How To Do It

Deal with problem colleagues

DAVID ROY

Relationships between medical practitioners, particularly in hospital practice, have always been complex, and attempts by colleagues or health districts to intervene when problems arise often lead to much bitterness and ill feeling. I do not intend to cover occasions when the law is concerned and the matter is dealt with directly by the disciplinary procedures of the General Medical Council, but rather to concentrate on the difficulties encountered by doctors who are mentally ill, including those suffering from alcoholism and drug dependence, and particularly when that illness directly affects the service that they are able to give to their patients. In addition, I shall discuss briefly clashes between colleagues, with particular emphasis on the blurring of issues between difficulties in professional relationships and questions of competence. These cases are much more complex than those concerning sick doctors.

Sick doctors

The medical practitioner's lot is traditionally perceived as a hard one, and few medical students enter their training without some idea, albeit minimal, of long hours on call, difficult life or death decision making, and, more recently, increasingly complex career choices with often dispiriting results. Many practitioners tend to be hard working, certainly ambitious, and to believe at the outset that they have resources to deal with an extraordinarily stressful way of life. Medical schools in the past, however, have tended to play down this aspect of medical practice and so have colluded with the doctors they are training and the profession as a whole in propagating the myth that a good doctor subsumes himself totally to the practice of medicine with disregard for personal health and wellbeing. The emotional needs of doctors have, for the most part, been ignored, and medical students appear to receive little training in these crucial matters. It is not surprising that doctors in general have not been quick to recognise the hazards of illness within the profession and the nature of these hazards, or that the methods of treatment and education deserve special consideration.

It is not easy to obtain data on the proportion of doctors who become mentally ill or develop alcoholism or drug dependence, and it seems that most surveys greatly underestimate the seriousness of the problem. Many doctors seek treatment outside the official information gathering services and it is possible that older doctors, who may be more liable to seek help for alcohol or drug dependence that has developed over some years, will be in a position to do so through the private sector. With the considerable increase in private health insurance this problem becomes more complicated, and the figures that are available from records of admission to NHS hospitals and referrals to confidential medical agencies must surely be the tip of the iceberg.

The commonest problem seems to be alcoholism and, to a lesser extent, drug addiction, with a variety of affective disorders also being diagnosed. Schizophrenia and organic brain syndromes seem to be infrequent. An explanation for this may be that schizophrenic illnesses tend to present at a younger age, and may account for some drop outs from medical school, while organic brain syndromes would tend to predominate towards retirement. Certainly all the evidence suggests that rates of alcoholism, drug dependence, and affective disorders are noticeably higher in the medical profession than in the general population, as is the death rate from suicide and cirrhosis of the liver. The presentation of these syndromes is no different from that in the general population; alcoholic doctors have the same general medical sequelae and psychological problems as anyone else. The only difference may be that, given the doctors' medical training, they are more adept at hiding the problem from their colleagues and possibly, because of their perceived stigma in receiving psychiatric treatment, denying it to themselves as well. Marital disharmony may be an important contributing factor in the onset of mental disorder, or indeed provoked by it, and medicine is not renowned as the profession designed to keep marriages harmonious.

ALCOHOL AND DRUG DEPENDENCE

The available surveys indicate quite clearly that alcohol dependence is the major hazard among doctors. This is hardly surprising considering the high status that alcohol achieves as a drug in medical schools and as a social stimulant in later life.

Quoted estimates in 1978 put the number of alcoholic doctors in the United Kingdom between 2000 and 3000. Given the increase in public awareness of problem drinking, the stringent campaign against drinking and driving, and the recent Royal College of Psychiatrists report on individual alcohol consumption which has resulted in a drastic lowering of the limit considered acceptable, there should be a reduction in these figures. Awareness of uninformed and uncontrolled alcohol consumption has, in the light of the alcohol policy recently formulated, resulted in the British Medical Association establishing a working party to investigate its own wine club.

Drug dependence in doctors is noticeably greater than in the general population and although some of the reasons given by dependent doctors are quoted as stress at work, overwork, and physical illness, detailed profiles of doctor addicts suggest that though they have fewer features of personality disorder than non-medical addicts, they have more disordered personality traits than the general population, and this seems particularly true for poly-addicts rather than monoaddicts.

In a 1967 sample the list of drugs abused was headed by amphetamines and barbiturates, with heroin and methadone trailing. The pattern of drug use has changed considerably since then and with the dramatic reduction in the prescription of short acting

Goodmayes Hospital, Ilford EG3 8XJ, and Medical College of St Bartholomew's Hospital, London EC1A 7BE
DAVID ROY, MRCPSYCH, consultant psychiatrist and senior lecturer

barbiturates and the greater control of prescriptions for amphetamines, that list must look quite different now, with the benzodiazepines and heminevrin possibly leading the field.

