IN-DEPTH REVIEW

Doctors’ health and fitness to practise: the need for a bespoke model of assessment

John Harrison

Abstract

Doctors’ performance and fitness to practise are attracting increased attention. High profile cases have brought into question the assessment of fitness to practise and the monitoring of professional performance. In the UK, the chief medical adviser for England has proposed strengthening systems to improve the performance of doctors which include addressing problems of ill-health. The behaviour of the impaired physician, or the doctor–patient, presents unique challenges and a review of the various issues highlights the need to address how the medical profession and society deal with the occurrence of illness in doctors. Conditions such as mental ill-health and substance abuse may affect doctors’ fitness to practise, but other conditions may also be relevant. This paper will discuss the occurrence of ill-health and the need for a bespoke model of assessment.

Key words

Assessment; doctors; impaired physician; mental illness; physical illness; physicians; substance abuse.

Introduction

The assessment of fitness for work is core to occupational health practice. Why, therefore, should it be necessary to selectively address issues relating to the assessment of doctors’ health and their fitness for work? There are a number of reasons. Doctors’ professional performance has become the focus of unprecedented public scrutiny [1]. A recent high profile case in the UK was the conviction for murder of a general practitioner (GP), Dr Harold Shipman. In the subsequent enquiry, the chairman, Dame Janet Smith, criticized systems purporting to protect the safety of patients and the proposed system for revalidating doctors’ licence to practise [2]. Consequently, the chief medical adviser for the UK produced proposals for strengthening systems to improve the performance of doctors [3], some of which related to the occurrence of ill-health and addiction in doctors. Doctors do not always behave like patients nor do their colleagues treat them like patients [4]. There is an increasing recognition that illness and disability is not managed well within the medical profession [5].

Concerns about doctors’ health tend to focus on mental ill-health and substance abuse. In the USA, the term ‘impaired physician’ has been used to describe those doctors with health problems affecting fitness to practise. The American Medical Association has defined an impaired physician as ‘one unable to fulfil professional or personal responsibilities because of psychiatric illness, alcoholism or drug dependency’ [6]. This definition, dating from the 1970s, has been widened subsequently. ‘Any physical, mental or behavioural disorder that interferes with the ability to engage safely in professional activities’ [7] is a definition that reflects current awareness that a range of conditions may impede the safe practice of medicine irrespective of knowledge and skills. In the USA, physician health programmes (PHP) have been established by most state licensing boards and medical societies to identify, treat and monitor impaired physicians [8]. The licensing body in the UK is the General Medical Council (GMC). In a recent review, only 1% of doctors who were referred to the GMC health committee had a problem with physical health [9]. GMC records show that 199 of 201 doctors under supervision at the end of 2001 had problems with alcohol, drugs or mental ill-health. There are no equivalent PHPs in the UK, although new programmes are about to be piloted, and arrangements for treating impaired physicians are sporadic with reliance on confidential counselling services [5].

Doctors are challenging patients and there are often complex reasons for this. A qualitative study of Norwegian physicians revealed a pattern of denial and delay in seeking help, despite the occurrence of symptoms that would have suggested diagnoses of concern if they had occurred in patients [10]. The doctor who becomes ill has difficulty in admitting the illness. This may be compounded by a role conflict concerning being a patient and a doctor at the same time. The treating physician may also have a role conflict in that he or she is also a colleague.
Doctors come to believe that they will not become ill and should be ‘strong and tough’ and ‘not overdramatize illness’. They also have concerns about other people discovering that they are ill, as this may demean them in the eyes of colleagues or patients. Boisaubin and Levine believe that ‘physicians, always aware of the importance and centrality of medicine in their lives, usually strive to delay or mitigate the impact of impairment upon their career, preferring to sacrifice first personal life and relations. When true impairment in clinical skills is apparent, the illness is usually severe and longstanding’ [6]. Reade [8] quotes a study of disruptive physicians by Neff where it is noted that many successful doctors are compulsive, perfectionist and self-directed individuals who resist being controlled and who are trained to direct others. The inability to cede control of care to another can undermine the doctor–patient relationship. In many cases, the doctor–patient knows best. Conversely, sometimes doctors are not allowed to be patients, with doctor colleagues finding it difficult to relate to the ill doctor as a patient.

It is also apparent that the medical profession does not deal well with disability among its own members. A recent working party convened by the Royal College of Physicians of London found that there was a stigma attached to having a disability and that doctors were reluctant to declare non-obvious impairments, particularly mental ill-health [11]. It also found that the culture in medicine tended to be hostile to doctors with disabilities and that patient safety, while of paramount importance, was sometimes used as an excuse to exclude doctors with disabilities. At a time when new measures are to be introduced in the UK to promote public confidence in health professionals [12], there is clearly work to be done to encourage openness and transparency in the management of ill-health in doctors. The importance of competent assessments of doctors’ fitness to work, therefore, cannot be overstated.

