SHORT REPORT

Do junior doctors take sick leave?

M R Perkin, A Higton, M Witcomb

Nosocomial infections place a heavy burden on overstretched health services. An audit of junior doctors’ sick leave behaviour was undertaken in 1993 and again in 2001. The object was to ascertain the level of common infectious illness and to investigate whether junior doctors were remaining at work inappropriately. The doctors were asked if any factors had influenced their decision to take sick leave or not. Between the two audits several initiatives have been introduced to improve the working conditions of junior doctors, including the New Deal to reduce hours of work. Eighty one junior doctors in a large teaching hospital participated in 1993 and 110 in 2001. The number reporting an infectious illness in the previous six months was similar (61.7% in 1993, 68.2% in 2001). There had been a significant increase in the percentage of infectious illness episodes for which the doctors took sick leave (15.1% in 1993, 36.8% in 2001, \( p < 0.001 \)). The most common reason for taking less sick leave than was felt necessary was concern about colleagues having to do extra work (72% in 1993, 68% in 2001). Consultant pressure was cited by 26% (1993) and 20% (2001). Use of the staff occupational health unit was minimal, with none of the ill doctors contacting the department in 1993 and only three in 2001. Overall, despite the reduction in the number of infectious doctors not taking sick leave, the majority remained at work. Fundamental changes are needed if potentially infected doctors are not to present a risk of iatrogenic infection.

A recent governmental report revealed that the average British worker takes 7.8 days sick leave a year. Social workers have the highest levels (19.2 days) and doctors the lowest (2.9 days). We undertook an audit of junior doctors in 1993 and again in 2001 to see if doctors are preternaturally healthy or whether other reasons underlie their level of sick leave. We were particularly interested to see whether changes in the working conditions of junior doctors, including the introduction of the New Deal, had made any difference to sick leave behaviour.

METHODS

A short questionnaire was completed by all available junior doctors in a large teaching hospital during one week in July in 2001 and in 1993. Respondents were asked whether they had had any of the following illnesses in the previous six months: diarrhoea and/or vomiting, upper respiratory tract infection (URTI), skin infection, or any other infectious illness. For the latter the doctor was asked to specify the illness. For each condition doctors were asked how many episodes they had had and the duration of any sick leave taken for each episode. Doctors who had been ill were asked whether any factors had influenced them taking sick leave. Finally, doctors were asked about hospital policy when they contracted an infectious illness. Differences in responses between the two surveys were compared using Fisher’s exact test for two by two tables and the \( \chi^2 \) test for larger tables. Analysis was done using the STATA statistical package (version 6).

RESULTS

The response rate was similar for both time periods: 1993, 81/106 (76.4%); 2001, 110/140 (78.6%). The sex ratio of respondents also differed little (percentage male: 56.8% in 1993 and 60.0% in 2001). The majority of doctors had had at least one infectious illness during the previous six months (table 1). The percentage of doctors reporting any of the illnesses in table 1 in 1993 and 2001 was similar: 50 (61.7%) versus 75 (68.2%). However, this disguised a 20% drop in URTIs (59.3% to 47.3%, \( p = 0.11 \)), but a dramatic 111% increase in diarrhoea and/or vomiting illness (19.8% to 41.8%, \( p < 0.01 \)). The number of episodes of diarrhea and/or vomiting per sick doctor had also increased (1.06 to 1.57).

There had been a reduction in the proportion of episodes for which the doctors did not take sick leave. In 1993 sick leave was not taken for 90/106 (84.9%) episodes, and in 2001 for 96/152 (63.2%) episodes (\( p < 0.001 \)). However, this reduction was almost entirely accounted for by a change in sick leave pattern for doctors with URTI. While there had been little change in the percentage of doctors not taking sick leave for

Main messages

- The majority of junior doctors experience one or more episodes of infectious illness over a six month period.
- There has been an increase in the proportion of infectious doctors taking sick leave between 1993 and 2001. However, the majority continue to remain at work.
- Increased work load for colleagues and consultant pressure were the most commonly cited reasons affecting decisions to take sick leave.
- Knowledge of the hospital’s infectious illness policy was poor and use of the occupational health unit remained minimal.

