Rosta and Aasland’s paper (2005) ‘Female surgeons’ alcohol use: A Study of a Nation-wide Sample of Norwegian Doctors adds to the evidence that doctors are at increased risk of becoming dependent at some point in their career.

The finding that detrimental drinking by surgeons was more prevalent than might be expected may point to important fitness-to-practise considerations.

The questions ‘Who cares about doctors as individuals?’ and ‘Who cares for doctors apart from family and friends?’ seem still to be difficult to answer.

A doctor’s independence and ability to become immersed in a patient’s plight are key components for effective medical practice.

Becoming a doctor can be an isolating experience.

Maintaining confidentiality, enabling others to cope with distress, dealing with uncertainty, and making decisions on the balance of probability, when each decision may have an impact on an individual patient’s life, is the stuff of medicine, irrespective of age, experience, discipline, or specialty.

Doctors are subject to an escalating compensation focus. Growing public acceptance of the conclusion that everything is predictable and, therefore, preventable, may be a contributing factor.

Hidden clinical morbidity in doctors is more likely because doctors seem to behave differently when it comes to their own health. The profession remains adept at self-diagnosis, self-prescribing, and not involving general practitioners. Doctors tend to adopt therapeutic roles for others when in treatment.

The insidious development of idiosyncratic practice which can be a consequence of ill health may be mediated by lack of support, escalating strain, inadequate training, or failing capacity and seems to be more likely when mutual respect within the profession is compromised.

Death by suicide is more likely than would be expected and the excess risk is linked to increased prevalence of mood disorder and substance misuse for doctors.

Data suggest that female doctors are up to three times more likely than would be expected to die by suicide. There may be significant differences between specialties with anaesthetists, psychiatrists, and general practitioners having higher vulnerability. Differences seem to be independent of seniority and time in the specialty (Hawton et al., 2000).

The misuse of alcohol and other drugs by doctors forms a major component of concerns about conduct, performance, and health within the medical profession. Those concerns often come to clinical attention because of media publicity. When substance misuse is evident, there is every indication that early intervention is therapeutic and would be preventative. Pervasive uncertainty on how to intervene persists (Fowlie, 1999).

The Canadian Medical Association’s (CMA) guide to physician’s health and wellbeing highlights the need for culture and attitude change within the profession. There are widespread observations that medical training has neglected the topics of drug and alcohol misuse, and the importance of students’ attitudes to alcohol (CMA, 2003).

Within the United Kingdom: The General Medical Council Health Review Group concluded that Government (in partnership with the profession) should take responsibility for the identification of affected doctors through the provision of effective, accessible arrangements for intervention, assessment, treatment, rehabilitation, and support (Hine, 2005).

The Medical Council on Alcohol established professional support as a component of its remit in 2005.

The Scottish Intercollegiate Group on Alcohol determined in 2005 that clinical assessment of clinicians merited attention and concluded that undergraduate and postgraduate education on dependence should be augmented by training on attitudes.

CHITS (Clinicians’ Health, Intervention, Treatment and Support) a confederation established in 2002 brought together the work of the Sick Doctors Trust, the Dentists, Pharmacists and Veterinary Surgeons Health Support Programmes, the British Medical Association’s Doctors for Doctors Initiative (now incorporating the National Counselling Service for Sick Doctors). The Group acknowledged the work of local assessment and support programmes, forged links with the National Clinical Assessment Service, and has worked in sympathy with the Royal Colleges’ initiatives on clinician support (Wilks and Freeman, CHITS, 2003).

CHITS communications with the United Kingdom Health Departments have been augmented by a request to establish a network of assessment and treatment services dedicated to the special needs of clinical staff.

The CHITS group remains struck by the common association between detriment in clinical performance and clinicians’ substance misuse.

The CHITS principles are consistent with the conclusions of the Misuse of Alcohol and Other Drugs by Doctors report and with the Standing Committee of European Doctors’ statement on sick physicians with mental disorders, addiction behaviour, or both (Paimm, 2001). The group recognizes the benefits of local networks in supporting intervention, assessment, treatment, and rehabilitation.

CHITS has also proposed that student curricula identify attitudes and awareness, and deploy alcohol and drug use...
employment policies which are effective and readily utilized. CHITS has emphasized the importance of clinical staff not diagnosing and treating themselves, and not providing ad hoc opinions for colleagues. The group feels that information about national treatment and support services should be widely publicized.

CHITS is extending its involvement with the Medical Council on Alcohol and with the Royal College of Psychiatrists Addiction Psychiatry Faculty. The group has also contributed to the Scottish Executive Health Department’s proposals by emphasizing the need for active health assessment as a constant component to any investigation relating to fitness to practise (SEHD, 2004).

Meantime, there is no universal system in the United Kingdom to identify and treat healthcare professionals with alcohol and drug problems. This lack may contribute to clinicians working until a very late stage is reached in their dependence cycle.

The CHITS initiative endorses the benefits of active intervention and emphasizes the importance of local links between Clinical Services, Occupational Health Services, Clinical Directorates, and Employing Authorities.

Any reduction in the likelihood of developing alcohol dependence, coupled with effective access to assessment, treatment, rehabilitation, and support, both protects patient safety and limits the consequences of short- and long-term absence from work by individual clinicians.

The findings from this Norwegian study support the view that covert morbidity is widespread. Covert morbidity suggests that special measures to address health problems in clinical staff are required.

REFERENCES


