fad. On the contrary, there is a well-established and growing international transdisciplinary body of knowledge. In the US, for example, the entire healthcare sector has been transformed during the past 25 years as a result of the application of this research.

The Center for Health Design (http://www.healthdesign.org), based in California, is a recognised international resource that has compiled much of this research and has documented its influence on the overall healthcare industry. Its more significant resources include the meta-study by Ulrich and Zimring[4] and publication of the journal *Healthcare Design*.

Indeed, closer to home and within the Greater London area, there is a legacy of primary care practices that have intentionally and successfully used the environment to improve health: The Pioneer Health Centre and The Finsbury Park Health Centre (both 1930s); the Bromley-by-Bow Healthy Living Centre (established in 1984) and the Lambeth Community Care Centre (established in 1985).

In the realm of general practice, the active cultivating of 'generative space' for patients and their families, staff, clinical practitioners, and the overall local community can be aspired to as a new benchmark. Perhaps the establishment of this benchmark in the mainstream is a decade, or so, into the future. Nevertheless, it is already showing up on the radar screens of the top-of-the-class practitioners, and the leaders in the field are investing their time and money to learn more about this.

As idealistic as it might sound today, the future will see 'generative' GP practices dotting the landscape like lighthouses punctuating the nightime seacoast. As far as their 'generative' beams of life-enhancing professional practice reach deeply into the very workings of their respective local communities, they will function as health and wellbeing generators, transforming their contiguous local economies into actively flourishing hives of creative human enterprise.

Wayne Ruga,
International Executive Healthcare Architect, based in Manchester. Founder and President of The CARITAS Project.

REFERENCES

1. Rice G, Ingram J, Mizan J. Enhancing a primary care environment: a case study of effects on patients and staff in a single GP practice. *Br J Gen Pract* 2008; **58**: 465–470.
2. The Caritas Project. *The leading by design research project*. US: The Caritas Project, 2008. http://www.thecaritasproject.info/leading_jacques.html (accessed 05 Jun 2008).
3. Royal College of General Practitioners. *RCGP confirms next steps for practice accreditation scheme*. London: RCGP, 2006.
4. Ulrich R, Zimring C. *The role of the physical environment in the hospital of the 21st century: a once-in-a-lifetime opportunity*. http://www.healthdesign.org/ research/reports/physical_environ.php (accessed 2 Apr 2008).

DOI: 10.3399/bjgp08X302961

ADDRESS FOR CORRESPONDENCE

Wayne Ruga,
Founder and President, The CARITAS Project, PO Box 4309, Deerfield Beach, Florida 33442, US.
Email: wruga@post.harvard.edu

Do you have your own doctor, doctor?
Tackling barriers to health care

Doctors are more at risk of mental ill-health than the general population.[1] The risk of suicide is higher than the general population, especially among GPs, anaesthetists, and psychiatrists.[2] Studies from North America suggest that 8–18% of doctors will be affected by drug or alcohol abuse during their lifetime.[3] So the way that doctors do or don't access health care is important — for them, their families, their colleagues, and ultimately, for their patients. An article in this issue[4] reviews the literature on health behaviours of doctors and the barriers they experience in accessing care.

The review is timely in that the 2007 white paper, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century*[5] proposed a strategy for improving the health of health professionals. This will include appropriate prevention and early intervention for health concerns, promoting easier uptake of services and assuring confidentiality. In 2006 the Chief Medical Officer[6] recognised deficiencies in the provision of care to doctors impaired by mental health and addiction problems. In addition, the Department of Health published a report this year on mental ill health in doctors;[7] this was a response to the inquiry[8] into the suicide of a young psychiatrist with serious mental illness who received sub-optimal care.

Dating back to 1994, a variety of reports in the UK, from the Nuffield Trust,[9,10,11] the General Medical Council (GMC),[12] and the British Medical Association (BMA)[13] have identified the particular health needs of doctors and the barriers they experience in accessing care.