Policy implications

- Infectious doctors continue to remain at work with the potential of causing iatrogenic nosocomial infection. Doctors are not going to change their sick leave behaviour unless consideration is given to supporting their colleagues in their absence and ameliorating consultant pressure.
- Interventions to encourage junior doctors to utilise the occupational health system need to be considered.

Abbreviations: GMC, General Medical Council; HAI, hospital acquired infection; URTI, upper respiratory tract infection
diarrhoea and/or vomiting illnesses (62.5% in 1993, 59.2% in 2001, p = 0.52), for URTI there had been a statistically significant reduction (90.5% in 1993, 68.5% in 2001, p = 0.0005).

The majority of the ill doctors reported one or more factors influencing their decision to take sick leave. Reasons recorded were: consultant pressure (1993, 26%; 2001, 20%), colleagues having to do extra work (1993, 72%; 2001, 68%), illness would not influence capacity to work (1993, 28%, 2001, 22.7%), and no risk of transmission (1993, 12%, 2001, 6.7%). The sick leave behaviour observed was in stark contrast to the response to the question asking whether sick leave was required for these illnesses. The results were: diarrhoea and/or vomiting (1993, 88.5% yes, 5.1% depends; 2001, 97.3% yes, 0.9% depends), URTI (1993, 56.2% yes, 15.1% depends; 2001, 48.6% yes, 39.3% depends), and skin infection (1993, 61.6% yes, 15.1% depends; 2001, 53.9% yes, 11.8% depends).

When asked about hospital policy if they contracted an infectious illness, 42% of the doctors in 1993 and 40% in 2001 said that the policy was to contact the staff/student health department. More thought that the policy was to inform their own consultant (1993, 50.6%; 2001, 70.9%). A significant minority thought that no formal action was required for infectious illness (1993, 16.3%; 2001, 11.8%), literature from the staff/student occupational health unit states that “It is particularly important that staff with patient contact receive early advice regarding infectious conditions”. However, in 2001 only 15 (13.6%) of the doctors could recall receiving this documentation, with 25 (22.7%) not remembering and 70 (63.6%) denying receiving it. Among those who had been ill, the number contacting the staff/student health department was minimal (zero in 1993 and three (4%) in 2001).

DISCUSSION
The General Medical Council (GMC) in its booklet, Serious communicable diseases, states that “You must always take action to protect patients when you have good reason to suspect that your own health, or that of a colleague, is at risk to them. You must consider how any infection you have may put patients at risk”. Iatrogenic hospital acquired infection (HAI) is well described. A Public Health Laboratory Service report estimated that HAIs cost the NHS in England £86.36 million annually. The failure to use occupational health services appears to continue among fully trained doctors. This study shows that during a six month period the majority of doctors have had an infectious illness. Notable was the increase in diarrhoea and/or vomiting illness between the two surveys. Identifying the cause of this is not possible from our study, but the increase reflects the trend seen in the number of notifications of food poisoning in England and Wales. There were 68 557 notifications in 1993 and 86 500 in 2000 (a 26% increase), while the increase since 1990 has been 66%. Between the two surveys there had been a significant increase in the proportion of doctors taking sick leave. This difference was almost entirely accounted for by an increase in likelihood of taking time off for an URTI. However, even for a diarrhoea/vomiting illness, most of the doctors took no time off. The GMC guidance states that particular care must be taken if “you work with patients for whom exposure to infection may be serious, for example pregnant women or immunosuppressed patients”. Both surveys included junior doctors working in obstetrics, intensive care units, and paediatrics. The issues surrounding a junior doctor’s decision to take sick leave are complex. The necessity for a junior doctor to take sick leave will obviously be dependent on both their symptoms and the type of work they are engaged in. It is clear, however, that a number of issues need to be addressed if junior doctors are not to present an infectious risk to their patients, including provision of cover for sick doctors and measures to encourage use of the occupational health system.

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