NUFFIELD PROVINCIAL HOSPITALS TRUST

Taking care of doctors' *health*

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TAKING CARE OF DOCTORS' HEALTH

Reducing avoidable stress and improving services for doctors who fall ill

REPORT OF A WORKING PARTY

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TERMS OF REFERENCE

- To consider the problem of physical and mental illness amongst medically qualified personnel working in the NHS;
- to assess the extent of the problem;
- to examine the present system of providing medical services, help and advice to doctors;
- to identify any deficiencies in the present system with regard to prevention, amelioration or treatment;
- to consider whether there are grounds for the early issue of guidance on good practice;
- in relation to the above, to consider the relationship of illness with work stress and inappropriate careers;
- to take into account in considering the above matters the needs of, and responsibilities to, patients;
- to make recommendations for improvements considered necessary to rectify problems identified.

SUMMARY AND RECOMMENDATIONS

It might be thought self-evident that for the NHS to function effectively the doctors who work in it should be provided with satisfactory working conditions. More particularly when doctors suffer physical illness, or mental ill health as a result of high levels of work related stress, adequate means of support should be easily accessible. Yet doctors' notorious reluctance to admit to ill health, compounded by the willingness in the past of their employer, the NHS, to accept this, has produced the long standing situation that what support there is is fragmented, ill understood and little used.

Fortunately for their patients, most doctors enjoy good health most of the time. There is an increasing body of evidence, however, which shows that a substantial and growing minority of doctors working in the NHS at all levels, in general practice as well as in hospital medicine, is experiencing high levels of work-related stress. This is impairing their health, reducing their job satisfaction and ultimately must compromise their ability to provide high quality care for their patients. The NHS, as the principal employer of doctors in the United Kingdom, must accept a large share of the responsibility for this situation.

From the establishment of the service in 1948, little attention has been paid to the problems of doctors' health by those in charge of the NHS. Over the last decade or so, organisational and management changes have resulted in increased demands on doctors' time, through a new level of administrative and management requirements on top of pressures to increase clinical work rates, without corresponding increases in medical staffing levels. The consequences of these changes may be seen in the increasing numbers of senior doctors taking early retirement from the NHS, and in the levels of stress and its consequences recorded in recent studies for doctors at all stages of their careers. There have recently been welcome signs that the management of the NHS is alert to the problem, but the need for action is urgent. Continuing neglect might well damage the capability of the NHS to deliver that quality of medical care, across general practice and the hospital service, which it has hitherto been able to ensure.

To address these problems, the Nuffield Provincial Hospitals Trust, after taking the advice of an expert working party comprising senior members of the medical profession, recommends an approach which will not only tackle symptoms – that is, encourage improved services for doctors with health problems – but also have the capacity to identify underlying causes and as far as possible indicate remedies for them.

The central proposal of the Trust's Working Party is the creation of a network of independent regional bodies to be responsible for reviewing the services available for doctors with health problems, identifying steps that should be taken to improve working conditions where these are found to be unsatisfactory, drawing up recommendations for a longer term programme of improvements, monitoring progress, providing information

about existing services and developments, both local and national, and publishing an annual report. These regional bodies must be fully independent of local health authorities and providers, in order to establish their impartiality and neutrality vis-à-vis the interests of employing organisations.

The second main recommendation of the Working Party is that there should be in each locality a key individual to act as a first point of contact for doctors seeking advice on health problems, and to facilitate arrangements for treatment and counselling where necessary. This individual should be a senior member of the medical profession, and must be accessible on a secure and confidential basis.

The composition of the regional bodies should be determined locally, but they should be kept as small as possible. Each should be chaired initially by the Regional Postgraduate Medical Dean, and each should include two lay members, a consultant psychiatrist with a particular interest in the area, a consultant member, a representative of junior medical staff, a general practitioner and a trainee on a vocational training scheme. The regional bodies should be adequately resourced, and their funding should be guaranteed and should not be dependent on negotiated contracts; the Working Party looked to the NHS Executive to provide the necessary resources; it considered that an appropriate mechanism for routing these resources would be the budgets of the Postgraduate Medical Deans.

The role of the regional bodies would be facilitating, and they would be principally concerned to:

(a) identify the key individuals to act as first point of contact for doctors with health problems, and the colleagues of such doctors; publicising the means of contacting these key individuals would also be the responsibility of the regional bodies;
(b) collect and publicise information on local services, however provided, as well as on national services, to provide an information bank as a resource for doctors with health problems and their colleagues;
(c) following logically on from (b) identify gaps and deficiencies in the range of services available, and where possible, develop proposals to remedy these;
(d) monitor local services and conditions and identify causes of health problems among doctors, including factors likely to contribute to avoidable stress, and draw these to the attention of the organisations responsible, providing advice on how best to deal with them; encourage the provision of educational activities directed towards early recognition and treatment of doctors' health problems;
(e) publicise relevant activities and draw attention to outstanding concerns in an annual report.

Their overall concerns would be twofold: firstly, with ensuring that doctors with problems, and those who have grounds for believing they have colleagues with problems, know whom to approach in the first instance for help and guidance; and secondly, with the pattern of

services, taking NHS and other provision into account, needed to provide an accessible, flexible and sensitive system for doctors in need of help with health problems. Particular importance should be attached, at least to start with, to ensuring appropriate provision for GPs, because of the disproportionate lack of services for this group.

At the national level, it would be natural for a forum to develop through which experience would be shared between the regional co-ordinating bodies, but the Working Party was anxious to avoid recommending the creation of an elaborate national structure, and considered that a relatively informal system should suffice.

The medical Royal Colleges will need to consider what it would be appropriate for them to contribute in relation to this initiative; they could for example influence the working environment by requiring, as a condition of recognition of posts, that junior hospital doctors have pleasant, clean and appropriate facilities for eating and living in, when on call. They might also wish to take on a more direct role through the regional coordinating bodies and in actual service provision.

In conjunction with the GMC's new performance procedures and with the advice of the medical Royal Colleges and the BMA, guidance should be issued on how to recognise failing performance in colleagues in good time, and what action to take in such cases. The Royal Colleges may wish to provide retraining schemes for those of their members whose performance, though it does not yet bring them within the GMC procedures, is declining or is otherwise inadequate.

There is already an informal network of bodies which provides services for doctors in need of treatment and which can be expected to grow in effectiveness within the sort of framework proposed. The Faculty of Occupational Medicine also should be encouraged to develop its involvement in the NHS; an effective, consultant led occupational health service should be available throughout the NHS in the foreseeable future. To achieve this, resources will have to be identified in addition to those already allocated to OHS, and the number of occupational physicians being trained with a view to working in the NHS will need to be substantially increased.

The Working Party strongly recommended that the NHS Executive should issue guidance to the NHS in conjunction with the establishment of the new bodies, to provide a national agenda of matters on which action will be required; the Executive should also make arrangements for monitoring progress to ensure that this agenda is acted upon by commissioning Health Authorities and NHS Trusts.

Areas which should be covered in guidance from the NHS Executive should include the following:

short term:

- Working conditions in hospitals: ensure the availability of proper accommodation and of proper food throughout a 24 hour day.
- Locums: ensure that adequate locum cover is available, and that additional funding for locums is available where necessary (in general practice as well as in the hospital service).
- Registration with a general practitioner: ensure that all doctors are registered with an appropriate GP, or, where this is not feasible, that appropriate alternative arrangements are in place.
- Induction: ensure that induction programmes are provided for newly appointed doctors; these should include information on procedures in case of ill health and an emphasis on doctors' responsibility for their own health and that of their colleagues.
- Confidentiality and treatment: ensure that individual doctors needing treatment can be cared for outside their own hospital/practice, with appropriate confidentiality safeguards. This will involve ensuring that extra contractual referrals (ECRs) are available when required, and that this availability is not limited by commissioning authorities' budgetary positions.

medium and longer term:

- Training: develop training for all doctors in the special requirements of the doctor to doctor–patient relationship; ensure that the difference between a doctor's responsibilities to a doctor colleague and that doctor's responsibilities to a doctor-patient is clearly recognised in any regulations, advice or guidance that may be issued.
- Career guidance: improve or develop career guidance and counselling services for doctors whose careers may be jeopardised through ill health. Attention will be needed to the problems of doctors who by reason of their condition are not able to return to independent unsupervised clinical practice.
- Staffing: improve medical staffing levels so that they are such that when an individual doctor needs to take time off for a short period, e.g. to consult his or her own GP, colleagues can provide cover without their own workloads being unreasonably increased and without the necessity of arranging a locum.
- Occupational health services: improve occupational health services, and ensure the training programmes and resources needed are available to make consultant-led OHS accessible to all members of NHS organisations and, where required, to GPs.
- Education: review medical education to ensure that appropriate attitudes towards doctors' health problems are encouraged in medical school and during training. Doctors should have education in stress management and healthy lifestyles, with the clear message that these are as important for them as for their patients.
- Retraining: ensure that there is secured funding for retraining doctors who have had to cease practice because of ill health.

In bringing forward these proposals, the Working Party deliberately avoided attempting to draw up a blueprint. Its objects were to delineate a broad overall framework for the more effective local co-ordination and provision of services to doctors with health problems; and to outline an agenda of issues and areas of concern which it believed must be addressed if these problems and the underlying causes of them are to be dealt with effectively.

