IN-DEPTH REVIEW

Doctors’ health and fitness to practise: treating addicted doctors

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Abstract

The literature describing the diagnostic process in the addicted doctor is scant. Figures from North America indicate that the prevalence of alcohol problems in doctors may be no higher than in the population as a whole, whereas high rates of prescription drug use have been recognized. This practice of self-treatment with controlled drugs is a ‘unique concern’ for doctors. The development of substance misuse problems in doctors cannot be reduced to a single factor: Anxiety and depression, personality problems, stress at work, family stress, bereavement, an injury or accident at work, pain and a non-specific drift into drinking have been implicated. Early diagnosis is critical because doctors are often reluctant to seek help and colleagues reluctant to intervene. Medical schools and continuing medical education programmes must give greater emphasis to addiction and substance misuse in doctors with a view to reducing the incidence of ‘impaired physicians’ and promoting and encouraging early treatment and rehabilitation. The relationship between the addiction psychiatrist and the occupational physician is key given that these problems occur at the interface between occupational health and regulatory systems. The need for individually tailored back to work programmes requires careful coordination and monitoring and may be difficult to implement without their involvement. Generally, the prognosis for doctors’ recovery is good and it is possible to predict which doctors will ‘make it’.

Key words

Addicted doctors; addiction; alcohol and drug dependence; occupational health physicians; policy implications; prevention and detection; risk factors for substance misuse; treatment systems.

Introduction

The literature describing the diagnostic process in the addicted doctor is scant. There are probably a number of reasons for this, not least the need for discretion and confidentiality which have meant that this work has historically been carried out covertly, ‘under the radar’. Despite this, results from impaired physician programmes in North America, Australia and Spain are encouraging, with up to 75% of treated doctors being drug free and practising at follow-up periods of between 2 and 8 years [1–8]. Such programmes facilitate access to help and treatment, while emphasizing the need for confidentiality, long-term supervision and monitoring and membership of self-help groups.

Epidemiology

Reports of problems with alcohol and drugs among doctors are not new. In 1869, Sir James Paget reported on the fates of 1000 medical students whom he had taught between the years of 1839 and 1859. Of the 56 who failed entirely, 10 had done so ‘through their continuance in habits of intemperance or dissipation as had made us, even while they were students, anticipate their failure’ [9].

Figures from North America indicate that the prevalence of alcohol problems in doctors may be no higher than in the population as a whole [10,11] and rates of illicit drug use less. However, high rates of prescription drug use have been recognized, mainly opiates and benzodiazepines, in the context of self-medicating stress [12]. This practice of self-treatment with controlled drugs is a ‘unique concern’ for doctors, not least because of its potential to increase the risk of drug misuse and dependence [12,13].

Addiction problems extend across all specialities, to every grade of seniority, although some series have suggested that anaesthetists and family doctors may be at greater risk [4]. Comparative studies from North America have shown that psychiatrists and emergency medicine doctors have the highest rates of multiple drug use [14,12].

No large scale prevalence studies have been carried out in the UK, although it has been reported that as many as ‘one doctor in fifteen may be affected by drug or alcohol dependence problems at some point during their careers’ [15]. The perception in the British Medical Association report was that these doctors were mainly male, beyond

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the midpoint in their careers, and more likely to be in general than in hospital practice [15].

A retrospective case note study of 144 doctors (14% women) with substance misuse problems, seen at the Maudsley Hospital, London between 1969 and 1988, included doctors from a variety of specialities and grades of seniority [16]. The mean age at presentation in this clinical sample was 43.1 years (range 24–69 years), by which age the doctors had been experiencing problems with drug and alcohol use for 6 years on average. Alcohol was the major substance problem for 42% of the sample, drug misuse the main problem for 26% and combined drug and alcohol use the main problem for 31%. The drugs used were typically pharmaceutical preparations rather than black market supplies: opiates (30% of all subjects), barbiturates (24%), benzodiazepines (21%) and amphetamines (15%). The most frequently recorded pathways into substance misuse were personality difficulties (53%) and anxiety or depression (32%) [17]. Non-specific drift and family stress were recorded for 26% of subjects, stress at work was recorded for 23% and pain and bereavement were recorded in 10 and 9% of subjects, respectively. No differences were found between general practitioners (GPs) and hospital doctors. Consultants were older at onset of problematic use: they suffered fewer career problems and misused fewer substances than doctors from non-consultant grades. Principal components analysis of antecedent factors yielded one major component, termed the ‘disturbance score’, indicating a continuum of vulnerability to substance misuse across all age groups, suggesting that emotional problems were of major aetiological importance.

