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## SICKNESS IN THE MEDICAL PROFESSION

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**Abstract**—A questionnaire was sent to 200 doctors randomly selected from the *Medical Register* and replies were received from 63%. Of these, approximately 53% had had at least 1 day off sick in the previous 2 years but very few had taken more than 6 days off in that time. Of those who had not required hospital treatment, most had treated themselves and c. 82% of the respondents stated that they had prescribed treatment for themselves at some time or other. None of the doctors who had taken sick leave had ever consulted their occupational health service but just over 87% reported that they had worked when they felt too unwell to carry out their duties to the best of their ability. ]  
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## INTRODUCTION

The medical profession is curiously indifferent to its own health and this may be because, in general, doctors enjoy good health. They do suffer unduly from stress, however, and high levels of burnout have been reported in both hospital doctors (Humphris *et al.*, 1994) and general practitioners (Kirwan and Armstrong, 1995) which is in line with the lack of job satisfaction which many doctors now seem to experience (McKevitt *et al.*, 1996). Doctors are well known to be prone to abuse alcohol and drugs (Brooke *et al.*, 1991) and they are among the 10 highest occupational groups at risk for suicide, although it is noticeable that suicide rates among male doctors have declined in recent years; for the period 1982-1992, the proportional mortality ratio for suicide among male doctors was 144 and for female doctors, 322 (Kelly *et al.*, 1995).

It has been stated that doctors have difficulty in obtaining access to medical services (Richards, 1989; Silvester *et al.*, 1994) and it has been reported that many doctors prescribe for themselves and tend to treat themselves rather than defer to a colleague (Allibone *et al.*, 1981; Chambers and Belcher, 1992). Nevertheless, doctors seem to take relatively little sick leave (McKevitt *et al.*, 1996) and they generally do not make much use of occupational health services even when they have access to them (Silvester *et al.*, 1994; McKevitt *et al.*, 1996).

There are some informal mechanisms for helping doctors deal with illnesses which they feel may be affecting their ability to practice but information on their efficacy is not forthcoming because of issues of confidentiality. Should doctors become so unwell that their practice brings them to the attention of the General Medical Council (GMC) then they may be assisted by the Health Committee which apparently does have considerable success, at least insofar as it generally ensures that the doctor concerned is able to remain on the *Medical Register*. The situation is generally unsatisfactory, however (Nuffield Provincial Hospitals Trust, 1996), and many doctors consider that special services should exist for their use. The provision

of services for sick doctors in this country may be compared unfavourably with that in the United States where programmes to help them are many, vigorous and generally successful (Ikeda and Pelton, 1990; Bohigian *et al.*, 1994; Femino and Nirenburg, 1994).

I have been trying to establish a research programme which will provide information on the prevalence of sickness among doctors and how this impacts on their practice; I have been particularly interested to know the extent to which doctors have access to occupational health services, which might be thought to have some role to play in dealing with illness among doctors as it affects their work. The first part of this study has been to pilot a questionnaire with the results which are described in this paper.

#### METHODS AND MATERIALS

The questionnaire was designed to gain information on the number of days which doctors had taken off sick in the previous 2 years; on whether the illnesses required treatment and if so, who treated them; whether any of the spells of sick leave were caused by work; whether the doctors had access to an occupational health service and if so, did they use it; and, finally, whether any of the doctors worked when they felt they were too unwell to carry out their duties to the best of their ability.

The names of 200 doctors were selected at random from the *Medical Register* and a copy of the questionnaire was sent to each with a letter describing the aims of the study and a pre-stamped envelope for the return of the completed questionnaire. The doctors were assured that there were no identifiers on the questionnaire and that they would not be chased up if they choose not to complete it.

#### RESULTS

A total of 126 responses (63%) was obtained. Of these, 110 doctors returned completed questionnaires, 9 doctors or their relatives told me that they had retired or left the country and 7 questionnaires were returned by the Post Office because the doctor was no longer at the address shown in the *Medical Register*.

Of the 110 who completed the questionnaire, 76 were male and 34 female and the majority (78) had qualified since 1970. The majority of respondents 56 (50.9%) were general practitioners, 42 (38.2%) were hospital doctors, 5 were academics and 7 were working in other specialties, some in industry and 1 was an occupational physician.

A majority of the doctors 58 (52.7%) had had at least 1 day off sick in the previous 2 years but relatively few had had 6 or more days off (Table 1). Of those who had taken sick leave, 13 had been treated in hospital and a further 36 had required other kinds of treatment. The majority of those who required treatment, other than in hospital, had treated themselves (17); 4 others had been treated by their spouse, 6 by a colleague and only 9 by their general practitioner. Ninety of the sample admitted that they had prescribed medication for themselves in the past. There were no differences in the amount of sick leave taken between male and female doctors, or between general practitioners and other doctors.

