INTRODUCTION

The misuse of alcohol and other drugs by doctors forms the major component of any concern about the conduct, performance and health of the medical profession. The occasions when these concerns arise may attract widespread publicity, especially when the circumstances are linked to less than satisfactory patient assessment and management. When substance misuse is evident, there is every indication that early intervention is therapeutic and would be preventative, but equally there is a pervasive uncertainty among doctors about how to intervene.

Education of the profession by increasing awareness of the risks and prevalence of substance misuse and knowledge about assessment and treatment services were the key issues addressed by the Working Group on the Misuse of Alcohol and Other Drugs by Doctors at meetings hosted by the British Medical Association (BMA). The group included representation from the Academy of the Medical Royal Colleges, the Medical Council on Alcoholism, the Medical Defence Union, the Medical Protection Society, the Society of Occupational Medicine, and the General Medical Council (GMC). The Working Group was convened in 1997, and reported in 1998 (Working Group on the Misuse of Alcohol and Other Drugs by Doctors, 1998). This Commentary will review the report’s findings and then describe local action taken by Medical Council on Alcoholism advisers to identify local knowledge and the practical implementation of the working group’s recommendations.

REVIEW OF REPORT FINDINGS

Given that the misuse of alcohol and other drugs is a major threat to family health and livelihoods, the report confirms that in the case of doctors, misuse is also a threat to patients and indicates that the problem in doctors is not being addressed satisfactorily. The report outlines practical proposals for limiting risk to patients arising from impaired professional competence, by raising awareness within the profession and dealing with the denial associated with avoidance of assessment and treatment when substance misuse pertains.

Early identification

Early identification is the element most likely to prevent risk to patients. The need for access to appropriate diagnostic treatment and rehabilitation services is emphasized. The practicality of retraining for affected medical staff is raised.
Reluctance to seek help

The report identifies the reluctance of doctors to seek help, and emphasizes the detrimental impact of the lack of insight often associated with alcohol and drug misuse. It acknowledges that doctors avoid detection and tend not to seek help. The associated reluctance of a doctor’s colleagues to intervene is noted and is linked to the complexities of misplaced loyalty. Insufficient knowledge within the profession about means of intervening and available services is deemed to be a serious hindrance to early identification.

Formal procedures

There is a clear recognition that formal procedures including GMC health and performance procedures are both important safeguards and eventual sanctions. Affirmation that effective confidential local intervention with easy access to pertinent guidance is likely to be preventative is a vital conclusion.

Workplace policies

Comment that too little is done to ensure that alcohol employment policies (if available) are properly applied to doctors is borne out by the ongoing Workplace Alcohol and Other Drug Policy study commissioned by the BMA although the study only yielded a 36% response.

Performance and behaviour

The report indicates that alcohol and drug misuse problems affect male and female staff covering all degrees of experience from student years onwards in all specialties and locations. It also confirms that doctors are particularly likely to misuse prescribable preparations. If there is suspicion that a doctor’s health may be a factor in diminished performance a clear mechanism for reporting and independent assessment is necessary. If access to that mechanism is widely known, early intervention, prevention of entrenched morbidity, and effective resolution all become more likely. It is asserted that the essence of effective intervention is an expectation of recovery. The report outlines the GMC’s view that all doctors have an obligation both to recognize changes in conduct, performance, and health which might suggest alcohol and other drug misuse, and to report those changes lest there is danger to patients. It is acknowledged that junior doctors and nurses may be the first to recognize misuse problems in a senior colleague. The difficulties in reporting in those circumstances are highlighted. The report recommends that occupational health services are essential and should apply to doctors, in addition to ensuring that all doctors are registered with a general practitioner. These measures would limit the likelihood of doctors relying on their own assessment of their risk to patients.

The report is duly referenced. The succinct summary with 17 recommendations has many local implications.

ARE DEDICATED SERVICES NEEDED?