A more recent study from the same postgraduate centre reported on 62 health care professionals (21 doctors) referred over a 12-month period to a newly set-up dedicated drug and alcohol treatment service [18]. More than half of the interviewed sample \(n = 27, 59\%\) presented with a primary alcohol problem and 19 \(41\%\) presented with a drug problem, the main drugs being opiates or anesthetic agents. Almost three-quarters of the professionals reported the use of several drugs \(n = 33, 72\%\), mainly benzodiazepines. Just under half \(43\%\) of the referred professionals had a history of psychiatric treatment prior to referral, with 17 professionals \(27\%\) having had previous treatment for depression. Referral was made by the employer or the occupational health physician in 41% of cases and disciplinary action or threat of disciplinary action was relevant in 30% of cases. Physical, psychological and psychiatric problems were rarely a reason for seeking treatment. Referral often followed an incident involving intoxication at work or persistent absenteeism. The authors highlighted the need for those having responsibility for helping health care professionals (occupational health physicians, consultants in public health and local medical committees) to promote access to treatment and to enable this group to obtain help for their substance misuse problems at an earlier stage.

### Risk factors for the development of substance misuse problems in doctors

The development of substance misuse problems in doctors cannot be reduced to a single factor [17]. A number of studies have reported high rates of psychological and psychiatric problems including anxiety and depression. Personality problems, stress at work, family stress, bereavement, an injury or accident at work, pain and a non-specific drift into drinking have also been cited [17] (Table 1).

The relationship between perceived stress at work and substance misuse in doctors appears to be mediated by individual vulnerability [19–21]. Vulnerable personalities tend to deal poorly with their emotions, usually develop unhelpful defense mechanisms such as overwork and denial, and often find themselves professionally isolated. The need to maintain an image of competence often leads to isolation. Doctors are particularly at risk because of their knowledge of and accessibility to drugs, and also their tendency to self-medicate [22–24]. Long hours, the breakdown in family relationships and support are further risk factors. Although addicted doctors feel immense guilt and shame at their substance use, they ‘survive’ at work, using a combination of secrecy, denial and intellectualization.

Privileged access to mood-altering drugs and the ability to self-prescribe facilitate polydrug use in doctors. This occupational hazard is underrecognized and under-diagnosed. Even the most astute clinician may fail to take a urine sample when the (secretly) addicted doctor presents in crisis. Recent examples which come to this writer’s mind include a trainee doctor presenting in an acute confusional state while on-call, a doctor who experienced a generalized seizure while working in an intensive therapy unit and a doctor reported as ‘smelling of alcohol’ while on-call.

### Clues suggesting a substance misuse problem

Often the first clue is a subtle personality change and/or the development of mood swings or anxiety. Further investigations usually uncover changes in routine, an

| Table 1. Risk factors: pathways |
|---------------------------------|
| Personality problems |
| Non-specific drift into drinking |
| Anxiety or depression |
| Pain |
| Injury or accident |
| Stress at work |
| Family stress |
| Bereavement |
increase in the number of sick days, a loss of efficiency and reliability and perhaps concerns expressed by other colleagues. Intermittent episodes of bizarre behaviour and confusion may also have been noticed but not reported, as they were ‘explained away’ by the doctor in question. Secretaries may report the smell of alcohol (usually denied). Patients may voice tentative concerns, for instance smelling alcohol on the breath of the doctor or querying whether the medication prescribed by the doctor was indeed correct or safe. If concerns about ‘odd or strange behaviour’ are followed up, it often emerges that the doctor has begun to isolate themselves, is working more on their own, or has spent most of a recent shift in the on-call room, telling multiple groups of nursing staff that they were ‘busy elsewhere’. There may be obvious physical changes, with perhaps a tendency to turn up for work in yesterday’s clothes, unshaven or looking somewhat dishevelled. Latterly, memory loss and suicidal ideation may emerge. Other clues suggesting a substance misuse problem include drink-driving charges, frequent changes of address, multiple locum posts and practice outside the UK. Women doctors with alcohol problems often have a family history of addiction, were high achievers at medical school, have undetected depression and are at high risk of suicide [25].

**Why are doctors reluctant to seek help?**

Doctors usually hide their problems for fear of their professional future. Quite apart from the lack of insight or denial inherent to the addiction problem are their feelings of shame, their experience of how other colleagues have been treated (usually badly) and an insufficient knowledge of services. Their expectation is that referral to a psychiatrist will provide the evidence necessary to effect their dismissal [26]. Many doctors are not even registered with a GP.

