Doctor and dentist contacts with an NHS occupational health service

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**Background**

There is increasing acceptance that management of ill-health in doctors can be patchy and is not always optimal. Health can impact on performance and fitness to practice, placing an important responsibility on occupational health (OH) services.

**Aims**

To improve our understanding of OH contacts by doctors and dentists and make some comparison of this with available sickness absence records.

**Methods**

A retrospective descriptive evaluation of all doctor and dentist encounters with the OH service between April 2009 and March 2010 was undertaken. Doctor and dentist encounters from our electronic appointment system were analysed using Microsoft Excel. Comparisons were made with management-reported sickness absence data for this period.

**Results**

Blood tests, immunizations/immunization updates accounted for 49% (295) of contacts. Management and self-referrals accounted for 26% (157) of all OH contacts. Mental health conditions were the main reason for referral (approximately one-third of all cases referred). In this group, a much higher number presented to OH, absent from work, than were recorded with sickness absence by management. Musculoskeletal, infection and skin complaints were other predominant reasons for referral.

**Conclusions**

Doctors and dentists do utilize this OH service and the issues for which they need services are wider than those of mental health. Inconsistency in the reporting of sickness absence in doctors with mental health problems has also been highlighted. This baseline information is a useful stepping stone to identifying and meeting the specific needs of doctors and dentists and can be used as a benchmark in other organizations.

**Key words**

Doctors; fitness; mental health; ill-health; addiction; performance.

**Introduction**

The conflict in being both a doctor and patient is well recognized in the medical profession. The culture of self-diagnosis/treatment, minimizing personal health problems and avoidance of sickness absence is widely acknowledged [1–3]. Difficulty admitting to illness, concerns about stigmatization and presenting as challenging patients have also been reported [4,5]. As a safety critical and expensive resource within the National Health Service (NHS), the implications of ill-health in this professional group are significant. There is increasing acceptance that management of ill-health in doctors can be patchy and is not always optimal [4,6]. In recognition of this, doctor’s health has emerged as a specialist area of practice, with specific services to address health issues in this group [7]. Health can impact on performance and fitness to practice, placing an important responsibility on occupational health services (OHS) [8]. While physical illness in doctors should not be forgotten, concerns tend to be focused around mental ill-health and alcohol/substance abuse [2,4,8,9].

To better understand doctors' ill-health, we reviewed doctor and dentist encounters with one OHS, to identify illness-related encounters and compare these with
available sickness absence data held by the organization. No published studies looking at throughput and utilization of OHS by doctors and dentists have been identified by the authors to date.

**Methods**

A retrospective descriptive evaluation of all doctor and dentist encounters with the OHS between April 2009 and March 2010 was undertaken. The population was 960 doctors and dentists out of a total of 12,377 staff employed by a health board providing acute and primary care services. The service operates an electronic system holding attendee information, including occupation and appointment type. Following each encounter, the OH clinician inputs the outcome, including the active ill-health condition (broad disease category then specific clinical diagnosis), sickness absence status, work-relatedness and fitness for work. Doctor and dentist encounters with our service were analysed using Microsoft Excel. The data were anonymized at the extraction stage and did not include employee-identifiable details.

A sickness absence management programme operates within our organization, to which managers report staff absences, including occupation and reason for absence. Consent is sought from participating employees to use this data for audit purposes and approximately 99% provide consent. Anonymous sickness absence data were provided from this programme for the survey period. The NHS research and development manager confirmed that research ethics approval was not deemed necessary for this service evaluation.

**Results**

The total number of doctor and dentist contacts with the OHS for the year was 601. The types of contact are summarized in Table 1. Blood tests, immunizations/immunization updates accounted for 49% (295) of contacts. Management and self-referrals accounted for 26% of all contacts, 46% of these being management and 54% self-referrals.

Six per cent (59) of doctors and dentists were referred or self-referred to the OHS. The management and self-referral reasons were recorded in all cases by broad disease category and are presented in Table 2. Mental health problems accounted for 31% (18) of referrals (all cases in doctors). A specific clinical diagnosis was only available in 67% (12) and included stress/anxiety, depression, alcohol dependence, bereavement and personality disorder.

Musculoskeletal, infection and skin complaints were the other predominant conditions. ‘Other’ categories included post-operative, respiratory and no clinical diagnosis.

Work-relatedness, as considered by the OH clinician, is recorded in Table 2. Twenty-eight per cent of mental health referrals were believed to be caused by work. All skin cases were considered work related, possibly related to the introduction of new hand-hygiene products in this period.

