IN-DEPTH REVIEW

Doctors’ health and fitness to practise: assessment models

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Abstract

The assessment of doctors’ health and fitness to practise is recognized as a specialist area of occupational medicine practice. This paper will consider the involvement of specialists from a variety of disciplines in the overall assessment process and will discuss some current assessment models. The paper will make recommendations for further developments in this area.

Key words

Assessment; doctors; impaired; physicians.

Introduction

It has been argued that the assessment of doctors’ health and fitness to work is a specialist area of occupational medicine practice [1]. The compact between doctors, patients and the state is changing and there is a need for greater transparency in the methods of assessing fitness for practice [2]. This includes the health assessments that lead to decisions about fitness for work. However, there is a lack of published guidance about methods of assessment. A recent systematic review of the criteria and methods used for the assessment of fitness for work found only 39 publications for analysis [3]. Of these, only one paper was concerned with doctors. Guidelines for the psychiatric fitness for duty evaluations of physicians from the American Psychiatric Association provides detailed guidance on taking a history, gathering additional evidence, performing a psychiatric examination and writing a report [4]. This paper will discuss who assesses doctors’ fitness for work and will review models of assessment.

Who assesses?

It is apparent that the assessment of doctors’ health and fitness for work may be complex. Doctors may suffer from one or more medical conditions, which may or may not impact on fitness for work. Medical knowledge as well as medical culture may influence the way that doctors present as patients and to the occupational health physician. There is evidence that doctors are not good at looking after their own health and they may be reluctant to consult other doctors. In a review of the health of health care workers by the Nuffield Trust [5], the major findings were of ill-health related to psychological disturbances and unhealthy lifestyles, including excessive alcohol consumption. The review referred to a survey of junior doctors indicating that they tended to report frequent minor illnesses, rarely took time off work and commonly self-prescribed. In 1995, an Australian randomized sample postal survey of doctors’ attitudes towards their own medical care (with a 44% response rate) showed that while almost one-fifth had marital or emotional problems, 3% admitted to alcohol problems and 1% to drug problems; only 42% had a general practitioner (GP) and few had discussed their problems with them [6]. A 1999 New Zealand questionnaire study on a random sample of doctors found that although many claimed to be working under substantial stress, relatively few had regular health assessments. A Spanish questionnaire survey of 795 doctors showed that 49% did not have a family doctor, 82% self-prescribed and 47% did not attend occupational health appointments [7]. In the same year, a UK postal survey of GPs and consultants in the South Thames area found that although 96% of the doctors were registered with a GP, little use was made of their services. Almost a quarter of consultants would bypass their GP to obtain consultant advice. Most doctors prescribed for themselves and their family [8]. Only 11% of GPs reported availability of occupational health services compared with 95% of consultants, most of whom had never used them for preventive purposes. Perceived barriers were access, confidentiality, lack of occupational health services and difficulty in finding locum cover for GPs and consequent expense. A recent survey suggests that provision of occupational health for primary care staff has improved but that it remains difficult to access. In addition, general occupational health knowledge was reported to be limited among GPs [9]. This is likely to perpetuate their lack of trust in occupational physicians.
The most likely medical assessors of doctors’ health are organ-based specialists addressing particular health concerns. Occupational health physicians may be assessors, in some systems, in relation to employment processes, such as pre-employment health assessments and/or work performance concerns. Psychiatrists, orthopaedic surgeons or rheumatologists and cardiologists are the most likely specialists to be consulted in the UK. The complexities of mental ill-health in doctors, with implications for behaviour at work, substance abuse and suicide, imply the need for a close working relationship between occupational health physicians and psychiatrists when assessing fitness for work. The liaison psychiatrist with an interest in occupational health can assist not only in the rehabilitation of sick doctors [10] but also managing the ‘problem’ doctor with disruptive behaviour [11].