INTRODUCTION

There has for some time been a rising level of concern about the health of doctors, whether junior doctors in training or hospital consultants and principals in general practice. It has become increasingly apparent that morbidity and mortality among doctors, and in particular suicide, are linked to stress, which, in different forms, affects all in the medical profession from the most junior to the very senior and which may have serious consequences for patient care. It may be, indeed is likely, that this experience is compounded by the difficulties faced by doctors in the shaping of their careers[1]. What is evident is that recently the problem has been intensifying, because the nature of doctors' jobs has been changing very rapidly, in circumstances of uncertainty, while the notion of the profession is itself being undermined, leaving individuals in doubt about what they should be doing.

It might be expected that NHS employers, individually and jointly, would have given some thought to these problems, and to how best to deal with them; certainly major corporations in the private sector and the armed services provide examples which could be drawn on. Training doctors represents an enormous investment of resources: with annual cohorts of around 4,470 medical students (the 1995 intake level) and an average training cost per student of an estimated £184,000 to £192,000 (before postgraduate training) each cohort represents a training budget of around £830 million[2] – an investment worth taking care of, quite apart from the costs in human terms of failing to address the needs of doctors working under the handicap of physical illness or mental stress or disorder.

The Nuffield Provincial Hospitals Trust's initial contribution to the investigation of these concerns was to commission an inquiry by Professor Walter Holland and colleagues[3] at the United Medical and Dental Schools of Guy's and St Thomas's Hospitals into the nature and extent of the medical problems, both physical and mental, of doctors, and the efficacy or otherwise of the mechanisms that exist to help doctors with them. This preliminary study identified significant medical problems in doctors and deficiencies in the systems in place to deal with them; the Trust therefore commissioned a further study by Professor Holland with the object of following up in more depth key areas identified in his group's initial work, and determining more systematically the extent of the problems identified. This further study focuses in particular on how far doctors differ from other professional groups in their work stress, illness behaviour and use of formal services, and on the actual experiences of recently sick doctors in terms of their pathways into care and the services and support provided.[4]

At the same time as the Trust's interest in this area was developing, other individuals and bodies including the General Medical Council and the British Medical Association were becoming increasingly concerned at the strains faced by the medical profession. Accordingly, in keeping with its normal approach, the Trust sought to act as a facilitator, so

that the profession could, in a neutral context, explore the issues. This report reflects discussions held at the Trust by a small working party the members of which were drawn from concerned bodies with experience and knowledge of the problem.

During the period of its deliberations, the Working Party was greatly encouraged to learn that the management of the NHS is aware of and taking an interest in the problems identified. However, although there is thus an increasing understanding of the issues, and a growing consensus that something should be done, as yet there is not agreement on what is needed. The object of this report is to put forward a proposal for action. In the light of its experience the Working Party has no reason to believe that its views will give rise to controversy, and hopes that the responses to its recommendations will be framed in a spirit of co-operation.

1 THE NATURE AND SCALE OF THE PROBLEM

During the last decade, the medical profession has been under increasing pressure from the combination of changes in management systems in the NHS and demands for ever greater economy throughout the service. The successive introduction of general management, of the purchaser/provider split and contracting and of clinical directorates on the one hand, and cost containment and continuing demands for efficiency savings on the other have, through their effects on the way the NHS is run, significantly changed the working environment within which medicine is practised in hospitals. Both here and in general practice, increased administrative and management workloads have not been matched by corresponding reduction in clinical workloads. Doctors have thus been caught between two powerful forces: the effects of the changes in the way the NHS is managed, and the consequences of these for the attitudes of doctors themselves, in reinforcing the culture of not allowing illness or personal stress to interfere with the performance of clinical duties.

Most doctors most of the time are fit and healthy, and cope satisfactorily with the pressures of their work. However, there is a growing body of evidence which suggests that a substantial minority are increasingly finding this difficult, at all levels in the profession.

Starting with medical school, it has been estimated that one in eight students fails to complete, while among those who do qualify and go on to practise medicine, experience of stress and difficulty coping as students has proved a predictor of similar problems later on[5]. Although once they have entered on a career in medicine relatively few doctors leave the profession, many have said they have thought seriously of doing so, and a significant proportion regret their choice of career[6]. This apparent disillusion must be seen as connected with the levels of stress experienced by junior doctors: while a degree of stress is normally associated with rewarding and challenging work, the levels of stress found among junior doctors in recent studies, and the absence of job satisfaction reported by a substantial proportion[4], must be regarded as worrying. The main sources of stress for junior doctors are work related, and reflect in particular the long hours junior doctors have to work; by implication this can be seen to reflect a situation in which there are insufficient senior doctors to take on responsibilities, so that juniors are under increasing pressure and may not receive adequate support from their seniors.

Among senior doctors, both consultants and GPs, recent research shows stress levels and lack of job satisfaction may be even more of a problem than among junior doctors. Administrative and management workloads for these groups have increased substantially, without any corresponding reduction in clinical responsibilities, and it is unlikely to be a coincidence that numbers arranging early retirement from the NHS have been increasing in recent years.

Appendix 1 of this report is a review of the research evidence considered by the Working Party. In the view of the Working Party this evidence reflects the long term failure of NHS employers to recognise and respond to the needs of their workforce. The evidence it reviewed led the Working Party to conclude that problems of ill health, and in particular mental ill health, among doctors are symptomatic of an underlying problem with its roots in the way the provision of clinical services in the NHS is organised and run. Unless this problem is addressed, there is a real prospect that it will become increasingly difficult to ensure adequate medical staffing in the NHS, with inevitable consequences for the quality of patient care. In the view of the Working Party, concern with the health of doctors cannot be isolated from related questions of selection, training, morale, management and funding. Such large matters lay outside the remit of the Working Party but any programme of action which ignores these wider dimensions of the problems of doctors suffering from ill health will not be tackling the underlying causes, but only the symptoms.

2 THE PRESENT SYSTEM OF PROVIDING MEDICAL SERVICES, HELP AND ADVICE TO DOCTORS

When doctors are in need of medical care, the same NHS services are available to them as to the rest of the population. However, doctors have particular difficulties in the role of patient. The role itself is the antithesis of their normal activity, and they may as a result be reluctant to adopt it and put off doing so until their condition becomes too severe to ignore. Moreover, the practitioner to whom the sick doctor turns for treatment and advice may find it difficult to react to a doctor-patient in the same way as to other patients, compounding the problem for the sick doctor of becoming a patient.

There are a number of mechanisms for helping doctors who are having problems with physical or, more usually, mental ill health or stress or misuse of alcohol or drugs and the consequences of these. The Health Committee of the GMC, the National Counselling Service for Sick Doctors and, locally, the Three Wise Men procedure and occupational health services all offer support in one way or another. FHSAs and LMCs may provide support for GPs, and there is a wide range of local initiatives, varying with local circumstances and needs. However, before examining these mechanisms in more detail, it is worth considering the implications of recent changes in the organisational context of the NHS within which they operate. In particular, the move to NHS Trusts organised into clinical directorates has meant a major shift in the organisational culture and climate of the workplace of the hospital doctor.

In a Trust, a clinical director is responsible for the management of a department; this, together with other changes including the introduction of clinical audit, has given new opportunities for a medical manager to review the overall performance of the clinical directorate, and may result in earlier recognition that individual doctors may be having problems. If a clinical director realises that a doctor is underperforming for reasons of ill health, there is a need to address both the personal problem and issues of cost and departmental performance standards. These may create tensions and conflicts of interest and loyalty which may work against a more sympathetic, informal approach to the problems of the doctor concerned. Confidential management of problems within the profession may thus be difficult or impossible to achieve. It is as yet unclear to what extent this introduction of management imperatives is influencing the way doctors react to their own and colleagues' problems. But where it does, the effect may be compounded if NHS Trusts insist that doctors' problems are dealt with internally, thus reducing anonymity and increasing the chance of breaches of confidentiality, while there may be a fear that commercial pressures may even incline Trusts in the extreme to try to remove the source of the problem by ceasing to employ the doctor in question. It is of course likely that a clinical director would be aware of serious problems, but short of these, an organisational climate which may be felt to jeopardise the employment of a doctor who is for whatever reason unable to perform at

his best will not be conducive to early recognition of problems and sensitive intervention to prevent their becoming acute. There is, though, potential for clinical directors and Trust medical directors to develop a sensitive role in helping doctors with health problems to face up to the issues and find relief (which might include changes in clinical responsibilities to relieve pressure, as well as confidential access to medical treatment when required).

2.1 Occupational health services (OHS) (see also Appendix 2)

Under the terms of HSG(94)5, Occupational health services for NHS staff, all NHS authorities and Trusts have a responsibility to ensure that their staff have access to confidential occupational health services. OHS should therefore be seen as a potentially valuable source of support for hospital doctors in cases of ill health and stress. However there are grounds for believing that as things stand doctors do not regard OHS in this light. The position of OHS is complicated by its dual role as adviser to the employer as well as advocate of the employee; and the wider remit of OHS, in the provision of information for selection procedures, in routine medical examinations and in its general concern with health and safety at work, as set out in HSG (94)5, is likely to create an orientation in which there is relatively little scope for an emphasis on the needs of doctors with health (and especially mental health) problems. The dual role may also be perceived as giving rise to a conflict of interest, and though the guidance to occupational physicians (OPs) issued by the Faculty of Occupational Medicine lays considerable emphasis on the importance of maintaining confidentiality, this may give rise to doubts among doctors about OHS as a source of support.

