

Doctors' health and performance

Hamid Ghodse

Director, Board of International Affairs, and Editor, *International Psychiatry*

Concern about doctors' health has increased over the past decade. This is related to a growing awareness that their health problems are often work-related. A work-related health problem is defined by the Health and Safety Executive in the UK as any illness, disability or other physical problem which reduces, either temporarily or permanently, the functioning of an individual and which has been caused, in whole or in part, by the working conditions of that individual (see Ghodse, 2000).

There is considerable international evidence that doctors are suffering from high levels of stress. A national postal survey investigating occupational stress levels in accident and emergency (A&E) departments found high levels of psychological stress (Burbeck *et al*, 2002); for example, 44% of consultant staff were above a threshold level for 'distress', with 18% reporting depression and 10% reporting suicidal ideation. In The Netherlands, a survey found that 55% of medical specialists acknowledged high levels of stress (Visser *et al*, 2003). Burnout was experienced as a combination of a high level of stress and a low level of job satisfaction, rather than as stress alone, and the protective nature of high job satisfaction was demonstrated. Statistics from physicians' health programmes in the US have shown that some specialties carry a higher risk than others. For example, family doctors were over-represented among 'impaired' physicians, as were emergency medical practitioners, psychiatrists and anaesthetists (Bennett & O'Donovan, 2001; Winter & Birnberg, 2002).

Work-related ill health is usually the consequence not of unintended discrete events but of exposure to conditions over a considerable period. For some diseases, for example hepatitis, the causal factor or aetiology is clear cut but for many, such as anxiety disorder or depression, there are often several contributory factors. Moreover, even when ill health is work-related, this may reflect past rather than present working conditions and, with the rapidly changing patterns of work that occur nowadays, the number and type of illnesses in doctors and other healthcare professionals may change.

Public and professional concern about doctors' ill health naturally focuses on its potential effects on the standard of care provided to patients, which may become sub-optimal through incompetence, unethical behaviour or psychiatric impairment. Although such concerns are justifiable, it is also important to remember that ill doctors are patients too, needing and deserving the same standard of professional care as any other patient. In this context, a particular problem for doctors with health problems is a reluctance to reveal that they are indeed ill, particularly if they are suffering from a

psychiatric condition. They often perceive this as a personal failure and fear that their livelihood may be affected if their illness becomes public knowledge. They therefore often make strenuous efforts to hide symptoms of stress, for example anxiety, depression and substance misuse, and such concealment is often supported by others in the doctor's family and professional environment, who may suspect that something is wrong but be reluctant to intervene (Ghodse, 2000). The consequent conspiracy of silence and denial, albeit well intentioned, impedes early intervention. This is especially disadvantageous because the most successful outcomes of treatment occur when a sick doctor is approached in a friendly fashion by a fellow professional with an offer of aid and support, rather than a coercive approach and the imposition of sanctions, which are more likely if severe impairment is affecting professional competence.

When examining the cost of doctors' ill health, it is necessary to consider the various parties on whom such costs fall – first and foremost, the sick doctors themselves, but also their families, friends, colleagues, patients, employers and society as a whole. The financial implications of ill health include loss of income in the short term, as a result of absence from work, and long-term losses for those unable to return to the same work and for those who give up work prematurely. In addition to financial losses, there is also a deterioration in the doctor's quality of life resulting from the pain and suffering associated with illness, the worry and grief caused to family and friends and, in some cases, permanent incapacity. Although the financial costs are comparatively simple to assess, it is often impossible to put a value on all the other losses.

For all the above reasons, it is important that the problem of doctors' ill health is recognised, that appropriate treatment programmes are available and accessible, and that everyone involved in their care acknowledges their distress and suffering. There can be particular difficulties in caring for sick colleagues, and so appropriate training is required. For example, a doctor might find it embarrassing to carry out a full examination of a colleague and, indeed, may fail to do so in the absence of appropriate training; this would result in the sick doctor having a lower standard of care than other patients. Treatment programmes for doctors vary widely in different countries, in both the form of treatment and the way in which it is offered, but they should be based on the principle that sick doctors should be protected from the loss of their job. Temporary restrictions on practising may be necessary, which may include an agreement to practise only under supervision for a time (Ghodse, 2000).

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Finally, as society's expectations of professionals become even higher, there must be greater understanding for doctors and the risks that they personally take when dealing every day with the pain and suffering of others. As a minimum, patients' rights should surely extend to doctors when they themselves are patients, and healthcare professionals must acknowledge the fact that healers, when they are ill, may also suffer profoundly. They need healing too, not just by other experts, but by the understanding and compassion of their colleagues.

As the principal conditions potentially impairing doctors' fitness to practise are mental health problems, and alcohol-related and drug-related problems, psychiatrists have an important role to play, both in the destigmatisation of mental illness and by providing appropriate assessment and treatment. The National Clinical Assessment Authority (NCAA, 2004) in the UK comprehensively reviewed health-related factors

involved in doctors' performance as well as the personal characteristics and behaviour of doctors.

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THEMATIC PAPERS – INTRODUCTION

Women's mental health in a context of violence, exploitation and oppression

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London WC1 1EH, UK,
email d.skuse@ich.ucl.ac.uk

In this issue we address the sensitive issue of societal attitudes towards women, in particular violence, exploitation and oppression, and their consequences for women's mental health. The subject of exploitation and abuse of women, by men, is rarely out of the headlines. Yet the prevalence of the problem does not seem to diminish, despite widespread publicity. In their fascinating review of the confluence of partner violence and substance misuse with mental health problems, Cari Jo Clark and Grace Wyshak estimate that up to two-thirds of women are subject to such violence, extrapolating from studies conducted in a wide variety of countries and cultures. They make the point that substance misuse and mental health disorders are both risk factors for such behaviour and outcomes of it.

Psychiatric interventions to mitigate the effects of violence upon women's mental health must be sensitive to local cultural contexts, but there are formidable complexities. These are exemplified in the contribution from Drs Lari, Alaghebandan and Joghataei, on the psychosocial and cultural motivations for self-inflicted

burns among Iranian women. They provide an insight into aspects of a social phenomenon that is truly disturbing: the rising incidence of self-immolation among Iranian women, especially during the early years of marriage. There is a supposition that in many cases this course of action is taken to escape from a violent relationship, or one in which the woman is exploited by traditional male values, but the truth is we cannot be sure. In many cases the women concerned are killed by their actions; in others they deny intent and ascribe the burns to an accident.

Finally, Drs Medina-Mora and Lara have contributed a review of attitudes to women and their mental health in Mexico, a culture where the term 'machismo' still holds meaning. Mexican society has, by this account, clear divisions into what are regarded as appropriate male and female roles. Yet, as women in many countries in the Western world have found following their 'liberation' in the 1960s, all too often the freedom to join a male-dominated world of work means dual responsibilities and limited opportunities to advance along a parallel path to men outside the home. In

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