Table 1. Number of days taken off sick by doctors in the previous 2 years

Number of days	General Practitioners		Others		Total
	Male	Female	Male	Female	
None	20	8	20	4	52
1-5	11	8	14	8	41
6-10	3	0	3	2	8
11-15	1	0	0	0	1
16-20	0	0	0	2	2
More than 20	3	2	1	0	6

In 13 cases the doctors considered that their sick leave had been caused by their work. The reasons included infections which had been contracted from patients, stress and mental breakdown, and one doctor had been stabbed by a patient.

Although 51 of the doctors (all but three in hospital practice) had access to an occupational health department, not one had consulted an occupational physician on any of the occasions on which he or she took sick leave. Virtually *all* the doctors who responded, however, 96 in all, reported having worked when they were too unwell to carry out their duties to the best of their ability.

#### DISCUSSION

I began this paper by saying that doctors were indifferent to their own health and this is perhaps borne out by the low response rate to this survey, 63%. Nevertheless, this study has produced some interesting results. Perhaps the most important is the fact that although doctors seem to take little sick leave—the rate of sick leave indicated by the responses to the questionnaire is certainly not much more than 1% at most, compared with about 5% which is the mean of all National Health Service (NHS) workers (Seccombe and Patch, 1994)—most admit to working when they feel too unwell to be able to carry out their duties to the best of their ability. This bears out the findings with respect to sick leave of McKevitt and his colleagues (1996) who found that doctors took significantly less sick leave than a control group of workers in a multinational accountancy and management consultancy company.

Although I did not ask for specific comments, a few of the respondents gave them, especially in response to the question of working when unwell. "All doctors do", wrote one respondent, "Yes—dangerously", wrote another while a third reported that he had "frequently" done so. One female general practitioner wrote that she had worked "many times" when too ill to do so adding that "In a small practice, [one is] aware of the extra burden one would put on ones colleagues by going off sick. Locums are very difficult to get at short notice and there is no slack in the system to allow the remaining partner to absorb the extra load—hence one struggles on unless one is dying!"

Another respondent who was a consultant psychiatrist wrote, "I have seen a lot of difficulties due to doctors working when unwell—especially with mental health problems which are recognised by colleagues but no-one does anything for fear of offending the doctor concerned." Three of the respondents stated that they had had psychiatric illnesses, all said to be depressive in nature. One went off to have treatment but another stated that when, as a general practice trainee she had

reactive depression her general practitioner refused her a sick note. "I felt if I had been anyone else I would have been given one," she wrote. "His reason for not giving it was that I needed a reference from my trainer." The implication here must be that her own doctor felt that having a psychiatric illness was such a slur that her trainer would not recommend her for a substantive post; how her doctor could have supposed that it was preferable for her to work under the circumstances beggars belief. The third doctor said that his house jobs were one of the worst experiences of his life. "The mind numbing tiredness and dreadful working conditions led to stress and demoralisation sufficient for me to take 6 months sick leave between jobs." But he blamed his absence on an old knee injury rather than admit to being depressed.

One of the additional reasons for undertaking this pilot was to see the extent to which doctors had access to occupational health services and how frequently these were used. The impression of occupational physicians working in the health service is that doctors seldom consult with them except when they are forced to do so—in order to comply with the recently introduced regulations regarding hepatitis B vaccination and those undertaking invasive procedures, for example. There are a number of reasons why this might be; doctors generally feel able to cope with their own illnesses and the fact that well over 80% of the respondents had self-medicated seems to bear this out; they often do not hold occupational medicine in very high esteem and will not refer to their occupational health department especially if they find that they are being dealt with by a nurse or a doctor who is not a consultant; where there is a doctor whom they might feel they could trust, they may be unwilling to consult them feeling that this may later cause some embarrassment; finally, until recently, doctors were not 'managed' in the normal sense of the word, and it was not clear who was responsible for dealing with such matters as sick leave or poor performance at work. Some doctors see the occupational health service as 'an intrusion into their lives' or 'part of a punitive management structure' (Silvester *et al.*, 1994) and concerns about confidentiality are common (McKevitt *et al.*, 1996) although, in truth, occupational health records are probably the most secure in the NHS and there is no reason at all to suppose that occupational physicians are less trustworthy with a confidence than the doctors who consult them.

The results of the present survey leave no doubt that doctors working in hospitals feel that they have nothing to gain from their occupational health department since not a single one had ever consulted it during any of their spells of sickness. These results, again, are in keeping with those of McKevitt *et al.* (1996), who found that less than 3% of doctors in their survey consulted an occupational health service about their own health. For an occupational physician who feels strongly that doctors have a lot to *lose* by keeping themselves outside the occupational health service net, this was a particularly disappointing outcome of the survey even though one lone general practitioner slightly mitigated the gloom by saying that he wished he *did* have access. Doctors are obliged to comply with health and safety legislation like others in the workforce and there are several regulations with which they should be familiar and some should probably be under regular health surveillance, including, for example, those who may regularly be exposed to formaldehyde or glutaraldehyde and those who conduct invasive procedures and who do not sero-convert following a course of vaccination.

