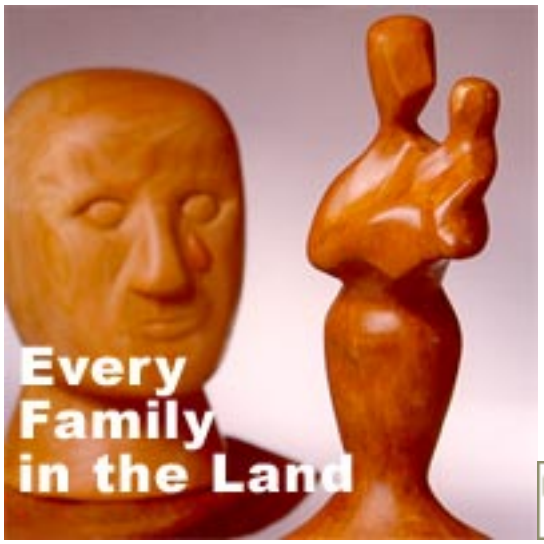
**CHAPTER 9 SOME STRATEGIES TO TACKLE STIGMATIZATION AND DISCRIMINATION Part Two: Social**

**Mental illness in medical students fitness to practice Rosemary Lethem**

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**Introduction**

Recent high profile cases of professional malpractice have focused attention on the medical profession and its capacity for self-regulation in order to protect the public from incompetent or unfit doctors.

Mental illness is one of the main causes of lack of fitness to practise. Doctors are physically healthier but more prone to mental ill health than the general population.

Mental illnesses are recognised clinically. Adopting a broad spectrum and dualistic approach, medical students and doctors, like the population in general, may suffer from:

| | |
|---|---|
| * 'Organic' mental illness | Substance related disorders (drugs and/or alcohol)<br>Cognitive decline<br>Secondary to physical disease (e.g. multiple sclerosis, AIDS) |
| * Severe mental illness | Schizophrenia<br>Major affective disorders |

| | |
|---|---|
| * Other mental illnesses and related mental health problems | Suicide<br>Deliberate self-harm<br>Mood disorders<br>Anxiety disorders<br>Somatoform disorders<br>Stress<br>Burn out |
| * Behavioural disorders | Eating disorders<br>Factitious disorders |
| * Intrapsychic conflict | |

Some illnesses, including mental illnesses, both in terms of their precipitation and their course, are known to be sensitive to adverse life events and related stress.

Certain illnesses and presentations are commoner at particular times. It is useful to think of the medical career as having its own 'life cycle' with a number of stages, starting with apprenticeship as a student doctor, graduating to become a novice, before progressing to medical maturity and finally 'winding down' in preparation for retirement (Wilhelm et al. 1997).

Many cases of impaired fitness to practise in medical students and doctors, at all stages in their medical careers, will present as inappropriate behaviour in a clinical setting, or through impaired performance (Wilhelm et al. 1997). Away from clinical settings, problems can present in a variety of ways. In clinical settings they may be noticed by peers, colleagues, lecturers and supervisors, or patients and their families. Unfit doctors may present to their own doctor or to medical administrators. There may be official complaints.

This article will discuss the concept of professional competence before discussing the mental illnesses and health problems to which medical students and doctors are vulnerable, the context within which they occur and an outline of some issues relating to prevention and management, particularly mechanisms for ensuring that the safety of the public is not compromised.

**Competence to practice**

In the United Kingdom the General Medical Council (GMC) is the regulatory body for the medical profession, under the Medical Act 1983. Doctors have a duty to meet the standards of competence, care and conduct set by the GMC. 'Fitness to practice' is not defined. The Act allows investigative procedures where there is concern over possible 'seriously impaired' fitness to practise, that is, such as to compromise the welfare of patients.

With the publication of *Good Medical Practice* in 1995, the GMC explicitly described for the first time the duties and responsibilities of doctors explicitly and set out the principles of good medical practice. Doctors were reminded

that registration with the GMC gave them rights and privileges in return for which they must fulfil their obligations to the public. Patient care must be the first concern of every doctor.

*Good Medical Practice* states that 'doctors must act when they believe that a colleague's conduct, performance or health is a threat to patients, if necessary by telling someone from the employing authority or from a regulating body' (General Medical Council 1998a). Such action thus has become a professional obligation.