Occupational psychologists can assess the role of personality in performance at work and can make inferences about doctors’ behaviour when suffering from stress. Firth-Cozens [12] has described a ‘chronic fear of being disapproved of and criticized’ as drivers of achievement and perfection, but at the risk of depression associated with self-criticism and feelings of unworthiness and guilt. Such individuals may be unduly defensive and respond badly to feedback about their performance. Research into the role of personality on performance has been undertaken in many settings, but rarely in medicine. However, it is believed that the findings from studies carried out within management, military, social and health psychology fields may be relevant to medicine [13]. The aviation industry has been cited as a comparator for medicine with regard to health and safety [14]. Safety attitudes of airline pilots have been studied and so-called ‘macho’ pilots—those who wanted total control with feelings of invincibility—were deemed to make the worst pilots [13]. The ‘big five’ personality factors—five factor model of personality—are considered to be reliable predictors of job performance in a wide variety of occupations. Conscientiousness, emotional stability, openness, extraversion and agreeableness make up the big five, of which conscientiousness is said to be the most consistently valid predictor of performance in occupations. Work on employees who ‘derail’, that is employees whose health, conduct or performance puts their employment or registration at risk, has identified some themes that appear to be persistent [13]. These are

(i) problems with interpersonal relationships
(ii) failure to meet business objectives
(iii) inability to build or lead a team
(iv) inability to change or adapt to a transition.

In complex cases, such as those involving interpersonal relationship difficulties or apparent unusual behaviour of the doctor being referred, the importance of informant information comes to the fore. When trying to identify the impaired doctor, it is recognized that social or personal difficulties can precede problems in professional practice [15]. Evidence from friends or family can assist the occupational physician to corroborate the medical history obtained or to challenge lack of insight. Similarly, detailed and accurate information from work colleagues can help elucidate claims and counterclaims about work performance. The utilization of skills laboratories and the recently devised workplace-based clinical assessments [16] could assist fitness for work assessments in the future, work colleagues becoming assessors of aspects of practice.

Models of assessment

To date, models of assessment have concentrated on either the evaluation of doctors who have got into trouble in clinical practice or screening for health problems at the point of entry into a new job. The assessment of the impaired physician is well established in the USA, and in the UK, doctors may be referred to either the National Clinical Assessment Service (NCAS) or the General Medical Council, the statutory licensing body. In Europe, it appears from published literature that national or local hospital policies for dealing with impaired physicians are lacking in many countries [17].

Physician health programmes (PHP) have been established in the USA, linked to licensing boards and medical societies. The remit of the programmes is to identify, treat and monitor impaired physicians [11]. In addition, individual hospitals have been mandated by accreditation organizations to establish non-disciplinary processes to address physician health, including an internal physician wellness committee whose role is to investigate complaints about physicians with suspected impairment and to make appropriate referrals for evaluation and treatment. The definition of physician impairment includes the ‘disruptive physician’ whose conduct may affect patient care or the ability to work with health care teams. The model relies on observers reporting physicians. However, identifying illness in colleagues may not be straightforward. Changes due to substance abuse often occur initially outside the workplace such that by the time performance at work has become evident an illness may have been longstanding [15]. Doctors’ responses towards other impaired or incompetent doctors may also depend on their status. In one study, house officers were much more likely to personally confront colleagues of similar status than confront senior physicians where there were concerns about impairment [18]. They were more likely to report seniors to the chief resident and all doctors considered to be incompetent. A more recent study, again in the USA, found that physicians would report other physicians to a PHP, but they were more likely to hypothetically report physicians suspected of substance abuse than those who were emotionally or cognitively impaired [19]. It is also recognized that, culturally, doctors displaying unusual behaviour are given more latitude than would be
Next steps