DEPRESSION

A recent study of 55 cases of suicide by doctors under 40 confirmed an excess mortality over that in the general population. There has, however, been a decline in the number of suicides by men, which is in line with national trends, but this was not evident in suicides by women and particularly so for young women doctors born overseas. They appear, on the evidence of this small but up to date study, to be at highest risk. A number of reported studies over the past 10 years have suggested increased vulnerability in individual specialities, with anaesthetists, psychiatrists, and pathologists being thought to be at greater risk.

The concept of "burn out" has gained currency in recent years. This syndrome can occur 10-15 years after practitioners are appointed to consultant posts and is often the result of waging the same battle over many years against a background of ever tightening resources within the NHS, complicated bureaucratic procedures, and an erosion of professional status. The rapid turnover of support staff with increasing difficulties of recruitment, a new management structure which many clinicians feel undermines their areas of influence, and the large patient load which is increasing in the face of diminishing resources, often lead to feelings of isolation, helplessness, pessimism, and inertia. Occurring at a time of great vulnerability, particularly for men doctors, this syndrome may explain the continuous, albeit reluctant, move of senior consultant staff from the NHS into private practice, and account for some of the increase in alcohol/drug dependence and depression.

PROBLEMS IN TREATMENT

Doctors make bad patients. They find particular difficulty in accepting the role of patient and there are certainly many professional tensions which arise between the doctor as patient and those who care for him, be they doctors, nurses, or others. The role of doctor as special patient further complicates an already difficult situation and may lead to early termination of psychiatric care on the part of the doctor. Although on one hand the therapist might be overindulgent or protective, the treatment given may also be cursory because of the reluctance of the physicians to pursue the therapeutic options as vigorously as they would with non-medical patients and this may result in poorer treatment and higher risk.

THE NATIONAL COUNSELLING AND WELFARE SERVICE FOR SICK DOCTORS

This service was set up as the result of an initiative by the president of the General Medical Council and the chairman of council of the British Medical Association in consultation with the royal colleges and their faculties. It is an autonomous organisation which is controlled by a national management committee and has appointed a number of national advisers who are senior doctors representing all disciplines. After an informal contact by the doctor in need, or a colleague, the national adviser, or a nominated specialist, may then contact the sick doctor making an informal offer appropriate to his or her needs and outside the district in which he works. No records are kept at any central point and, should the doctor need continuing treatment, records will be kept only as a part of routine hospital administration. This essential confidentiality will, it is hoped, enable doctors to take up various offers of help.

The Royal College of Psychiatrists has nominated 250 psychiatrists to act as counsellors in addition to 97 national advisers from various faculties.

The telephone number of the national contact point is 01 580 3160.

SICK DOCTORS AND THE GENERAL MEDICAL COUNCIL

Referrals through the national counselling service may fail or the situation may be too serious, and direct notification to the General Medical Council may be needed. For many years the only mechanism of notification was a formal one with a punitive referral to the council's disciplinary body, and health districts are instructed to have a procedure known as "three wise men" available whereby consultant colleagues, one usually being in the same discipline, are asked to make an assessment with particular emphasis on "illness." More recently an informal confidential procedure has been introduced whereby health authorities or professional colleagues (through the "three wise men") can initiate the screening of a potentially sick doctor by examiners appointed by the council. These medical examiners (two in each case) will report back to the preliminary screener on the doctor's fitness to practise and it may then be thought appropriate to impose certain conditions, such as the doctor accepting limitations on his practice while undergoing treatment. A medical supervisor, who may or may not be the doctor's treating physician, would keep the case under review reporting back to the preliminary screener and, should satisfactory progress be made, no further action will be taken. Should these informal and fairly benign procedures break down it would then be necessary for the case to be referred to the health committee, which may take statutory action by imposing conditions such as suspension. Only at this stage would notification of such a condition be passed to regional health authorities.

HEALTH EDUCATION AND THE MEDICAL PROFESSION

It is clear that doctors face considerable and particular health problems with attendant social and emotional consequences. Some medical schools have introduced counselling services for students, while others will only deal with the more serious problems when a student's performance is suffering. These necessary introductions are hardly innovative, and have lagged far behind the university campuses, polytechnics, and colleges, where such services are an integral part of student life. This may highlight a problem in attitude on the part of the medical schools towards the emotional needs of their students, who will be the doctors of the future facing the appreciable health problems outlined in this article. Medical students should be encouraged to take part in counselling courses, which will not only teach a technique basic to the practice of medicine, but enable students to engage in frank discussion of emotional issues. There is little discussion in schools of those aspects of medicine which do not appear in the textbooks, such as career choice and the increasing number of doctors failing to achieve their chosen discipline, management, relationships with colleagues and paramedical professions, being part of a team, and so on. Many of these issues will or should be part of specialist training in hospital, but the groundwork needs to be laid to avoid later problems. A straw poll among recent graduates from various medical schools indicates that they do not, on the whole, think that their medical schools deal with these issues satisfactorily, which is disappointing, particularly as pilot schemes have been introduced in some schools with success—although in others they have met with considerable resistance from the teaching staff and consultant body. The fact that most young graduates recognise the problem indicates that the schools are going some way towards facing it and they should be wholeheartedly supported in this.