A further problem is the relatively undeveloped state of OHS in the NHS: there are not enough consultant status OPs working in the NHS to provide a universally consultant led service, and the Faculty has estimated that a development programme of up to 10 years will be needed to remedy this deficit. In the meantime, services are inevitably patchy, and may be led by individuals calling themselves occupational physicians without having been adequately trained or attaining the Faculty's qualification, or may be provided by local GPs on a sessional basis.

In the longer term it is to be hoped that OHS will be able to play an important role throughout the NHS, but it has to be recognised that at the present state of the speciality this situation is some way from being achieved, and that in the greater part of the NHS, doctors with health problems are likely to look elsewhere for support.

2.2 The "Three Wise Men" procedure

At the local level, the Three Wise Men procedure, established under the terms of Department of Health Circular HC(82)13, Prevention of harm to patients resulting from physical or mental disability of hospital or community medical or dental staff, offers the

attraction of an initially informal process for dealing with the problems of hospital doctors. The procedure can be a very effective and efficient means of dealing with complaints and the concerns of colleagues and others about the competence of individual doctors whose behaviour suggests that they are experiencing difficulties. In practice the chairman of the panel occupies the key role in the procedure, and in the majority of cases referred to the panel may be able to resolve problems informally. In the "pre-reform" NHS, it was possible to arrange for the temporary removal from duty of a doctor who had become unfit to practise, for treatment on sick leave, drawing on the assistance of the District Medical Officer (DMO) and the Regional Medical Officer (RMO), and using if necessary the resource of supernumerary posts controlled by the latter.

However, the effectiveness of the procedure has to a great extent been compromised by the confidentiality and secrecy which characterise it[3]. It is not widely understood how the system works; arrangements for appointing the chairman and members of the panel are shrouded in mystery, and panel members are themselves not always clear about their role; and the procedure itself depends upon colleagues of doctors with problems being prepared to act, so that in many cases problems are unreported, or there are delays before the procedure is activated, during which the situation may deteriorate. The new structure of the NHS has the effect of detaching the Three Wise Men procedure from the DMO (now Director of Public Health) and RMO (now Regional Director of Public Health and shortly to become an officer of the NHS Executive) so that the scope for informal resolution of problems is restricted, and the future of this aspect of the system is unclear. It increasingly appears that support for an individual doctor in difficulty will largely be a matter for the employing Trust. It is worth noting that there is a particular problem with NHS community Trusts; these may have only a handful of consultants, often working in isolation, so that it may be impossible to establish the Three Wise Men procedure. It is understood that the Department of Health intends to review HC(82)13 over the next year.

2.3 Training and continuing education, and the role of Postgraduate Medical Deans

Regional Postgraduate Medical Deans have a continuing responsibility towards doctors in training, to ensure that they are subject to regular appraisal, that they receive periodic personal and career counselling and that their working conditions are generally monitored; recently Deans have also taken on responsibility, jointly with Trusts, for providing induction training. Their role has, therefore, considerable potential for helping with the early identification of problems and in particular stress related disorders being experienced by junior doctors. Deans are embarking on a programme of training in counselling and related techniques for clinical tutors, speciality advisers and educational supervisors. It is too early to evaluate the success of this development, which will depend on adequate resources being available. Nonetheless, Postgraduate Medical Deans do have a potentially key role, especially as it seems clear that the origins of stress-related disorders in doctors often lie in the early part of their careers, during their education and training, when they lack advice and career guidance. Contracts for doctors in training are being transferred to NHS Trusts, but Postgraduate Medical Deans still have powerful levers of influence through their

contribution to funding for individual posts and their power to give or withhold funding. So far few Deans have felt able to intervene on basic matters such as the living conditions experienced by junior doctors in residence, but there are opportunities for them to check that Trusts do everything in their power to give doctors in training an environment in which they can learn successfully, including support in coping with the stresses of their clinical responsibilities.

Clearly the role of the Postgraduate Medical Deans is in a transitional phase, and there is an opportunity for it to develop in ways which could positively assist with the problems of sick doctors. Here it seems there may be scope for the Postgraduate Deans and the Royal Colleges to act in concert. Royal College inspections could provide an opportunity to draw attention to removable sources of stress for junior doctors in connection with renewing recognition of training posts. Hitherto there has been reluctance to consider withdrawing or qualifying recognition on such grounds, because of the concern that to do so might result in or contribute to hospital closures. It is possible that the educational network could acquire a degree of responsibility for identifying at an early stage when doctors are in difficulty; but to be effective this would need to be matched by an adequately resourced and sensitive system for helping such doctors to deal with their problems.

With the demise of Regional Health Authorities, the contractual position of Postgraduate Medical Deans will change; after April 1996 they will be jointly appointed by universities and regional offices of the NHS Executive, and will have split university and Civil Service contracts, with scope for clinical working if they wish. It remains to be seen what effect on their role this new part-Civil Servant status will have.

2.4 Support for general practitioners: FHSAs and LMCs

The general practitioner, because of the very different context of primary health care, does not have access to the Three Wise Men procedure; the procedures required under HC(82)13 are intended to apply to hospital and community medical and dental staff. There is no equivalent of the hospital occupational health service for GPs because of their independent contractor status. The Family Health Services Authority is in practice seen as primarily management orientated by GPs, and is consequently not widely regarded as a source of support, although in some FHSAs the problem has been recognised and efforts are being made to help, for example, by arranging contracts with local NHS Trusts to supply occupational health services to GPs. The FHSA is in any case responsible for dealing with complaints about GPs which cannot be resolved at practice level, and for disciplinary procedures. This can make it difficult for GPs to be confident in the FHSA in a parallel but separate support and counselling role in relation to their problems. From April 1996 FHSAs are to be merged with DHAs into unitary health authorities, and in many areas management arrangements have anticipated this change. It is hoped that within the formal legal requirements there may be scope for managers to help GPs to recognise and resolve any underlying health problems.

The Local Medical Committee (LMC) is a source of support for GPs. The LMC is supposed to provide a scheme of special referees which is intended to be comparable to the Three Wise Men procedure, but which varies considerably in its implementation; in some areas the role is fulfilled by the LMC Secretary. In practice, however, LMCs tend to be seen by GPs as a useful source of advice and as intermediaries in dealing with patient complaints, but not as a source of support for doctors with health problems. Moreover, the LMC has an obligation to advise its FHSA as to the fitness of a doctor to practise on grounds of health if the FHSA asks for its opinion.

Like hospital doctors, GPs tend to be reluctant to take sick leave; practical difficulties in arranging locum cover have been reported, and absence from the practice for any length of time imposes additional workloads on partners; where locum cover is available, this involves an additional cost; and it is probable that GPs with problems would prefer not to acknowledge to partners an inability to continue (even temporarily) to practise, for whatever reason.

2.5 The National Counselling Service for Sick Doctors (NCSSD)

The NCSSD was set up in 1985, to provide an accessible, confidential and non-coercive counselling service: the primary aim is to persuade doctors in need of help to seek appropriate treatment. The initial contact may be made by the doctor in need of help or by a colleague or relative; an appropriately located Adviser is then identified, and offers an opportunity to discuss the problem, with encouragement and assistance in seeking help. Psychiatric Counsellors from a list maintained by the Royal College of Psychiatrists are able to provide advice or arrange treatment. Both they and the Advisers place a very high value on strict confidentiality. But unfortunately the NCSSD is not widely known (though it advertises in the BMJ) and it is often misunderstood – with some believing that it is related to and reports to the GMC – and so far the service has not been used as widely as hoped (it receives some 400 referrals a year though this number is increasing) while its effectiveness to those who use it has not yet been reported on.

2.6 Association of Anaesthetists' Sick Doctor Scheme

In 1977, the Association of Anaesthetists, jointly with the Royal College of Psychiatrists, introduced a Sick Doctor Scheme primarily designed for anaesthetists. This scheme is advertised in the journal *Anaesthesia* and its existence is well known to anaesthetists. Funding – costs are said to be minimal – is provided from the Association of Anaesthetists.

The scheme's aims are to provide support and treatment on a confidential basis for anaesthetists who are perceived by their colleagues to be sick. Treatment offered is given in a region distant to the place of work of the anaesthetist. A feature of the scheme is that should the individual sick doctor refuse treatment or support, this does not in any way reduce the responsibility of the referring doctor or doctors to take the necessary steps through official channels to protect the welfare of patients.

As the scheme is totally confidential it is difficult to assess its overall efficacy. However, it is reported that around 25-30 cases of anaesthetists with problems are dealt with each year. Alcohol and depression are the main causes of referral and there is a small but worrying amount of evidence of abuse of other drugs.

