committee" (OHD, IROs).

Generally the secrecy surrounding the procedures and membership of the committee made it difficult for respondents to have an objective view of their efficacy.

HOSPITAL SENIORS

Hospital seniors are reluctant to refer colleagues to services formally. When a problem is dealt with formally the normal progress of the doctor's life is interrupted and consultants are reluctant to be involved. They do not wish, as one said, "to get their hands dirty". Again as with Wisemen, because the ethos of medicine prevents doctors from exhibiting need, it is unlikely that the support of seniors will be sought (DHR). However, should a problem come to the notice of the public or the patients, or the problems of a senior be raised by a junior, then it was recognised that formal mechanisms would come into play. Up to that point the system of informal "corridor medicine" is seen to be adequate and effective. Whilst few observations were made, it was recognised that the support and advice seniors themselves provide is so informal that it is not possible to be objective about its worth.

OCCUPATIONAL HEALTH SERVICES

For those groups of respondents involved with hospital doctors, occupational health services were seen to be the main mechanisms of support. Accounts of the failure of OHS vary depending on the group of doctors considered. OHS is seen to be part of a "punitive management structure" in the provision of medical information to personnel departments. This view was expressed by 4 hospital juniors, one of whom had known colleagues not to complete OHS pre-employment questionnaires for this reason. JHDs had little to say on the efficacy of OHS, their experience of it being limited to screening procedures and the updating of vaccinations. Ignorance of the service amongst all hospital doctors, largely because the services do not advertise themselves enough, was identified as a problem, particularly by IROs, who also described OHS as "not able to cope with consultants" because of problems of "status and credibility". The poor status of OHS, also perceived by DHRs, DPHs and Consultants, was seen to arise from the fact that in the majority of cases OHS are not consultant led, and are not treatment services. As such they are seen as services mainly for nurses.

INTERACTION OF MECHANISMS

FHSA and LMCs do interact. This relationship is written into statutes which govern their procedures but because they tend to liaise informally there is no

formal unified approach to support doctors with problems, and little interaction or feedback between the mechanisms. Where the system works well it is because good personal relationships exist between the two bodies.

For hospital doctors, apart from involvement between occupational health services and Wisemen procedures, there was felt to be little evidence to suggest there is any interaction "between the different NHS mechanisms". This lack of interaction between the mechanisms, consultants explained, is because there is lack of awareness of them. Also a concern with confidentiality means that consultants prefer to proceed informally and do not feed back to eg. DHRs etc.. As one DHR explained, to ensure confidentiality "it is important to maintain divisions and lines of communication" (DHR (E)).

TREATING OTHER DOCTORS

Responses to the question of doctors treating other doctors were mixed. Amongst hospital juniors and GPs there was feeling that the doctor patient is not treated as well as others, being subject to anxieties about being considered trivial, and not being taken seriously by colleagues. For the relationship to be successful, it was recognised that the doctor patient should "behave as a patient" and "allow himself to be treated" (GP (H)).

Half of the GPs interviewed stressed the importance of being registered with a GP outside of the partnership. Whilst there is a need to be treated as other patients, said GPs, it is important that doctors are considered "not like any other patient". This involves "not being made to feel a burden", and to being treated as "an intelligent person", with whom treatment and the management of illness could be discussed. Some suggested that the ability to treat doctors effectively came with age and experience. Others felt that this was not as significant as having an accepting attitude and being aware of their particular needs and difficulties as doctors. Hospital juniors were afraid that in treating other doctors they might appear incompetent, given that doctors all have their own ways of doing things, and not all will agree with an individual diagnosis or treatment.

ACCESSIBILITY

Junior hospital doctors were supported by seniors in voicing concerns about being unable to access services due to working hours and their job mobility. Few other respondents, however, felt health services were any less accessible to them compared to other full time workers.

DPHs felt that the real barriers to seeking care are psychological ones. Many of those who commented, including DHRs and GPs, felt that doctors are the best placed of all to access good medical treatment, provided as a number of consultants observed, that they are prepared to behave as patients and seek proper consultations. However, proximity to the work place and the public nature of services such as occupational health were seen as prohibitive because of juniors' reluctance to be seen using them. OHDs recognised that the services need to be sufficiently distant from the workplace to be private but not so far as to limit access. In four areas occupational health services overcame the access problem by offering a flexible service to staff who found it difficult to consult during normal hours. In one area there was a GP service located in the grounds of the hospital. However, there was little evidence that it was used by JHDs or that the majority were registered there. As a number of OHDs and FHSAs commented, the issue of accessibility is probably an excuse used by hospital juniors, who in truth probably do not wish to use, or be seen to use, or need the services. One DHR remarked "peer pressure has an important affect on the perception of who is available" (DHR (B)).

CONFIDENTIALITY

The issue of confidentiality was raised by most categories of respondents interviewed. Hospital doctors in particular, were reluctant to access work based supports such as senior colleagues, or occupational health services, because of their fears that services could not be trusted to be confidential. Whilst all respondents were aware of the need for services for doctors, as for all patients, to be confidential, a number raised questions as to the feasibility of this. A small number of juniors and Chief Executives felt that confidentiality for the doctor–patient would not be maintained because of the way doctors "gossip" to each other. One CE observed that "Doctors' anxieties about confidentiality reflect on the way *they* treat confidentiality" (ie. they talk about everyone) (CE of DHA (F)). Also, as juniors mentioned, because of the ambiguity in the rules which protect patient confidentiality when the patient is a doctor: "........confidentiality is not breached so long as the person you discuss the case with is another doctor. So technically, I suppose, you can ethically blab to your friends" (JHD (E)).

Problems of confidentiality are traditionally solved by both hospital juniors and GPs keeping health problems away from colleagues. It is accepted practice to seek treatment for eg. psychiatric problems and sexually transmitted diseases, across districts. However, this emphasis on discretion can mean that the presence of services to help is obscured: "there is a need for procedures to be more transparent and open so that those concerned can access the system and know what to do about problems" (FHSA (H)).

Several respondents, particularly amongst IROs, IMAs, DPH, Chief Executives and LMCs, observed that where patients are at risk it is not always appropriate to maintain confidentiality. It was suggested that doctors whose capacity to practice is impaired through illness, substance abuse etc. cannot be treated as others, and cannot expect confidentiality to be maintained in the same way. It is in the interest of patients that responsibility be taken to protect patients and that information of this type is passed to management: "doctors want trust and so must accept high levels of investigation if they abuse" (LMC (C)). A number of DHRs and IROs felt that it is these links that support systems are seen to have with management and disciplinary procedures, and anxieties about them, that form the basis of concern about confidentiality. It is the confusion over roles, and the rights of access to information, explained one DHR, that creates the perception that there is absence of confidentiality.

AMBIGUITY AND AMBIVALENCE OF MANAGEMENT

Clinical Directors, DHRs and OHDs to a greater or lesser extent manage medical staff – the end point of which it is believed, leads to disciplinary procedures which can end a doctor's career. OHPs, DHRs and HA CEs were clearly aware that such perceptions, commonly held by doctors about OHS, account for their failure to use them. Managers are seen, believe LMCs, FHSA managers, an IRO and a number of hospital juniors, as not cognisant of welfare issues relating to doctors' health, accomodation or conditions of work, and in general present something of a threat to doctors. In practice this mistrust means that the roles of managers vis a vis medical professionals are at best ambiguous. Whilst hospital managers describe involvement in doctors' health problems as one aspect of their personnel responsibilities to all staff, they are unclear about what they can feasibly expect from doctors in terms of contractual obligations. Half of the OHDs interviewed suggested that managers and hospital seniors do not respond to doctors in the same way as they do to other staff, for example nurses. This is so in terms of routine pre-employment screening by OHS, as it is with the problems of full-blown illness: "Managers of other staff will act but not managers of doctors ... They rarely come to our attention, unlike nurses who may be referred by managers ... They're specially treated in a way, they're the only group of hospital workers, which includes managers, who are not expected to come through the department before their contracts are confirmed" (OH nurse (F)). The difficulty, argued one DHR, is that "one is questioning their medical judgement when one asks about their health" (DHR (B)).

Whilst NHS managers are doubtful of their responsibilities, there is also a degree of ambivalence amongst hospital seniors as to the nature and extent of their

management roles. Several consultants, whilst expressing concern for 'the sick doctor', were quite unequivocal about not wanting any responsibility for them. An occupational health physician explained responsibility for colleagues with serious problems is 'shifted on' because "... no one really knows what to do. Any other complex problem, you publish a paper about it" (OHP (E)). Both OHDs and DHRs drew attention to the fact that recent NHS management changes mean that there is the possibility that hospital doctors will be increasingly treated like other employees. DHRs were to some extent optimistic that the changes will bring increasing accountability, raising questions of the responsibilty of all groups – managers and consultants included – with problems relating to poor performance, and illness being increasingly exposed. However, together with OHDs and hospital juniors some had little confidence that doctor illness will be addressed more sympathetically. IROs, DHRs and JHDs observed that the current emphasis on financial accountability and ensuring performance may mean failure, due to illness, will not be tolerated: with doctors who under-perform due to sickness being penalised. Consultants overall, and a small number of OHDs, agreed that the changes would be retrograde, or would not make much difference to the way doctors' health is managed. They felt that the responsibility for welfare had been lost in the recent "rehash of management". There is, said one OHD, "greater confusion over the role of managers and their responsibilities" and he included in this clinical directors. A small number observed, "no circle of responsibility". If the doctor does not appear to function correctly the only avenues left are punitive; ultimately it is up to the sick doctor to seek help himself.