Issues of competence and problems of professional relationships

In contrast to those cases concerning sick doctors, problems of competence have caused major difficulties in the NHS and there is considerable blurring of the issues in what can often become a cause célèbre, particularly where referral to the General Medical Council is not appropriate.

The source of this confusion is a document entitled *Disciplinary*

Proceedings in Cases Relating to Hospital Medical and Dental Staff (HM(61)112). Originally circulated to health authorities in 1961 by the Ministry of Health, this document remains unchanged since that time. The fact that the health service has moved apace, as has society, seems to have gone unnoticed. The document establishes, though by no means clearly, a series of steps starting from preliminary investigation for the establishment of a prima facie case and progressing through to a formal inquiry. These inquiries are formal and legalistic, requiring a high standard of proof, with many rights enshrined for the consultant under investigation, including the ability to comment on the proceedings, to make a plea of mitigation, and to appeal to the Secretary of State. In practice this results in years of delay and excessive cost to the various health authorities. There are currently approximately 40 NHS consultants suspended on full pay pending such inquiries, and this could add up to a cost of £4 000 000 to the health service. There is certainly a case to be made for reviewing this disciplinary procedure which benefits neither the doctor nor the service. Until we have a clearer system which has the support of consultants and health authorities, difficult and often painful cases will continue to arise in which problems of competence may be confused with difficult relationships and interpersonal problems.

Teaching districts and university based medical schools have different disciplinary procedures. The teaching districts' consultant contracts are district based and disciplinary procedures receive the attention of the district medical officer rather than being directed to the region, while teaching hospitals may direct problems through the university disciplinary procedure. Cases concerning professional conduct and competence in general practice will be directed to the family practitioner committee.

Conclusion

It seems that the procedure for dealing with a sick doctor has improved in recent years, although the reasons for doctors' greater vulnerability to particular health problems have received little attention, especially in medical schools. Where illness is not an issue, however, the position is clearly unsatisfactory and in need of change.

Basic Molecular and Cell Biology

Stem cells in normal growth and disease

T M DEXTER

Mature blood cells have a short life span. Erythrocytes, for example, are functionally active for only a few months before being sequestered and destroyed, and granulocytes persist for only a few hours. In practical terms this means that about $3{\cdot}7\times10^{11}$—that is, 370 000 million—mature blood cells are lost each day.[1] Cell loss of a similar magnitude undoubtedly occurs in other regenerating systems such as the skin and intestine.[2] Obviously, these cells need to be replaced to maintain the integrity of the various body tissues, and some mechanism is required to ensure that the means of cell production is maintained throughout a normal lifetime. The mature cells of the regenerating tissues are highly specialised cells which are themselves incapable of further growth. Their numbers must therefore be replaced through proliferation and development of more primitive cells, known as stem cells.

Origin of stem cells

Two models have been proposed to explain the persistence of stem cells throughout life.[3-5] The first model suggests that a fixed number of primitive cells is laid down during embryogenesis to supply the body's needs throughout its lifetime. These cells are randomly recruited into proliferation, differentiation, and development as required—like the recruitment of oocytes. As these stem cells proliferate there is a progressive loss in their ability to produce more stem cells or to act as founder cells of the various mature cell lineages—in other words, the stem cell pool declines with age. The second model also suggests that a small population of stem cells arises during embryonic development but that these cells can reproduce themselves (undergo self renewal) to produce daughter cells which retain the same proliferative and developmental potential as the original parental cells. In this model, therefore, the recruitment of stem cells into proliferation and development does not necessarily lead to a reduction in the number of stem cells. The weight of evidence strongly supports this second model of a self renewing stem cell population.[6,7] The critical point here is that birth and death processes must be balanced: the input of cells into the stem cell compartment must be balanced by exit from the stem cell compartment as a consequence of differentiation and death.[8] It follows that a prolonged, albeit minor, perturbation in this balance would have dramatic consequences. If too many stem cells underwent self renewal then the production of mature cells would be reduced to life threatening levels; if too many stem cells underwent differentiation and development then the small pool of stem cells would rapidly become exhausted. It is clear, however, that some degree of flexibility must be built into the system to allow for the extra proliferative demands imposed by stress conditions such as hypoxia or wound healing. How, then, are the regenerating tissues organised? Many lessons have been learnt from the haemopoietic system, and this will be used as an example, although a similar cellular organisation is seen in the skin epidermis and the intestinal epithelium.

Paterson Institute for Cancer Research, Christie Hospital and Holt Radium Institute, Manchester M20 9BX

T M DEXTER, DSC, MRCPATH, professor of haematology