THE BARRIERS

The review by Kay *et al*[4] notes that there is little data on doctors' health access behaviours and the barriers they experience. It does, however, provide some useful pointers. Factors that affect access to health care by both doctors and their patients include self-care, concerns about confidentiality, lack of time, costs in accessing care, fear, and embarrassment about the triviality of the condition. Those with mental health problems experience these barriers more severely.

Additional barriers for doctors identified

in the review are concerns about the quality of care they may receive and that their specific needs as a doctor–patient will not be recognised. While most UK doctors are registered with a GP, some choose one who is a relative or practice partner. 'Corridor consultations' occur and doctors may not get preventive care or the care for chronic conditions that would be available to their patients. Doctors feel the pressure from peers and their community to be healthy. They lack training in seeking care for themselves or in treating doctor–patients.

THE RESPONSE

To tackle these problems, it is important to identify current resources, and identify what more might be required.

What's available now?

Many doctors will choose to use their GP. Doctors using health services, like all other patients, need to be assured that the doctor who is treating them fully understands the limits of their competence and will refer on if necessary. Many clinicians do find treating their own peers to be uniquely challenging, and may experience real problems in probing those health beliefs which may lead doctor–patients to over- or under-diagnose their own illness, or to fear the worst (and rare) diagnosis from common symptoms. Ultimately, doctors need high-quality care like any other patient. While doctor–patients are of course not unique in being challenging, nevertheless there is clearly a place within training and education to discuss these concerns. As in any consultation, the good practitioner will probe the patient's ideas, concerns, and expectations, and this may require appropriate assertiveness, an ability to negotiate and a willingness to take responsibility where this is needed. The potentially difficult issue of knowing when and how to confront a colleague who may be ill needs to be considered in the training of health professionals in many specialties.

When doctors are sick they may need to take time away from work, as they would advise their patients to do, but there can be real difficulties in taking time off, particularly for GPs. A doctor treating a work colleague may feel a conflict when the advice they provide has consequences for his or her own workload. Personal and/or practice financial consequences may be serious and doctors may need help to plan for income protection and sickness insurance.

More use could be made of specialist services for doctors already in place. These include the BMA helpline, Doctors for Doctors, support schemes set up by some colleges, and peer support groups such as the Sick Doctors' Trust, British Doctors and Dentists Group, and the Doctors' Support Network. In addition some deaneries fund services, for example MedNet (London), House Concern (Newcastle), Take Time (Leeds), Medic Support (Oxford), and the Individual Support Programme (Wales). Local medical committees may also offer help.

Occupational health services are available to some doctors but are often poorly used. Their role needs to be clarified and promoted, and rules of confidentiality understood. Occupational health doctors also need good consultation skills to handle doctors, which some say are their most challenging client group.

What more is needed?

GMC guidance on doctors' health[14] makes it clear that the GMC expects all doctors to be registered with a GP who is not a family member, but this could be strengthened to exclude registration with a work colleague (except where there is no alternative). The GMC could, and maybe should, advise that doctors attend for a formal consultation when they are unwell, rather than seek informal contact, and counsel against any form of self-diagnosis or treatment beyond that reasonable for any non-medical person. Sickness absence should be properly certified by an appropriate clinician — to do otherwise risks depriving both patient and employer of an optimum level of care.

Doctors need to be clearer about when they have a duty to report a colleague with a health problem to the GMC and when this is not required. Referral to the GMC purely on health grounds is required for only a tiny fraction of doctors who are sick — those cases where a doctor's illness poses a serious risk to the safety of their patients and the individual is unwilling to take sick leave and cooperate with treatment and monitoring of their condition.

The National Clinical Assessment Service has identified health concerns in 20% of cases referred to it.[15] When a doctor is not working to the standard expected, or when their behaviour is difficult with colleagues or patients, there may be an underlying health problem — mental health, alcohol dependence, cognitive impairment, or some other condition. We need to be more aware of this and encourage the individual to seek help.