**Ill-health in doctors and fitness for work**

The assessment of the individual’s capacity to work without risk to their own or others’ health and safety [13] is a commonly cited definition of fitness for work [14]. A doctor’s fitness for work, as a health care professional, builds on this definition to include the elements of professionalism. This, in turn, must take account of public expectations of the role of a medically qualified practitioner. Being a good doctor is about more than just technical and clinical competence, skills or knowledge [1]. The document *Good Medical Practice* [15] highlights the importance of non-clinical attributes, such as teamwork, leadership and communication. In a recent review of medical codes and standards in the UK, USA and Canada [16], examples of contemporary definitions of medical professionalism include ‘a dynamic concept, rooted in a long tradition of service and high ethical standards, and shaped by public expectations’ [17] and ‘a set of values, behaviours and relationships that underpins the trust the public has in doctors’ [18]. The maintenance of trust in the medical profession underpins any consideration of fitness to work. Thus, as societal attitudes and expectations change, the assessment of doctors’ fitness for work must change.

The commonest reasons for doctors taking early retirement from the National Health Service (NHS) in the UK are psychiatric (33%), musculoskeletal (27%) and cardiovascular (17%) illnesses [19]. This does not reflect morbidity patterns. It might be expected that doctors would have insight into the implications of physical illnesses with respect to their fitness for work and present for assessment. This may not be the case when the problem is substance abuse or depression. Pension scheme rules are also a factor, in that physical illnesses might be more likely to be judged to cause permanent ill-health. A comprehensive review of the health of health care workers, including ill-health among doctors, was carried out on behalf of a partnership of organizations convened by the Nuffield Trust [20]. The major findings were of ill-health related to psychological disturbances and unhealthy lifestyles, including excessive alcohol consumption. An attempt to quantify how many doctors are sick [9] combined a literature search with an enquiry of organizations including the Department of Health, the GMC and care organizations such as the National Counselling Service for Sick Doctors. The results reinforced the impression that psychiatric illness is the main affliction of doctors. It was noted that calls for help about drugs and alcohol had reduced in recent years. This was felt to be an indication of a reluctance of doctors to seek help rather than a decrease in the incidence of addicted doctors.

Depression is as common in physicians as in the general population [21]. A lifetime prevalence of 13% was found in a prospective study of 1300 male medical graduates in the USA, which was similar to a lifetime prevalence of major depression in adult US males aged 45–55 years. However, depression is said to occur later in physicians. The lifetime prevalence of depression in female US physicians is 19.5%, which is comparable to that of women in the general population [22]. The occurrence of depression is important as it not only affects behaviour but also the associated effects on cognitive function which may alter clinical performance. There is also the risk of substance abuse and suicide.

Bipolar illness is an important illness in doctors. In the UK, the lifetime prevalence is said to be 1% overall [23], the same as in the USA [24], with increased risks if other family members are affected. Although the condition usually develops in late adolescence or early adulthood, it may develop later in life. It is a chronic illness
but the various mood states are considered to occur within a spectrum or continuous range, with severe depression at one end and mania at the other. Bipolar illness occurs in doctors and the diagnosis is not incompatible with clinical practice. However, its occurrence poses occupational management problems. A hypothetical case of a consultant pathologist with a bipolar disorder was cited by Donaldson [25] to highlight the complexities surrounding such cases and the then lack of organizational structures in the NHS to deal with such cases. The diagnosis of bipolar disorder is often delayed either because the illness is not recognized or because of the occurrence of co-morbidities, such as substance abuse, anxiety and eating disorders [26,27]. It has also been realized that, even during periods of clinical euthymia, mood scores may be worse than a healthy control group and that there may be cognitive impairment [28]. In particular, response times have been shown to be slower as well as impairment across a range of cognitive domains including attention, executive function, immediate (spatial) memory and delayed verbal and visuospatial declarative memory. The dysfunction was evident after controlling for mood and cortisol levels, but relative role of medication was not evaluated. The direction of causality could not be determined. For doctors who have successfully completed medical training, it might be assumed that they do not have clinically relevant cognitive impairment in the early part of their careers. The effect of continuing illness on cognitive function should, perhaps, be part of an occupational health assessment (Box 1).

Although definitive studies on suicide in physicians are lacking, it appears that there is an increased suicide rate compared to the general population of at least 2-fold [29]. The overall physician suicide rate ranges between 28 and 40 per 100,000 compared to 12.3 per 100,000 in the general population [29] and it is the commonest cause of death for young physicians. Rates in male and female physicians are approximately equal, although a study from England and Wales suggests an increased risk in female physicians but not male physicians, compared to the general population [21]. Suicide rates in female physicians are about four times greater than women in the general population [21]. Suicide rates in male and female physicians are approximately equal, although a study from England and Wales suggests an increased risk in female physicians but not male physicians, compared to the general population [21]. Suicide rates in female physicians are about four times greater than women in the general population [21].