Doctors are most likely to maintain good practice when they work in properly functioning clinical teams (Irvine 1999). Effective teams have a sense of collective and personal responsibility for their professional performance, a no blame culture and a commitment to understand and look after each other and their patients.

**Mental illness in medical students**

*Student life*
The pressures on students in general are acknowledged to have increased greatly in recent years (Rana et al. 1999). Reasons for this include the widening access to higher education, political pressure to include greater numbers of those who hitherto have been under-represented in higher education, increased financial pressures, societal shifts reflected in increased instability in family life, and decreasing accessibility of mental health service provision.

The proportion of students applying for higher education who indicate that they have a disability on mental health grounds has remained small at approximately 0.05%. However, there is broad agreement from university counselling services that the severity of emotional and behavioural disturbance amongst students is increasing (Rana et al. 1999). Student suicide is a not uncommon phenomenon. Serious psychiatric disorders such as schizophrenia, bipolar affective disorder and eating disorders are likely to present most acutely in the 16-25 year old age group. Substance use and misuse is highly prevalent.

The Disability Discrimination Act (1996) has raised mental health related issues for institutions, by granting rights to training, education and employment to people with disabilities. Disability is defined as 'a physical or mental impairment which has a substantial long-term effect on a person's ability to carry out normal day to day activities'. Mental disability is not further defined. Mental illness is recognised on clinical grounds but there is debate over the status of stress disorders and fatigue. Reasonable adjustment to student life is expected but 'reasonableness' is context-dependent.

*Medical student training*
Undergraduate medical training must be completed within seven years. There

is no facility for restricted registration with the GMC on the grounds of mental or other illness.

Medical students face additional stresses due to the nature, length and intensity of their training. There are some sources of stress that are generic to medical students throughout the world: adjusting to medical training, including the realities of disease and dying patients; coping with the volume of material to be learned; confronting ethical dilemmas; balancing academic demands with life outside medicine; and delaying gratification of many wishes (Myers 1997).

The personality characteristics of medical students and doctors may constitute a source of stress. The selection processes of medical schools place a high degree of emphasis on academic success. They cannot be expected to predict future personality development. Competitive, successful individuals who deal poorly with emotional pressures by intellectualising or denial are often selected.

Medical training tends to concentrate on 'head' and 'hands' skills at the expense of 'heart', often leading to varying degrees of alienation and cynicism due to an 'emotionally marasmic existence' (Coombs and Virshup 1994).

*Nature and prevalence of mental disorders*
Studies of utilisation of psychiatric services have shown that between 4 and 18 % of medical students annually identified themselves as 'impaired', with a further unknown number not seeking help. About half of help seekers make only a single contact (Myers 1997).

Many medical students suffer from intrapsychic and interpersonal conflicts, for example delayed psychosocial and psychosexual development, sexual dysfunction, the sequelae of earlier sexual abuse, confusion over sexual orientation or being HIV positive (Myers 1997).

Relationship problems amongst students and doctors are common (Myers 1997), frequently caused or exacerbated by their lifestyle. Lack of an intimate relationship or marital conflict are psychosocial causes of stress and may be precipitating factors in the onset of many mental illnesses.

Common illnesses in medical students are:

* Substance related disorders (especially involving alcohol and cannabis) see third next paragraph
* Mood disorders (especially major depressive disorder) (up to 5%)
* Anxiety disorders (panic disorder, phobias, obsessive compulsive disorder, post traumatic stress disorder, generalised anxiety disorder) (up to 7%)
* Adjustment disorders

* Eating disorders (anorexia nervosa and bulimia nervosa) (Myers 1997) (up to 10%)

Rarely, severe mental illnesses classified as psychoses in ICD 10 and characteristically involving loss of insight (schizophrenia and hypomania) may present in this age group.

Suicide is a leading cause of death, along with accidents, amongst medical students, although it is a rare event. Figures collected from a questionnaire survey of American medical schools for the period 1989-94 demonstrated a lower rate than in earlier studies and than in the nation as a whole. Of 15 reported deaths, 9/13 had known psychiatric histories (Hays et al. 1996).