EXAMPLES OF GOOD PRACTICE

Whilst existing services overall appear to be ineffective, some albeit limited examples of good practice were identified in different districts, mainly in services offered in occupational health and supports provided to GPs by LMCs. The better practices in NHS OHS – providing good information, minor treatment – in encouraging staff to use the services, tend to be more like those of the private sector industrial organisations, visited as part of the preliminary investigations for the study (Appendix XVIII). To what extent these services are any more effective in addressing doctors' more serious health problems is unclear given the continuing failure of doctors to seek help.

Discussion

The aim of this study was to examine the services provided to doctors should they become ill and how they might be improved. Doctors' knowledge and use of the services, and the reasons for their failure to access supports when needed were investigated. Researchers experienced some degree of resistance to their questions because of the sensitivities surrounding doctor illness and were not able to record detailed accounts of doctors seeking treatment for themselves, or of any other experiences of services. They were not able therefore to investigate the efficacy of services in known cases.

The adoption of an informal, open-ended interview schedule provided the opportunity for wide ranging investigation. The frequency with which certain central themes were repeated across different groups of respondents suggest that the findings presented have validity.

All respondents commented that changes must be made to the way in which the illness of doctors is addressed. Their comments reinforce the view that a strategy to address the health problems of doctors must be wide ranging, and as several writers have argued, be preventive (Cox 1981, Chambers 1989, Richards 1989, Harrington 1990), as well as providing coping mechanisms for those in practice, and support for the doctor who is ill (Richards 1989). The findings of this study suggest that there is a need for widespread change in current services. In achieving this organisational issues must be addressed, with a particular focus on the roles and responsibility of management (Cox 1981) and the welfare of doctors in the workplace.

Whilst some information is disseminated about the services available, knowledge of them tends to be limited, and few are perceived by doctors as providing support. There is limited understanding of the formal procedures associated with the GMC, FHSA, Wisemen professional panels (BMA 1992) and hospital doctors are unaware of work-based services such as OHS. Support services generally come into operation only following the identification of problems affecting professional performance (Chambers 1989). Only very few doctors come to the attention of services via such routes. Hospital juniors, whose job mobility and working hours make the routine accessing of services difficult (Richards 1989, Myerson 1990, Hale 1992), are unlikely to be referred. The GPs and hospital doctors interviewed had little confidence that the occupational health and GP services available have any real potential to provide them with a service they cannot provide to themselves. NHS occupational health services, in their present form, have a limited role in terms of doctors' health care. Whilst the

services which exist are variable (Waldron 1992) doctors in general are unlikely to use them (BMA 1992). The specialty has poor status compared to others, partly because OHS staff tend to be less well qualified, and few departments are consultant led (Cox 1981, Harrington 1990, Waldron 1992).

Where possible GP services should be the focus of care for doctor–patients, as they are for the population at large. Consideration must be given to the particular problems of hospital juniors in accessing GP services, and the difficulties which can arise where GPs are registered within partnerships. The identification of problems in colleagues, particularly in GP practice, is fraught with anxiety because of the questions they raise about competence, and associations they have with partnership disputes.

The experience of seeking treatment from close colleagues can be disappointing, resulting at least in part, as Allibone (1990) suggests, because doctors have problems responding to colleagues as patients. Evidence from this study shows that in addressing problems a doctors' colleagues are frequently reluctant to intervene because they are unsure about how to act. This is as much the case for Hospital Seniors in managerial roles as it is for GPs.

In seeking help the issue of confidentiality and how it can be ensured is a major concern (Allibone et al 1981, a Brook 1990). The identification of support services with management and apparently punitive disciplining bodies accounted in large part for the perceived absence of confidentiality. The legitimacy of managers' access to information about doctors' health is questioned because they are are not trusted. Managers are not seen to understand doctors' concerns and so in practice are limited in the ways they can provide support. Whilst it is recognised that recent developments in NHS management structures will provide the much needed potential to define responsibilities and increase accountability, there is some anxiety that emphasis on financial concerns will mean welfare issues are increasingly ignored, and little will be done to improve the way doctors' health problems are addressed.

A recent campaign by two of the Royal Colleges (Psychiatrists and GPs) in conjunction with the major retailing company, Marks & Spencer, suggest that there is some recognition of the need for management to consider work organisation and its impact on the mental health of employees. The Health & Safety Executive (HSE 1993) recommends that all employers institute effective occupational health policies which routinely consider mental health issues. Such

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preventive strategies are important because by addressing causes, problems are depersonalised (BMA 1992). A main focus of preventive strategies for doctors must be improving the facilities provided, and conditions in which they carry out their work (BMA 1992, Hale & Hudson 1992). Given their increased likelihood of suffering stress and depression compared to men (Firth Cozens 1990) the particular experiences of women in medicine must also be addressed.

The most basic of preventive health strategies requires there to be a profound change of ethos in medicine, to engender a climate in which doctors feel safe to admit illness and seek help for their problems. The attitudes doctors hold about illness, and the professional loyalty expected, prevents recognition of personal problems and those of colleagues. Whilst they know themselves to be at risk from stress and related psychiatric disorders, as a group doctors are reluctant to identify and acknowledge problems, particularly of this type (Richards 1989). Their perceptions of themselves as needing to be strong and coping (Richards 1989, a Brook 1990) seen as essential to securing good career prospects (Davison 1990, Hale & Hudson 1992) are learned early in medical school training (Roy 1987, Mc N Styles 1993) and from an early stage they do not seek help (a Brook 1990, Sutherland & Cooper 1992). The preferred approach to dealing with health problems amongst doctors is an informal one, with doctors frequently treating themselves and risking iatrogenic disease (Allibone 1990).

Changing the attitudes doctors hold about their own health problems will ultimately require a reexamination of medical education. Students and doctors must be encouraged to recognise and accept signs of their own stress and understand their susceptibility to it, not regarding the need for help as a sign of weakness (BMA 1992). They need to be provided with more information about the supports and services which are available, and undergraduate education should include substantial occupational health and safety elements (Cox 1981).

Self-help systems such as stress management are not sufficient in themselves. If anything is to be achieved in terms of prevention there must be regular feedback systems on presenting complaints and recurring sources of stress (Brown & Campbell 1991). Improved pastoral care of medical students and junior doctors, and effective feedback between consultants and juniors (Hale & Hudson 1992, King 1992), is required. Consultants and Senior Registrars need to develop management skills to maintain an effective pastoral role (BMA 1992, Hale 1992), and where it is formalised as a system of appraisal, further training for them may also be needed.

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The work of the doctor means that the person who practises medicine is specially placed. S/he is a high cost resource whose practice by its nature is bound by an ethic to do no harm. Where the health of a doctor is impaired it must not be allowed to impede that practice. S/he must be recognised as not only subject to the same rights of employment as any other health workers but also as entitled to them. To ensure that patients continue to receive safe and effective medical care, and that doctors receive proper health care for themselves, it is essential that steps are taken to improve the supports available to them.

Recommendations

Emphasis must be placed on encouraging doctors to behave as patients and to develop a pattern of consulting so that potentially serious problems are detected early, and treated before they become entrenched. If doctors are to be encouraged to recognise and address their problems, there must be mechanisms to provide counselling, diagnosis and treatment. So far as possible, provision should be standardised across all regions. This will be facilitated by:

1. Mandatory registration with a GP as a condition of employment for all doctors. For GPs, registration must be with a GP outside of the partnership within which the individual is practising, and where possible in a separate locality.

2. There must be provision made for the treatment of sensitive problems for all grades of staff, to take place, where possible, outside the district of employment.

3. Three Wisemen procedures to be made more transparent. Individuals to be selected for membership after appropriate training. Appointment to be made by the purchasing authority to whom they will be accountable.

4. Occupational Health Services to be developed and their status enhanced. More specialist consultants to be appointed and staff to have specialist training.

5. Confidentiality must be improved in all aspects of the services provided, and must be the same as that observed by consultants in Genito-Urinary Medicine.

6. All doctors to have access to a telephone helpline service as a backup to existing supports.

7. Hospital Juniors must be properly supported and trained. Inspection for pre-registration house jobs must be considered more seriously. Posts for general and specialist training must include the following:

(i) For GPs–FHSAs to have a duty to establish guidelines for identifying and coping with the health problems of GPs. Programmes of support to be developed for GPs at Post-graduate education centres.

(ii) Job descriptions of appointments to specialist posts to also include guidelines for identifying and coping with health problems, which apply to trusts.

(iii) Royal College and Faculty advisers who approve job descriptions must consider the adequacy of the arrangements.

(iv) Trusts which do not have adequate arrangements should be considered as providing inadequate quality of care and providers should be advised **not** to place contracts with them.

8. Each district to draw up codes of practice which outline all the supports available and the processes in place, and to circulate them to all doctors employed, and to all new appointees thereafter.

9. Emphasis must be placed in medical education on learning the communication and interpersonal skills needed to address the emotional impact of medical practice and identification of personal stress. The hospital based services/supports which are available to help, as well as the role of the GP, must be considered.

The attitudinal changes needed will be encouraged by the establishment of a pastoral structure to be operated amongst all grades of trainees, whereby all are involved in providing support–Oxford University's 'Uncle' system may be considered as a suitable model.