2.7 The GMC Health Procedures

Practically all the cases referred to the GMC's health procedures involve alcohol, drugs, mental illness or some combination of these, though with a total of 552 referrals in the period 1980 to the end of 1994 (some 37 a year) the numbers are not large. The health procedures are designed not only to protect patients, but also to help doctors recover from any illness from which they may be suffering. They may involve four main stages: preliminary consideration of evidence; medical examination of the sick doctor; medical supervision and rehabilitation of the sick doctor; the Health Committee. The proceedings of the Health Committee are strictly confidential. Most doctors under the health procedures do not need to appear before the Committee; four-fifths of cases have been handled informally, and of these a substantial proportion have been able to remain throughout in independent, though supervised, professional practice, while of the 106 doctors referred formally to the Committee, 34 were enabled in due course to return to unsupervised independent professional practice. The small numbers suggest a widespread reluctance to refer cases to the GMC. Those familiar with the GMC believe that it performs its statutory functions with skill and humanity; however, the GMC's association with maintaining standards and its disciplinary role make it, for the majority of the medical profession and despite its best endeavours, a remote and possibly somewhat frightening body with the power of depriving doctors of their livelihood. Thus doctors may fear that if they report a colleague to the GMC, this may endanger that colleague's employment. So although, as noted above, the GMC health procedures can achieve very satisfactory outcomes, referrals to them by colleagues are very few.

3 THE DEFICIENCIES OF THE PRESENT SYSTEM

Deficiencies in the current arrangements for providing medical services to sick doctors have origins of two main related types: the attitudes and practices of doctors; and the nature and orientation of existing mechanisms and doctors' perceptions of them. Attempts at solutions which do not address both types of origins of the problems are unlikely to be successful, as are those which do not recognise the influence of the context in which the problems have arisen.

3.1 Medical Education

It is increasingly recognised that the origins of problems that occur later in doctors' careers can often be found during their years as medical students. The influence of the attitudes and behaviour of qualified doctors on students is likely to be considerable, and habits formed at this stage will be difficult to change later.

The selection of medical students is clearly of great importance, and frequent reference is made to the need to improve it; but unfortunately no reliable method has yet been demonstrated which will select good potential doctors. There is however considerable evidence that many of those doctors who present with serious emotional or behavioural problems after qualification have shown clear manifestations of these problems during their undergraduate years[5]. On the whole universities have been reluctant to terminate the career of a medical student on grounds other than non-completion of an approved course of study or examination failure. Both pre-clinical and clinical teachers are in any case often reluctant to suggest that a student is unsuitable for clinical practice even where the indications are evident. This may be because of reluctance to send down an individual with nothing to show after years of study or the hope that the individual will practise in some non-clinical branch; but once qualified an individual is entitled to specialise and practise in any branch of medicine.

The situation might be improved by establishing procedures for screening, supervision, counselling and if necessary treatment programmes for students whose problems are recognised in medical school. Where a balanced judgement is reached that an individual is unsuited for medical practice an opportunity should be provided to qualify for another degree with due credit for the time spent in medical school. Where an individual is unwilling to accept transfer or termination of studies a mechanism is required which would protect the university from consequent litigation and which is fair to the individual. This might involve a system of registration as a medical student with clear requirements and provisions for termination and appeal, so that it would be clear before a student embarked on a course of medical studies that under certain defined circumstances he or she would not be permitted to continue.

Medical students are subject to a different system of supervision than qualified doctors: welfare and disciplinary issues are combined with education and are the responsibility of the Deans of the medical schools. However, although the GMC is not formally responsible for the regulation of medical students, it is currently looking at ways in which help and guidance on the conduct and health of medical students might be provided to medical schools.

3.2 The attitudes and practices of doctors

A corollary of the necessary preoccupation with the needs of patients is a reluctance among doctors to admit that they can themselves become patients. Instead there is a tendency to deny health problems, to continue to work when ill, and to believe in effect that some sort of stigma attaches to ill health, and especially to inability to cope with stress, in members of the medical profession[4]. Closely related to this is a reluctance to "inform" on colleagues who clearly are neglecting health problems, out of a sense of professional solidarity. Doctors notoriously rely on self-medication and, where they recognise the need for advice, on "corridor" consultations with colleagues. Thus there is little formally recorded evidence of their ill health, and the culture of non-recognition of health problems is reinforced. This appears particularly to be the case among junior doctors, who may fear the consequences of a poor health record for their career prospects, while medical students are encouraged by example to adopt the same attitude of denial towards illness. Yet the evidence suggests that most junior doctors are aware from their own personal experience of a range of psychological and physical problems among their peers.

This kind of attitude naturally predisposes doctors to ignore or at best be suspicious of systems designed specifically to address problems of ill health, and particularly of stress and stress-related disorders. Essentially the culture of the medical profession requires the response that these systems are or should be unnecessary, so that they tend to be called into play only at the stage at which problems have become crises or are obviously endangering patients.

Perhaps as a consequence, doctors tend to be ill-informed about or ignorant of the supports available to them, and lack of knowledge of their possible effectiveness may serve to complete the cycle of denial, it being easier to ignore a problem if there are no obvious and reliable means available to provide a solution. Evidence is not readily available of the extent to which consultants are aware of problems among junior doctors, but the notion of the senior doctor as a survivor, and the expectation that medical education and training must, among other things, inculcate the ability to cope, is likely to be reinforcing the culture of denial.

3.3 Existing provision: weaknesses and deficiences

One of the difficulties underlying the provision of medical services for sick doctors is that, as in most organisations, no one body or part of the organisation has responsibility for the overall health of employees. Responsibility for health issues varies with doctors of different status, and becomes formalised only when management procedures relating to absenteeism (the problem with sick doctors is not absenteeism but its opposite[4]) or disciplinary action in relation to personal or professional conduct or performance competence are involved. Most of the mechanisms which are presented as providing support for sick doctors do so in pursuit of the primary goal of ensuring the safety of patients. This concern with preventing harm to patients necessarily has the effect of introducing, if only implicitly, the final fall-back requirement that if all else fails, the doctor whose performance is impaired by health problems should be reported to the authorities, and ultimately referred to the GMC.

The GMC itself, while requiring that doctors keep confidential any information concerning someone seen as a patient, recognises that there can be circumstances that justify a breach of this guideline[7]. The BMA Council recently approved guidelines on the ethical responsibilities involved in treating doctor-patients which impose on doctors a duty, if a doctor-patient refuses to accept advice, to alert the employer through the appropriate occupational health physician or, in the case of a GP, the Local Medical Committee Secretary; if the doctor-patient's refusal to comply with advice poses a risk to patients, the doctor must consider whether to consult the GMC. Doctors are warned that they may be personally liable for failure to act in such situations. The GMC places a duty on doctors to protect patients when they believe a colleague's conduct, performance or health is a threat to them, and if necessary, to inform the employing authority or a regulatory body[7].

Thus when doctors are aware of the mechanisms (in addition to generally available NHS services) to which they can turn, or to which they can refer colleagues for support, they must also be aware above all of the dilemmas that confront those responsible for the operation of these mechanisms, and may well regard the mechanisms themselves as primarily admonitory or disciplinary in purpose. It is unfortunate that there appears to be widespread ignorance and misunderstanding of how the various support mechanisms work; and doctors appear not to be aware of how to gain access to them. As a result, current arrangements do not generate confidence. Confidentiality in particular will always be a central concern, and while the various support mechanisms have only low visibility and are poorly understood by most doctors, the extent to which confidentiality will be guaranteed, and the circumstances under which it cannot be, will continue to be in doubt. It is therefore essential to distinguish between the doctor as colleague, and the doctor as patient, and for it to be recognised that the latter is entitled to the same right of confidentiality as any other patient: that is, total confidentiality unless there is some overriding public interest[8].

With the current and continuing structural change, with its attendant turbulence, in the NHS and with the increased importance of management, the position and attitudes of

managers, which are clearly of great significance, are at present unclear, though there are informal indications that pressure from NHS managers and the "aggressive" management attitudes of some may increasingly be a source of stress among senior consultants. The separation of providers from purchasers and the introduction of clinical management potentially destabilise the informal networks and arrangements through which problems were frequently resolved in the past. Managers are often ambivalent about the position of doctors in the organisation, and may be content to accept as a convenience that doctors are seldom or never ill, being unclear about what they can or should do if problems do arise. As the problem with doctors already is that they work when they are ill, it would be a serious matter if Trusts took any steps, including the introduction of financial incentives to reduce sickness absence, which might encourage this. On the other hand, there could be commercial incentives to NHS Trust managers either to try to "export" problems (by ceasing to employ the individuals concerned), or alternatively to insist on dealing with them internally, without reference to outside bodies. Referral for outpatient or inpatient treatment should be funded by the health authority in which the doctor resides. Referral to an outside centre sufficiently remote from the employing organisation to protect confidentiality may be covered by an existing contract, but may require an extra-contractual referral (ECR). This may in itself be a disincentive to making such referrals; or ECRs may not be available when required. It is difficult to define the extent of problems in this area, though developments will need to be carefully monitored. It is important that in the current structure and the system of financing of the NHS there should be adequate provision for dealing with poor performance in doctors and the factors that may underly it (such as physical and mental health problems and stress).

3.4 The organisational context

It has become almost commonplace to attribute the way in which doctors respond to ill health and the problems that result to the influence of the culture of medicine, the implication being that effecting changes to improve the situation can be seen as primarily the responsibility of the medical profession. While it should be acknowledged that the examples and expectations of senior doctors must influence the behaviour of their juniors and students, and that peer group pressures are of great significance, it is worth reflecting that this culture did not come into existence unprompted and does not sustain itself in a vacuum. The organisational context of the NHS and the way in which doctors' work environment is structured should be recognised as determinants of doctors' behaviour. In particular, the way that doctors' work is organised is a main cause both of stress and of their denial of sickness behaviour.

