# Services for sick doctors in the UK

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*Despite the many services now on offer, doctors' special problems in seeking healthcare advice and treatment remain unsolved*

Since the 1970s, when the Association of Anaesthetists responded to much-publicised suicides by setting up the first dedicated service for its members, much has changed in the provision of special help for "sick doctors" (those stressed and in need of professional psychological support, as well as those with physical and mental illness) in the United Kingdom. Now there are over a dozen national "sick doctor" services (details can be found at www.ncssd.org.uk) and many more local ones. This growth has led to increased choice, but has also raised questions about why they are all needed and how effective they are.

## Local services

Doctors in the UK are entitled to use the National Health Service (NHS), and, as most provide services to patients under the NHS, are also entitled to use the NHS occupational health service. Their past reluctance to do so lay in the perceived closeness to management and general lack of availability. This was compounded by incorrect and unsubstantiated concerns about confidentiality.

Local services are largely provided by government-funded organisations, including primary care trusts (which are responsible for the governance of primary care services provided by general practitioners and other healthcare staff) and postgraduate deaneries (which are responsible for doctors in training).[1,2] These local entities usually contract with an independent body, usually staffed by professional counsellors and sometimes by doctors, to provide services for discrete groups of doctors. The services often emphasise psychological counselling for those experiencing difficulties at work.

## National services

Although many of the national services concentrate on problems related to drugs, alcohol, stress and mental health, they vary considerably in their characteristics. None receives permanent government funding, although several had start-up support from the Department of Health. The National Counselling Service for Sick Doctors (NCSSD) was established in the mid-1980s through the vision and leadership of the eminent psychiatrist Kenneth Rawnsley. It was set up partly to provide an alternative to the statutory health procedures operated by the profession's regulatory body, the General Medical Council (GMC).[3] The NCSSD was the first, and remains the only, independent doctor-to-doctor service dealing with all health issues, and available to all doctors.[4] In the mid-1990s, the NCSSD was receiving about 400 calls per year and had a panel of about 80 medical advisers (now it receives 250 calls per year and has 50 advisers). The NCSSD's main aim remains helping doctors gain access to appropriate healthcare before their health problems prejudice their ability to work safely. It does not provide a healthcare or (despite its name) a formal counselling service for doctors. Its advisers and management committee are volunteers.

Other national services have been set up to meet specific needs. The medical defence organisations provide support for their members who get into difficulties over professional matters. The British Medical Association (BMA) has a counselling service, established in 1996, which receives about 200 calls a month from members, who are provided with 20–35 minutes of telephone counselling by a professional counsellor and, if necessary, given help in gaining access to further one-on-one counselling. The BMA has recently developed its own "doctors for doctors" service, which primarily supports the BMA's industrial relations officers in their dealings with BMA members in difficulty, and also provides a signposting service to other sources of help.

A distinctly different approach is adopted by other organisations which rely on volunteers who have themselves been ill and are in recovery. These include the British Doctors and Dentists Group (a support group for addicted doctors and dentists, reached through the Medical Council on Alcohol, which also provides information about alcohol-related problems and promotes alcohol education in medical school curricula); the Sick Doctors' Trust,[5] which helps addicted doctors; and the Doctors' Support Network,[6] which helps doctors with mental health problems. These organisations provide direct interventions, one-on-one, and group support. The Doctors' SupportLine is a telephone helpline staffed by trained volunteer doctors, which provides a first step for doctors in getting help with personal or work-related problems.

Two medical colleges have recently identified the need to provide extra help for their members — the Royal College of Surgeons of England has launched a national, confidential support and advice service providing surgeon-to-surgeon telephone and face-to-face help, and the Royal College of Obstetricians and Gynaecologists offers the services of members and fellows who are trained mentors. The British International Doctors' Association also provides mentors and a health panel for doctors whose problems may be caused by cultural or linguistic factors. A web-based service has been created through British Medical Journal Careers, part of the BMJ publishing group, offering mentors for doctors with chronic illness and those who have suffered discrimination in their careers. Finally, the Royal Medical Benevolent Fund

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provides much-needed financial help to sick doctors and their families.

All these organisations maintain appropriate confidentiality, but operate within the governing ethic that patient safety is a pre-eminent consideration. Doctors who continue to practise, but whose state of health is a danger to patients, should be reported by their colleagues to their employer and/or to the General Medical Council. It is the NCSSD's experience that this sanction is rarely needed, and, once doctors are helped to recognise that they are ill and to seek appropriate treatment, they respond well.

## Challenges and the future

The need to preserve confidentiality about doctors as patients has made evaluation of the effectiveness of services difficult. In future a more open approach may be needed. The smaller organisations rely heavily on the unpaid commitment of enthusiasts and long term funding is always a problem. Their future is not secure. The plethora of services presents a confusing picture. Some rationalisation is probably needed.

And still there are unmet needs. Doctors often remain reluctant to acknowledge their need for help. Despite GMC policy to the contrary,[7] they continue to self-diagnose and self-prescribe,[8] and to present late when they are ill. Virtually all the services are reactive, becoming involved only after problems have arisen.

A statement produced by European experts in 2000 describes doctors as "one of the most unattended populations, in terms of health".[9] Certainly, in the UK, it is often difficult to arrange appropriate care for sick doctors away from the area where they work. A new initiative by the umbrella organisation the Clinicians' Health Intervention Treatment and Support (CHITS)[10] to provide dedicated addiction treatment centres for healthcare professionals may help, but substantial government funding is required. The NHS occupational health service is being strengthened, but this will take time and gaining doctors' trust may take even longer. Where specialist services have been established for some time, use by doctors has increased, although the changing climate of medical practice may also be a factor. In some occupational health services, use by doctors is now greater in proportion to the numbers of staff than by any other occupational group (Kit Harling, Consultant Occupational Physician, Director, NHS PLUS, personal communication, 2004). The ability of specialist occupational health services to influence employers to make job changes to facilitate return to work after illness is a key benefit.

There is now a greater knowledge of the stressors that doctors have to cope with,[11,12] suggesting primary prevention is possible. The shortage of doctors in the UK and the high cost of early retirement[13] may provide incentives for better services.

The GMC's statutory health procedures will soon cease to exist as a separate entity and, whatever happens in terms of independent sick-doctor services, it is essential that all organisations that employ, support, guide and control doctors have clear policies and practices that take full account of the impact of stress and ill-health on doctors' performance. The special problems that doctors have in seeking healthcare advice and receiving timely and appropriate treatment have not yet been solved. Doctors require services that they trust, will use and that meet their diverse needs. Doctors themselves could help greatly by continuing to explore their attitudes to their own healthcare needs and those of their colleagues.[14]

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