Members of the profession are conspicuously at risk of developing alcohol-related problems (Medical Ethics Committee, 1995) with a markedly increased proportional mortality ratio for cirrhosis of the liver, cancer of the liver, alcohol-related diseases, falls on stairs, and suicide (General Household Survey, 1998). Since 1980, substance misuse and mental illness have been the main problems triggering assessment by GMC appointed examiners (Irvine, 1997).

Brandon (1997) outlined reasons for having special services for doctors, emphasizing the need to protect patients and confirming that doctors are a scarce resource with a high morbidity. Given that doctors have tended both to diagnose and treat themselves, the above author recommended the special requirement for confidentiality if that trend is to be countered. Self-regulation for the profession places a responsibility on doctors to ensure that sick colleagues are identified and receive appropriate care. If straightforward procedures providing confidential clarification of whether a problem exists are in place, then that obligation will be discharged earlier and more often.

Strang et al. (1998) also confirmed that doctors are at special risk of developing addiction problems. Although many non-doctor patients with similar problems receive outpatient treatment whilst continuing to work, the same disability may be incompatible with medical practice. Removing a doctor from work may be necessary to protect both the doctor and the public. The above authors argued that, if special services for doctors are created, then confidentiality, early intervention, and public safety will be promoted. Access to treatment should be simplified. Services must include crisis intervention and special arrangements for supervision and
post-treatment monitoring. Strang et al. (1998) concluded that a lack of dedicated services has left many addicted doctors unchallenged, untreated, and abandoned.

Prevention of misuse of alcohol and drugs by doctors is a complex concept related to conditions of service, the creation of supportive clinical teams, limitations on stress, real involvement in service planning, an ability to influence decisions, and avoidance of isolation. These threads are not drawn together merely by imposing a reduction in working hours (Firth-Cozens and Moss, 1998).

Guidance about action to be taken within Scotland for doctors with health-related problems (Working Group on Professional Standards, 1998) outlined workable performance, discipline, and sickness procedures. The concept of a ‘confidential adviser’ was promoted.

The likelihood is that clinical governance, revalidation procedures, the reconstruction of job plans, the creation of definable and practical workloads, adequate manpower planning, limitation on the use of long-term locums, recruitment to establishment, the promotion of information alliances, the pairing of consultants, and the promotion of mutual support within multi-professional clinical teams are all issues which will emerge in the course of the current reorganization of the National Health Service (NHS) (Parboosingh, 1998).

The Medical Council on Alcoholism is a charity concerned with the education of medical and allied professions about the effects of alcohol on health (Medical Council on Alcoholism, 1998a). It recognizes that medical students and doctors have a particularly important role in understanding and supporting public health measures to reduce the level of alcohol-related harm in the population. It acknowledges that students and doctors need to consider their own drinking. The Medical Council on Alcoholism membership is drawn from the full spectrum of medical specialties and is served by a web of Regional Advisers. The Council publishes handbooks, leaflets, booklets, a newsletter, and this journal. It promotes the provision of support and confidential treatment for all categories of staff as early as possible. It acts as a national focus for agencies offering information, advice, guidance, support, and treatment for clinical staff affected by alcohol and other drug misuse. The current edition of the Medical Students’ Handbook (Medical Council on Alcoholism, 1998b) lays particular emphasis on medical students and doctors, giving special consideration to whether their drinking is interfering with their ability to practice and in encouraging colleagues to do the same.

A LOCAL REGION’S RESPONSE FOLLOWING PUBLICATION OF THE REPORT

The Medical Council on Alcoholism advisers for North Scotland sought to clarify both the extent of local knowledge about the recommendations in the Misuse of Alcohol and Other Drugs by Doctors and the availability of a local procedure to promote early assessment and intervention for the profession. They distributed copies of the report and then arranged meetings and discussions with the Dean of the Medical Faculty, the professor with responsibility for medical student welfare, the Postgraduate Dean, Regional Advisors in key specialties including occupational medicine, psychiatry, general practice, and anaesthetics, three Medical Directors, three NHS Trust Chief Executives, the General Manager and Medical Non-Executive Director of the Health Board, the Chairman of the Medical Advisory Committee, the Director of Public Health, the local secretary of the BMA, and the President of the Postgraduate Medical Education Society. Each contact confirmed that the conclusions from the report were fully supported, but considerable uncertainty was revealed about the extent to which special provision, locally, for medical staff was necessary, and there was a lack of clarity about how local mechanisms worked, what the access arrangements were and how pertinent guidance might be procured should concern arise. Details of the local organizations and the roles and responsibilities of the individuals approached are available from the author on request.