Recent surveys have found organisational factors to be responsible for much of the stress and emotional distress experienced by doctors. McKevitt and colleagues found that the top three stressors for all doctors – senior and junior hospital doctors as well as GPs – have their origins in work organisation. These were: pressure on time (difficulty managing the workload in the time available); the impact of work interfering with home life; and the

demands and expectations of other people[4]. There is much less flexibility in the way doctors' work is organised than is usually the case for other professions: clinics cannot be rearranged, and doctors are conscious that if they take time off because of illness colleagues whose own workload is already onerous will have to cover for them. McKevitt and colleagues found that doctors take significantly fewer short spells of sickness leave than management consultants (though the latter have similar experiences of pressure of work) and explain this in terms of "working through" illness (over 85% of their sample reported "working through" illness) in order not to let down patients and colleagues, as well as to avoid appearing unprofessional. Another reason advanced for not taking sick leave is the difficulty of obtaining locum cover, again an organisational factor.

The "culture of denial" which researchers have documented can then be seen as a response to organisational pressures as well as in terms of the expectations of the professional peer group. The NHS requires junior doctors to contract for up to 72 hours a week of which 56 hours (or more in some cases) are spent working*, and GPs to be on call at night as well as working a normal day; the cumulative effect of tiredness over long periods is an accepted part of life, as well as a cause of emotional distress and lowered performance standards. The development of distinctive coping strategies, including informal "corridor" consultations with colleagues for health problems and excessive use of alcohol, may therefore be expected. The demands put on doctors can be contrasted with the limitations placed on the hours of work of other groups and professions (eg airline pilots, train drivers) whose work involves an implicit care for the lives of others. The conclusion must surely be that attempts to meet the needs of sick doctors for medical services are unlikely to achieve more than limited success unless they are part of a wider approach which takes into account the causes of the exceptional stresses to which the profession is subject.

* To outsiders it might appear astonishing that when junior doctors, who are not especially well paid, are required to work extra hours, these hours are paid for at a rate *below* the basic.

4 THE PARTICULAR CIRCUMSTANCES OF DOCTORS' WORK

The Working Party was aware of the argument that the stresses faced by doctors at work are very similar to those faced by other professionals and senior managers. This, however, is hardly grounds for reassurance from the patient's point of view, or a reason to exonerate doctors' employers from concern at the potential consequences for both doctors and their patients of the pressures which recent research confirms characterise doctors' working conditions. The pressures inherent in practising medicine have become substantially greater in recent years, both in terms of increased expectations and because of the ever-increasing complexity of medicine itself. Moreover, by contrast with individuals of similar status in other contexts, doctors have to make decisions of a different order, which may literally involve life or death for their patients. Patients and their relatives understandably expect doctors to put patient needs before their own, and to perform at the peak of their abilities, whatever the circumstances and without regard to the pressures they may be under; the increasing demands from patients in exercise of their "rights", of which the rising tide of litigation is only one aspect, add substantially to these pressures. And colleagues rely on colleagues for cover and support when called upon, on top of normal duties. It should be borne in mind, moreover, that the conditions under which doctors work are often far from satisfactory. Junior doctors may be required to work very long hours; and while on call and required to live in may have to use poor accommodation, without access to decent fresh food at times when their workload (which cannot be predicted) allows them to take breaks. They face the stress of taking serious and difficult decisions, at times without easy access to the experience and support of senior colleagues; and when they are ill, unlike everyone else who turns naturally to a doctor, they have to face the difficulties inherent in approaching a peer. Their working arrangements allow very little flexibility, and they cannot control when and what they will have to perform. GPs face similarly acute pressures, with the added problems of relative organisational isolation, and an increasing administrative workload; they and consultants find complaints from patients a growing problem; consultants too face ever new administrative burdens without any corresponding reduction in clinical responsibilities.

There is now evidence that, in great part as a result of their working conditions, a significant proportion of all doctors (GPs and consultants as well as junior doctors) are subject to considerable stresses, which in turn cause clinically significant emotional distress and depression in a significant minority. Doctors are also exposed to some specific health hazards in the performance of their duties[9]. Almost all doctors admit to working through illness, physical and mental, even though many acknowledge that this can adversely affect their performance, and that patient care can suffer, sometimes seriously, as a consequence. Yet doctors cannot shed responsibility for their patients at the end of the working day. This too distinguishes them from other professions. And the substantially higher rate of suicide among doctors (relative to the rate in other professional groups) must be a serious cause for concern.

5 WAYS FORWARD

A good, easily accessible medical service to which doctors can turn is an essential, but like the fire brigade, cannot be considered the whole answer. Recommendations on the elements and organisation of such a service must be taken in conjunction with those concerned with underlying causes of the problems that create the need for the service.

Doctors' physical health is normally good, and common sense suggests that where physical illness is concerned, if doctors can be persuaded to seek treatment, existing provision, whether NHS or from the independent sector, should be able to respond at least adequately. The difficult problems exist firstly in the habit of many doctors of denying ill health for as long as possible and secondly in the stresses which doctors experience as a result of their working conditions, the mental health problems to which these can give rise for some doctors, and the difficulties inherent for doctors in seeking psychiatric help.

As noted in section 2 above, at both national and local levels, there are organisations with an interest and involvement in providing help, and a concern to improve the situation. For example, the GMC's Health Procedures exist to assist doctors with health problems, and will shortly be complemented by performance review procedures, which should strengthen this role. In the meantime a working group of the GMC's Education Committee is currently looking at a range of problems identified in the pre-registration year of training, focusing on anxieties about the overall quality of the educational experience, and taking into account sources of stress in the lives of pre-registration house officers and seeking ways of alleviating this stress. The BMA is considering a proposal for a national help line, and has recently endorsed a report from its Medical Ethics Committee on chemical dependence in the medical profession. The NCSSD is receiving an increasing number of referrals. There is also an increasing number of locally organised schemes involving help lines and support groups in different parts of the country.

What is missing, however, is a single recognised agency responsible for taking an overview and for monitoring provision to ensure as far as possible that it is comprehensive, effective and accessible. The Working Party recognised that different combinations of services and approaches to provision have developed in different places, and considered that these should be encouraged and developed, building on local successes where possible and encouraging the spread of good practice. Accordingly it decided that it should not attempt to develop a detailed blueprint of best practice for universal adoption; instead it set itself the object of outlining a general framework within which the provision of services for doctors with health problems can be developed and improved, and sources of avoidable stress identified and dealt with.

Two main requirements were identified by the Working Party. The first was the necessity of

creating at regional level or sub-regional level an independent body which would be responsible for reviewing the services available for doctors with health problems, for identifying steps that should be taken to improve working conditions where these are found to be unsatisfactory, and for drawing up recommendations for a longer term programme of improvements. This regional body would also be responsible for monitoring progress, gathering information about existing services and developments, and for making information about services available to all who may need it; and should publicise both its activities and the range of services being provided in its locality and on a national basis. These regional bodies must be fully independent of local health service commissioners and providers, and of their local regional offices of the NHS Executive, in order to establish their impartiality and neutrality vis-à-vis the interests of employing organisations. The Working Party resisted the suggestion that the new bodies should be based on health authorities, on the grounds that this might compromise their independence, and limit their effectiveness; moreover, as purchasing agencies, responsible for ensuring the provision of services, health authorities would not be the right bodies to fulfil the monitoring role. It was recognised, however, that the areas covered by some of the regional offices of the NHS Executive could be too large for effective arrangements to be developed, and that these might need to be sub-divided.

The second main requirement identified by the Working Party was for there to be, in each locality, a key individual who would act as first point of contact for doctors seeking advice and guidance on how to deal with health problems, whether their own or those of colleagues, and to facilitate arrangements for treatment and counselling where necessary. The Working Party considered that to engender the trust and confidence needed to be effective in this role, the key individual would need to be a senior member of the medical profession; and given the different context and problems of general practice, it might be necessary to identify both a GP and a hospital doctor in each locality. These key individuals must be well known and easily identifiable, and access to them on a secure and confidential basis would be essential. Areas of responsibility larger than individual NHS Trusts but smaller than those covered by the regional bodies would therefore need to be defined; in the Working Party's view these arrangements should be determined locally; it would be natural that the individuals identified in each region would meet periodically, perhaps under the chairmanship of that member of the regional body most directly concerned with this aspect of the Working Party's proposals.

The composition of the regional bodies would need to be determined locally, but the Working Party considered that they should be kept as small as possible. It was felt that the Regional Postgraduate Medical Dean would be the natural person to be chairman (certainly initially). The regional bodies should include two lay members, a consultant psychiatrist with a particular interest in the area, a consultant member, a representative of junior medical staff, a general practitioner, a trainee on a vocational training scheme and a public health doctor. The regional bodies must be adequately resourced, and their funding should be guaranteed and not dependent on the negotiation of contracts; the Working Party

considered that this need not involve major funding implications. (For the Working Party's more detailed suggestions for the composition of the regional co-ordinating bodies, see Appendix 3.) The Working Party took the view that responsibility for the costs of the regional bodies should be met by the NHS Executive; the most appropriate funding mechanism might be through the budgets of the Postgraduate Medical Deans.