Substance related disorders are rarely diagnosed in medical students but many doctors subsequently treated for alcohol or drug dependency report that their pattern of overuse began during medical school or even earlier. Alcohol and 'soft' drug use are endemic amongst medical students as socially sanctioned means of escape from the pressures of the training. A questionnaire study of the drinking behaviour of medical students from 13 British medical schools revealed that 23% of male students and 10% of female students reported drinking more than the recommended sensible limits in a typical week (Howse and Ghodse 1997). Older medical students may have an established disorder during medical school. Some medical schools have peer support programmes for students with substance dependence problems (Myers 1997, Brookes 1995).

*Prevention*
Medical schools must be aware of selection pressures on would-be medical students and institute screening procedures to identify and deal with vulnerable applicants (Hays et al. 1996).

As those with vulnerabilities generally become visible only as the course progresses, there should be health surveillance throughout (Brookes 1995).

Medical students should be taught about suicide risk, with particular attention to drugs and alcohol (Hays et al. 1996).

There should be greater emphasis throughout medical training on emotional and psychological development and practice (Wilhelm et al. 1997).

The responsibility for such teaching should not be left to psychiatrists or to the psychiatry module. There should be effective clinical role models at all stages of training (Wilhelm et al. 1997, Hays et al. 1996).

Medical schools should have a variety of measures in place to integrate students into the life of the medical school and ensure effective support and counselling (for example, pairing with a more senior student, tutoring systems, social clubs, minority groupings) (Coombs and Virshup 1994).

There should be rapid and easy access to counselling or health services.

*Treatment*
A biopsychosocial orientation is crucial when assessing and treating medical students (Myers 1997).

There should be rapid and easy access to services (Myers 1997). In most cases, there will be a university health or counselling service with access to conventional general medical and psychiatric services. Alternatively students may consult their general practitioners.

Students should not be assessed or treated by clinicians who are involved in their training (Myers 1997).

Privacy and confidentiality must be respected (Myers 1997).

Students who develop serious mental illness should be managed along conventional lines. There will need to be careful supervision throughout the course and beyond, firstly, to ensure that patients are not put at risk, and secondly, to ensure that the student or new doctor remains able to cope.

**Mental illness in doctors**

*Background*
Doctors are a distinctive group in occupational health terms (Wrate and Baldwin 1997). They are more prone to anxiety/depression, suicide, and alcohol and substance misuse than comparable occupational groups, for example nurses, veterinarians, lawyers or accountants. None of these groups suffers the medical profession's twin afflictions of a comparatively high suicide rate and alcoholism with a remarkably low sickness absence rate.

Mental illness in doctors in general presents in the same way as elsewhere but is more often concealed. Many doctors are not registered with their own general practitioner and may prescribe for themselves or colleagues.

Doctors' working conditions create psychosocial stress and render them vulnerable to mental illness (Wrate and Baldwin 1997). These include: excessive workloads; out of hours on-call duties extending throughout their careers; the relative inflexibility and competitiveness of medical career pathways; prolonged exposure to patients' pain and relatives' needs; unavailability of locum cover for sick leave; and ethos of stoicism and denial. 'Presenteeism' is common: 80% of recently qualified doctors in one survey reported having worked through illness where they would have advised a friend or colleague to take time off (Baldwin et al. 1997). Doctors are deified and then blamed when, inevitably, solutions cannot be provided. Health service reforms have shifted power and control away from doctors, with consequent increase in stress.

Doctors fear loss of confidentiality and the stigma of mental ill health, particularly in career advancement and working relationships. Opportunities exist for unconventional behaviour such as self-medicating or prescribing.

There is currently a lack of rigour in the health surveillance of doctors. Outside the regular career structure, opportunities abound for anonymous locum work and unsupervised non-training posts. In private practice there are no constraints.

The nature of the problem and the type of intervention required tend to vary with the stage within the medical 'life cycle'. Amongst younger doctors, prevention and early intervention are important needs, whilst assessment and treatment take precedence in older doctors (Wilhelm et al. 1997).

*Problems in young doctors*
On graduating, young doctors acquire additional stress from sleep deprivation, overwork and disillusionment. Typical problems in the young doctor group (age 25-34) are: adjustment to hospital life, anxiety and somatoform disorders, and alcohol and substance misuse.