Formal mechanisms for appraisal should be introduced to provide an opportunity for the routine review of problems. Hospital Seniors to receive management training to facilitate this.

10. Further evaluative research to be undertaken with a view to improving existing services/mechanisms – including schemes currently provided by the GMC, LMC, Occupational Health Services, etc. Account must be taken of both management goals and the views of those doctors who have sought help and have experience of the procedures. Any new initiatives introduced must be audited. The particular needs of women medical practitioners must be a priority, given the high levels of distress and numbers of suicide experienced by them.

Acknowledgements

APPENDIX I – *SUICIDE FIGURES*

As one of the major consequences of inadequate services for sick doctors may be suicide, it was decided to use suicide as a marker of adequate and inadequate services and as a method of identifying districts which may have problems in dealing with their sick doctors.

OPCS figures were obtained for deaths amongst medical practitioners up to the age of 75 years in England who have died during the period 1979–1991 from the following causes:

E950–E959 Suicide (Death caused by purposeful self-inflicted injury)
E980–E989 Injury undetermined, whether accidentally or purposely inflicted.
Poisoning by drugs, medicaments and biological substances (adverse effects of medicinal agents).
Alcohol psychoses.
Alcohol dependence syndrome.
Drug dependence.
Non-dependent abuse of drugs.

The number of recorded deaths from these causes was small, in the range 2–5. Averaged over the numbers of doctors in each health authority district they ranged from 0.5% to 2.5% of all deaths amongst doctors. Four districts were selected from those with the highest death rates from suicide and related causes, in various urban/rural areas, in different geographical locations. The presence or not of a university teaching hospital was also taken into account. Each district was then matched with another where there were low/nil deaths from these causes. The 8 districts chosen are presented in Appendix II.

APPENDIX II – *DESCRIPTIONS OF CODED DISTRICTS*

A   Inner city area served by a university teaching hospital trust. Suicide rate 0.16.

B   City suburban area served by an NHS hospital trust. Suicide rate 0.16.

C   City suburban area served by an NHS hospital trust. Suicide rate 0.

D   Area including city with a university teaching hospital. Suicide rate 0.10.

E   City and outlying rural area served by a university teaching hospital trust. Suicide rate 0.12.

F   Town in a rural setting served by an NHS hospital trust. Suicide rate 0.

G   Inner city area served by a university teaching hospital. Suicide rate 0.21.

H   Town served by two DGH's. Suicide rate 0.

APPENDIX III – *INTERVIEWEES*

Four groups of people within the health authority and hospital structure were identified for interview in each district.

HEALTH AUTHORITY
Chief Executive
Director of Public Health
Chief Executive FHSA
Independent Medical Adviser to the FHSA
Chairman/Secretary Local Medical Committee

HOSPITAL
Chief Executive/Director of Human Resources
Chairman Consultant Staff Committee
Chairman Professional Review Committee/Three Wisemen.
Ocupational Health Physician

DOCTORS
GP Trainers – 2 per District
Junior Doctors' Mess President

DOCTORS/PATIENTS REPRESENTATIVES
BMA Industrial Relations Officers
Chair/Secretary CHC

Junior hospital doctors and GPs were included, both groups it was felt, having only loose attachments to the NHS management structure, face particular difficulties accessing support and advice about health. Given their general experience and involvement with other, younger GPs, we decided to select GP trainers, and 2 were picked at random from a list for each district. The problem of sampling junior doctors was overcome by selecting mess presidents in the belief that they would, to some extent, provide a representative view in each hospital. Insofar as they are providers of support and advice, it was also felt that the BMA's Industrial Relations Officers would be a useful source, and for the patients' view, representatives of Community Health Councils were included.

THE PROBLEMS OF IDENTIFYING RESPONDENTS

Identifying incumbents of senior posts in hospitals and health authorities was limited, in the case of 'Wisemen', because of the esoteric nature of the procedures of which they are a part, and in the case of managers more generally, by the confusion and disarray accompanying establishment of trust status in many of the districts visited. The process of identifying prospective respondents was therefore a very painstaking one and was the main occupation of both researchers during the first 3 months of the study. Numerous telephone calls were necessary to identify the departments, subsections of the departments, and the personnel within them who were finally able to provide the information required.

Letters detailing the aims and nature of the study, and requesting an appointment for an interview, were followed up by more telephone calls to agree dates, which again was by no means straight forward. The field work was carried out in the summer months and coincided, in a large number of cases, with respondents' arrangements for annual leave. As well as this, the busy work schedules of many of them were to make it difficult in any event, to identify dates and times which were mutually convenient. In most instances several calls were required to agree interview arrangements, and in a number of cases where respondents were cooperative, but elusive, over a dozen telephone calls were made. Arrangements for interview were confirmed in writing, and all respondents received a copy of the study outline.

WWH/CW/PM   ext.3144

Dear

HELP FOR SICK DOCTORS

I have been asked by the GMC to initiate a study to investigate the identification of sick doctors and the provision for services for them. The study will attempt to show how doctors manage their own illnesses and how they use the services which are available. It is hoped that by the end of the study there will be sufficient data to enable recommendations to be made.

The study is to be carried out in eight Health Authority Districts throughout England and Wales, including (name of district). As part of the investigation members of the research team aim to discuss these matters with a sample of doctors and key health care professionals in each of the districts selected, and would appreciate a discussion with you. It is envisaged that such a discussion would last about an hour and it would, of course, be confidential. The researchers Stella Silvester and Helen Allen are aiming to complete this work in (name of district) during the the week _____. One of them will telephone you shortly to arrange a meeting during that time.

With best wishes,

Yours sincerely

W W Holland CBE FFPHM

STUDY TO LOOK AT THE PROVISION OF MEDICAL
SERVICES TO SICK DOCTORS

Project Outline

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INTRODUCTION

There is considerable concern about how the medical profession deals with morbidity and mortality amongst its fellow doctors. National and local services for sick doctors do exist but there are great inadequacies in the use of these services and probably great variability in use between districts. It is felt that doctors fail to use the locally available mechanisms which in turn fail to identify and deal with sick doctors' problems at an early stage. The reasons for this could be three fold:

1. Ignorance of the existence or purpose of the mechanisms.
2. Reluctance by the medical profession to use them.
3. Failure of the mechanisms themselves.

As a result of this, many sick doctors reaching the GMC's procedures have advanced health problems (mainly addiction and mental illness) which have become largely intractable. If treatment had been given earlier, intervention by the Council might have been unnecessary, patients might have been better protected and the doctor given a better chance of full recovery and return to work.

This study is a pilot study at the suggestion of the GMC to investigate the provision of services to provide help for sick doctors.

AIMS

1. To consider how doctors who might require treatment are identified.
2. To ascertain the effectiveness of the local mechanisms in the management of doctors whose fitness to practice is impaired by health reasons and who may, as a consequence, endanger patients.
3. To consider how these mechanisms might be improved.

METHOD

As there is probably a great variability in the use of the mechanisms for sick doctors between districts, it has been decided arbitrarily to choose eight Health Authority Districts which differ in terms of geographical location, industrial characteristics and the presence or not of a university teaching hospital. A series of key people will the be chosen to interview in these districts.

The interviews will elicit their views on the following questions:

1.   What mechanisms exist in their district for the detection and treatment of illness among doctors?

2.   What use has been made of national mechanisms, e.g. GMC., National Counselling Service for Sick Doctors?

3.   How often are the mechanisms used and when were they last used?

4.   How effective have they been and what are the difficulties?

5.   How could they be improved?

6.   What events and episodes have occurred in their district?

Appendix VI–VIII – *INTERVIEW SCHEDULES*

INTRODUCTION

A series of three interview schedules was designed, for use with the different groups of respondents.

We were aware from the literature that doctors' reluctance to address their own illness would limit the terms in which those questioned could respond to us. As a result, it was felt necessary to explore the issue of doctors' health beyond the question of 'sickness' and the associated psychiatric problems and addictions. This was so, not only because respondents might have little knowledge of them, but because of the belief that understanding would be best developed by considering service provision for general health, and not simply the most stigmatising problems which individuals in general are reluctant to address. Doctors' failure/inability to access services for apparently 'trivial' ailments being part of the process responsible for their failure/inability to access them for these more serious complaints.

Before addressing the central issues of how doctors are identified and supported should they become ill, the interviews began by asking respondents to state what they considered to be the main health risks faced by medical professionals. In this way the focus of the interview was clearly established and it enabled us to gauge whether or not respondents denied the existence of the problem, a characteristic we thought might be commonplace. Following this there was discussion of known cases and the procedures followed in addressing doctors' health problems, and how services might be developed. GPs and Hospital Juniors were also questioned about their knowledge and experience of illness amongst colleagues (as well as their own, where they wished to discuss it), and to what extent they are involved in accessing support for others.

CONFIDENTIAL

MANAGEMENT OF DOCTORS' HEALTH

QUESTIONNAIRE 1
MANAGERS/HOLDERS OF RESPONSIBILITY

STELLA SILVESTER

HELEN ALLEN

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BLOCK 8 (SOUTH WING)
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HEALTH OF DOCTORS - QUESTIONNAIRE TO MANAGERS

DHA: .... Position Held: ....

SECTION ONE:
PERCEPTIONS AND RESPONSIBILITIES

1. Could you explain what exactly the role of .... in this district involves?

    ....

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2. What do you believe are the main risks generally to the health of doctors?

