Editorial

The sick doctor

The sick doctor was the subject of a workshop organised by the Faculty of Occupational Medicine at the Royal College of Physicians on 22 June 1989. A series of short papers was presented outlining many aspects of the problem, followed by a discussion involving representatives of the royal colleges and invited specialists in occupational medicine.

Standardised mortality ratios (SMRs) for doctors were shown to be reassuringly low for some major physical diseases—all neoplasms: SMR 58, carcinoma of the trachea, bronchus, lung: SMR 25, ischaemic heart disease: SMR 62, with an overall SMR for the profession of 81.

The audience was reminded, however, that in some areas of ill health doctors are significantly worse off than their peers. The suicide rate for all doctors is three times that of the general population and twice the rate found in social class I. Suicide rates for women doctors are up to six times that of the general population. This may reflect the additional burdens and the pressures from home and family commitments that may conflict with professional work. Drug and alcohol dependence figures are not readily available but some studies in the United States have shown alarmingly high prevalence rates with as many as one in 10 doctors having an alcohol problem and one in 100 narcotic addiction.

The alcohol dependence problem is reflected indirectly in the threefold increase in cirrhosis of the liver (SMR 311) for the medical profession.

Many doctors do not seek help either at an early or a late stage of their addictive or behavioural problems. In recognition of the need to provide increased help the National Counselling and Welfare Service for Sick Doctors was established in 1985 and Professor K Raunsley reviewed the work and progress of this service. The majority of presentations at the workshop outlined the extent of the problem and considered ways to deal with the major issues of addiction and high suicide rate. Occupational health doctors will be primarily concerned to establish measures to prevent this morbidity and mortality. The paper by Dr Michael a'Brook was a valuable help. He emphasised that certain personality traits in doctors—obsessionality, lack of pleasure seeking, feeling of indispensability—may predispose to affective disorder in middle life. He gave important advice to all doctors: “Do not self medicate. Do not refer yourself for specialist advice without consulting your own general practitioner. Do not prescribe or provide medication for your spouse. Do not attempt to diagnose your spouse's ailments or decide appropriate referral for him/her. Remember the psychiatric illnesses to which the medical profession is particularly subject—alcoholism, drug dependence, and depression.” If certain personality traits predispose to depression and drug and alcohol dependency can and should candidates with these traits be selected out from those applying for medical training? Roberts and Porter have made a plea for more professionalism in selecting medical students and they advocate greater use of psychometric testing and personality assessment.1 This is an area where more research is needed.

Inadequate access to primary health care for junior hospital staff may lead not only to unnecessary anxiety and possible recourse to drugs and alcohol but also to encouraging doctors at an early stage in their careers to ignore the wisdom of Dr a'Brook’s advice. The establishment of self referral and self treatment at this stage may set the pattern for the rest of their medical careers. While the NHS occupational health services should not be the direct providers of primary health care, it must be a high priority for these services to ensure that junior medical staff have ready access to such care. Occupational health services do not always fulfil this important responsibility.

It is not usual practice for doctors to have an occupational health assessment before returning to work after serious physical or mental illness. Opportunities for modifying work commitments or the number of sessions are missed and the potential for further illness may be increased. The strains on doctors in high technology specialties are enormous and in their middle and late 50s these pressures may become incompatible with good health and safe practice. Many occupational physicians are working in industries where managers recognise similar pressures on older executives and managers and arrange for appropriate medical assessments. There is a good case for similar reviews to be made available for the medical profession, arranged with referrals between health authorities to avoid the difficulties of personal acquaintance.

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Reference