At the national level, the Working Party looked to the early establishment of a forum through which experience would be shared between the regional co-ordinating bodies. The Working Party was anxious to avoid the creation of an elaborate national structure, considering that a relatively informal system should suffice, given the existing links through the Committee of Postgraduate Medical Deans. But this does not imply that the forum would be a debating body. It should have the authority to speak from a national perspective and be active in such matters as spreading best practice.

The regional bodies would be principally concerned to:

(a) identify those key individuals, members of the medical profession, to act as first point of contact for doctors with health problems, and the colleagues of such doctors; publicising the means of contacting these key individuals would also be the responsibility of the regional bodies;
(b) collect and publicise information on local services, however provided, as well as on national services, to provide an information bank, perhaps in the form of a directory of services, as a resource for the key individuals acting as first point of contact and for doctors with health problems and their colleagues;
(c) following logically on from (b) identify gaps and deficiencies in the range of services available, and where possible, develop proposals to remedy these;
(d) monitor local services and conditions and identify causes of health problems among doctors, in particular factors likely to contribute to avoidable stress, and draw these to the attention of the organisations responsible, providing advice on how best to deal with them; encourage the provision of educational activities directed towards early recognition and treatment of doctors' health problems;
(e) publicise relevant activities and draw attention to outstanding concerns in an annual report.

The role of the regional bodies would be facilitating. They should act as catalysts, co-operating with employers and the profession; they should not become directly involved in the provision of services or in the treatment of individual cases, except in this facilitating connection (for example, it might be necessary to draw attention to difficulty getting approval for an ECR for a doctor needing to be referred for treatment to a remote provider, but it would not be appropriate for the regional bodies to become involved in diagnosing and providing treatment). They should be clearly seen to be independent, and not part of the management structure of the NHS. Their overall concerns would be twofold: firstly with ensuring that doctors with problems and those who have grounds for believing they

have colleagues with problems, know whom to approach in the first instance for help and guidance; and secondly with the pattern of services, taking NHS and other provision into account, needed to provide an accessible, flexible and sensitive system for doctors in need of help with health problems. Particular importance should be attached, at least to start with, to ensuring appropriate provision for GPs, because of the disproportionate lack of services for this group.

The Working Party considered that it was of great importance that the regional bodies should consult closely on local arrangements with the medical profession through the profession's local representatives. It considered that these arrangements would need to vary according to local circumstances, and that it could not therefore set out a general blueprint for them in this report. Consultation with the profession would therefore be necessary not only to ensure that the profession would be satisfied that local arrangements would be adequate, but also, and in consequence, to create the climate of confidence which the Working Party saw as essential to their success.

The medical Royal Colleges will need to consider what it would be appropriate to contribute in relation to this initiative; they could for example influence the working environment by requiring, as a condition of recognition of posts, that junior hospital doctors have pleasant, clean and appropriate facilities for eating and living in, when on call. They might also wish to take on a more direct role through the regional co-ordinating bodies and in actual service provision.

In conjunction with the GMC's new performance procedures and with the advice of the medical Royal Colleges and the BMA, guidance should be issued to the medical profession on how to recognise failing performance in colleagues in good time, and what action to take in such cases. The Royal Colleges may wish to provide retraining schemes for those of their members whose performance, though it does not yet bring them within the GMC procedures, is declining or is otherwise inadequate.

The Faculty of Occupational Medicine should be encouraged to develop its involvement in the NHS; the Working Party hoped that an effective, consultant led OHS could be available throughout the NHS in the foreseeable future. To achieve this, resources will have to be identified in addition to those already allocated to OHS, and the number of occupational physicians being trained with a view to working in the NHS will need to be substantially increased.

The provision of services, including rehabilitation, and the implementation of improvements and developments identified as needed by the regional bodies, is likely to be primarily the responsibility of the NHS. The Working Party believed that it is in the best interests of the Health Service to ensure that the problems identified in its report are addressed with some urgency; it did not consider it within its remit to advise in detail on courses of action, bearing in mind that circumstances inevitably vary between different parts of the country.

It should however be recognised that concern for confidentiality is likely to mean that a proportion of doctors in need of help may prefer to seek it from an independent body such as the NCSSD. Arrangements for provision of services for sick doctors should not, therefore, be limited to a single monolithic "official" system; the advantages of a plurality of sources of support should be recognised, and funding should be available to support worthwhile independent initiatives (an example, drawn from one FHSA's current practice, might be to place a contract with a separate provider for a confidential support and counselling service: in the particular case, the FHSA pays the bill for the service but is not informed about the cases of GPs who take advantage of it).

In order that the work of the regional bodies should not be carried out in a vacuum, and to emphasise the importance of the issues involved, the NHS Executive should issue guidance to the NHS in conjunction with the establishment of the new bodies to provide a national agenda of matters on which action will be required; the Executive should also make arrangements for monitoring progress to ensure that this agenda is acted upon by commissioning Health Authorities and NHS Trusts.

Areas which should be covered in guidance from the NHS Executive should include the following:

short term:

- Working conditions in hospitals: ensure the availability (appropriate to the hours of work) of proper food throughout a 24 hour day; and of proper accommodation.
- Locums: ensure that adequate locum cover is available, and that additional funding for locums is available where necessary (in general practice as well as in the hospital service).
- Registration with a GP: ensure that all doctors are registered with an appropriate GP, or, where this is not feasible, that appropriate alternative arrangements are in place.
- Induction: ensure that induction programmes are provided for newly appointed doctors; these should include information on procedures in case of ill health and an emphasis on doctors' responsibility for their own health and that of their colleagues.
- Confidentiality and treatment: ensure that individual doctors needing treatment can be cared for outside their own hospital/practice, with appropriate confidentiality safeguards. This will involve ensuring that extra contractual referrals (ECRs) are available when required, and that this availability is not limited by commissioning authorities' budgetary positions.

medium and longer term:

- Training: develop training for all doctors in the special requirements of the doctor to doctor-patient relationship; ensure that the difference between a doctor's responsibilities

to a doctor colleague and that doctor's responsibilities to a doctor-patient is clearly recognised in any regulations, advice or guidance that may be issued.

- Career guidance: improve or develop career guidance and counselling services for doctors whose careers may be jeopardised through ill health. The problems of doctors who by reason of their condition are not able to return to independent unsupervised clinical practice will need particular attention.
- Staffing levels: improve medical staffing levels so that they are such that when an individual doctor needs to take time off for a short period, e.g. to consult his or her own GP, colleagues can provide cover without their own workloads being unreasonably increased and without the necessity of arranging a locum.
- Occupational health services: improve occupational health services, and ensure the training programmes and resources needed are available to make consultant-led OHS accessible to all members of NHS organisations and, where required, to GPs.
- Education: review medical education to ensure that appropriate attitudes towards doctors' health problems are encouraged in medical school and during training. Doctors should have education in stress management and healthy lifestyles, with the clear message that these are as important for them as for their patients.
- Retraining: ensure that there is secured funding for retraining doctors who have had to cease practice because of ill health.

The Working Party recognised that adopting these proposals will involve costs, but if appropriate conditions of service for doctors can be assured – and it seems inevitable that increasing medical staffing levels will be necessary to achieve this – then the need for extensive use of services for sick doctors, and the loss of doctors from the NHS as a result of the poor conditions they often have to work under, should diminish quite rapidly. While it is difficult to determine to what extent the investment involved will pay for itself in purely financial terms, the Working Party was confident that overall the benefits of improving doctors' working conditions and the support available to them when they have problems with their health would be considerable, not only in terms of the well being and morale of doctors working in the NHS, but also for the quality of the service provided to patients. More generally, the costs that Trusts could incur by neglecting the health of the doctors they employ could be considerable, and could include:

- loss to the service of experienced doctors;
- recruitment and training costs for replacements of doctors leaving the service (as pointed out at the beginning of this report, it currently costs over £200,000 to train a doctor, if postgraduate training costs are included – though these costs do not fall directly on Trusts, they nevertheless have to be met);
- costs of locums to cover doctors unable to work because of ill health, with the attendant risk of providing a lower quality of service;
- costs of prolonged sick leave and early retirement on health grounds, which might have been avoided by earlier counselling and treatment;
- the personnel costs of dealing with crises arising as a result of neglected health problems, which may cause extreme difficulties;

- the costs involved in dealing with avoidable patient complaints; these can consume considerable amounts of management time, as well as taking clinicians, nurses and others away from their primary concern with caring for patients;
- the costs, in extreme cases, of references to the Health Service Commissioner, and of litigation.

The costs of positive action are likely to be relatively low, when set against those of failing to act, or to act in good time. It is worth reflecting that if only a few cases of serious medical accidents involving patients and leading to litigation could be avoided by improvements in arrangements to take care of doctors' health, then the costs of these arrangements could be saved many times over. The Working Party did not advance this as the prime reason for taking action, but it is worth considering that failing to act to limit the damage to doctors' health in the ways identified in this report would not only be to fail to recognise the responsibilities of the employer: it could also have serious consequences for employers' financial health.

