



# **STRESS IN ANAESTHETISTS**

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## SECTION I - SUMMARY

1. A stressed doctor is not necessarily a bad doctor but difficulties may occur when the stress gets out of control.
2. The multiplicity of support groups attests to the fact that problems are widespread and solutions complex.
3. The organisational difficulties in the workplace lead to an inability to reach desired goals and produce frustration. It is clear that lack of control and the problems of administrative responsibilities figure most highly as stressful factors.
4. Consultants are responsible for each other by moral obligation and for trainees and non consultant grades by convention. In stressful situations discussions with a friendly, understanding colleague may be all that is required to resolve difficulties.
5. The skills of stress management are integral to the management of many conditions at work and in everyday life.
6. Communication skills are basic in our personal and professional lives and the ability to stand up for one's rights without violating the rights of others is important in the practice of assertiveness. It is necessary to learn to say no, when appropriate, in a constructive and non confrontational manner and there is need to be able, politely, to resist unrealistic demands from others. Some distorted beliefs may be long-standing and encouraged by our environment.
7. When problems occur the first action of the Clinical Director must be to discuss the situation with the person involved or to get another senior colleague to do so. Any reported problems should be approached with diplomacy and confidentiality must be respected. However documentation, statements and witnesses are also important. It must always be remembered that patient safety is paramount.
8. At any stage in a consultant career support and advice may be needed. It is not widely understood how the various support systems work. All directorates should practise their methodology of dealing with problems and of providing support for colleagues. A mentor system may be worthy of exploration.
9. All doctors should be discouraged from self diagnosis and, especially, self treatment.

SECTION I - SUMMARY

10. Support and treatment should always be on a confidential basis.
11. The Association of Anaesthetists of Great Britain and Ireland can provide confidential guidance in all these matters. The President or the Senior Officers are available at all times.

## SECTION II - INTRODUCTION

Stress can be defined as mental, emotional or physical strain or tension and is an integral part of life. Moderate amounts of stress provide the driving force which enables mankind to function optimally. Undue stress, however, is eventually unsustainable and may in extreme situations result in mental or physical disintegration. It is inevitable that events both in personal and professional life will prove stressful. Learning to cope with these stresses is an important part of development.

Stress occurs when there is a perceived imbalance between the demands being made and the ability to meet those demands. A career in medicine attracts conscientious and introspective individuals (1) and studies suggest that many doctors lean towards the so called type A personality (2) featuring insecurity of status and a high amount of anxiety. This personality type is often associated with increased aggression and a constant sense of time urgency. Type A individuals tend to be susceptible to stress, have a higher incidence of coronary artery disease and may have problems coping with and responding to difficult situations. There is an interaction between stress and psychological dysfunction. Recent evidence has shown that 30% of all health care workers, including doctors (3), will experience psychological dysfunction at some time in their career. Excessive stress increases vulnerability and in some circumstances, at extremes, the outcome may be suicide.

It is essential to organise life so that it is possible to cope with stress, maximising the positive and minimising the deleterious effects. The management of stress hinges on the recognition of the nature and causes of stress and an understanding of how individuals respond. Changes and modifications to lifestyle can then be made to control the situation.

In the specialty of anaesthesia it is now well recognised that anaesthetists do suffer from stress. In a recent survey (4) 30% of anaesthetists felt stressed a lot of the time while 5% felt stressed all the time; 33% described themselves as severely stressed and 7% felt their stress was more than severe. In the work related environment the stressful elements were lack of control (42%), strained professional relationships (25%), work overload (24%), difficult work (6%) and potential litigation (3%). In the area of administrative and social factors, administrative responsibilities (42%) and

## SECTION II - INTRODUCTION

work-home conflict (35%) were the most stressful while money (14%), teaching responsibilities (6%) and peer review (4 %), were less so.

Thus it is clear that lack of control and administrative responsibilities figure most highly while work overload, professional relationships and work-home conflict are also significant factors. All these stresses can be modified in a positive way by the use of appropriate stress management skills.

While many of the stress precipitating factors have in recent times become more clearly apparent (5,6), the solutions are increasingly more difficult to institute and there is still a poor understanding of the basic ways of tackling the situation. All consultants in a directorate should be familiar with potential problem areas and be aware of the signs of strain. There are support mechanisms available and they should be familiar with them and should be prepared to initiate necessary measures. Directorates need to have a policy of education and caring, devoting some time to the discussion of the existing mechanisms which are available for the support of both career and trainee grades.