    (Record as listed EG. 1) HIV 2) Drug abuse, etc. Probe cause of eg. drug abuse, alcoholism if mentioned)

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3. Do the doctors in this district/hospital have any special concerns - YES/NO?

    If YES, say why:

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4.   What is the role of .... in this district in the management of doctors' health?

WHERE THE POST INVOLVES NO RESPONSIBILITIES FOR DOCTORS' HEALTH – GO TO NEXT SECTION

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5.   In what ways might a doctor who is ill, come to you/be brought to your attention? (Refer self, be referred by colleagues, others, etc.?)

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6.   Why might a doctor who is ill, NOT be brought to your attention?

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7.　　When did you last deal with a doctor who was ill? What happened?

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8.　　As a ...., what would be your aim in addressing the case of a doctor who is ill?

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SECTION TWO:
MECHANISMS TO SUPPORT SICK DOCTORS

9. Are you aware of mechanisms existing to identify and support sick doctors?

[Prompt – within NHS: OHS/'3 Wisemen Procedure'/ FHSA/ LMC/ Counselling Services/ Staff Support Groups.]

Outside NHS: National Counselling Service for Sick Doctors, BDDG, private counselling etc.]

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10. To what extent do the mechanisms which exist within the structure of the NHS, interact with one another?

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11. In providing a system of support for a doctor with, for example, a psychiatric or drug problem, how much use is made of the mechanisms which exist outside of the NHS?

Where little use is made of non-NHS mechanisms, ask WHY?

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12. How effectively does the the existing structure (including OHS) meet the health needs of doctors?

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13. The present structure has been criticised because it is not preventative, and does not deal with stress related problems, to which doctors seem particularly prone. What strategies could be adopted to help doctors deal with stress?

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SECTION THREE:
HEALTH SERVICES FOR DOCTORS

14. What information do staff, new to this district/hospital, receive about the systems of support available to them?

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15. Some doctors believe that existing health services cannot meet their needs and that there should be special provision for them (they are inaccessible; doctors are not treated as patients; problems with maintaining confidentiality, etc.). What is your view?

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16. How might confidentiality be assured in health services for doctors?

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17. How might health services be made more accessible for doctors?

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18. How might work-based health/counselling services be provided, and be seen to be, independent of management?

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19. Could resources be made available to establish separate health services for doctors?

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20. What is the likelihood that resources would be made available to establish such services?

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SECTION FOUR:
OTHER MECHANISMS/POSSIBLE DEVELOPMENTS

21. Some health service workers have a system of staff group support. Would such a system be valuable for doctors and could time be allowed for it during the course of normal working hours?

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22. What is the likelihood of such a scheme being established?

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23. What else could be done to get doctors to address their health needs more?

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24. Recent changes in NHS management mean that management of medical staff no longer necessarily lies with those who have clinical responsibility. What are the implications of this for the way doctors' health may be addressed in future?

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CONFIDENTIAL

MANAGEMENT OF DOCTORS' HEALTH

QUESTIONNAIRE 2 – GPs and HOSPITAL DOCTORS

STELLA SILVESTER

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HEALTH OF DOCTORS –
QUESTIONNAIRE TO GPs/ HOSP. DOCTORS

DHA: .... POSITION HELD: ....

SECTION ONE:
PERCEPTIONS AND BEHAVIOUR

1. What do you believe to be the main health concerns of doctors/GPs?

    HIV   Hepatitis B   Alcohol Abuse   Drug Abuse

    Mental Illness/Stress

    Other..

2. What information is provided to you on appointment to this DHA about
    the health services and supports available to you?

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3. What mechanisms exist in this hospital/district to manage the health
    problems of doctors?

    (Hospital – OHS, '3 Wisemen' procedure, Consultant, etc.) (GP – FHSA,
    LMC, Support group, etc.)

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4.   What would you need to do to mobilise this support?

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5.   Have you ever had cause to be concerned about a colleague's health?

   If YES – What happened? What did you do?

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6.   Have you ever had cause to refer a colleague to OHS, or to discuss their health with a senior member of staff?

   If YES – What happened?

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SECTION TWO:
MECHANISMS TO SUPPORT SICK DOCTORS

7.   Do you know of any mechanisms of support being available to doctors outside of the NHS?

   (Probe – NCSSD, BDDG, etc).

   If YES – have you, or your colleagues used them?   YES/NO

   If NO – Why?

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8.   How effective, do you think, are the existing mechanisms for meeting the health needs of doctors?

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9.   Could anything be done to prevent the stress related health problems to which doctors seem particularly prone?

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10. What could be done to encourage doctors to address their own health more?

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11. Some doctors believe that existing health services cannot meet their needs (are inaccessible; doctors are not treated as patients; problems with maintaining confidentiality, etc.) What is your view?

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12. How do services need to be organised to meet the health needs of doctors?

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13. What is the likelihood do you think of services changing to meet doctors' needs?

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14. Recent changes in NHS management mean that management of staff no longer necessarily lies with those who have clinical responsibility. What are the implications of this for the way doctors' health may be addressed in the future?

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APPENDIX VIII – *INTERVIEW SCHEDULE*

MANAGEMENT OF DOCTORS' HEALTH

QUESTIONNAIRE 3 –
COMMUNITY HEALTH COUNCILS

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HEALTH OF DOCTORS - QUESTIONS TO CHC'S

1. How often are complaints made to the CHC about doctors, because of their health, or alcohol or drug abuse?

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2. Have you ever had to deal with such a complaint?   YES/NO

   If YES - What happened?

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3. What procedures, if any, are laid down to deal with a complaint where a doctor's competence/capacity to practice is questioned on health grounds?

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4.   Are you aware of the mechanisms which exist to deal with illness amongst doctors?

(Prompt – '3 Wisemen' procedures, LMC, GMC, etc)

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5.   Have you ever referred a doctor via one of these procedures?   YES/NO

If YES – what happened?

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6.   In your view, do the existing mechanisms do enough to protect patients? YES/NO

If NO – What would you like to see implemented?

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SS/HA/PM/dphm   EXT.3144

Dear,

HELP FOR SICK DOCTORS

We wrote to you recently, asking for your help with a study concerning the identification of sick doctors and the provision of services for them. Following this we were aiming to arrange a meeting with you but our attempts to make further contact have not been successful.

As we have been unable to meet with you, we wonder whether you could help us by completing the enclosed questionnaire. We are aware that there are many demands on your time and so the number of questions have been kept to a minimum, and concern very much the same issues as we would have hoped to explore in a discussion.

Any information you are able to provide will, of course, be treated as strictly confidential.

The research which we are inviting you to support, aims to provide information which may be used to make recommendations, to improve the supports which are available to doctors when they become ill. Your views as a (Junior Doctors' Mess President/GP Trainer) are considered to be valuable and would be very much appreciated.

Yours sincerely,

Stella Silvester   Helen Allen (Researchers)

Enc. (incl. SAE)

CONFIDENTIAL

MANAGEMENT OF DOCTORS' HEALTH

POSTAL QUESTIONNAIRE – GPs and HOSPITAL DOCTORS

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TELEPHONE: 071 928 9292 EXT. 3144

HEALTH OF DOCTORS –
QUESTIONNAIRE TO GPs/HOSP. DOCTORS

DHA: .... POSITION HELD: ....

SECTION ONE:
PERCEPTIONS AND BEHAVIOUR

1. What do you believe to be the main health problems of hospital doctors/GPs?

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2. What information is provided to you on appointment to this DHA about the health/welfare services and supports available to you?

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3. What mechanisms and supports exist in this hospital/district to deal with doctors' illness? For each one listed, please briefly describe how you would access the service.

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4.   Have you ever had cause to be concerned about a colleague's health?

YES/NO (Delete as appropriate)

If YES – Please describe briefly what happened and your responses.

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5.   Have you ever had cause to discuss a colleague's health with a senior member of staff, or to refer them to occupational health services, etc.

YES/NO (Delete as appropriate).

If YES – Please describe briefly what happened and your responses.

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SECTION TWO:
MECHANISMS TO MANAGE ILLNESS

6. Apart from those services provided within the hospital/Health Authority and already discussed, are you aware of there being any other supports available to doctors when they become ill?

    YES/NO   (Delete as appropriate)   If YES – please list them below.

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7. Have you, or any one you know, ever used any of the services you have listed?

    YES/NO   (Delete as appropriate).

    If NO – please explain your answer.

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8. In your view, how effective are the existing supports and services (both within and outside the NHS) in meeting the health needs of doctors? Please give reasons for your answer.

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9.   Some doctors believe that existing health services, such as hospital based occupational health services, GP services, etc cannot meet their needs (they are inaccessible; doctors are not treated as patients; problems with maintaining confidentiality, etc.) What is your view?

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10. How do health services need to be organised to meet the needs of doctors when they become ill?

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11. What can be done to ensure that the doctor who seeks medical help is treated as a patient by the doctor consulted?

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12. What, in your view, is the likelihood that existing services would be changed to meet the health needs of doctors? Please give reasons for answer.

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13. What could be done to get doctors to address their health needs more, especially the stress related problems to which they seem particularly prone?

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14. If you would like to add any further comments on the subject of doctors' health, or its management, please write them in the space below.