APPENDIX 1

MORTALITY AND MORBIDITY IN THE MEDICAL PROFESSION

Two recent British Medical Association (BMA) publications[10,11], provide a starting point for examining current knowledge about sickness among doctors. The BMA has for a considerable time been concerned about the high level of stress to which doctors are subject, and the causes of this, primarily in terms of workload and the nature of doctors' work, but also recognising a range of other factors.

OPCS data show that within the medical profession SMRs for most physical diseases are low compared to the general population, and are comparable to those for social class I. However, the incidence of suicide among doctors stands out as a cause of death, at two to three times the rate for the general population; and there is evidence[12] that suicide as the cause of death is underrecorded in the medical profession.

In the absence of a general survey of morbidity in the profession it is more difficult to be confident about levels of physical and mental ill health among doctors. Localised studies suggest that these levels may be broadly comparable with those for other professional groups, such as teachers[13]. However, studies of junior doctors[5,14,15] have found high levels of emotional distress, depression and "burnout" in these groups. A recent study of hospital consultants by Caplan[16] found an unexpectedly high level of stress and depression in this group too (thus casting doubt on the assumption that the incidence of stress among senior doctors was much lower) and McKevitt and colleagues[4] have confirmed this finding, and report stress among consultants at a higher level than among junior doctors. And stress among GPs has also been documented,[17,18] with a recent focus on possible effects of changes in the NHS[4], while other studies have found an increase in GPs' self-reported feelings of stress or exhaustion[19] , decreased job satisfaction and poorer mental health[20] and higher than expected levels of burnout[21].

From these reports, a general conclusion that there is a real problem in the profession seems justified: in particular the high incidence of suicide supports this concern, as does the mounting evidence of high levels of stress among medical students and junior and senior doctors. Work under way may be expected to confirm this view, and to cast more light on problems of stress management in doctors. The BMA has commissioned a study into stress management interventions, initially in hospital doctors, from Professor Cox of Nottingham University; if successful, this study may be extended to general practice. And under the NHS Workforce Initiative, the Institute of Work Psychology at the University of Sheffield is investigating the mental health of NHS employees, including doctors, in 20 NHS Trusts, looking at levels of stress, the impact of mental ill health and the extent to which it is associated with work factors, and the effectiveness of selected interventions.

The Extent and Nature of the Problem

It is increasingly recognised that a major source of difficulty in estimating the extent of physical and mental ill health in the medical profession is the reluctance of doctors to recognise health problems in themselves or in colleagues. Drawing on the experience of the GMC as well as on the studies referred to above, a number of problem areas can be identified to which doctors are prone and which they may find it difficult to manage: marital and family problems, alcohol misuse, drug abuse, mental illness and depression and stress in particular fall into this category. The consequences of such problems can be disabling in terms not only of a doctor's health, but also for reputation and ability to care for patients and family, consequences which are likely to be exacerbated by delay before referral.

Although students and junior medical staff are expected to register with a GP, junior doctors in particular may not do so, and even those who are registered seem to consult their GPs only rarely, preferring instead to seek help from their peers, or from other, more senior doctors in training. Doctors tend to self medicate and seek informal advice rather than use formal services,[5,22,23] and they tend to take little time off work for sickness[4,24]. There is often considerable pressure on junior doctors to deny ill health and to carry on working even when ill, out of a sense of loyalty to patients and from unwillingness to take time off when this would result in increased workloads for junior colleagues. Junior doctors are also likely to be reluctant to draw the attention of their consultants to what they may fear these would see as weakness or inadequacy, with potentially damaging effects on the sufferer's career prospects. There is a general expectation, rooted in the culture of the medical profession from the beginning of training onwards, that doctors will not succumb to ill health, and will cope with the stresses imposed on them by their work and the context in which it has to be carried out. Illness among junior doctors thus often goes unrecorded. And there is now a growing body of evidence in the form of research studies which suggests that the price in terms of stress and mental illness exacted from medical students and junior doctors, though unacknowledged in the institutions in which they work, is considerable[14] and that the situation may be getting worse.

Baldwin and colleagues, in their late 1994 follow up of a cohort first surveyed in 1986 as medical students, found that junior doctors, though contracted to work 72 hours or less, were working an average of 75 hours, with a mean of 58 hours working on their feet in the previous week; 20% had been on their feet for 70 hours or more. Of this cohort, in the 1994 survey a "caseness" level of mental ill-health was found in 30%. Overall, the researchers found evidence of an association between long hours and poor functioning in junior doctors[25]. Although relatively few junior doctors leave medicine altogether, there is evidence of declining morale among this group, as reflected in the increasing proportion of hospital juniors who have regretted taking up medicine[6,26]; while there are indications that the stresses that underly this are adversely affecting patient care (certainly a proportion of junior doctors believe this is the case, seeing it as due predominantly to tiredness and overwork)[5]. It is difficult to be sure of the significance of data that show that up to a fifth

of medical school graduates are, within five years, not practising in the UK NHS, since this figure includes those who have gone abroad, as well as women taking a career break[2].

It may be argued that for doctors in training, it is essential to learn to cope with the stresses that are inherent in practising in the medical profession. These stresses include having to face the inability in a proportion of cases to prevent death, and the consequent necessity of dealing with the bereaved. This has always been a feature of medicine, but with the development of new technologies and interventions and new treatment methods there is in practice an increasing tendency to regard death as a failure rather than as the inevitable outcome at least of certain conditions. This compounds the pressure on doctors, not only from the standpoint of the skills and competences with which their training is intended to provide them, but also in terms of the expectation on the part of the public that they will exercise these skills successfully. And though there is a lack of studies comparing the working conditions of junior doctors now and say 20 years ago, there is anecdotal evidence that the pressures on juniors are much greater than those experienced in the early part of their careers by today's senior doctors[27,28].

Until quite recently, it was thought that among consultants there was a different picture: it has been argued that doctors who become consultants are by definition survivors who have proved their ability to cope with the stresses of the profession, and it was believed that only a small proportion were in need of help for health problems related to their work. Recently, however, evidence has been presented of a reality at variance with this presumption. As noted above, Caplan's study[16] found a level of stress in a group of hospital consultants, as well as among general practitioners and senior NHS managers, twice what would be expected for the general population, while McKevitt and colleagues found a higher level of stress among consultants than among juniors[4]. And it is known that an increasing number of consultants are seeking help, although these cases are not being notified. Complaints appear in particular to be a significant source of stress for consultants, as for general practitioners, and with no sign of the recent trend of increasing incidences of complaint and litigation abating, it can be presumed that this problem will if anything become more severe.

General practitioners' working environment is different from that of hospital doctors, but their problems of ill health, both physical and mental, are no less important and serious, and in many cases it may well be more difficult for them to find informal mechanisms for dealing with problems. They are relatively isolated professionally, since they work in the community; and they may be reluctant to consult their partners (in group practices) about other than fairly minor conditions (though it can be argued that GPs should register with GPs outside their own practices in order to receive independent and confidential advice). They are under constant pressure to keep up with the rapidly advancing science of medical care. In recent years they have been working in a climate of considerable change and uncertainty, not only because of the renegotiation of the terms of their NHS work that preceded the introduction of the new general practitioner contract, but also because of the continuing process of change in the wider NHS, including the introduction of GP

fundholding. The result has been an increase in GPs' administrative workload, and evidence of increasing levels of anxiety and depression and of falling satisfaction among GPs[4,20]. General practitioners have always been exposed to stress in relation to their work – including the risk of physical violence – but it may be that as well as the level of stress increasing, the type of stress has more recently been shifting from the more familiar clinical variety to encompass pressures of an administrative and managerial kind for which their training has not prepared them. Complaints can also be a source of stress to GPs: a survey in early 1995 by the Medical Defence Union of GP members in SW England who had notified the MDU of a complaint against them to their FHSA found that around three-quarters had experienced considerable stress in coping with this situation.

At the same time as the profession has been subject to these increased pressures, public expectations, fuelled by media coverage of developments in medicine, have risen and are rising, and the number of complaints is increasing: although this may reflect increased expectations and to some extent have been encouraged by the Patients' Charter, it may also be an expression of a wider tendency in late twentieth century society which shows itself in greater reluctance to take professions at their own valuation, and an increased willingness on the part of the lay public to challenge expert authority.

Overall, it appears that in a health service already under strain, the stress inherent in the profession of medicine is being exacerbated by contextual changes affecting doctors across the profession, junior and senior hospital clinicians and general practitioners alike. Finding out to what extent doctors' problems may result in harm to patients will not be easy; the attempt has not yet been made in the United Kingdom, although such work as has been carried out in the United States tends to reinforce the commonsense assumption that if doctors are physically or mentally ill or exhausted, this poses a real (and avoidable) risk to patients. Commonsense also dictates that doctors whose condition gives rise to serious risks should be temporarily removed from practice. The implication of this conclusion is that unless effective systems are developed and put in place to prevent and deal with these problems among doctors before they become serious, there is the prospect that shortages of doctors may become a problem, not only because prospective medical students may be deterred from entering the profession*, but also because an increasing proportion of qualified doctors may become, temporarily at least, unfit to practise. This prospect may be thought the more worrying in the light of the finding of the Medical Workforce Standing Advisory Committee that the UK is relying increasingly on overseas-trained doctors: in 1993 the percentage of SHOs qualified outside the EC was 26% (up from 20% in 1988) and overall just over a quarter of SHOs, registrars and senior registrars were from overseas. Moreover, among consultants the Committee recognised an increasing problem of dissatisfaction, stress and low morale which it attributed to the increase in non-clinical work which has resulted from recent changes in the NHS and which has not been balanced by a reduction in clinical workload; the Committee concluded that there could be a connection between this problem and the recent steady increase in early retirements, and that the increase in non-clinical workload might be persuading some doctors to leave the NHS for

*The British Medical Association has set up a longitudinal study of a cohort of medical students, to investigate numbers entering different specialities, and also numbers leaving medicine altogether.

a clearer clinical role in the independent sector[2]. Further evidence of the consequences of the declining attraction of medicine in the NHS as a career may be shown in the 1995 Recruitment Survey carried out for the Medical Practices Committee. The conclusion drawn from this survey was that though good candidates could still be found recruitment was becoming more of a problem, with fewer and poorer quality applicants for vacancies for partners in general practice[29].

