SICK DOCTORS 1

Illness among doctors

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Introduction

FOR the years 1970-72 the Office of Population Censuses and Surveys reported a Standard Mortality Ratio for doctors of 81 (OPCS, 1978). This largely derives from the better health and life expectation enjoyed by those in professional and managerial occupations and the fact that fewer doctors now smoke cigarettes (Doll and Peto, 1976). As a result there were only 31 deaths from lung cancer among doctors instead of 51 expected, and the incidence of ischaemic heart disease was lower than in the general population. Doctors are, however, just as liable as anyone else to suffer from those common disabling diseases of still imperfectly understood causation for which no curative treatment is yet available. Epilepsy, multiple sclerosis, diabetes mellitus, rheumatoid arthritis and Parkinson's disease are among those most frequently encountered; they are all disastrous afflictions to anyone, but to doctors they present some special difficulties. In the discussion that follows, the prevalence rates are estimated from the number of doctors and the known national rates.

Epilepsy

Epilepsy often first manifests itself in early adult life, a time when the young student, after success in the intense competition for a medical school place, is entranced by the unending interest of the profession he has chosen and is looking forward to a career of happiness and perhaps distinction. The future is obviously in jeopardy but in some there may never be any further trouble. In others anticonvulsant drugs completely control the condition, while in a further group the attacks may occur only at night. In most, however, major and minor manifestations continue and, though a medical qualification is usually obtained, the inability to drive is a serious disadvantage and to follow a career involving independent clinical responsibility is very difficult; even in non-clinical work the occurrence of major convulsions at inopportune occasions may ultimately make it impossible to continue, however supportive colleagues may be. Valuable though advances in anticonvulsant therapy have been over the last two decades, epilepsy remains one of the cruellest crosses to bear and one which may ruin a life once full of happiness and promise. The exact number is unknown, but perhaps as many as 500 doctors in the United Kingdom have experienced some epileptic symptoms.

Multiple sclerosis

It cannot be long before a medical student or doctor afflicted with multiple sclerosis realizes the nature of his or her disease, and knowledge of the severe disability it so often produces inevitably causes gloom and despondency before the frequent euphoria of the later stages develops. Though no treatment of any significant value can be offered, encouragement can be given by pointing out that many patients after a single episode of demyelination recover almost completely and never have any more trouble, while in others the disease advances very slowly and exacerbations are infrequent. The majority of victims will, nevertheless, end up totally paraplegic and incontinent, with gross ataxia of the upper limbs, bedsores and mental changes, and for them there will be a long period before death when work is impossible. Even in the earlier stages of the disease, exacerbations may cause periods of prolonged incapacity, ataxia may make many clinical procedures extremely difficult and the spastic weakness of the legs may greatly impair mobility. How many doctors in the United Kingdom are suffering from multiple sclerosis is also not known, but it is probably about 50.

Diabetes mellitus

Because of his or her medical knowledge, the doctor is better equipped to cope with insulin-dependent diabetes than are others, and as most diabetic doctors do not smoke cigarettes, the cardiovascular complications may be delayed or reduced. Nevertheless it is a serious burden. The exigences of practice, such as a surgical procedure taking many hours or a day when there is no time for lunch, may lead to hypoglycaemic attacks and, if these occur whilst driving, the driving licence may be endangered. The greatest handicap is that at the time of life when a doctor should be at the height of his or her

powers, the diabetic complications develop. Photocoagulation has improved the prognosis of retinopathy and dialysis and transplantation that of chronic renal failure, but both conditions, however successfully treated, threaten the ability to practise; myocardial infarction, peripheral vascular disease and peripheral and autonomic neuropathy are hazards almost as great. There are very few insulin-dependent diabetic doctors who live and are able to work until they reach normal retirement age. In the United Kingdom there are about 1,500 doctors with diabetes; most of these have maturity-onset diabetes and many are retired, but there is a substantial number of younger doctors whose life span and capacity to earn is reduced by their disease.

Rheumatoid arthritis

The increasing proportion of women doctors will make rheumatoid arthritis a greater problem in the profession. Fortunately, in many it remains mild in degree and only very slowly progressive, but in some with severe and widespread joint damage the difficulty in ambulation and the impairment of grip and manual dexterity make clinical work very difficult, particularly for those in the surgical specialties. Despite the succession of new antirheumatic drugs, the progressive sophistication of domestic and personal aids for the handicapped and new surgical procedures, rheumatoid arthritis remains a disease capable of causing a degree of crippledom incompatible with any form of work.

Ankylosing spondylitis, though not a common disease, is increasingly recognized. It does not often impair the capacity to work, but if gross kyphosis and ankylosis of the cervical spine develop, the inability to look up or turn the head makes driving and many other activities difficult, while recurrent iritis may be a troublesome problem.

Parkinson's disease

Unhappily, Parkinson's disease often develops long before retirement age is reached; indeed it is not uncommon in relatively young people. The disability produced by the rigidity makes it very difficult for those in the surgical specialties to continue working once the disease becomes established, and though amantadine, levodopa, carbidopa and bromocriptine often produce considerable reduction in the severity of the symptoms, they do not restore the full normality of function which a surgeon requires. Parkinson's disease becomes increasingly common as life expectation extends; many doctors continue to work long after they reach retirement age and probably about 100 doctors suffer from the disease.