## SECTION III - ASPECTS OF STRESS

### 1. Recognition

The stress reaction is a basic physiological response to real or perceived danger which enables the individual to stand and fight or flee. Modern threats, while great, are largely intellectual and the fight or flight response is therefore inappropriate. The psychological response to stress in the 20th century appears to arise not only from the original physical reaction but also from its suppression. There is a delicate balance between the positive effects of stress helping one to rise to a specific challenge and the eventual inability to cope with constant, unremitting stressful situations. At the extreme of inability to cope lies suicide. Medicine has a markedly higher rate of suicide than other similar professional groups and within it the specialty of anaesthesia has the unenviable distinction of having one of the higher rates (7).

Most people can cope with stress for short periods; indeed some seem to relish it. Chronic stress produces prolonged changes in the physiological state leading to alterations in both heart rate and blood pressure with weight loss and sleep disturbance. Emotional and behavioural changes occur, demonstrated by increased anxiety, irritability and aggression and these may be accompanied by increased use of drugs or alcohol. Personality changes are common, with the individual becoming cynical, paranoid or unrealistic and there may be intellectual impairment with poor concentration, judgement and creativity. Such changes are often more readily recognised in others than in oneself.

### 2. Causes

Certain circumstances occurring at work or in one's personal life are particularly associated with stress. Frustration, conflict and 'hassle' often occur in medicine, while the disruption of circadian rhythms is a common result of any 'on-call' schedule. Life changes, even apparently pleasant ones, have also been shown to be stressful (8). However, irrespective of whether the primary cause is domestic or professional, the two areas rarely remain isolated and there will often be a spill over from the one into the other.

When work and stressful episodes are analysed it can be shown that they are typified by three main characteristics. These are:

- (a) **Lack of control** of the work environment. This is a major area of frustration in anaesthetic practice.
- (b) **Unpredictability of work** leading to a high level of permanent anxiety. This is part of all emergency work and may need to be taken into account in career selection.
- (c) **Over-extension** due to being pressed beyond real or perceived limits. This is compounded by the current NHS climate of targets to be met and budgets to balance.

### 3. Sources

It is convenient to consider the sources of stress as being from environmental, interpersonal and personal factors. There is usually a significant degree of overlap between these areas.

- (a) **Environmental.** For all anaesthetists there is a continually increasing pressure for the maintenance of ever higher standards. Continuing Medical Education and the demands for performance indicators pressurise all doctors. Inability to have control and to organise work to ensure reaching desired goals produces frustration. Irregular hours of work and sleep deprivation accentuate the problem. In addition, anaesthesia trainees face the heavy responsibility of service work with its large proportion of emergency work, coupled with the increasing necessity to be successful in postgraduate examinations at the first attempt. There is danger in overextension of the individual in any of these areas.
- (b) **Interpersonal.** Medicine of necessity involves working with people and difficult interpersonal relationships produce a stressful environment. For the anaesthetist the most important interaction is with surgeons. This is an area of considerable stress where anaesthetists may perceive themselves as powerless to change or control the situation. In medicine the pressure on time for all doctors and especially for trainees also puts a strain on their personal relationships. The 'front line' specialties with a large content of emergency work have a particular problem.

### SECTION III - ASPECTS OF STRESS

The incidence of both physical and mental illness is higher in people who experience significant life changes such as marital difficulties, bereavement, personal illness or job loss. Any instability in this area is accentuated by the life style which many doctors are forced to adopt or which they inflict on themselves.

#### **(c) Personal**

- (i) Impending litigation. Allied to the climate where there is an increased incidence of complaints, the worry of impending litigation for medical negligence is a further source of personal stress.
- (ii) Pressure on time. There may also be pressures to achieve more in less time. Instances include delivering contracts in an NHS trust or endeavouring to earn more in private practice. These pressures actually foster and reward type A behaviour but the demands must be kept in perspective.

## SECTION IV - STRESS MANAGEMENT

Although some causes of stress can be removed, others will always be present. It is, however, possible to modify many of them and to control the responses to them. This is the basis of stress management.

While this document cannot provide extensive details of the skills required for stress management, the simple outlines provided will give a basis on which these skills can be built.

### 1. Control

It is important that strategies are developed which can help to control stress and it is essential to learn how to recognise the things that cannot be changed. In general the only person with the ability to change is oneself. While this can be daunting it can also have impressive results on relationships and interactions with others.