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THANK YOU

Appendix X – *RESPONSE RATES BY DISTRICT*

District Code:	Possible Response	Actual Response	%
A	14	12	86
B	14	11	79
C	14	13	93
D	14	12	86
E	14	12	96
F	14	13	93
G	14	11	79
H	14	13	87
Total	112	97	87

APPENDIX XI – *RESPONSE RATES BY GROUPS OF PERSONNEL*

Responses by Personnel

Personnel Group	Total Possible	Actual	%	Reason for lack of response by district
HEALTH AUTHORITY:				
Chief Executive	8	6	75	District A – refusal E – out of post
DPH	8	8	100	
FHSA General Manager	8	8	100	
IMA	8	7	86	G – out of post
LMC	8	8	100	
HOSPITAL:				
DHR	8	7	86	D – N/A
Chair Consultant Staff Committee	8	8	100	
Wisemen	8	3	38	A, B, H – not identified G, E – refusal
OHD	8	8	100	
JHD questionnaires	8	6	75	B, G – unreturned
GPs	16	12	75	C – refusal
IRO questionnaires	8	8	100	B, D, G – unreturned
CHC	8	8	100	
Total	112	97	87	

Appendix XII – *THE FIELDWORK EXPERIENCE*

Whilst the researchers were generally well received, in some cases questions were resisted and the quality of the data collected adversely affected.

The overall response rate of respondents to the study was 87% which was gratifying. However, this should be seen in terms of the different experiences and therefore length of the interview and quality of data collected. Generally interviews lasted about an hour and varied in length from just less than 15 minutes to over 2 hours in one instance. On the whole the researchers were received well and in one particular area (G) there was a very positive interest in the study and many requests for the results. Requests for results came also from A-2, B-1, E-2, F-3 and H-3. It was sometimes difficult to keep respondents to the agenda since some had a great deal which they wished to contribute. This was the case with 10 respondents although the quality of data collected was not adversely affected given the richness of their responses. In four instances there was a marked reluctance to agree to an interview and indeed a resistance to being interviewed. These interviews were difficult and short in length, and resulted in relatively poor data.

REFUSERS

A number of potential respondents were reluctant to be interviewed as they felt they had little to offer. In three districts (A,B & H) it was not possible to identify any Wisemen, committee chairmen or otherwise. In 2 areas (E & G), Chairmen of Wisemen Committees refused to be interviewed.

One of the Wisemen identified was reluctant to be interviewed as he was in "an ethical dilemma" over the study, which he did not explain. Once assured about sampling, methodology and confidentiality, however, he agreed to a meeting. The meeting was arranged to take place in a relatively public place, thus limiting the possibility of effective interviewing but so as to achieve some data from this group, this was agreed to. On arrival at the appointed time, the researcher was informed by the Consultant's secretary that he had given no indication that he intended to make himself available. No apology was made. The researchers did not pursue the matter further. The other Wiseman identified, but not interviewed, was on leave for the duration of the fieldwork. She was asked to nominate another "wise person" in her stead. It appeared that this request was misunderstood as another member of staff in the same speciality was nominated. Follow up revealed that the original consultant was not actually a Wiseman and no one knew who was. During the course of the fieldwork in that district another senior physician with a deep interest and knowledge of doctors' health and welfare was brought to the notice of the researcher. An interview was arranged

and proved most fruitful. The true identity of the Chair of 3 Wisemen never was discovered.

The Chief Executive of one HA/Trust was very reluctant to be interviewed on the basis that he had little to contribute. Despite a series of telephone calls and faxes, he passed the researchers on to the DHR of the trust.

GPs were difficult to tie down because of the nature of their work, but 12 were interviewed out of the possible 16. Of the GP trainers identified, researchers were unable to make telephone contact to arrange interviews in two cases, and the third was unavailable for interview at the time of field work in his district. The fourth refused on the grounds that he had no time in which to be interviewed, despite assurances that the interview could be limited to as little as 20 minutes.

Seven out of eight IMAs were interviewed, the post of IMA in the eighth district being vacant.

Junior hospital doctors – Mess Presidents were difficult to identify and then arrange interviews with because of the hours they worked and the peripatetic nature of their employment. However, five were interviewed, and one completed and returned a postal questionnaire. Of the two remaining JHDs, one was on terminal leave and the other cancelled his appointment, and then failed to return a postal questionnaire.

Appendix XIII – *THANK YOU LETTER*

Dear,

HELP FOR SICK DOCTORS

Following our recent meeting, we would like to thank your time and the interest you have shown in our research.

We aim to complete the study by February of next year, and hope then to be able to send you a summary of our findings.

With very best wishes.

Yours sincerely,

Stella Silvester   Helen Allen (Researchers)

Appendix XIV – *HEALTH CONCERNS OF DOCTORS*

All groups of interviewees responded to this question by discussing stress and the factors which cause it. Whilst CHCs were not asked to comment, they too are aware of doctors's stress, perceiving a need for doctors to receive guidelines on how to deal with the signs and effects of stress. There was recognition that doctors who are able to help themselves are better able to assist their patients. Many were aware of research findings which indicate a high incidence amongst doctors of psychiatric and drug/alcohol related problems, marital breakdown and suicide. Blood borne infections were the other major category cited as causing risks to doctors' health and were discussed by by Hospital Juniors (largely as the result of needlestick injuries), the majority of OHDs (who tend to see people anxious about risk rather than cases of actual infection), as well as a number of FHSA managers, DPHs and DHRs. However, in relation to the emphasis in responses on stress, concern about blood borne infections was minor.

STRESS

Stress is seen to relate to the decline in morale associated with recent changes in the NHS (for both hospital juniors and GPs). Those who discussed stresses of Hospital Juniors – DHRs, OHDs, Senior Consultants, DPHs and Hospital Juniors – also largely agreed on the causes of doctors' stress and the health risks faced by them. Working hours and extended periods of work without breaks; short-term contracts and the resulting need for constant mobility and relocation; poor working conditions; poor attitudes of managers and apparent abuse of juniors, goodwill, were given as main health concerns by juniors themselves. OHDs echoed the views of juniors in citing lack of sleep and quiet places to rest, poor meals, long hours of work and continuing to work when ill, as major health concerns. "Most juniors when they want time off, it's not because they have anything you could put on a certificate, like angina or pneumonia or any thing like that, it's just exhaustion........ problems coping with work. Then that escalates into other things and it starts to affect your health" (JHD (C)).

Another Hospital Junior (E) described poor accommodation as the "single biggest cause of depression amongst Juniors".

The stresses of being in GP practice were, agreed GPs and their FHSA and LMC colleagues, related to an all round increase in workload arising from imposition by the government of new contracts, the patients charter, as well as increasing patient expectations. The generally stressful nature of medical work and the 24 commitment were seen by them as major stressors insofar as they deny time needed to relax, to prevent stress from becoming problematic. A particular feature of GP stress is the feeling of no longer being in control of work. In

addition, the fact that there are so few supports, was cited by one FHSA manager as a further stressor in itself. There are particular concerns (CHCs) about single handed GPs, "no one sees them, well or ill".

The competitive nature of medicine and the medical career structure was seen to be a major cause of stress by a number of IROs, Senior Consultants and Hospital Managers.

APPENDIX XV – *KNOWN CASES OF ILLNESS*

Dist. etc.	*Psychiatric Depression*				*Physical*			Total
	Alch.	Drugs	Suicide	Un-stable etc.	Heart Stroke/Resp	Aids/Hep	Specified	
A	1	0	1	1	3	1	3	10
B	0	1	1	7	1	0	2	12
C	5	2	3	4	2	0	9	25
D	3	0	5	6	2	0	3	19
E	2	0	8	4	1	0	4	19
F	7	0	3	12	7	0	2	31
G	5	3	0	8	0	0	1	17
H	6	3	0	6	0	0	7	22
Total	29	9	21	48	16	1	31	155
Range	0-7	0-3	0-9	1-12	0-7	0-1	1-9	

108   17

77

APPENDIX XVI – *ROLES AND RESPONSIBILITIES*

CHIEF EXECUTIVES HA (CEs)

Having a mainly purchasing role and now directly employing a small number of Public Health doctors, Chief Executives have only a very limited involvement in dealing with doctors' health problems. In purchasing health care for the populations they served, Chief Executives were in agreement that the health of doctors must be assured in order to provide acceptable services. However, there was disagreement about where responsibility must lie to ensure that the doctors employed by providing authorities are in fact able to provide the services purchased. Some respondents, commenting on the self regulating nature of the medical profession, felt that health problems are the responsibility of the trust. When questioned about how purchasing authorities might ensure that the trusts are dealing with the problem, the solutions most obvious seemed to be via medical audit procedures. Where audit procedures fail to detect health problems, or are not affected by them, one Chief Executive raised the question of the DHAs' responsibilities should problems come to public notice through, for example, court cases, patients' complaints etc.

DIRECTORS OF PUBLIC HEALTH (DPH)

Whilst in the past the DPH would have had a role in the health management of doctors, his or her role varies in relation to the health authority's role as a purchaser of services and whether or the not the doctors overseen are employed by a trust. Generally, as their formal responsibilities are becoming concerned with the question of purchasing health care, involvement in medical staffing matters is declining. Whilst the study was being conducted, the role of the DPH, vis a vis trust employed doctors, was being negotiated in several areas. Some will continue to be involved in disciplinary proceedings concerning consultants, but since junior doctors continue to be employed at regional level, they will not be formally concerned with them. Seven of the DPHs had worked in the same geographical area for many years and being well known and respected members of the medical community, their advice regarding doctors health problems is frequently sought.

