Book review

DOCTORS AS PATIENTS
Michael Shooter (Foreword), Petre Jones (Editor)
Radcliffe Medical Press, 2005
PB, 216 pages, £24.95, 1-85775-887-0

This is a book about mental illness in doctors — written by doctors with personal experience of mental illness. The editor Petre Jones, a practising GP in London, has written a very useful chapter on setting up a practice to enable support and flexible working among partners.

It starts with a foreword by Mike Shooter, President of the Royal College of Psychiatrists:

> *'Is it too much to hope that the climate of the NHS itself might change, from one in which demands are made of doctors that they would not dream of making of their patients, to one in which doctors can be patients too, without fear of what it might do to their career?'*

Looking towards the media, labels such as '"mentally ill" health professional' and high-profile cases such as that of Beverly Allitt come to mind. The Allitt case led to the Clothier Report, which recommended that people should not be employed if they had been mentally ill in the past 2 years. This has since been amended. However, there is significant discrimination and a reluctance to seek help from those within the medical profession. A study by Caplan in 1994 showed that 47% of the doctors taking part in the study had high stress levels, and 29% were suffering from clinically significant levels of stress.[1]

And it is not just doctors. A report published by the Mental Health Foundation showed that nearly half of the country's secondary school teachers have suffered mental health problems.[2] Mental illness is, therefore, common. But there is a climate of fear against mentally ill people, precipitated by the reporting of cases, such as that of John Barrett, which has lead to the government's controversial Mental Health Bill. A lot of money has been spent by the government on protecting us from 'these people', even though cases of mentally ill people who kill are extremely rare. But what about spending money on helping the millions who are affected? Funding has recently been withdrawn from SANELINE, a national helpline set up to help people with mental distress.[3]

In this climate, writing this book has taken a lot of courage — especially for high profile doctors such as Mike Shooter, who has publicised his own experiences of depression in order to try and create change.

Doctors have also been shown to be more likely to commit suicide than other professionals, and so quite clearly, something needs to be done. The message from the doctors who wrote this book is that the 'something' is not, at present, adequate. It can be seen from the personal stories that often it is difficult to seek help away from where the doctor is working. There is stigma from within the profession, and the climate can be such that doctors have to seem 'invulnerable'. As well as this, there is the fear of loss of career and earnings. GMC health procedures are perceived to be unsuitable and too punitive.

The 2003 inquiry into the extended suicide of Daksha Emson made recommendations into reducing the stigma (that doctors and senior managers can be perceived as being prejudiced against staff with mental illness), setting guidelines on doctor-to-doctor treatment and care by making recommendations on the nature and structure of services for doctors with physical and psychological illnesses, and by strengthening occupational services by setting standards and monitoring quality.[5]

Hopefully, *Doctors as Patients* will further reduce stigma. Written largely in a narrative style, it begins with personal stories by practising doctors. The stories have many common themes, including how mental illness need not be a bar to working as a doctor, and how 'the invulnerable doctor is a myth'.

The second part of the book includes chapters on stigma and discrimination, issues for medical students and schools, and GMC health procedures. The final section is on: dealing with mental illness; ongoing support; relapse prevention; flexible working; the financial cost of illness; employment issues; the doctors support network; and finally, a very comprehensive resources section. There are many poems running throughout the book.

I particularly found the section on financial support interesting because as doctors, we may be complacent that we are coming into a profession that has good job security and a low unemployment rate. Although we may refer many of our patients to social services and sign, for example, DLA forms, how many of us would know how to claim benefits or know what we are entitled to from the NHS if we were suddenly to lose our jobs due to ill health? Mike Shooter wrote:

> *'Following my consultant around the wards one night, I watched him take a dying patient in his arms and comfort him in his loneliness and his terror. "I can't do that", I thought. "I shall never be a doctor." I can now, because so many people have cradled me when I have needed it over the years.'*

Hopefully people suffering from these illnesses will be able to use this as a valuable reference book, as well as understanding that they are one of many. They are not alone and can receive support.

I think this book is a highly valuable resource: I hope that policy makers, doctors, medical students and people who may be supporting doctors with illnesses will read this and further their understanding.

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RCGP/Boots Research Paper of the Year Award

Some people think people who read academic journals are sad. I find reading articles less fun than seeing patients or teaching students, but infinitely preferable to marking exam papers or answering emails. And it's much more fun when they are good articles in your own discipline, with that edge of competition added by having to decide which is 'best'. And then you get to go to the RCGP for half a day and have fiery debates about their pros and cons with clever colleagues. And THEN people are pleased to win! Ah the joys of being on the awards panel for the Research Paper of the Year.

But enough of process issues. We had another very varied set of papers of high quality and exemplary rigour, and couldn't choose between the final two winners, which clearly both deserved the prize. It was pleasing to see that both had come out of regional investment in primary care research, and were deeply grounded in routine GP issues, while employing widely differing methods and being about very different issues. Hussey *et al*[1] used qualitative approaches to encourage in-depth reflection and debate about the role of UK GPs in sickness certification — contested territory. It can be uncomfortable in its need to make views explicit in ways that can be disruptive if the patient is vulnerable psychologically, or even just diffident about their return to work. Greaves *et al*[2] threw down a more direct gauntlet, showing how a simple screening based on the link between glucose intolerance and high BMI can improve early detection and potential modification of the pathway towards insulin-dependent diabetes.

The implications for practice may be debated — I can hear a few cynics muttering 'tell them to stop malingering/we've got enough to do without testing our fatties'; while other more tender souls may say 'just sign the paper/why medicalise them before we have to treat them'. But we agreed that the value of these papers (and many others) lay in part in the fact that they made us think. So much of practice is routine, driven by external imperatives: stopping to think about how to make our work both more thorough and to maximise patient benefit is the gift of reading research and exchanging views on best practice with colleagues. It is also the duty of general practice to aim to maximise therapeutic benefit to our patients across a broad range of psychosocial as well as biological risk factors, and both our papers have implications for how we motivate ourselves and patients to regain and maintain health. They both demand a dialogue that makes our 'doctor' view visible to our patients — exposing tensions, discussing barriers to recovery, risking anxiety in the hope of motivating healthier habits. And similarly, perhaps choosing NOT to act as an agent of the state, or as a population health specialist, but to at least remember that every choice we make to act or not has implications for our patients and their wellbeing. Excellent work, and well worthy of the award.

Amanda Howe

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