In the whole field of stress management it is essential to preserve personal time and to establish hobbies to act as a diversion and counteract the undesirable effects of stress. It is valuable to be able to discuss major stressful areas and frustration with friends, family or colleagues. These measures, together with others such as regular physical and relaxation exercises and possibly meditation can help to keep the stresses of work and everyday life in perspective.

Fundamental skills for control are those of communication and assertiveness and their use in dealing with others. In the workplace, as an example, both can lead to a decrease in aggression among colleagues. It is important to learn to respond appropriately to aggression and to situations of conflict. The refusal of certain requests, if felt necessary, should be done in a factual and constructive way. Anaesthetists make good managers and often have the ability to produce constructive change in a way which can be beneficial to everyone.

Another area of control is to review the unfounded beliefs which are at times fostered within the medical system especially among trainees. Doctors are neither infallible nor superhuman. All are subject to stress and fatigue and while some hide the effects better than others it should be acceptable to display on occasion some normal human weaknesses. Finally, time management will allow not only the most efficient use of

work time but also the recognition that time cannot be expanded infinitely to meet demands.

## **2. Use of Communication Skills**

The objective of communication skills is to ensure that the information is imparted clearly and without ambiguity and is understood. Communication is a two way process in which listening and clarifying by questioning on the one side is balanced by explanation and reinforcement on the other. At times the answer to a difficult question may be achieved by reflecting the question back thus encouraging the person to come up with the answer rather than have the solution imposed by an outside party. Non verbal behaviour and body language are equally important in the way messages are conveyed and received.

Communication skills are also the basis of the other important skill, assertiveness. Good communication can prevent many crises in the workplace and can remove many irritations which lead to undue stress especially where these are due to misunderstanding. Many changes are taking place in the NHS: consultation about these changes is essential and where possible is best done between those of equal professional status. Time spent in communication can reap great benefits to morale.

## **3. Use of Constructive Assertiveness**

People feel anxious in both social and work situations when they are unsure of how to speak up for what they feel is right. They may go along with a plan of action rather than cause unpleasantness. This is being unassertive and merely breeds resentment which can only be deleterious. Learning when and how to say 'No' for good reason will have huge long term positive effects.

To be assertive, thoughts, feelings and beliefs must be expressed in a way that does not violate the rights of others and which is open, direct, honest and appropriate. In particular it is important to avoid being aggressive when being assertive, although this may initially be difficult. There is an art in being assertive and in its adjustment to suit a particular situation. This art is best learnt with practice and with guidance from those with experience.

**4. The Control of Aggression**

Handling aggression directed at oneself is an art and improves with practice. It is important that aggression is not met with aggression and that personal remarks are ignored. They may give short term satisfaction but in the long run only demean the speaker. Emotional response to such remarks moves discussion on to an aggressive basis. Instead it is better to be factual and demand facts in return. Try to remain calm but firm and be sure that you are clear as to what is both reasonable and possible. The backing of colleagues is invaluable.

On occasion conflict can ensue. In these situations the optimal outcomes will be achieved, if, while remaining assertive and holding on to one's principles, one also tries to be as co-operative as possible. This approach often leads to the desired collaboration.

**5. The Problem of Distorted Thinking**

Medicine has the ability to foster the development of ideas and beliefs which are not always rational. One is that doctors should be capable of anything and everything which is demanded of them. Objectively this is easily refutable but much less so in the heat of the moment or when refusal could be implied to mean inadequacy. Such beliefs and unrealistic demands may stem from a feeling of general inadequacy, are usually misplaced and require to be challenged and rationalised.

Beware of an emphasis on pessimism and do not demand too much of yourself. Anything less than 100% is not necessarily total failure. Remember positive experiences; do **not** jump to conclusions and do **not** magnify mistakes and minimise successes. Avoid emotional reasoning and seeing oneself as responsible for negative external events. Try to learn from the bad experiences of yourself and others to avoid similar problems in the future. Look at the bottom line and know what is really important.

**6. Efficient Time Management**

Efficient use of time conflicts with the excessive and unreasonable demands which are often part of the work place environment. It is fundamental not to take on more than can be realistically coped with although most of us may be guilty in this respect. Demands, if not realistic and legitimate, should be rejected.

#### SECTION IV - STRESS MANAGEMENT

It is fundamental to establish priorities and to distinguish between the urgent, the important and the unimportant. It is important to be selective in tasks to be done, to allocate appropriate time to them and also to do things well but not obsessively. The most difficult tasks should be undertaken when fresh and it is better not to postpone unpleasant matters.