Other disabilities

Other, all too frequent disabilities are strokes, deafness and impairment of vision.

Dr Thomas Lawrence, who was President of the Royal College of Physicians 1767-75, developed angina and deafness in 1773, and a stroke nine years later left him hemiplegic and dysphasic. Despite this he continued to practise and when he was examining his friend and patient Dr Samuel Johnson, who was in cardiac failure, Mrs Hester Thrale said "Old Lawrence his physician worse than he; dead on one side. Such a scene."

Operations for otosclerosis and to repair tympanic perforations and progressively improved hearing aids have done much for the deaf, but there are still many doctors who must, despite lip reading, find it difficult to grasp all that is said to them and to use a stethoscope effectively.

The visual loss caused by diabetic retinitis, retinitis pigmentosa, neuromyelitis optica, retinal detachment and other ophthalmic conditions must impede reading, adequate physical examination of patients and the many technical procedures which clinical practice inevitably involves.

Finally age itself must be considered. The Acheson Report on primary health care in Inner London showed that, of 106 in general practice over the age of 70, 21 were over 80 and one was over 90 *(Primary Health Care in Inner London,* 1981).

In advising doctors regarding their physical fitness to practise, one can only express an opinion. Fortunately, today there is better financial provision for doctors unfit to practise than there was before the advent of the National Health Service in 1948; another deterrent to continuing practice despite severe disability is the increasing danger of an action for damages by the relatives of patients whose family consider that the unsatisfactory result of an illness or operation may have been attributable to the doctor's unfitness. Nevertheless, to many disabled and older doctors their work is their life; they are still capable of giving devoted and efficient service to their patients and any attempts to impose an age limit or require something similar to the annual test for cars would be against the interest of both patients and doctors.

Psychiatric disorders

There can be no doubt that much medical incapacity for work results from affective disorders and abuse of alcohol and drugs. The latter was acknowledged by the General Medical Council in its evidence to the Merrison Commission in 1973 (*Committee of Inquiry into the Regulation of the Medical Profession,* 1975), and the Office of Population Censuses and Surveys reported a Standard Mortality Ratio for 1970-72 of 311 for cirrhosis of the liver for doctors in England and Wales, while for suicide it was 335 and for accidental poisoning 818 (OPCS, 1978). Murray, in his excellent study of 41 doctors treated for alcohol abuse at the Maudsley, showed how poor the prognosis is and in another study in Scotland found the admission rate of doctors to

hospital more than twice that of others in Social Class I (Murray, 1978).

There are many difficulties. Firstly, even the most experienced clinicians may fail to recognize that alcohol or drug abuse is the problem. Secondly, even if they do, it may prove impossible to influence the situation, the patient being unable or unwilling to alter his or her habits. Even in mania and depression, recognition of the nature of the illness may be delayed and the doctor reluctant to accept treatment.

When the request for help comes from the spouse, family or employers rather than the patient, suspicion of alcohol or drug abuse or an affective disorder should always be aroused. Unpunctuality, untruthfulness, paranoia, marital warfare, job difficulties, debt and depression should reinforce the awareness that a high intake of alcohol may be the real problem. Non-specific symptoms and signs such as lack of energy, diarrhoea, anorexia, nausea and insomnia, the facies, the breath, hepatic enlargement and inco-ordinate tremor add confirmation. A few words alone with the spouse is often all that is required but, if there is still doubt, the blood alcohol, serum aspartate transaminase, serum urate and mean cell volume are helpful. The gamma glutamyl transpeptidase, though commonly raised in those with a high alcohol intake, is frequently elevated for other reasons and is a less reliable marker (Whitehead *et al.*, 1978).

Recurrent road traffic accidents and a reduced work output suggest the possibility of drug abuse. Regional poisons laboratories will usually be able to confirm or refute such suspicions from blood and urine examinations, but the electroencephalograph will often reveal an abnormal pattern for which there is no other explanation.

Where the diagnosis of alcohol or drug abuse is missed, it is not a serious error, as it is only those who admit their difficulties and ask for help who are likely to show any response to treatment.

References

Committee of Inquiry into the Regulation of the Medical Profession (1975). Chairman: A. W. Merrison. London: HMSO.

Doll, R. & Peto, R. (1976). Mortality in relation to smoking: 20 years' observations on male British doctors. *British Medical Journal,* **2,** 1525-1536.

Murray, R. M. (1978). The health of doctors: a review. *Journal of the Royal College of Physicians,* **12,** 403-415.

The Registrar General for England and Wales (1978). *Occupational Mortality (1970-72).* Decennial Supplement. London: HMSO.

London Health Planning Consortium (1981). *Primary Health Care in Inner London.* Chairman: E. D. Acheson. London: LHPC.

Whitehead, T. P., Clarke, C. A. & Whitfield, A. G. W. (1978). Biochemical and haematological markers of alcohol intake. *Lancet,* **1,** 978-981.

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