The pre-registration year or intern year has been found repeatedly in surveys to be stressful. An Australian study (Hume and Wilhelh 1994) reported 8% of interns as seeking help during the year, with anxiety, depression and eating disorders as their main concerns, 3% had entertained (but not acted on) suicidal plans. 72% of the entire group had experienced significant episodes of anger. In another study, 79% of British house officers had experienced emotional distress with over 50% of the females reported as becoming clinically depressed (Firth-Cozens 1990).

*Problems in mid / late career*
Mature doctors (age 35-55) commonly suffer from depression, alcohol and substance misuse/dependence and marital problems. In the older doctor (age 55+), common presentations are with depression, early physical and cognitive decline, alcohol dependence and delusional disorder.

A random survey of doctors in which senior doctors were over-represented on the New South Wales Medical Register (Pullen et al. 1995) found that 26% had a condition warranting medical consultation, 18% had emotional disorders and 3% alcohol problems. Almost a fifth reported mental problems. Under half had their own general practitioner.

According to the British Medical Association's health policy and research unit, up to a third of consultants and a half of GPs are currently showing signs of stress serious enough to affect their health and impair the quality of care to patients due to excessive workload and other factors (see Wrate and Baldwin 1997). Suicide rates are two to three times higher than in the general population.

*Prevention*

A BMA working party in 1998 reports that up to one in fifteen doctors have an addiction problem at some time in their career.

The first step in seeking to improve the mental health of those in the medical profession must be to acknowledge and define the problem, before seeking to prevent the development of serious problems, at all stages in the training and career of doctors. In addition, the profession needs to have good systems for the detection, management and, occasionally, removal of doctors with mental health problems (Smith 1997).

From the earliest stages in the recruitment and training of doctors there should be greater emphasis on emotional wellbeing, including learning appropriate strategies to maintain psychological health and allow help-seeking behaviour.

There should be more emphasis placed on developing communication time and anger management skills in the year after qualification. Psychiatrists are in a position to highlight issues with those responsible for the welfare of young doctors (Wilhelm et al. 1997).

The stigma of mental illness, both within and without the medical profession, remains highly resistant to change. Progress in this area is more likely to come from a change in emphasis to non-discrimination against those suffering from mental ill health, backed by legislation, in the same way as has been achieved in the area of race, physical disability and sexual orientation.

Effective occupational health schemes (including for general practitioners) should be available for screening, surveillance of vulnerable individuals and to encourage access for doctors with problems.

The Ritchie report, published in June 2000 following the inquiry into the work of Mr Rodney Ledward, has made wide-reaching recommendations to protect the public from unfit doctors. These include the assessment of all students starting medical courses and doctors changing jobs for their mental and physical suitability. Private health care should have the same standards of care as the NHS. How this might be achieved in practice has not yet been determined.

The cultures of continuous professional development and revalidation, as proposed by the GMC, could be used to promote a sense of responsibility in doctors for their own wellbeing and that of colleagues.

Working conditions should be improved. Coherent teamwork and good organisational practice are innovative and necessary developments to improve both quality of work and life for doctors (Firth-Cozens and Moss 1998).

Reduction in the stresses imposed by excessive workload currently

experienced by senior British doctors would be achieved by implementing straightforward remedies: evaluating work demands and reviewing staffing levels, increasing the number of consultants, implementing the working time directive which caps hours at 48 per week, encouraging uptake of annual and study leave and organising properly trained locum cover.

Consideration should be given to detecting and treating mental health problems in doctors who work as locums and in private health care.

The British Medical Association's medical students' committee agreed at their annual conference that there should be random drug and drink tests performed on doctors and other health care workers, as in other professions, in order to protect the public and identify doctors with addiction problems at an early stage.

*Management*
Doctors willingly presenting should be referred, assessed and managed along conventional lines, although the nature of the medical profession is such that frequently this does not occur.

The situation commonly arises where it becomes apparent that a trainee or colleague is suffering from mental illness or a mental health problem but is either unaware of the need to seek treatment or unwilling to do so. Possible approaches in such situations are described by Brandon (1997). In the first instance the affected doctor should usually be approached in a sympathetic and private manner and encouraged to seek help in a conventional manner.