It is useful to take a critical look at one's use of time and to analyse those factors which interrupt and steal time. There is a tendency to delay difficult tasks and it is usually better to do important projects as early as possible. There is also a responsibility to delegate to others and so to increase the experience of the whole team thus adding to its strength.

## SECTION V - STRESS SUPPORT

### 1. Personal and Professional

When difficulties do occur there are many steps which can be taken both to care for the affected doctor and at the same time to ensure that the paramount concern for patient safety is preserved.

Recognition of stress in oneself or in a colleague and the acceptance that there is a real problem is fundamental though it may be difficult or unpalatable. Discussion of the perceived situation with a friendly but uninvolved colleague may be all that is required to put matters right and return affairs to the correct perspective. Such informal counselling or mentoring is often a valuable method of gaining insight. There must be a follow up to confirm that the situation is resolved.

When the symptoms are evidence of a more severe reaction to stress, then access to training in relevant areas of stress management should be sought. The sources of the problem need to be identified and a strategy constructed to counteract them. Stress in medicine is very common but good relationships within directorates, objective friendships and an understanding general practitioner usually resolve the majority of stress problems. Their changing role has perforce brought Postgraduate Deans into a pivotal position in dealing with problems affecting trainees and the Clinical Psychology Department may be helpful. Anaesthesia Directorates must be aware of the support mechanisms which are available; they should be organised to find and supply such support and training when needed.

Doctors in need of medical care have the same NHS services available to them as do the rest of the population but may have particular difficulties in the role of patient, the antithesis of the doctor's normal activity. Doctors are often reluctant to accept the need for help and may put off seeking it until their condition becomes too severe to ignore. All doctors should be registered with a general practitioner with whom they have an easy professional relationship formed in an atmosphere of mutual trust and respect. This is essential but is often lacking. Hospital doctors have a tendency to bypass the general practitioner and to think they know best while the general practitioner is often wary of the hospital doctor's expertise. All doctors should be discouraged from self diagnosis and especially self treatment.



While there may be problems in helping doctors with physical illnesses the real problems seem to arise with non physical problems such as the effects of stress, possibly compounded by the misuse of alcohol or drugs. At a local level, there may be a variety of initiatives offering types of support ranging from the Director of Medical Administration in some hospitals through the Occupational Health Services to the Three Wise Men procedure. At national level the Association's Sick Doctor Scheme and the National Counselling Service for Sick Doctors are confidential and have no immediate risk of any backlash. The Health Committee of the GMC can also be useful but while initially confidential, it is perceived as close to statutory restriction. The move to NHS Trusts and the organisation into clinical directorates is a major shift in structure and climate of the workplace of the hospital doctor. The full effects of these changes still have to be assessed but to date the fears of a less sympathetic employer for doctors have proven groundless.

Unfortunately, all too often the first words which a doctor hears when performance is suboptimal are those containing threats of discipline or complaint. This can occur because of directorate inexperience or because the situation has been allowed to develop to an advanced stage. Directorates should therefore establish procedures to recognise and cope with stressed members at an early stage offering them realistic help and support to change both the job and the way they cope. Directorates are in a position to audit present working practices and to press for and contribute to more efficient management, realistic work plans and constructive planning for the future.

In severe stress, often the most formidable step is to get the affected person to admit that all is not well. There has to be acceptance that there is difficulty coping either at home, at work or often in both areas and the next step then involves admitting the problem to others. There are now in existence completely confidential advice systems which can be very efficacious (vide infra).

There is a clear methodology for approaching any of the schemes. Remember it is important that the person in need realises that they are not unique or alone, nor are they abnormal even if that is how they may feel at that moment. Many people have had difficulties at some time in their lives and have found a way to cope with them. These people and others are sympathetic and often have worked out systems and strategies which others may find useful.

When doctors, whether due to stress, illness or a combination of both, prove incapable of coping with their work and when the general measures so far outlined have proved unable to rectify the situation, there is need for a more radical approach to the situation. In extreme cases the doctor may have adopted methodologies of self treatment which could be detrimental to patient safety.

## 2. Support Mechanisms

In a Trust, **the clinical director** is responsible for the management of a department. This, together with other changes including the introduction of clinical audit, has given new opportunities for a medical manager to review the overall performance of the clinical directorate and should result in the earlier recognition of individual doctors having problems.