Medical students and postgraduate trainees should be provided with information about the risks of health problems among doctors, how to identify and manage them, and how the risk can be reduced. They should be warned about factors that may predispose them to ill health, for example, career transitions, workload, and job mobility leading to lack of support from family and friends. Mobility may also lead to difficulty in follow-up of chronic illness, with resulting risks, particularly for enduring mental health conditions. All medical students and postgraduate trainees should be required to confirm GP registration in their application for places. The GMC might reinforce this by setting out the expectation of registration with a GP in its guidance for medical students.[16]

While this is a worldwide problem, in the UK the GMC, the BMA, and the medical royal colleges could do much to raise awareness of the issues. They could help by openly acknowledging that doctors, like everyone else, become ill, that they need to look after their own health and encourage their colleagues to do so.

The BMA is hosting the International Conference on Physician Health in London, 17–19 November 2008. This will be an ideal opportunity to raise awareness about doctors' health in the UK and to promote the lessons from abroad. In the US almost all states have a physician health programme. A prototype

service based on the Ontario model will open in London in October 2008 for doctors unable to access suitable local care for physical or mental ill-health or addiction. It should provide a great opportunity to address at least some of the barriers to health care identified in the review by Kay and colleagues.[4]

Rosemary Field,
Deputy Director, National Clinical Assessment Service, London

David Haslam,
President, Royal College of General Practitioners and National Clinical Adviser, Healthcare Commission

REFERENCES

1. Ghodse H. Doctors and their health — who heals the healers? In: Ghodse H, Mann S, Johnson P (eds). *Doctors and their health.* Sutton: Reed Healthcare Limited, 2000.
2. Hawton K, Clements A, Sakarovitch C, *et al.* Suicide in doctors: a study of risk according to gender, seniority and specialty in medical practitioners in England and Wales, 1979–1995. *J Epidemiol Community Health* 2001; **55(5):** 296–300.
3. Boisaubin EV, Levine RE. Identifying and assisting the impaired physician. *Am J Med Sci* 2001; **322(1):** 31–36.
4. Kay M, Mitchell G, Clavarino A, Doust J. Doctors as patients: a systematic review of doctors' health access and the barriers they experience. *Br J Gen Pract* 2008; **58(552):** 501–508.
5. Secretary of State for Health. *Trust, assurance and safety — the regulation of health professionals in the 21st century.* London: the Stationery Office, 2007.
6. Chief Medical Officer. *Good doctors, safer patients.* London: Department of Health, 2006.
7. Department of Health. *Mental health and ill health in doctors.* London: Department of Health, 2008.
8. North East London Strategic Health Authority. *Report of an Independent Inquiry into the care and treatment of Daksha Emson MB BS, MRCPsych, MSc and her daughter Freya.* London: North East London Strategic Health Authority, 2003.
9. Silvester S, Allen H, Withey C, *et al. Provision of medical services to sick doctors; a conspiracy of friendliness?* London: Nuffield Provincial Hospitals Trust, 1994.
10. Nuffield Provincial Hospitals Trust. *Taking care of doctors' health.* London: Nuffield Provincial Hospitals Trust, 1996.
11. Williams S, Michie S and Pattani S. *Improving the health of the NHS workforce: Report of the partnership on the health of the NHS workforce.* London: Nuffield Provincial Hospitals Trust, 1998.
12. General Medical Council. *Report of the Health Review Group.* London: General Medical Council, 2005.
13. Health Policy and Economic Research Unit, British Medical Association. *Doctors' health matters.* London: British Medical Association, 2007
14. General Medical Council. *Good medical practice.* London: General Medical Council, 2006.
15. National Clinical Assessment Service. *Analysis of the first four years' referral data.* London: National Clinical Assessment Service, 2006.
16. General Medical Council. *Medical students: professional behaviour and fitness to practise.* London: General Medical Council, 2007.

DOI: 10.3399/bjgp08X302970

ADDRESS FOR CORRESPONDENCE

Rosemary Field,
National Clinical Assessment Service, Market Towers, 1 Nine Elms Lane, London SW8 5NQ
E-mail:rosemary.field@ncas.npsa.nhs.uk