Local arrangements in trusts

It emerged that considerable deliberation about these issues within one trust was not known to the other two. Informal confidential mechanisms proposed by that trust were in turn not transferable to the other employing trusts, even though medical staff, especially those in training, worked across all three trusts.

The Acute Services Trust had a ‘Substance Misuse at Work’ policy and trust directors were
working on a ‘Framework for Support for Health-related Performance Concerns’ within the medical profession in conjunction with the Local Negotiating Committee of the BMA.

The geographical Trust had no special provision within its workplace alcohol policy for clinical staff.

The Community Services Trust had an alcohol and drug abuse policy and procedure which included a specific process for clarifying problems with doctors. The ethos was to separate that process from employment and disciplinary procedures. The process was well documented, but not widely known or publicized.

**Local arrangements in general practice**

Within general practice, formal complaints were dealt with by the Primary Care Agency of the Grampian Health Board through Service Committee hearings. When those processes revealed a problem linked to alcohol and drug misuse, any preventative benefit from early confidential intervention had by then been lost. Consequently, a local support network was established in 1995, to allow concerns to be considered by an informal grouping of three listed practitioners. The secretary of the local Medical Committee was the contact. Repeated publicity about the mechanism confirmed that the process was separate from any formal procedure and was confidential.

**Local arrangements in the medical school**

Medical undergraduates had a range of welfare provisions, including a regent scheme, access to a counselling service, Student Health Service, and chaplaincy. Each phase within the curriculum had an advisory committee which played a pastoral role. In addition, a Student Progress Committee identified students with difficulties. An assistant faculty officer had responsibility for student welfare and individual members of teaching staff both identified and helped students with problems. The convener of the Student Progress Committee received concerns from other students about the welfare of their peers. Substance misuse was periodically identified. It was acknowledged that postgraduate students posed different problems, because they were more likely to be working in isolation, in unfamiliar surroundings, and to be using English as a foreign language.

**General conclusions and comments**

Prior to the local discussions, it was assumed that workplace alcohol policies provided a mechanism for identifying and managing substance misuse problems in doctors. In discussion, it became clear that the policies were inextricably linked to managerial and disciplinary action and contained too little provision for informal anonymous guidance relating to the particular problems of medical staff.

The local meetings revealed that there was no stipulation that North of Scotland doctors should register with a GP, no universal mechanism for members of the profession to have access to a consultant in occupational medicine and no delineated requirement for assessment and treatment facilities to be made available away from clinical settings where a doctor had worked. These issues were firm recommendations arising from Misuse of Alcohol and Other Drugs by Doctors and the Working Group on Professional Standards 1998 reports. The Priorities and Planning Guidance for the National Health Service in Scotland 1999–2002 confirmed that consultant-led occupational health services would be in place by 2002 (The Scottish Office, 1998).

The responsibilities of the Dean and Postgraduate Dean in recognizing and managing drug and alcohol misuse problems in students, doctors in training, and doctors as teachers and trainers were accepted, but the concepts had not been incorporated into induction, training or continuing medical education programmes.

The Undergraduate and Postgraduate Deans, Medical Directors of Trusts, Director of Public Health, and Regional Advisers in relevant specialties were all committed to their role of supporting the rehabilitation and retention of colleagues who may have become affected by alcohol and drug misuse, but each in turn was less clear about how to proceed if a problem arose.

The need for universal repeated publication of how to secure informal, confidential, informed discussion of any concern about health or performance seemed especially pertinent to the local setting. The requirement for support for anyone expressing a concern was also acknowledged, but no local mechanism was established for this purpose.

