

Impact of hospital consultants' poor mental health on patient care

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SUMMARY

This short report is an offshoot from an important paper published two years ago.¹ A confidential postal questionnaire was sent to 1,794 UK hospital consultants in 2002, the sample comprising all oncologists, and randomly chosen gastroenterologists (2 in 3) and radiologists (1 in 5). The survey sought information about mental health and harmful drinking using standardised screening tools, and about impaired clinical practice assessed by self-reported irritability to patients or colleagues, and failings in standard care. A 73% response rate was respectable. The prevalence of psychiatric morbidity assessed by the GHQ-12 was 32%, which accords with other surveys. Sixteen to eighteen per cent of consultants reported drinking hazardous amounts of alcohol measured by the AUDIT, irritability towards patients, reduced standards of care, and planning for early retirement. These features varied with gender and age, but all were independently associated with psychiatric morbidity.

The authors commented on the design weaknesses inherent in this type of survey, but were confident about the representativeness of their sample. The headline prevalences of mental disorder and alcohol abuse support this conclusion given their consistency with previous surveys. The fact that middle-aged men were particularly at risk was also known. What was new knowledge was the impact of mental health problems on patient care, albeit this relied on self-reporting with an assessment tool that lacks the credentials of the GHQ and AUDIT.

OPINION

This paper's importance lies not in its findings but rather in highlighting the need to act on what has repeatedly been

shown about the prevalence of mental ill health and alcohol abuse among doctors, for their patients' sakes as well as their own. Mood illness and substance abuse are by far the most common diagnoses made in doctors whose ill health comes to the attention of the GMC: how many would have been spared this ignominy and stress if their disorder had been identified earlier? Unless the doctor self-presents, nothing is done until a problem emerges, and by then it can be too late: the high rate of suicide in the profession, as well as the ruination of careers and harm to patients, testifies to this.

While there are mentally ill or alcoholic doctors who intentionally hide their condition and have to be caught out and confronted, for many, the features of mild depression or a hazardous level of drinking go unrecognised or misattributed. It becomes normal to feel hopeless, constantly tired and low, or to drink a bottle of wine after a day's work. Helping these colleagues identify their problem shouldn't necessitate instant referral to a psychiatrist or AA, nor antidepressant medication or sickness absence. Brief interventions that include recognition, support, problem-solving and changing behavioural patterns will often be all that is required.

Doctors would benefit from incorporating screening scales, such as the GHQ and AUDIT, in the health component of clinical appraisal. Of course, key issues like confidentiality, voluntariness and follow-up pathways would have to be resolved, but the principle of proactivity to prevent damage is surely paramount. Ignorance is rarely blissful for these colleagues.

REFERENCES

- 1 Taylor C, Graham J, Potts H *et al.* Changes in mental health of UK hospital consultants since the mid 1990s. *Lancet* 2005; 366: 742–4.