Many doctors are reluctant to consult their own GPs. There are a number of other support agencies which can be approached by the affected doctor, a close relative or a colleague. These include: the Medical Council on Alcoholism, the National Alcohol Help Line, the National Association for Staff Support and the National Counselling Service for Sick Doctors. The last was set up in 1985 and deals with about 500 referrals annually, yet the majority of doctors are unaware of it (see Brandon 1997 for details). In addition, many health regions have their own guidance and support units.

If these approaches are unsuccessful, formal procedures designed both to protect the public and to help the sick doctor may have to be invoked. It has been proposed that in each locality there should be a key individual nominated who will act as the first point of contact for doctors seeking advice (Nuffield Provincial Hospitals Trust 1996). He or she may be able to persuade the affected individual to seek help. Alternatively, the National Counselling Service for Sick Doctors (NCSSD) can be contacted, anonymously.

If further measures are required, at present the 'three wise men' procedure can be invoked. (This is due to be revised to take account of new NHS structures.) The local medical community can convene a trio of 'wise men' following the expression of concern about a colleague. If advice is rejected,

action may be taken to protect patients. This may involve arranging suspension of the affected doctor and/or informing the GMC.

The GMC itself may be approached directly and anonymously by any doctor wishing to discuss anxieties about a colleague. Formal notification of the GMC may result.

**Formal measures to deal with seriously impaired doctors: the health procedures of the GMC**

The GMC receives 2,500-3000 enquiries each year from employers, patients and other doctors or from the police following criminal conviction (General Medical Council 1998b). In 1997, the Fitness to Practice Policy Committee was established to co-ordinate policy in dealing with dysfunctional doctors. If the doctor in question seems to be seriously impaired because of ill health then the case will be referred to the health procedures, which have been in place since 1980. Almost all such cases involve mental illness or addiction.

Psychiatric presentations of sufficient severity to come to the attention of the GMC's health procedures or equivalent tend to be spread through the 20-40 year age group. Cases of drug self-administration tend to present in the 30-50 year group and alcohol abuse slightly later. Problems in older doctors are likely to be under-reported. Many doctors have suffered from serious problems for years, often known to colleagues who have hesitated to take action.

All information received by the GMC which suggests that a doctor is suffering from a health problem of any kind is considered by an appointed medical member of council known as the Screener for Health, who will decide whether there is evidence of a problem sufficiently serious to warrant formal action under the health procedures. Most doctors are willing to co-operate.

The health procedures are designed: (i) to protect the public from doctors whose fitness to practise is seriously impaired on health grounds and (ii) to assist the doctors concerned in following a programme of medical supervision and rehabilitation.

If further action is to be taken, the doctor is invited to agree to medical examination by at least two examiners chosen by the Screener. They are usually psychiatrists. Between 1980-1995, 606 doctors suffering from various impairments have been asked to undergo examination (Table 1) (Kesteven et al. 1997).

**Table 1: Impairment in doctors seen by GMC Health Screeners, 1980 - 1995**

| *Impairing Condition* | *Number* | *(%)* |
|---|---|---|
| Alcohol only | 168 | (28) |
| Drugs only | 104 | (17) |
| Psychiatric illness only | 147 | (24) |
| Physical illness only | 9 | (1) |
| Illness involving two of the above | 155 | (26) |
| Illness involving three of the above | 23 | (4) |
| *Total* | *606* | *(100)* |

If the examiners conclude that the doctor is fully fit to practise then the case will be closed. Otherwise they will make recommendations for the doctor's medical supervision and treatment, and perhaps to limit or prevent practice.

If the doctor cooperates with this process, a system of monitoring is set up with the medical supervisor who liaises with any consultant involved with treating or supervising the doctor. Supervision is likely to continue for a period of years, given that most doctors are suffering from relapsing conditions.

The outcome of the medical examinations conducted between 1980-1995 was as follows: 11% fit, 66% fit with limitations, 23% unfit (Kesteven et al. 1997). In 1997, 181 doctors were under supervision. Approximately 40-50 doctors are placed under or discharged from supervision annually (GMC 1998b).