This local review indicated that drug and alcohol employment policies were seldom applied to clinical staff and were not well publicized. The
exception was the general practice informal support mechanism which was repeatedly described in regular information bulletins: this reached all GPs and was in use. None of the policies were brought to the attention of medical students, pre-registration house officers, or doctors in training. No reference to these issues was included in any induction programme. No employment contracts encouraged doctors in North Scotland to register with a GP. Primary care services for resident doctors were not identified.

No confirmation was in place at recruitment to remind doctors not to prescribe for themselves and not to prescribe for colleagues, except following a formal clinical consultation. Whilst clear arrangements via Grampian Health Board for out of area referrals were in place, these arrangements were not widely publicized and were not known to the profession generally. No local directory of services or resources was published.

Whilst the three Medical Directors and the Director of Public Health each had an accepted role as the recipient of concerns about doctors’ performances and all four met together periodically, it was not clear to the profession locally that this was the case. That group also had disciplinary responsibilities, which may have made it less likely that concerned individuals would call for clarification of what to do next. Individual doctors were in doubt about who to contact if they were concerned.

Information about pertinent national services was not publicized locally (namely the Medical Council on Alcoholism, the National Counselling Service for Sick Doctors, the BMA Counselling Service, the Sick Doctors Trust, the British Doctors and Dentists Group, the Association of Anaesthetists’ Sick Doctor Scheme, and the Overseas Doctor Association). In turn, it seemed likely that these services could promote the use of a local contact point if one was established.

Recommendations

Enquiries made by Medical Council on Alcoholism advisers revealed limited implementation of the conclusions from this national report. It seems that a National Alcohol Strategy for England will be followed by similar proposals for the rest of the UK. Such strategies will include a requirement for health services to provide alcohol services, a component of which should be dedicated to the special requirements of clinical staff.

NHS changes including the establishment of Acute Service and Primary Care Trusts and the refinement of health authority and university roles promote an expectation of full co-operation and collaboration between agencies. An opportunity now arises to promote local coordination to deal with alcohol and other drug misuse in doctors, and if these issues are addressed, then isolated practice, idiosyncratic approaches, and the progressive failure to recognize detrimental performance, are all likely to be diminished.

In considering a local mechanism to enable anyone to express concern about a doctor’s performance, recognizing that the concern could be linked to the possible misuse of alcohol and other drugs, it was agreed that the local Postgraduate Medical Society, which is linked to the Students’ Medical Society, would support the establishment of a telephone contact point. The line will be serviced by a group of experienced doctors nominated by the Society and augmented by the lay involvement of a non-executive director of the Health Board.

The doctors will have a knowledge of all local workplace policies and all clinical resources (local, out of area, and national).

The group will facilitate appropriate intervention, once the nature and validity of any enquiry is established. It will be supported by the Medical Council on Alcoholism’s Regional Adviser, the BMA local secretary, the Chairman of the Medical Advisory Committee, and the Secretary of the Medical Society. It is intended to audit the number of contacts and conclusions about how concerns were validated to clarify whether early intervention was achieved. The utility of the arrangement will be tested and outcome statistics will be shared with the Health Board, Trust Boards, Postgraduate Medical Education Committee, and Curriculum Committee in the first instance. It seems likely that this local group, whose membership will reflect a range of specialties, will also act as a facilitator of further developments. The intention is to provide a confidential, informal, effective mechanism for anyone to express concern about themselves or their colleagues.

FUTURE PLANS

Further discussion is needed to ensure that concepts relating to the misuse of alcohol and other
drugs by doctors become an integral part of student education, medical training, continuing medical education, and professional development through incorporation into the medical student curriculum and all induction programmes relating to medical staff.

Further national consideration may be needed to identify a mechanism for funding retraining and to ensure that a doctor’s awareness of the identification and management of substance misuse in the profession becomes a component of the registration process with the Specialist Training Authority and any future revalidation procedure.

REFERENCES