INDEPENDENT MEDICAL ADVISERS (IMAs)

As with other groups, IMAs have no formal responsibility for doctors' health but given their daily involvement with GPs, they are likely to hear of problems should they arise.

INDUSTRIAL RELATIONS OFFICERS (IROs)

The role of the IRO is to provide advice on various work related issues to those doctors who are members of the BMA. Those IROs interviewed said they do "get caught up in" cases where doctors have health problems, and all had experience of them. In such cases they provide advice not only to those doctors who are ill, but frequently also to their seniors, clinical managers and others. Partners of GPs frequently seek the help of IROs where they are concerned about colleagues, largely as one IRO put it, "because of the need to sort out livelihood issues". Two described the IRO as providing "a conduit, to refer people on". However, one observed that the problem with regard to doctors' health problems is 'there isn't a proper structure to refer people onto' (IRO (H)).

The following groups of respondents have, to a greater or lesser extent, a formal role which may involve dealing with the health of doctors:

FAMILY HEALTH SERVICE AUTHORITY (FHSA) MANAGERS

FHSA managers must ensure that medical care provided to patients of the district served is "competent" but, like most other respondents, their involvement with doctors' health problems is limited, despite the fact that as holders of the NHS contracts of GPs they describe themselves as having a "quasi employment role". FHSA management may have a greater role in the case of the single handed GP who is ill because of their responsibility to ensure service provision. The FHSA's statutory responsibilities are to ensure contract compliance, which they do largely without invoking formal procedures. The most likely course of action should health problems of doctors come to their attention is to refer them to the LMC.

LOCAL MEDICAL COMMITTEE Chair/Secretary (LMCs)

The representatives of the LMCs interviewed described their role as "reactive". Statutory procedures which regulate the FHSA involvement with doctors' health problems mean that the LMC will be involved when and if they are called to do so. Representatives of the LMC will, if requested by the FHSA, provide a medical opinion in the case of a doctor who is ill, and make recommendations for treatment, etc. as appropriate.

SENIOR CONSULTANTS and WISEMEN

Responses of these groups were considered together as "senior consultants". In one area the same person occupied both positions.

WISEMEN

The nature and extent of the role of Wisemen varied by district. Most Wisemen interviewed described themselves as having a "general responsibility for medical staff. .....specific but ad hoc". In theory the committee acts to investigate disciplinary matters, the aim is to deal with problems before they require GMC involvement. Like LMC chairs they are reactive, and the focus of their concern tends to be with consultants rather than with hospital juniors.

CHAIR OF THE CONSULTANT STAFF COMMITTEE (CSC)

Only one Chair of the CSC described his role as being concerned with providing advice or involvement in mechanisms to support sick doctors.

OCCUPATIONAL HEALTH DOCTORS (OHDs)

Those interviewed were not all physicians. The 4 consultants interviewed were in the university teaching hospitals. OHS in DGHs had medical input from GPs on a part-time basis. 3 GPs were interviewed and one senior OH nurse. Again, although their role is concerned with the health of all hospital staff, they have no specific responsibilities with regards to doctors. The main work of such departments in relation to doctors is in terms of pre-employment screening, checking immunity and updating vaccinations especially, for example, Hepatitis B.

DIRECTORS OF HUMAN RESOURCES (DHRs)

DHRs have no specific responsibilites for health apart from those which arise as part of their normal management concerns for all staff.

APPENDIX XVII – *NUMBERS OF MECHANISMS NAMED*

Personnel Groups	Mean per group	Mechanism most frequently mentioned
IRO	4.6	LMC
DHR	3.0	OHS
IMA	2.76	LMC
DPH	2.75	OHS
GPs	2.67	LMC
OHD	2.5	OHS
Senior Consultants	2.76	OHS
LMC	2.25	LMC
FHSA	2.00	LMC
HA CE	1.5	OHS and 3 Wisemen

OCCUPATIONAL HEALTH SERVICES IN PRIVATE SECTOR INDUSTRY

Occupational health services in some of the larger industrial organisations may be seen to offer examples of good practice in the way staff health and stress are monitered. Those visited as part of the preliminary investigations of this study provided a welcoming environment and detailed information about the range and nature of the services provided, as well as how health data is used and in what situations it may be passed to management. OHS staff placed great emphasis on maintaining confidentiality and worked at demonstrating this to the rest of the work-force. In providing a variety of health promotion programmes and minor treatment services, with limited prescribing – services employees do use – OHS staff are able to maintain an informal watchdog role, by which stress levels may be monitered. Alternatively, confidential support for a wide range of health, financial and emotional problems was provided for staff in one organisation through provision of access to a telephone help-line service outside of the company.

NHS OCCUPATIONAL HEALTH SERVICES – the best examples found in this study differ in small part only from those examples cited above.

OHS DISTRICT A – Proactive in limiting alcohol consumption on hospital premises and at Medical School functions (especially induction programmes/ freshers' events). If psychological problems are detected in pre-employment screening help is offered. The trust is in the process of establishing a confidential telephone counselling service for all staff. Specialised counselling is provided as part of OHS.

OHS DISTRICT F – Very proactive in maintaining vaccination status of all medical staff, each individual being provided with a personal – credit card style – immunisation record which is updated by OHS, who regularly recall staff for vaccination updates. Lists of staff who fail, following reminders, to attend for revaccination, are provided to management who take action as appropriate. Information is provided to newly appointed juniors about local GPs and they are strongly encouraged to register with them.

OHS DISTRICT E – Occupational health services are provided in a building apart from the main body of the hospital. Juniors receive a booklet containing information about all aspects of their welfare, including accommodation and other hospital facilities, and there is a separate section which addresses

the health of the doctor. A list is provided of hospital seniors from different departments who are available to give support if required. Telephone numbers are given so that they may accessed easily. Guidelines are provided about avoiding blood-borne virus infections, as well as the GMC statement on duties and responsibilities of doctors who know/suspect they have been exposed to HIV.

OHS DISTRICT H – Provides a clear, 'user friendly' booklet about OH services to all staff. OHD addresses hospital juniors as part of their induction programme. Contracts of juniors are not confirmed until a health screening questionnaire is completed and they are confirmed as medically fit. All juniors are expected to visit OHS within the first few days of being appointed, when they are provided with information about local GPs and encouraged to register with them. Doctors appointed at regional level are expected to attend OHS for the purposes of assessing vaccination status and follow up of any problem identified by screening at regional level. Staff are encouraged to attend a treatment service provided for accidents/illness arising at work. OHD stated that this was an important route into the department and a means by which other, perhaps stress related, problems might be monitored.

OHS DISTRICT G – Attempts are made to see all new consultants who are appointed – "are long term appointments and are valuable resources". It is also recognised that consultants are older and those who are unwell may have problems which are entrenched.

EXAMPLES OF GOOD PRACTICE – GPs

There were districts where LMCs established supports for GPs

DISTRICT G – Appointment of medical adviser to the LMC who acts independently to provide information and support to GPs about a wide range of problems (financial, family, etc) including those relating to health.

DISTRICT E – Chair of LMC is a well established local figure, known to be supportive and available for help. A system of contacts and supports is being established to provide backup to GPs who are the subject of a complaints.

DISTRICT F   –   A network of older GPs is available to provide telephone and personal counselling to those in need of support. Information about them and how to access them is regularly repeated in LMC newsletter.

DISTRICTS   –   Both have active postgraduate centres which act as a
G & E   focal point for GPs; programmes are both educational and supportive and appear to go some way to limiting isolation of GPs.

DISTRICT E   –   Offers a programme (with FHSA funding) to address management issues relating to practice as well as individual and professional issues, which have arisen as a result of current changes in primary care.

Appendix XIX – *THE NEED FOR CHANGE*

IMPROVING EXISTING SERVICES

There was acknowledgement of the wide variety of counselling/support services available and used by the public at large, which doctors could, if they wished, also access, and little support expressed for the view that there is a need for a third tier of health services specifically for doctors. Overall, it was felt unlikely that funding would be forthcoming for separate services given "the lack of political will", to make such changes.

(a) *Improving Occupational Health Services*
Only 3 groups of respondents raised this issue, the views of occupational health doctors themselves were varied and said little about the need for improvements.

DPHs who commented said there is a need for regionally agreed, standard services for all staff, which would include counselling services and supports for rehabilitation. The nature of the service should be more prescriptive, and like DPHs, the other main group who responded, CEs said OHSs should be consultant led. One CE emphasised the need to work on cultivating an "image of safety and trust" for OHS, so that the service is used more: "The situation has yet to evolve where people voluntarily go to occupational health. It could be and should be a nice centre for people to go....." (CE (D)).

In achieving this process it was felt that OHS literature must emphasise respect which is given to confidentiality, and OHS staff must be seen to act this out.

(b) *Develop Role of GP Services*
What is needed, it was agreed, amongst a number of respondents across most groups of those interviewed, is for services to take account of doctors' particular needs, to become "doctor sensitive", as one DHR commented.

GPs, DPHs, IMAs and LMCs, agreed that the role of the GP could be developed to meet the needs of the doctor-patient better, an idea summed up by the phrase, "a doctor's doctor", who might offer special sessions for the treatment of doctors.

(c)   *Flexible Consulting Hours*
Flexible consulting hours, argued GPs and Hospital Juniors, would be one way of overcoming the problem of accessibility. Whilst IROs acknowledged the disagreement over whether problems accessing care are actual or perceived, it was argued that it must be addressed, the GP relationship being of central importance, "the lynchpin of continuing care" (IRO (D)).