Physical illnesses in doctors should not be forgotten despite the paucity of studies [4]. Diabetes mellitus, epilepsy, multiple sclerosis, Parkinson's disease, arthritis and inflammatory bowel disease are all sufficiently common to require assessments of fitness to work each year in either hospital or community settings. Diabetes mellitus is referred to as an unseen disability [31]. Doctors working in night shifts, or long and stressful hours, and not eating properly and regularly must overcome problems of glycaemic control. Occasionally, symptoms associated with poor glycaemic control, such as fatigue or impaired performance during operating theatre sessions or in other safety critical areas of practice, may require occupational health assessment to modify hours of work and activities undertaken. Unfortunately, there is still a stigma attached to the diagnosis of epilepsy that can discourage doctors from admitting the problem to their colleagues, let alone to patients. Frequent seizures can be very disruptive to the delivery of care, especially in an era of intense pressure to meet clinical targets. Multiple sclerosis usually begins in the early years of working life. In any deanery or NHS region, it is likely that there will be several junior doctors and two or three career grade doctors, either in hospital practice or in general practice, with the condition. Adjustments can be made to assist doctors with

Box 1. The patterns of mood change may vary between individuals and four categories have been described

- bipolar 1 with the occurrence of mania
- bipolar 2 with depression
- hypomania; rapid cycling, with at least four episodes of mood swings in 12 months
- cyclothymia, with less severe mood swings which may last longer

Box 2. Physicians at high risk of suicide

- Male or female
- 45 years or older (women); 50 years or older (men)
- Race—White
- Marital status—divorced, separated, single or going through marital disruption
- Risk factors—depression, alcohol or other drug abuse, workaholic, excessive risk taking (high-stakes gambling, thrill seeker)
- Medical status—psychiatric symptoms or history (depression, anxiety); physical symptoms (chronic pain, chronic debilitating illness)
- Professional—change in status, threats to status, autonomy, security, financial stability, recent losses, increased work demands
- Access to means—legal medication, firearms
mobility problems including the provision of electric vehicles for moving around hospitals. Upper limb ataxia may be a significant disability with respect to clinical practice. In one case, a junior doctor in paediatrics was able to continue in clinical practice despite lower limb problems, but when her left arm became affected she had to give up routine practice and adopt a teaching role. Some doctors with multiple sclerosis lack insight into how badly they are affected.

Parkinson’s disease presents later in life and is unusual in junior doctors. Typically, it will present in a hospital consultant or a GP principal. The four cardinal signs of Parkinson’s disease—tremor, rigidity, slowness and difficulty in starting and stopping walking—contribute to the disabilities of the illness [32]. The doctor–patient ‘shuffles’, handwriting becomes small and untidy and rapid movements of hands and feet are impaired. Such problems mean that continuing to practise medicine after the diagnosis has been made is unlikely in specialties involving fine hand movements and rapid responses, unless a new restricted role is available. Surgeons normally have to cease to operate once the diagnosis has been confirmed, even if symptoms can be controlled by medication. From a safety perspective, the risk to patients of an adverse outcome due to failure to control symptoms, albeit intermittently, is too great.

During exacerbations, ulcerative colitis can cause malaise and tiredness as well as the need to leave the workplace to use the toilet. Associated conditions such as uveitis or arthropathy can also be problematic. In addition, treatment of severe exacerbations can cause steroid-induced behavioural changes that create difficulties if the doctor has tried to continue in clinical practice. In an extreme case, apparent abnormal behaviour caused by steroid treatment has led to disciplinary proceedings.

Rheumatoid arthritis or seronegative arthritis can interfere with clinical practice, if a doctor is required to spend a lot of time standing or walking, or must maintain set postures at work, perhaps in anaesthetics, surgery or interventional radiology. Arthritis of the hands is particularly important if manipulation of instruments is a feature of the job.

Deficient vision has been shown to be important when assessing histopathologists [33]. Out of 132 doctors, 13% had colour-deficient vision. Fourteen were deutan (green colour deficient) and 1 was protan (red colour deficient). Doctors with colour deficiency were significantly poorer at identifying test slides than doctors with normal colour vision. In addition, the severity of colour deficiency correlated with the number of mistakes made, including missing mycobacteria, amyloid or *Helicobacter pylori*.

**Conclusion**

Doctors represent a special occupational group requiring specialist occupational medicine assessments of fitness to work. Although any health problem may have to be considered when assessing fitness to work, mental ill-health, substance abuse and cognitive impairment are key areas. Because of their knowledge of medicine and also because of the culture in which doctors are trained and work, their attitude to being ill and to becoming a doctor–patient may influence assessments of their fitness. In keeping with new concepts of medical professionalism, it is incumbent upon the profession to ensure that methods of assessment of doctors’ fitness to work are consistent with best practice and that the occupational physicians responsible for carrying out the assessments are suitably trained and experienced. There is a need for a defined model of assessment that incorporates best practice and promotes consistency and increasing transparency in assessing fitness for work.

**References**

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