**The mentor system** is worthy of greater exploration. This is a more formal structuring of the general measures described earlier and may be appropriate in large departments where it is easier for individuals to become isolated either in work or in the social context. It is possible to make arrangements with neighbouring Trusts although the mentor does not necessarily have to be someone from the same speciality.

It is paramount that members of all grades and seniority in a directorate support each other constructively. Factions within departments are destructive. The single-minded loner may accomplish a lot but the price can be unreasonable. No person has the right to make life miserable for those around them.

**(a) Clinical Director**

A clinical director takes responsibility for the whole directorate in terms of process and outcome. This includes the performance of all staff within the directorate. The clinical director often finds himself in an unenviable situation as the first person to hear that a member of the directorate is having a problem in coping with work. Finding a solution to such problems is a serious responsibility and a ruling of the GMC has made it even more explicit. As an arm of management, the clinical director may be perceived as not necessarily the best person to make preliminary enquiries though there may be no alternative. It is worthwhile for a directorate to give consideration to a structure to take this into account.

Changes in working practice and requirements for flexibility may provide stresses creating problems for everyone in an anaesthetic department. However a change in the normal habits of a colleague may give a clue to problems they may be having at the work place. If such behaviour is noted or is the subject of discussion between colleagues, then it is the responsibility of any consultant or indeed of any individual within the directorate to make sure that the clinical director is informed and measures for patient safety put into place.

If a clinical director realises that a doctor is underperforming for reasons of ill health, there is a need to address the personal problem to ensure that the colleague has every chance of a complete recovery and so is enabled to resume full activity. The issues of cost and departmental performance standards must also be considered. Conflicts of interest and loyalty could begin to surface at this point and work against a sympathetic, informal approach to the problems of the doctor concerned.

The first action of the clinical director or his deputy must be to discuss the problem with the person involved and attempt to arrive at an assessment of the situation. If a difficulty is admitted it may then be possible to seek a solution. If a difficulty is not admitted, continued review of the individual's practice should occur whilst seeking advice from other consultant colleagues.

It may be appropriate at this time to discuss the matter with the medical director who now takes ultimate responsibility for issues which in the past were dealt with by the regional medical officer or the director of public health.

While it may be an acceptable short term measure it is not appropriate in the long term to use trainees to bolster the service and so attempt to decrease the stress on more senior colleagues. It is important not to ignore the situation after the first steps have been taken. Good practice suggests that there should be a revisitation of the colleague who is in difficulty, possibly with a witness who may be either another anaesthetic colleague or someone from the personnel department. Emphasis should be placed on the fact that discussion has arisen because of concerns for the best interest of the doctor and their patients. The opportunity may be taken to discuss possible options, either short term or long term, such as a review of the job plan of the colleague, the dropping of a particular list for a time, having a break either by annual leave or sick leave, going part time or even taking early retirement if appropriate.

Other measures may be necessary such as retraining to cope with changes in practice. The colleague should be persuaded that discussing their difficulties with their general practitioner may be useful or as an alternative, the personnel officer may suggest occupational health assistance. In the case of a severely disturbed doctor or in an instance where patient safety is deemed to be at risk, suspension from duty may be the preferred option while an investigation into the circumstances is made. This then introduces the use of more formal measures.

The occupational health service should have an important part to play but unfortunately it is often perceived as too closely allied to management to be accepted as neutral.

In a smaller hospital department some support functions may be undertaken by the chairman of medical staff. In all these general measures those involved must remember that they have a primary function to preserve patient safety at all costs.

By the measures so far outlined many problems can be resolved rapidly. If a problem is incapable of resolution by informal

measures then it will be necessary to move to formal mechanisms.

**(b) Mentor System**

There are now several projects in the field of general practice, some offering a mentor/mentee type of support and others offering reciprocal co-mentoring or co-tutoring. These projects are relatively new but they appear to be successful in providing personal and professional support and diminishing levels of stress.

A mentor is usually assumed to be a more experienced colleague who can be seen as offering support, advice and an opportunity to discuss problems. A mentor should be seen by the mentee as independent and trustworthy as well as knowledgeable. In some instances a mentor can be a senior colleague in the same department but in other circumstances this may be inappropriate because of conflict of interests. In nursing there are statutory requirements for newly qualified professionals and those moving to another area of work to have a designated preceptor for the first four months. This type of relationship, if found to be supportive, may continue for a much longer period. In social work and psychiatric nursing it is usual to have professional and personal supervision in clinical work. Such supervision may take the form of a senior colleague advising a junior colleague or may be arranged on a more equal and reciprocal basis in pairs or small groups.