(d)   *Network of GPs/Counsellors*
The setting up of a network of doctors, and possibly counsellors, across districts was also suggested, so that doctors consulted would not necessarily be linked to the district in which the doctor-patient works. This was felt to be a reasonably inexpensive way of providing healthcare and would facilitate diagnosis and treatment in the early stages of illness.

(e)   *Health Cash Voucher System*
Financing such a system, suggested an IMA, could be through a system of Health Cash Vouchers, organised centrally and enabling every doctor to consult any GP they should choose.

(f)   *Improve Information*
OHPs, IMAs and LMCs commented upon the need for improving the provision of information at a variety of levels.

One LMC representative stressed very strongly the need for any scheme aimed at addressing doctors' health to be promoted well, existing schemes not having high profiles are not remembered when they are needed.

(g)   *Increase Information*
OHPs felt that, as for other groups targetted by health promotion programmes, doctors need better information about services, particularly information about services apart from those provided by the GP.

(h)   *Guidelines*
For OHPs themselves, one OHP commented that guidelines are needed about how to deal with the sick doctor, there being little knowledge available as to how best to proceed.

CONFIDENTIALITY

Whatever is provided, the service must be seen to be trustworthy: "The answer lies in finding a service which a doctor will avail himself of without feeling at additional risk, at a time when he is admitting that he can't cope" (LMC (G)). Establishing a good reputation is vital, argued 2 OHPs to encouraging doctors to use services.

(a) *Access Care Across Districts*

There were limited suggestions as to how the problem of confidentiality might be improved, apart from continuing the traditional practices of accessing care out of district. In one district plans were in place to introduce a telephone counselling service, given the greater chances afforded by such a scheme to ensure confidentiality.

(b) *Educate Managers*

Suggestions for improving OHS came mainly from OHDs. Overcoming the problem of confidentiality, they argue, involves educating managers, as well as changing practice in existing services. Management, it was stressed, do not have an automatic right to confidential clinical information: "Is a problem of perception of management – we have got to get the message across to management that in order to maintain confidentiality, we can't spill the beans" (OHP (E)).

·(c) *Demonstrate Confidentiality*

In addition there was widespread recognition of the need to **demonstrate** that confidentiality exists. "Must make a very conscious effort not to talk about people – we do that in occupational health. Everyone talks about patients, especially within their specialties – in corridors, on wards, everywhere. It is very bad practice" (OHP (E)).

Three main suggestions were put forward:

1. Improve Communication

Good communication i.e. explaining to the doctor (or any other patient) the service's remit; how the information placed on record might be used, etc.

2. Demand High Standards of Professionalism

High standards of professionalism i.e. protecting confidentiality at all levels. Details of a person's health status are not passed to management without written consent: steps are taken to ensure OHS staff do not discuss patients (raised in 4 areas) and all staff to be discouraged from discussing patients casually: restricting access to files, eg. locked cabinets away from other files.

3. Relocate Services

Location – a small number of OHPs (2) felt locating services away from the main hospital buildings reinforces the idea of the service as independent.

ORGANISATIONAL DEVELOPMENT

A number of DHRs observed that there are "systematic structural problems which add to the stress of the life of junior doctors". Reducing stress, it was suggested "is about making the organisation work properly". There was widespread recognition for the need for management, clinical managers included, to seriously address the question of staff welfare, to establish lines of responsibility, and to create a working environment in which stress is reduced.

MANAGEMENT

The NHS and hospital structure are seen to generate stress through poor management, absence of consistency in decision making and lack of support from above. Amongst GPs there was a strong feeling that they need to regain control of their work, for the profession to be consulted when government is considering change, for them to be involved in goal setting. CE (F) – commented that an enlightened management would stress improvements in service provided which would come with increased morale, and a motivated work force (readdressing problems of stress). Overall, he and another suggested, medical staff should be recognised as the "precious commodity they are": "We spend a lot of money, a lot on medical staff, the problem is proof of value. But investments are about reasonable risks. If medical staff are ill, partly as a result of work, the employer has a responsibility and should make reasonable investment" (CE (D)).

(a) *Clear Policy on Responsibility for Doctors' Health*

Most groups of senior managers and doctors stressed the need for clear policy to be developed and for management to define their responsibilities with regard to doctors' health, particularly, as DPHs observed, that with

the primacy of their purchasing roles, their traditional responsibility, is not being passed on to others, but is being "phased out".

(b) *Legislation on Doctors' Responsibility for Personal Health*
There is a need it was argued by DHRs, DPHs and IMAs for legislation, at the same time there must be corporate recognition that doctors should look after their own health as well as they do patients: juniors must take responsibility for themselves when ill and seek treatment (DHPs and DHRs).

To achieve this process of change, it was argued, doctors must be seen to set an example, to not perpetuate the myth of the doctors' invincibility (DHPs). At the same time several groups of respondents argued for doctors being treated much more like other NHS employers, being targetted in the self-help campaigns (where they exist) for smoking, diet, exercise and stress.

(c) *Routine Health Checks and Health Screening*
Nearly all of respondents (apart from Senior Consultants and IROs) argued for more routine health checks and better screening procedures as a way of identifying early warning signals.

(d) *Examine Student Selection Procedures*
One OHP argued for selection procedures to be tightened up so that problems presented by students might be identified, also for more research into the predictors of problems (OHP(A)). A small number of OHPs and IMAs suggested that fitness standards must be laid down for practising doctors, as exist in other professions such as airline pilots.

GPs, JHD, IMAS, DHRs and FHSA managers argued for doctors to be subject to regular compulsory health checks as a way of encouraging them to address their own needs, particularly at the pre-employment stage (GPs included), following absence from work, and those who continued to work over the age of retirement.

(e) *Maintain Performance*
CEs stressed that maintaining performance was a managerial responsibility of clinical directorates who should be monitering staff in this way, both on a personal basis as well as in clinical teams. A number of them and DPHs

identified clinical audit as a means by which problems may be detected and argued for all to be involved.

(f) *Accreditation*
With regard to GPs, IMAs and LMCs argued for accreditation procedures to be used as a way of identifying and addressing problems early on. Such procedures would need to be enforced given that the facility to refuse accreditation at the end of training already exists, but is rarely used even when appropriate. Those failing to gain re-accreditation would need to be retrained; how this would be financed must be addressed.

Such a scheme might address the problem of dealing with problems amongst lone GPs but at the same time, FHSA managers argued, there is a need for colleagues, particularly in partnerships, to address problems identified in colleagues and to provide support, "not to let it go". As observed by a CE (H): "Is incumbent on management to build or create an atmosphere where everyone is involved".

WELFARE AND DOCTORS

In discussing the question of health amongst doctors, several hospital juniors commented that there are very basic needs which should be addressed: "Is about basic facilities and conditions of work" (JHD KUT).

(a) *JHD Work and Mess Facilities*
Improvements to accomodation and mess facilities are seen as contributing significantly to improvements in morale and subsequently better patient care.

A number of DHRs and DPHs were also aware of the need for better living environments, and places for juniors to relax, where they can meet informally and establish links to provide support. There was recognition that this community, or "family", aspect of hospital life has been lost in recent years, resulting in much higher degree of isolation amongst juniors. Juniors felt managers need to understand the importance of these factors to them, and to make improvement of them a priority. In hospitals, several respondents suggested that there is scope for Wisemen to have a broader welfare role.

(b) *JHD Job Rotation*
The need to reorganise working practices to reduce stress was discussed by most groups of respondents in addition to hospital juniors. Regional rotation of jobs, rather than contracts of 6 months, was suggested by a DHR (E) as a way of limiting the problems brought by continuous mobility.

(c) *JHD Reorganisation of Working Hours*
Whilst some OHPs and CEs argued for a reduction in working hours others, particularly JHDs, suggested that there is a need for hours to be changed by:

- Limiting continuous periods of duty and establishing guaranteed rests. Such changes might mean that "Juniors are not working so intensely they can't stop to eat" (OH nurse (F)).

- Introduction of standard rotas with, for example, 10 working hours instead of 36 i.e. manageable units of work which could allow juniors to cover for others if necessary. Is apparent that it is not possible to do others' work in such long shifts. Such arrangements must allow, in the words of a DHR, "proper rest and rehabilitation rather than odd days off".

- Bleep rests

- Reducing workloads by passing routine jobs to nurses and allowing them more autonomy was suggested by a small number of JHDs, DHRs and OHPs.

(d) *Provision for GP Deputising Services*
From the point of view of GPs workloads might be reduced, it was suggested, by extending limited lists, and the introduction of out of hours cooperatives/deputising services as standard.

(e) *Provision of Locum GPs*
Both DPHs and IMAs said there should be more resources available for locums and packages of long-term cover when illness is more protracted.

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(f)   *Re-organisation of GP Complaints Procedures*
The need for reorganisation of complaints procedures was raised by LMCs. It was felt that the problem of the time lapse between notification of complaint and invoking of procedures needs special attention.

PREVENTIVE MEASURES – DEALING WITH STRESS

Chief Executives agreed that taking a solely reactive approach to health problems, particularly stress, is not sufficient, preventing stress in the work place is about improving management. The Chief Executive of the hospital (with medical advice from senior colleagues) should have some overall surveillance of stress in various departments and then implement solutions. Solutions suggested were varied.