Current models of assessment, however sophisticated, are essentially reactive. There is a need for a proactive
approach to physician health and well-being that encourages individual responsibility for health and fitness for practice and that promotes systems to encourage early intervention when health and performance deteriorates. The rationale for paying particular attention to the health of doctors and their fitness for work relates fundamentally to patient safety. Doctors whose clinical practice affects decisions about individual patient care must be considered to be in safety critical jobs. This means that if their performance is sub-standard patients may be harmed. Concern may be about an acute event that would incapacitate a doctor, for example, a surgeon conducting an operation or a chronic fluctuating problem causing impairment of functioning. With regard to the latter, it might be the behaviour of the doctor as much as the decision-making capabilities that is the cause for concern. The assessment of the health and fitness to work of doctors should, therefore, be in the context of a health and safety system, but also a quality assurance system, such as clinical governance [29]. To refer again to the aviation industry, medical checks are carried out on pilots routinely, according to age and type of flying. A recent review of 1000 fatal accidents between 1956 and 1995 revealed that 47 had a medical factor of which over half were cardiac in origin [30]. In most cases, pilots of aircraft are part of an onboard team and commercial aircraft have two pilots to guard against the eventuality of one pilot becoming incapacitated. It is also appreciated that ~10% of the flying task is safety critical (take off and landing). Medical incapacitation of up to 1% per annum is considered unlikely to affect the target accident rate for the industry and medical screening is designed to keep incapacitation rates below this level (R. Johnston, personal communication). In addition, there are organizational resources designed to mitigate the impact of impaired performance. Crew resource management (safety training and involvement of the cabin crew) operates in the event of a sudden or subtle incapacitation. Feedback to the pilot followed by subsequent time on the flight simulator aims to address the problem. Team resource management is a process of giving feedback on the performance of colleagues as part of a no-blame culture. There is a mandatory occurrence reporting system providing information on incidents to the Civil Aviation Authority.

The closest similarities between flying and medicine are probably in the surgical, interventional and investigatory disciplines, where standard operating procedures either exist or are possible. Such activities are team based. Technical skills as well as judgement are required and these can be assessed using simulators, in some cases. However, other branches of medicine do not fit the analogy. For example, general practice and psychiatry may involve doctors working in relative isolation with complex patient interactions. However, clinical governance, which should incorporate processes akin to crew resource and team resource management, applies to all branches of medicine and occupational health assessments should occur in this context.

Should doctors have regular medical screening? As with any question about screening it is necessary to determine what is being proposed, why, the cost and how it will benefit the population being screened, as well as the public [31]. In an occupational health setting, the implications of findings on fitness for work and future employability must be addressed as well as the provision of medical treatment. A recent study in the USA has questioned the value of an annual physician check-up, while supporting the uptake of established public health screening programmes [32]. There is also some evidence that untargeted physical examination of Royal Air Force personnel is of little value in addition to screening tests when performed as part of routine health surveillance [33]. The aim of medical screening in doctors, from a health and safety perspective, should be to identify underlying health conditions that are likely to increase the risk of medical events or impaired performance during safety critical procedures with an associated increase in the risk of an adverse patient outcome. There is a need, therefore, for analysis of doctors’ activities and the current control systems for preventing such adverse outcomes. Research into the influence of underlying medical conditions on the occurrence of serious untoward incidents would help identify the priorities for screening programmes.

However, patient safety will be protected most effectively by changing medical culture and attitudes towards physician impairment and towards promoting health and well-being. It is estimated that ‘when all conditions are considered, at least one-third of all physicians will experience, at some time in their career, a period during which they have a condition that impairs their ability to practise medicine safely’ [34]. Unfortunately, there is evidence that, despite advances in medical technology and treatment options, many physicians remain wary of disclosing illnesses because of the perceived risk of professional, societal or legal sanctions [15]. The American Medical Association has put forward recommendations for addressing the issue of impairment based on its code of medical ethics [35]. It places obligations on doctors, as individuals, and as part of the medical profession to promote health and well-being and to act responsibly in identifying and supporting the impaired physician. The role of occupational health expertise is seen as a key element in assessing fitness for work. Occupational health services, with suitably qualified and experienced specialists, should play a central role in helping to prevent ill-health at work and in assessing illness and the need for rehabilitation and adjustments to working practices.

Conclusions

The need to replace ad hoc assessments of doctors’ fitness for work and fitness to practise is clear. The impaired
physician may pose a risk to patient safety and it is important that concerns relating to health and behaviour are fully assessed taking into account individual and workplace factors. Countries such as the USA and the UK have started to develop models of assessment that have much in common although methods of delivery differ. There is an increasing realization that a proactive approach to assessment is required that begins with a promotion of general health and well-being of doctors and which includes the provision of appropriate treatment options and support to encourage participation. The role of occupational health expertise is becoming recognized as being of central importance in the assessment model. More research into the relevance of doctors’ ill-health to patient safety, when working as part of health care teams with embedded safety systems, is required.

Conflicts of interest

None declared.

References