When a doctor is sick it is generally taken to mean that he or she has a psychiatric illness or is abusing alcohol (Scally, 1996) or some other substance and on this account, the view is widespread that occupational health services have little or nothing to offer in this respect. Doctors will frequently treat themselves, as this survey shows, confirming other reports (Silvester *et al.*, 1994; McKeivitt *et al.*, 1996); or they refer themselves to colleagues who collude in the irregularity. It is interesting to note how many different authors recognize that stress and psychiatric morbidity may be high in doctors and yet bemoan the fact that there is no adequate way to treat doctors. Occupational health services may be mentioned but it has rather patronizingly been stated by one physician that while they may be adequate for nurses or ancillary staff, they are "certainly inappropriate for consultants" (King, 1985) a view vigorously rebutted by a group of occupational physicians working in the NHS (Zacharias *et al.*, 1985). The recent report by a working party set up by the Nuffield Provincial Hospitals Trust, however, chose to reinforce the view that occupational health services were not suitable to treat doctors. They recommended the creation of a network of independent regional bodies to decide on the best way to develop services for sick doctors and suggested that in each locality there should be a key individual to act as first point of contact for doctors seeking advice on health problems. The working party chose to ignore evidence submitted by the Faculty of Occupational Medicine and the fact that there already is a network of practitioners to whom sick doctors could turn, that is, the occupational physicians who are already in post. It is interesting to note that the working party did not include an occupational physician and suggests that it had decided against involving occupational health services before it started to consider its recommendations.

The reason why occupational health physicians *should* be involved are firstly that they are competent to judge fitness to work, in doctors equally as in other members of NHS staff; they are able to advise management about fitness to work and recommend ways in which an ill doctor may best be introduced back to work after an illness; they can refer sick doctors for appropriate treatment if the doctor does not have a general practitioner, or liaise with the general practitioner when he or she does; and they can recommend relocation, retraining or retirement on medical grounds as appropriate. As Baxter (1991) has said, occupational health should be seen as an integral part of health care; there is clearly a need for occupational physicians to consider how best they can persuade their colleagues that this is the case.

#### REFERENCES

- Allibone, A., Oakes, D. and Shannon, H. S. (1981) The health and health care of doctors. *J. R. Coll. Gen. Pract.* 31, 728-734.
- Baxter, P. J. (1991) Research in occupational health. The UK National Health Service. *J. Soc. occup. Med.* 41, 7-9.
- Bohigian, G. M., Croughan, J. L. and Sanders, K. The impaired physician. *Mo. Med.* 91, 275-277.
- Brooke, D., Edwards, G. and Taylor, C. (1991) Addiction as an occupational hazard: 144 doctors with drug and alcohol problems. *Br. J. Addiction* 86, 1011-1016.
- Chambers, R. and Belcher, J. (1992). Self-reported health care over the past 10 years: a survey of general practitioners. *Br. J. Gen. Pract.* 42, 153-156.
- Femino, J. and Nirenburg, T. D. (1994) Treatment outcome studies on physician impairment: a review of the literature. *Rhode Island Med.* 77, 345-350.

- Humphris, G., Kaney, S., Broomfield, D., Bayley, T. and Lilley, J. (1994) *Stress in Junior Hospital Medical and Dental Staff*. University of Liverpool and Mersey Regional Health Authority, Liverpool.
- Ikeda, R. and Pelton, C. (1990) Diversion programs for impaired physicians. *West. J. Med.* **152**, 617-621.
- Kelly, S., Charlton, J. and Jenkins, R. (1995) Suicide deaths in England and Wales, 1982-92: The contribution of occupation and geography. *Population Trends* **80**, 16-25.
- King, R. C. (1985) Helping the sick doctor. *Br. Med. J.* **291**, 1199.
- Kirwan, M. and Armstrong, D. (1995) Investigation of burnout in a sample of British general practitioners. *Br. J. Gen. Pract.* **45**, 259-260.
- McKevitt, C., Morgan, M., Simpson, J. and Holland, W. W. (1996) *Doctors' Health and Needs for Services*. Nuffield Provincial Hospitals Trust, London.
- Nuffield Provincial Hospitals Trust (1966) *Taking Care of Doctors' Health: Report of a Working Party*. Nuffield Provincial Hospitals Trust, London.
- Richards, C. (1989) *The Health of Doctors*. King Edward's Hospital Fund, London.
- Scally, G. (1996) Physicians can't heal themselves. *Lancet* **347**, 1059.
- Seccombe, I. and Patch, A. (1994) *Health at Work in the NHS: Key Indicators. Final Report*. Institute for Employment Studies, University of Sussex.
- Silvester, S., Allen, H., Withey, C., Morgan, M. and Holland, W. W. (1994) *The Provision of Medical Services to Sick Doctors. A Conspiracy of Friendliness?* Nuffield Provincial Hospitals Trust, London.
- Zacharias, P., Gatley, M., Heap, D., D'Auria, D., Wilson, P., Harling, K. and Symington, I. (1985) Helping the sick doctor. *Br. Med. J.* **291**, 1576.