

Editorials

All doctors are problem doctors

Doctors worldwide must do better with managing problem colleagues

Britain has in the past few weeks heard much about "problem doctors,"^{1 2} and a book has just been published on the subject.³ The public reaction to the cases reminds us that self regulation for doctors is not a right but a privilege that has to be deserved every day. And the book makes clear that doctors worldwide do badly with managing their problem colleagues. It also shows that in a sense all doctors are problem doctors. That is why we do so badly.

A fatal accident inquiry in Scotland heard how surgeon Gerald Davies operated on patients when he had a blood alcohol concentration that was probably twice the legal limit for driving¹; while Britain's General Medical Council struck off obstetrician and gynaecologist Patrick Ngosa for continuing to treat patients when he was infected with HIV.² Both cases led to calls for compulsory testing of doctors for alcohol or HIV, and the sheriff hearing the Scottish case observed: "There appears to be a culture among members of the medical profession where it is regarded as inappropriate ... to report on certain matters, including in particular a colleague's apparent excessive drinking."¹ *Sun* columnist Anne Robinson put it more starkly: "In truth there is not a single reason to suppose these days that doctors can be trusted any more than you can trust British Gas, double glazing salesmen, or the man in the pub."

We shouldn't be surprised by problem doctors. Why wouldn't they exist? Think how surprised we would be by a community of 130 000 people (the number of doctors in Britain) where nobody committed terrible crimes, went mad, misused drugs, slacked on the job, became corrupt, lost competence, or exploited their position. Such a community cannot be imagined. And yet doctors often behave as if they are surprised by the existence of problem doctors. We choose to turn the other way rather than understand and develop ways of responding.

The new book shows that no country has an adequate system for managing problem doctors. British doctors, for instance, have been regulated by the General Medical Council for well over a century, but the council is only now introducing a system for dealing with poorly performing doctors. In the United States problem doctors can skip from state to state, always one jump ahead of the regulatory machinery. Swedish researchers conclude that there has not been enough emphasis in the Nordic countries on tracking problem doctors and taking preventive action. The Canadians observe that bad doctors are insensitive to the threat of discipline whereas good doctors are needlessly worried by it.

Self regulation is the main distinguishing feature of a profession. The unwritten social contract says: "You have special skills and wisdom. You have unequalled access into the intimacies of people's lives. It is important that the state should not seek to control the development of your professional wisdom or interfere as you deal with the most profound of human difficulties. We therefore trust you to regulate yourselves. These special privileges are given in exchange for special service."

And perhaps self regulation is part of the problem as well as part of the solution. Doctors are set apart. We are a

priesthood with our own rites, beliefs, systems of initiation, and tribal practices. And we have special powers. The public turns to us in moments of extremity and expects an answer, even a solution. Often we cannot provide it. We cannot defeat death, sickness, and pain. Everybody within the priesthood knows its vulnerability. But the public doesn't want to know too much about that vulnerability. They hope we can deliver, and we want to. Indeed, our privileges depend to some extent on us being able to. We are thus permanently conflicted: expected and wanting to deliver but often not able to.

Against this backcloth we can understand why doctors have such difficulties dealing with problem doctors. We are all problem doctors. And even if we aren't problem doctors today we might be tomorrow. Who wants to criticise a colleague in such circumstances? We understand how they grapple with the most awful difficulties with limited means, and we don't want to condemn them. We would rather turn away until we are forced—by criminal proceedings, publicity, or ghastly consequences for a patient—to act. Then we will, but reluctantly.

Marilynn Rosenthal—a sociologist who has made a special study of problems doctors in Britain, the United States, and Sweden—describes this phenomenon in the book. Through her ethnographic studies she has identified how doctors practice in a state of "permanent uncertainty" and must accept that "fallibility ... [is] an intrinsic part of the practice of medicine." All doctors have made mistakes, often serious ones, and their experiences "create a powerful pool of mutual empathy and an unforgettable sense of shared personal vulnerability." Living this way, doctors are unsurprisingly "quick to forgive," and "non-criticism" is the norm. "Where uncertainty surrounds all members of the profession daily and all see themselves vulnerable to accidents," writes Professor Rosenthal, "it is not difficult to understand a tacit norm of non-criticism, a conspiracy of tolerance."

Although readers of the book will understand why the medical profession has dealt so badly with problem doctors, that understanding cannot be an excuse. Doctors have to do better, and they need help from managers, lawyers, and sociologists. As always, the first step must be to acknowledge, understand, and define the problem. Next must come prevention. Although each country must have good systems for detecting, helping, managing, and sometimes removing doctors with serious problems, the main emphasis must be on preventing the development of serious problems in doctors.

The most crucial step in prevention is to recognise that, far from being less likely than ordinary members of the public to develop serious problems, doctors are in some ways more likely to. Doctors have the good health that goes with wealth, status, and rewarding employment. But young people are sometimes attracted to medicine by the care they have received when ill themselves. It may be that those who are afraid of death gravitate towards a profession that seems to be trying to defeat death, or that those with poor mental health want to join a group trying to understand the vagaries of the mind.

Once they arrive, medical students are put through a gruelling course and exposed younger than most of their non-medical friends to death, pain, sickness, and what the great doctor William Osler called the perplexity of the soul. And all this within an environment where "real doctors" get on with the job and only the weak weep or feel distressed. After qualification, doctors work absurdly hard, are encouraged to tackle horrible problems with inadequate support, and then face a lifetime of pretending that they have more powers than they actually do. And all this within an environment where narcotics and the means to kill yourself are readily available. No wonder some doctors develop serious problems.

The medical profession in each country needs to develop a long term strategy for preventing or at least reducing

problems in doctors. One strand of the strategy should be to help the public and applicants to medical school understand better the limitations of medicine. This should reduce the pressures on doctors but also help people recognise the need to take more responsibility for their own health. Those who seek a career in medicine because of some special vulnerability should not be denied entry but should be given greater support from the beginning. We need to move from a culture that encourages doctors to hide distress and difficulties to one where we learn to share them and ask for help. Perhaps this will happen inevitably as medicine becomes less male dominated. Medicine also needs to move to a culture that encourages healthier working patterns, with shorter hours, better appraisal and guidance, and more flexibility.

Developments like these should help both doctors and patients, because problem doctors—as the two recent cases show—harm not only themselves but also their patients.

Richard Smith, *Editor BMJ*^a

^a London WC1H 9JR

This editorial is adapted from the introduction to the new book. I received no fee and will receive no royalties.

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1. Christie B. Inquiry calls for doctors to be tested regularly for alcohol. *BMJ* 1997;314:769. [\[Full Text\]](#)
 2. Dyer C. Doctor who refused HIV test is struck off register. *BMJ* 1997;314:847.
 3. Lens P, Wal G van der. Problem doctors: a conspiracy of silence. Amsterdam: JOS Press, 1997.