In medicine, it is assumed that a consultant acts as an adviser to trainees working with him and each trainee is required to have an educational supervisor. The supervisor is concerned with managing what work is to be done and how education is to be delivered in terms of theoretical knowledge and practical training. The supervisor should also be concerned with the personal and professional well-being of the trainee and how they relate to colleagues and other staff, their timekeeping, attitude to patients and other areas of professional behaviour.

In contrast on appointment to a consultant post the doctor is not usually given any further formal supervision. If he needs advice he must find his own mentor from among his colleagues. It is at this stage that support from experienced colleagues may be particularly needed and when the availability of a designated

mentor could be extremely helpful. However, at any stage in a consultant career support and advice may be needed and in some situations may not be readily available.

The development of a mentoring scheme should only be seen as one part of the total support system for consultants. Good relations within departments are obviously a basic need. The role of the mentor is to provide support and advice but in no sense to provide therapeutic help for a consultant who is becoming unwell. A mentoring scheme should be seen to supplement the sick doctor scheme, while consultants should be encouraged to use ordinary medical channels if they feel they are in need of personal help.

**(c) Association of Anaesthetists Sick Doctor Scheme**

In 1977, the Association of Anaesthetists of Great Britain and Ireland, in consultation with the Royal College of Psychiatrists, pioneered their innovative Sick Doctor Scheme primarily designed for their members. This scheme is quietly promoted in the Association's literature and its initiation and existence are well known to anaesthetists.

The scheme's aims are to provide support and arrange treatment on a confidential basis for anaesthetists who are perceived by their colleagues and agreed by themselves to be sick and in need of care and advice. To access the scheme it is merely necessary to call the Association's offices in Bedford Square and ask to be put in contact with the Sick Doctor Scheme. They will then be referred to the responsible anaesthetist who will make the necessary arrangements.

Treatment offered may be given locally or in a region distant to the place of work of the anaesthetist. Should the individual sick doctor refuse treatment or support, this does not in any way reduce the responsibility of the referring doctor or doctors to take the necessary steps through official channels to protect the welfare of patients.

The confidentiality of the scheme renders it difficult to assess the overall efficacy. Fortunately, since its inception, the numbers involved have been relatively small but nevertheless there has so far been an inexorable growth in the use of the scheme.

Addiction to alcohol and mental illness are the main causes of referral though there is a small but worrying amount of evidence of abuse of other substances.

**(d) Three Wise Men**

The 'Three Wise Men' procedure was established under the terms of Department of Health Circular HC(82)13, dealing with the prevention of harm to patients resulting from physical or mental disability of hospital or community medical or dental staff. It was set up to tackle situations where a doctor's clinical performance was well below acceptable standards. There is still a major need for local measures and the relationship between them and the new Performance Procedures being set up by the General Medical Council still needs to be resolved.

Previously the procedure was initiated by a hospital in discussion with the Director of Public Health. It offered the attraction of a semi-informal largely confidential process for dealing with the problems of hospital doctors. The chairman of the panel, usually a very senior and respected practitioner in the same discipline, had the key role in the procedure and the majority of cases referred to such a panel were capable of resolution by informal means. When well handled, it often proved to be a very effective and efficient means of dealing with complaints and concerns of colleagues about the competence of individual doctors whose behaviour suggested that they were experiencing difficulties.

However, the effectiveness of the procedure was always somewhat negated by the confidentiality and secrecy which attended it. The arrangements for appointing the chairman and members of the panel were not always clear, and panel members were themselves sometimes unsure about their role. As in all similar procedures, it had the weakness of depending on colleagues of doctors with problems being prepared to make a report about them.

The new structure of the NHS has effectively detached the Three Wise Men procedure from the Director of Public Health and Regional Director of Public Health. The scope for informal resolution of problems is potentially more restricted, and the future of the system is unclear. Increasingly the support for an individual doctor in difficulty will largely be a matter for the

employing Trust. It is likely that the new procedure by the General Medical Council to assess the incompetent doctor will alter the Three Wise Men procedure as a formal measure, though some informal mechanism based on the procedure could survive as a useful tool.

**(e) Occupational Health Services**

Under the terms of HSG (94)5, 'Occupational Health Services for NHS Staff', all NHS Authorities and Trusts have a responsibility to ensure that their staff have access to confidential Occupational Health Services. OHS should therefore be seen as a potentially valuable source of support for hospital doctors in cases of ill health and stress. However there are grounds for believing that as things stand doctors do not regard OHS in this light.