Separately, review of the management-reported sickness absence data between April 2009 and March 2010 confirmed that for doctors and dentists, the most common sickness absence events were gastrointestinal and cold/cough/flu, accounting for approximately half of all events recorded. Mental health conditions accounted for only three out of 168 recorded absences in the survey period. In contrast, 18 mental health sickness absence cases were seen at OH. In 15% of absence events among doctors and dentists the reason was ‘unknown’ compared with 4% in ‘other’ staff groups.

**Discussion**

This service evaluation confirmed that this population of doctors and dentists do utilize OH services and that the issues for which they need services are wider than those of mental health. Inconsistent reporting of sickness absence in doctors with mental health problems has been highlighted, with a much higher number presenting to OH, absent from work, than recorded with sickness absence by management.

There was a higher proportion of absences for ‘unknown’ reasons in doctors and dentists compared with ‘other’ staff groups. This may be a reflection of sensitivity about recording of their sickness absence cause. Managers may have some responsibility by not reporting sickness absence or not accurately recording the health problem.

This would support previous reports suggesting a fear of stigmatization in this group [4]. The strengths of this evaluation are its simplicity and that it confirms some of the OH needs of this population of doctors and dentists. A weakness in the OH contact recording was a lack,

<table>
<thead>
<tr>
<th>Table 1. Total numbers and types of contact with OHS between 1 April 2009 and 31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of contact</strong></td>
</tr>
<tr>
<td>Advice</td>
</tr>
<tr>
<td>Blood test</td>
</tr>
<tr>
<td>Immunization update</td>
</tr>
<tr>
<td>Immunizations</td>
</tr>
<tr>
<td>MR (first appointment)</td>
</tr>
<tr>
<td>MR (review)</td>
</tr>
<tr>
<td>Needlestick</td>
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<tr>
<td>PEHA</td>
</tr>
<tr>
<td>Self-referral (first)</td>
</tr>
<tr>
<td>Self-referral (review)</td>
</tr>
</tbody>
</table>

MR, management referral; PEHA, pre-employment health assessment.

*Percentages do not add up to 100 because of rounding.
in some cases, of a specific clinical diagnosis within the broad disease categories.

Improved education of doctors and dentists is required about the importance of seeking help for health problems from their general practitioner, their obligation to address these problems under General Medical Council guidance [10] and the support available from OH. Managers should be encouraged to identify doctors and dentists with health problems to OH and report their sickness absence more consistently. It is also important that those involved in the care of this professional group are aware of their wider OH needs as well as the general health care issues.

This baseline information is a useful stepping stone to identifying and meeting the specific needs of doctors and dentists and can be used as a benchmark in other organizations.

### Key points
- Doctors and dentists do utilize occupational health services, and the issues for which they need services are wider than those of mental health.
- This evaluation highlights inconsistency in the reporting of sickness absence in doctors with mental health problems.
- Medical managers should be encouraged to identify doctors and dentists with health problems to occupational health and report their sickness absence more consistently.

### Funding
None required.

### Conflicts of interest
None declared.

### References
6. Harrison J. Illness in doctors and dentists and their fitness for work—are the cobbler’s children getting their shoes at last? *Occup Med (Lond)* 2006;56:75–76.

### Table 2.
Overall figures for management and self-referrals and work-relatedness attributed by the assessing OH clinician

<table>
<thead>
<tr>
<th>Reason for referral</th>
<th>Mental health n (%)</th>
<th>Musculo-skeletal n (%)</th>
<th>Infection n (%)</th>
<th>Skin n (%)</th>
<th>Pregnancy related n (%)</th>
<th>Cardiac n (%)</th>
<th>H1N1 reaction n (%)</th>
<th>Neurological n (%)</th>
<th>Other n (%)</th>
<th>Total n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caused by work</td>
<td>5 (28)</td>
<td>1 (12)</td>
<td>1 (17)</td>
<td>3 (60)</td>
<td></td>
<td></td>
<td>3 (100)</td>
<td>1 (11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Made worse by work</td>
<td>3 (17)</td>
<td>2 (25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 (100)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not work related</td>
<td>10 (55)</td>
<td>5 (63)</td>
<td>5 (83)</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>2 (100)</td>
<td></td>
<td>8 (89)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18 (31)</td>
<td>8 (14)</td>
<td>6 (10)</td>
<td>5 (9)</td>
<td>3 (6)</td>
<td>3 (6)</td>
<td>3 (6)</td>
<td>2 (3)</td>
<td>9 (15)</td>
<td>59 (100)</td>
</tr>
</tbody>
</table>