(a)   *JHD Support from Seniors*
JHDs said that the support of more senior doctors whilst working is important – those at Registrar level often being expected to work without consultants.

(b)   *JHD Improved Access to Counselling Services*
Many comments were made by CEs, FHSAs, IROs, DHRs about improved access to support groups and counselling. It was felt that medical staff should be encouraged to take up the stress counselling available in many hospitals for nurses.

Aware of the need for more obviously independent services, DHRs and IMAs felt that a network of GPs and/or counsellors might be set up across districts, or that perhaps a new service might be set up away by an organisation well placed to provide independent support, such as the BMA (FHSA managers + IROs).

(c)   *JHD Work based Support Groups*
Work based support groups were favoured by a small number of DHRs who were aware of them working well in some specialities, such a paediatrics. There is the potential, they argued, for them to be incorporated into the process of the normal working day, as an appropriate follow-on from audit and other work sharing practices.

(d)   *GP Support*

IMAs proposed that support may continue to be provided to GPs once qualified, where trainee groups extend into "Young Practitioner Groups".

(e)   *GP Sabbatical/Practice Swaps*

FHSA managers suggested that stress amongst GPs might be reduced by implementing developments such as sabbaticals, allowed "time out" "practice swaps – to reduce the strain of being in the same room, practice, town etc" (FHSA Wandsworth).

(f)   *Legislate Support for GPs from FHSAs*

FHSAs also argued strongly for legislation to increase the role of the FHSA where GPs are stressed or ill and are placing patients at risk.

EDUCATION AND TRAINING

The consensus of opinion is that there is much that should and could be done in the future to address doctors' health and self-care during their "long and arduous training".

(a)   *Limiting Expectations*

At the outset of medical training students are aware not only of the very high esteem in which the public holds doctors, but of the equally high expectations demanded of them (LMCs).They learn, as students, to enjoy the status accorded the profession which historically has been perpetuated by the attitudes and behaviour of their seniors.These attitudes have prevailed over many decades and prevent doctors in training from learning humility (FHSAs, DHRs). They need to be taught to accept that they can be ill and that they are allowed to be patients by understanding their own frailties.

(b)   *Allowing the Doctor to be ill*

Students and young doctors must be encouraged to be more "worldly and less cocooned" (OHPs). They must address the fact that they have very high personal expectations (GPs, CHCs) which causes stress and that they cannot be expected to "always be right" or "superhuman"; that "stress does not mean failure" (DPHs) and to dispel the myth that "careers end due to illness" (IROs).

(c) *Assessment of Medical School Candidates*
Several respondents (WP,DPH,) say there is a real need to assess candidates for entry to medical schools in terms of their psychological capacity to deal with stress. Other respondents commented (OHPs, IROs) how students with problems may be identified early in their medical careers, and were aware of "some who were quite bizarre" (OHP(A)).

(d) *Shift of Emphasis Towards Skill Training*
A number of interviewees (JHDs, OHPs and LMCs) discussed the need for there to be a shift in training from an emphasis on scientific knowledge and rote learning, towards development of interpersonal and reasoning skills which, they agreed, are of greater value. The experience of practice does not match the expectations of those newly qualified, and is often a major cause of stress and disillusionment (JHDs, DHRs).

(e) *Stress and Personal Health Management*
Students should be taught about self-awareness and methods of self-appraisal, and to be able to identify and address illness/stress in themselves and their colleagues (JHDs, GPs, IMAs). The tenets of good health care that doctors endeavour to pass on to their patients should apply to themselves also. Registration should be mandatory for all medical students and doctors (GPs, IMAs), with students instructed in their training on how GP services are accessed and most effectively used.

All students would greatly benefit from learning management skills. Whether they will become partners in general practice or clinical directors there is an increasing onus on doctors to perform managerial tasks at many levels in economic terms. For GPs this training may be best offered in the general practice setting. GPs are notoriously bad at choosing partners (IMAs,FHSAs,GPs) and choose them often for the wrong reasons. Perhaps a system of support, provided by older more experienced GPs, to prepare them for their future roles as GPs would be appropriate. In training for management and surviving the enormity of NHS reforms, new contracts and the Patients' Charter a "catalyst" system may be used (LMCs,FHSAs,GPs). (See Appendix XVIII - district E).

There must be corporate recognition that doctors' attitudes to their own health prevents them from seeking most appropriate advice or help when necessary (all groups of respondents discuss this matter except for the senior managers and chief executives). All groups of respondents (apart from FHSA- management and Chief Executives) argued that in developing a more appropriate system of

training for the medical profession, management, senior medical staff and educators must also be aware that they have a clear responsibility to "create an environment of confidence and trust" and "develop a family philosophy" (DPHs,CEs). Unless the barriers to seeking help are broken down by continuous teaching and emphasis throughout training, it will be difficult to provide help.

Appendix XX – *INDEPENDENT AGENCIES*

The following agencies currently provide independent confidential support:

NATIONAL COUNSELLING SERVICE FOR SICK DOCTORS
Park Square West, London NW1 4LJ

To obtain the name and telephone number of an adviser, call the National Contact Point: **071 935 5892**

The telephone line is normally staffed from Monday to Friday between 0930 to 1630.

MEDICAL COUNCIL ON ALCOHOLISM
St Andrew's Place, Regent's Park, London NW1 4LB

Mainly concerned with the education of the medical professions about the effects of alcohol on health. Also acts as a liaison between the **BRITISH DOCTOR'S and DENTIST'S GROUP** and those in the Medical Profession seeking help.

THE BRITISH DOCTOR'S AND DENTIST'S GROUP
Regular meetings take place (throughout Britain) for support, advice and discussion on alcohol and drug related problems within the profession. Many members are also members of Alcoholics Anonymous or Narcotics Anonymous.

Concerned persons should telephone: **071 487 4445**

(The above information was taken from literature currently distributed by the organisations named)

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Conventions

Throughout this report titles of respondents are abbreviated according to the following:

Chief Executive Health Authority	HACE or CE
Director of Public Health	DPH
Chief Executive/Manager FHSA	FHSA
Independent Medical Adviser to FHSA	IMA
Chair/Secretary Local Medical Committee	LMC
Chief Executive Hospital/Director of Human Resources	DHR
Chairman Consultant Staff Committee	CSC
Chairman Professional Review Committee/Three Wisemen	Wisemen
Occupational Health Physicians/GPs/Nurses	OHD
Occupational Health Service	OHS
Trainers in General Practice	GP
Junior Hospital Doctors	JHD
Industrial Relations Officers (BMA)	IRO
Chair/Secretary Community Health Council	CHC

DESCRIPTION OF CODED DISTRICTS

A   District typical of many densely populated inner city areas with high unemployment and deprivation existing alongside areas of greater affluence. The population is perceived by GPs as being highly stressed, a problem for many of whom are older, single-handed practitioners. The hospital visited is a large university teaching hospital. Special concerns: For JHDs are pressure and the need to be noticed which are more apparent stressors in the competitive world of a teaching hospital. There was concern at the time of the study over an outbreak of a viral infection amongst SHOs which was protracted because of junior doctors' failure to take appropriate sick leave.

B   A trust composed of two former DGH's.

Special concerns: Management perceive more sickness absence than would normally be expected amongst JHDs. The GPs are described as a fragmented group of individuals who do not react en masse with national opinion ie. fundholding, health promotion issues.

C   Area with leafy, affluent suburbs. The hospital, formerly DGH, is now a trust. The longest established of all the hospital trusts in the study, it is still experiencing major management problems.

Special concerns: Grave concern was expressed by senior physicians, at the trust management's political involvement with the DHA. Consultants, at the time of interviewing, were working three weeks in every four because the DHA failed to purchase sufficient care from the trust. The result of which is a high level of anxiety existing amongst doctors whose futures are uncertain.

D   This district located on the coast covers an area which includes a large cathedral city with university and university teaching hospital.

Special concerns: Whilst the district is perceived, by those interviewed, as not having special concerns, local GPs feel that the great shift to providing more care in the community has imposed great strain on them. The university teaching hospital is in the process of applying for 5th wave trust

status. Hospital doctors are seen to experience greater pressure due to the competitiveness of specialist medicine.

E   A city with a university and university teaching hospital, this district provides a contrast with district F. This large town is surrounded by rural communities.

Special concerns: A particularly fierce elitism exists within the hospital which leads to peer pressure and anxiety to succeed. GPs consider it a privilege to practice in the area which is relatively affluent and well resourced.

F   This area is rural with many small close knit communities and includes a large seaside resort. The DGH became a trust and is still coping with change and new management structures.

Special concerns: There are many single handed GPs and small practices, unsupported by deputising services. During the summer months when the local population is substantially increased by tourism GPs find it difficult to cope with the increased work load.

G   The district is part of a large city which is currently enjoying regeneration. It is a university city with a university teaching hospital and DGH which together will probably be granted trust status. Within the district the full range of inner city and suburban characteristics are present. The problems of stress for doctors in the hospitals are similar to those experienced by doctors in other teaching hospitals. GPs concerns are the same as those voiced by GPs in other inner city areas; those of anxiety, physical abuse and violation of property.

H   In contrast this area is a market town. The two DGH's are applying for trust status with finance to extend facilities. There is a substantial immigrant population and doctors representing minority groups, mainly Asian. There are a number of single-handed GPs who, with some of the Asian doctors, are felt to be particularly isolated.

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