The OHS has a dual role as adviser to the employer as well as advocate of the employee. This has the potential to compromise their position and their ability for confidentiality and may also be perceived as giving rise to a conflict of interest. The wider remit of OHS, in the provision of information for selection procedures, in routine medical examinations and in its general concern with health and safety at work, is likely to create an orientation in which there is relatively little scope for dealing with doctors with health (and especially mental health) problems.

At present the OHS is relatively undeveloped in the NHS with a paucity of consultant physicians involved in providing a universally consultant led service. It is hoped that the OHS will be able to play an important role throughout the NHS but doctors with health problems are still likely to look elsewhere for support.

**(f) Postgraduate Medical Deans, Specialty Advisors, College Tutors, Regional Advisors**

The role of the Postgraduate Medical Deans is in a transitional phase but within it there may be an opportunity for developments in ways which could assist with some of the problems of stressed and sick doctors. Postgraduate Deans will have many points of contact with trainees and with all bodies affecting trainees and could have a pivotal responsibility in their welfare. In anaesthesia the network of Specialty Advisors,



College Tutors and Regional Advisors have obviously also a close involvement and liaison with trainees and through them with the staff of many hospitals.

These roles, while primarily involved with training, have therefore, considerable potential for helping with the early identification of problems, in particular with stress related disorders in trainees. It seems clear that the origins of stress-related disorders in doctors often lie in the early part of their careers. Postgraduate Deans should check that Trusts do everything in their power to give doctors in training an environment in which they can learn successfully, including support in coping with the stresses of their clinical responsibilities.

**(g) National Counselling Service for Sick Doctors (NCSSD)**

The NCSSD was set up in 1986 as an independent body to provide a non-coercive advisory service to any doctor in the United Kingdom who is unable, for mental or physical reasons to perform his work adequately. Most doctors who fall ill in ways which impair their fitness to practice are aware of the problem and take appropriate steps. A minority, through lack of insight or for other reasons, continue to work in the face of serious difficulties. The primary aim of the NCSSD is to persuade doctors in need of help to seek appropriate treatment.

The NCSSD provides a service for all doctors, equivalent to the Association's Sick Doctor Scheme for anaesthetists. If a doctor is concerned about his health or that of a colleague and wishes to seek advice from the Counselling service this can be accessed via a National Contact Point. They are then given the name of a national adviser who will be a senior member of the same specialty as the 'sick doctor'. The Adviser verifies the nature of the problem and may then decide to recruit appropriate help as a counsellor. Once a counsellor has taken on the sick doctor, the Adviser will withdraw and the care of the sick doctor will revert to a normal confidential patient/doctor relationship. No permanent records are kept of the transactions. If the sick doctor refuses the proffered help the referring colleague is informed and the matter, so far as the NCSSD is concerned, is closed.

Unfortunately the NCSSD is not as widely known as it deserves and so far the service has not been used as widely as hoped.

**(h) General Medical Council**

Use of the support mechanisms discussed so far has been largely dependent on self referral or voluntary utilisation. The list is not exhaustive or exclusive. The other very important body and the one with statutory powers is the General Medical Council. Most problems can be resolved without recourse to the GMC but an understanding of its role is appropriate.

There is evidently a widespread reluctance to refer cases to the GMC though those familiar with the GMC believe that it performs its statutory functions with skill and humanity. However, the GMC's association with maintaining standards and its disciplinary role make it, for the majority of the medical profession, a remote and possibly somewhat frightening body with the power of depriving doctors of their livelihood. Thus doctors may fear that in reporting a colleague to the GMC, this may endanger their employment.

It is necessary for the GMC to differentiate between the doctor who is ill and the doctor who is incompetent. The GMC health procedures can achieve very satisfactory outcomes, but referrals to them by colleagues are few.

Medical practitioners are licensed by the GMC under the Medical Act of 1993. Under Section 37 of the Act, if the fitness to practise of any doctor whether fully or provisionally registered or with limited registration 'is judged by the Health Committee to be seriously impaired by reason of his physical or mental condition', the GMC can direct the suspension of registration or conditional registration of the doctor involved. Doctors may appeal against directions for erasure, suspension or conditional registration, but Section 38 (1) provides that the professional conduct and health committees have the power to order immediate suspension pending appeal if the decision was erasure or suspension 'if satisfied that to do so is necessary for the protection of members of the public or would be in the best interests of that person' (that is the doctor).