Those few doctors unable or unwilling to co-operate with the voluntary procedures come under the jurisdiction of the Health Committee, referral to which can be made at any stage. In 1997, there were 39 doctors on its caseload. There were 4 new referrals, 13 doctors subject to conditional registration and 23 suspended (GMC 1998b).

The Medical (professional performance) Act 1995 enables the committee to impose indefinite suspension, once a doctor's registration has been suspended for a total period of not less than two years. By 1997 this power had been used in 13 cases (GMC 1998b).

There is a considerable backlog of cases of allegedly dysfunctional doctors waiting to be considered by the GMC. There have been calls for the GMC to be abolished and its health and disciplinary functions to be taken over by new bodies. In November 1999 the government proposed that the GMC's monitoring function should be taken over by an alternative assessment and support service, details of which are not yet available.

**Conclusion**

Mental illness generally in medical students and doctors is very common and more so than in comparable professional groups and the general population. Of particular concern are the high rates of depression, suicide and addiction problems.

The reasons for this include the personality types of many doctors and medical students, selection pressures, neglect of emotional issues during training, stressful working conditions and the expectations of society. The profession itself promotes concealment of mental health problems and inappropriate methods of treatment. Doctors are not empowered to take responsibility for their own health care.

There is growing awareness of these problems and considerable professional and public controversy over possible solutions. Although the duty of the medical profession is primarily to protect the welfare of patients, in recent years there has developed much greater concern over the identification, treatment and rehabilitation of sick doctors. However, it is clear that much more could and should be done to promote good mental health in practising doctors and the doctors of the future.

**References**

Baldwin PJ, Dodd M & Wrate RM (1997) Young doctors' health: how do working conditions affect attitudes, health and performance? Social Science and Medicine 45: 34-40.

Brandon S (1997) Persuading the sick or impaired doctor to seek treatment. Advances in Psychiatric Treatment 3: 305-311.

Brookes D (1995) The addicted doctor: Caring professionals? [editorial]. British Journal of Psychiatry 168: 149-153.

Coombs RH & Virshup BB (1994) Enhancing the psychological health of medical students: the student well-being committee. Medical Education 28: 17-34.

Firth-Cozens J (1990) Sources of stress in women junior doctors. British Medical Journal 301: 89-91.

Firth-Cozens J & Moss F (1998) Hours, sleep, teamwork, and stress. Sleep and teamwork matter as much as hours in reducing junior doctors' stress [editorial]. British Medical Journal 317: 1335-1336.

General Medical Council (1998a) Good Medical Practice (2nd edition). London: GMC

General Medical Council (1998b) Annual Review (1998). London: GMC.

Hays LR, Cheever T & Patel P (1996) Medical student suicide, 1989-1994. American Journal of Psychiatry 153: 553-555.

Howse K & Ghodse AH (1997) Hazardous drinking and its correlates among medical students. Addiction Research 4: 355-366.

Hume F & Wilhelh K (1994) Career choice and experience of distress among interns. Australian and New Zealand Journal of Psychiatry 28: 319-327.

Irvine D (1999) The performance of doctors: the new professionalism. Lancet 353: 1174-1177.

Kesteven S, Mann S & Sims A (1997) Health Procedures of the General Medical Council (1997). 297-304.

Myers MF (1997) Management of medical students' health problems. Advances in Psychiatric Treatment 3: 259-266.

Nuffield Provincial Hospitals Trust (1996) Taking Care of Doctors' Health. London: Nuffield Provincial Hospital Trust.
Pullen D, Lonie CE, Lyle DM et al. (1995) Medical care of doctors. Medical Journal of Australia 162: 481-484.
Rana R, Smith E & Walkling J (1999) Degrees of Disturbance: the New Agenda. The impact of increasing levels of psychological disturbance amongst students in higher education. A report from the Heads of University Counselling Services, Association for University and College Counselling. Rugby: British Association of Counselling.
Smith R (1997) All doctors are problem doctors [editorial]. British Medical Journal 314: 841-842.
Wilhelm K, Diamond M, Williams A (1997) Prevention and treatment of impairment in doctors. Advances in Psychiatric Treatment 3: 267-274.
Wrate RM & Baldwin PJ (1997) Health of tomorrow's doctors: obstacles to appropriate health seeking. Advances in Psychiatric Treatment 3: 290-296.