APPENDIX 2

OCCUPATIONAL HEALTH SERVICES (OHS)

The Faculty of Occupational Medicine submitted a memorandum to the Working Party, and gave oral evidence at its second meeting. The following paragraphs draw extensively on the Faculty's evidence to the Working Party.

The NHS has lagged behind other large employers in the provision of occupational health services, which have developed in a piecemeal fashion in the last 15 years. This development has been accelerated by the removal of crown immunity in 1987, and the clear delegation of management responsibility consequent on the creation of NHS Trusts. Under the terms of HSG(94)51, Occupational Health Services for NHS Staff, all NHS Authorities and Trusts have a responsibility for ensuring that their staff have access to confidential occupational health services. It is the hope of the Faculty of Occupational Medicine that this will stimulate further provision of service and help to encourage concern for the well-being of staff.

Occupational health services exist to promote and maintain the physical, mental and social well being of all staff*, and the occupational physician (OP) has a number of roles in pursuit of this aim: he is an adviser to employer and employee on the technical aspects necessary to safeguard health and safety at work; he provides care to employees in respect of their health and its relationship to work; and he may be called on to provide impartial advice in response to specific questions about the fitness for employment of individual employees. In all these roles the OP acts as a medical practitioner, and is under a duty to observe the ethical requirements of this position; the Faculty of Occupational Medicine publishes guidance[30] to help OPs interpret these requirements.

The Faculty summarised the functions of an OHS in the context of the sick doctor for the Working Group as follows:

- advising on return to work after sickness and organising rehabilitation, being an advocate for the disabled, e.g. the surgeon with MS or Hepatitis B, the anaesthetist with depression or alcohol dependency;
- providing confidential advice and support, e.g. to the psychiatrist with stress, the physician with ischaemic heart disease, the doctor who is Hepatitis A or B sero-positive;
- providing access, in consultation with the general practitioner, to appropriate specialist care, often outside the Trust, district or region where the illness is particularly sensitive;
- providing pre-placement/pre-employment advice where health issues may give concern for the doctor, colleagues or patient;

* World Health Orginisation definition

- identifying and advising on control of hazards at work: physical, chemical, biological and psychological;
- monitoring the health of the group to identify unrecognised hazards, e.g. occupational asthma, high rates of miscarriage, stress, musculo-skeletal disorder;
- providing preventive programmes such as immunisation, training;
- advising, planning and supporting initiatives to promote health in the workplace.

Because of the dual role of the OP as advocate of the employee and adviser to the employer, doubts have been expressed about the extent to which confidentiality can be assured to the sick doctor who consults the OHS. The Faculty's position is clear on this: OPs are, like other doctors, bound by the rules on confidentiality set out by the GMC. The only circumstance in which an OP provides information to a manager is when the manager has asked a question about a specific employee with that employee's knowledge and consent and when the employee has given informed consent for the reply to be sent. In general, the Faculty takes the view that OPs are more rather than less likely to be aware of confidentiality needs, particularly in view of its guidance on the topic. Moreover, the OP would not be directly involved in treatment, for which the sick doctor should be referred to a GP or appropriate specialist: the OP's role is that of advocate and counsellor, whose object is to ensure that everything possible is done to ensure the individual's fitness to work, and, where limitations on this are inescapable (eg the HIV positive surgeon) to help identify suitable alternative work.

The occupational physician thus seems well placed to play a major role in the provision of medical services to sick doctors (although primarily with doctors as employees in the hospital setting; GPs, as independent contractors, may have difficulty gaining access to OHS, unless their FHSA has a contract with a local occupational health department). And where there is a consultant OP in post, the evidence in terms of the numbers of doctors seen suggests that at least as many doctors with problems turn to OHS as seek help from any of the alternatives. There are however a number of problems, which the Faculty recognises. A proportion of the doctors practising occupational health are not members of the Faculty, and have not been trained in the provision of OHS. Among the 1,600 or so members of the Faculty itself, the great majority do not work in the NHS and most training posts are also outside the NHS. Some 60 fully trained and qualified occupational physicians of consultant status in the UK (10 of them in Scotland) work in the NHS, compared with the 200 it is estimated would be needed to provide a full consultant-led service for the NHS as a whole (and this estimate relies on the assumption that each consultant OP would provide services for several NHS Trusts). So while in the long run OHS could make a considerable contribution to meeting the needs of sick doctors, a development programme over some 10 years, with significantly increased resources, will be needed to achieve this.

In the meantime, problems remain with the visibility of OHS and with perceptions of its role among medical staff. As HSG(94)51 makes clear, by far the greater part of the work of

OHS is concerned with activities unrelated to the problems of sick doctors, and has a strong "management" flavour. For their part, junior doctors tend not to be aware of the existence of their local OHS (to the point of not knowing the location of the department), and where they do know of the service, tend to see it as not relevant to their needs, and have little awareness or understanding of its role[3,24]; senior doctors are equally not very likely to perceive OHS as other than a provider of, for example, immunization for trips abroad. At the moment, then, OHS must be seen more in terms of their potential than as providing an immediate solution to the medical needs of sick doctors.

APPENDIX 3

THE PROPOSED REGIONAL BODIES

The Working Party's first main recommendation is that a network of independent bodies should be created at regional or sub-regional level and should be responsible for (a) reviewing the services provided to support doctors with health problems, (b) identifying steps that should be taken to improve working conditions where these are found to be unsatisfactory, (c) drawing up recommendations for a longer term programme of improvements, (d) monitoring progress, (e) providing and publicising information about services, and (f) publishing an annual report.

The composition of these bodies should, in the view of the Working Party, be determined locally, but it is recommended that they should initially be chaired by the local Postgraduate Medical Dean, and that each should include:

two lay members,
a consultant psychiatrist with a particular interest in the area,
a consultant member,
a junior medical staff member,
a general practitioner,
a member on a vocational training scheme,
a public health doctor.

If none of the medical members is one of the key individuals identified as first point of contact for doctors with health problems, then an additional member will be needed to represent this group.

The Working Party recognised that Postgraduate Medical Deans are already managing a heavy and increasing workload; and that their role and status are in a transitional phase in consequence of the changes introduced by the Health Authorities Act 1995. However it was considered by reason of their experience and the responsibilities they already have in relation to doctors in training that Postgraduate Medical Deans would be uniquely well placed to take on this additional role, though to do so they will undoubtedly need additional support, for which the Working Party looks to the NHS Executive. The Working Party was strongly of the opinion that the regional bodies should be chaired initially by the Postgraduate Medical Deans in person, though the Deans would not necessarily be committed to continuing in the role once the framework was established.

The Working Party considered that it was essential that the members of the regional body should be knowledgeable about and actively interested in the problems identified in this

report. In its approach, the Working Party sought to define a broad framework rather than lay down a detailed blue print, but it considered the need for action to be so pressing that it made the following precise recommendations for the first selection of members of the proposed regional bodies.

Making an early start and avoiding a lengthy consultation process before constituting the regional bodies should be of prime concern. Accordingly a simple and flexible interim system for selecting the initial memberships is proposed. As regards the clinical members, it is suggested that the Postgraduate Medical Deans should consult the Regional Advisers of the medical Royal Colleges; in the case of the consultant psychiatrist member the National Counselling Service for Sick Doctors and the GMC Screener for Health might also be able to offer helpful advice; for junior hospital doctor members, the BMA might be a helpful source of suggestions. The lay members should be appointed in consultation with appropriate representatives of local organisations, who might include the Chairmen of Health Authorities and the Vice-Chancellors of local universities, and in particular of those with medical schools. After such consultation, it would then be the responsibility of the Postgraduate Medical Deans to issue invitations.

Longer-term arrangements for the selection of members of the regional bodies should be an early agenda item for consideration at the national forum; the aim would be arrangements which establish a recognisably national system, with opportunities for appropriate exchanges of information and experience, while preserving a degree of local flexibility. To insure against rigidities it is suggested that appointments of members should be for an initial three-year term, which would not normally be renewable more than once.

Support arrangements for the regional bodies will be of great importance, and it is suggested that the Postgraduate Medical Dean should appoint an assistant to be responsible for day to day activities. The details of this post should be determined locally; it need not be full-time, but should be at an appropriate level of seniority, and a medical training and experience of working as a doctor would probably be an advantage. Funding for this post and appropriate clerical support should be provided through the Postgraduate Medical Dean's budget.

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