A recent amendment to the Medical Act means that the practitioner may now be referred to the GMC Performance Committee which will review practices so far below par as to put patients' safety at risk. In the same way, investigations of this Committee could lead to a doctor's name being erased from the register, suspended from the register or registration being permitted to continue only on stated conditions.

The GMC procedure begins with a preliminary screening followed by an assessment of performance, remedial action, reassessment and finally referral to the professional performance committee. A panel of two anaesthetists and one lay person will be involved in the investigation of the complaint and will make a report after the assessment of performance.

### **3. Conclusion**

Doctors have a responsibility to minimise stress in the work place though the doctor's health is basically the responsibility of the doctor himself. The provision of medical services for sick doctors is a safety net. The importance of a good general practitioner is fundamental and the advice to consult with them and be treated through them cannot be overemphasised. Self treatment and self prescription are unwise. Most of the mechanisms which are presented as providing support for sick doctors start from the initial purpose of ensuring patient safety. If all else fails, the doctor whose performance is impaired by health and related problems can be reported to the appropriate authorities and ultimately referred to the GMC.

The current and continuing structural changes in the NHS make this advice all the more important. Doctors still have the opportunity to be, to some extent, self regulatory.

The behaviour of doctors over many years has largely dictated the way in which they respond to the stress which is inherent in their work and which can lead to breakdown and ill health. It is acknowledged that the example and expectations of senior doctors must influence the behaviour of their juniors and students and that peer group pressures are of great significance. In particular, the way that doctors' work is organised is a main cause both of stress and of their 'denial of sickness' behaviour.

#### SECTION V - STRESS SUPPORT

There is much less flexibility in the way an anaesthetist's work is organised than is usually the case for other specialties. Operating lists are difficult to rearrange and doctors are conscious that if they take time off because of illness or any other cause, colleagues whose workload is already onerous will have to cover for them.

Ways of dealing with these problems have to be devised. Some directorates manage this situation in an exemplary manner. The Association of Anaesthetists of Great Britain and Ireland can provide confidential guidance in all these matters.

## APPENDIX 1 - VOLUNTARY AGENCIES

1. **The Sick Doctor Scheme, Association of Anaesthetists of Great Britain and Ireland.**  
Confidential access at:  
The Association of Anaesthetists of Great Britain and Ireland,  
9 Bedford Square,  
LONDON WC1B 3RA.  
Tel: 0171 631 1650 (0900 to 1730).
2. **The National Counselling Service for Sick Doctors**  
National telephone contact point on 0171 935 5982.  
Further information from:  
The Chairman, National Management Committee,  
National Counselling and Welfare Service for Sick Doctors,  
1 Park Square West,  
LONDON NW1 4LJ.
3. **Drinkline** (National Alcohol Helpline) 0345 320202
4. **Sick Doctor's Trust** (helpline for addicted physicians) 01252 345163
5. **Local services, Church support.**
6. **Work based support:** Occupational Health Services
7. **Saneline** 0171 724 8000
8. **Support for Re-training.**  
The General Medical Council aims to work with the co - operation of doctors, to encourage remedial action and rehabilitation. 0171 915 3642.
9. **British Medical Association Stress Counselling Service for Doctors.**  
0645 200169. This is a 24 hour a day all the year round service.

## REFERENCES

1. Vickers, M D., Reeve, P. Selection methods in medicine: a case for replacement surgery? *Journal Roy Soc Med* 1990; **83**: 541 - 3.
2. Friedman, M., Roseman, RH. Type A behaviour pattern: Its association with coronary heart disease. *Ann Clin Res* 1971; **3**: 300.
3. Caplan, RP. Stress, Anxiety and Depression in hospital consultants, general practitioners and senior health service managers. *British Medical Journal* 1994; **304**: 1261-1263
4. Linkman Conference, Association of Anaesthetists of Great Britain and Ireland 1995, Birmingham.
5. Dickson, DE. Stress. *Anaesthesia* (Ed) 1996; **51**: 523-4.
6. Seeley, HF., The practice of Anaesthesia - a stressor for the middle aged? *Anaesthesia* 1996; **51**: 571-4.
7. Neil, HA, Fairer, JG, et al. Mortality among male anaesthetists in the United Kingdom 1957-1983. *British Medical Journal*, 1987; **295**: 360-2.
8. Burke, RJ. Occupational and life stress and family: conceptual frameworks and research findings. *International Review of Applied Physiology* 1986; **35**: 347-369

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