**Why are colleagues reluctant to help?**

Colleagues may have a misplaced loyalty and worry about ‘victimizing’ the doctor if there is insufficient evidence. They may identify inappropriately with the individual on the one hand, while on the other hand shying away from the emotional burden and its very complexity. Too often, action is delayed because of uncertainty of what to do. The answer is to refer to specialist treatment; once in treatment, the outlook is transformed [21]. The motivation to return to work and the fear of sanctions are key factors to good outcomes. Informal approaches may succeed in ‘nudging’ the doctor into treatment. If such approaches are ignored then further, more robust action is needed. Doctors have a responsibility to act if they are concerned that patients are at risk [27,28].

**Diagnosis and intervention**

Early diagnosis is critical. However, many years can elapse before doctors seek help. Very few refer themselves and little is written about the diagnostic process. As Griffith Edwards aptly put it 30 years ago: ‘the late dramatic intervention might not be called for if minor, sensible, and friendly interventions were more often practised at an earlier stage’ [26].

Historically, doctors accessed treatment through the ‘old boy network’. In the UK, psychiatrists were, until recently, able to treat colleagues discreetly. However, with changes in commissioning across the National Health Service (NHS) it has become increasingly difficult for addicted doctors to access confidential specialist treatment directly. A referral from a GP to an addictions specialist can be rejected, with the requirement that the doctor–patient be referred initially to a local general adult psychiatrist, a community drug and alcohol team or a community mental health team. This is not helpful, particularly when the doctor in question might be a senior figure locally, or is well known in the area and might find it difficult to confide in a local psychiatrist or specialist nurse who may come from their social network. Doctors should be able to access treatment easily, and this treatment should be confidential. They fear breaches of confidentiality and ‘local gossip’.

Doctors sometimes access treatment in a crisis. Their problem may be a longstanding or chronic one, but has come to light in an acute manner. Crises offer excellent opportunities for assertive outreach and/or treatment interventions, and in such situations entry to specialist treatment should be facilitated as soon as possible. Unfortunately, what often happens is that doctors presenting in crisis are suspended, left to fend for themselves and shunned by colleagues, their employer. Despondent and left to their own devices they defer treatment.

Doctors often find it difficult to be patients. It is therefore important to identify a cohort of experienced psychiatrists, usually addiction psychiatrists, with experience and expertise in treating doctors. These psychiatrists will typically be attached to an institution and have local continuous professional development and other support networks. Treating doctors can be extremely burdensome work, so it is important that psychiatrists offering the treatment have access to support for themselves.

**The occupational health physician and the addiction psychiatrist**

The addiction psychiatrist works at the interface of the occupational health and regulatory systems. Thus, the occupational health physician is an important person in the network of the addiction psychiatrist, and these two professions increasingly work in tandem. Often the
occupational health physician will seek telephone advice concerning a substance misuse problem in a doctor that has just come to light. In an ideal situation, the addiction psychiatrist should be able to see the doctor in question and advise the occupational health physician on the extent of the problem and the probability that this doctor will able to return work at some point. Having assessed the doctor, they may be able to offer further advice and in some situations to institute treatment, either outpatient or inpatient based. Following the acute treatment episode, the addiction psychiatrist may undertake a longer term monitoring role in order to facilitate a return to work.

Treating sick doctors

Doctors come to see addiction psychiatrists by a variety of pathways ranging from self-referral through to a request from the General Medical Council (GMC) to carry out a medical assessment. Referrals from occupational health services typically involve doctors who have been sent on sick leave or have been suspended following a crisis, for instance having been obviously intoxicated at work or dazed and confused while on-call. A search of the on-call room may uncover supplies of alcohol (e.g. vodka in a water bottle), discarded needles, empty ampoules or empty blister packs. Evidence needs to be actively sought, because the addicted doctor is extremely adept at covering up. At the same time, they are nearly always relieved to be ‘found out’. Astute clinicians will arrange for blood alcohol levels and urinary drug screens in such situations and these can be helpful in confronting the doctor.

Unfortunately, it is often difficult for the occupational health physician to refer directly to a specialist addiction psychiatrist, and referral must be via the primary care team. The evidence indicates that doctors respond well to specialist treatment, so the sooner they are referred on to such treatment the better [3,29,30].

Specialist assessment

At the first appointment with the addiction psychiatrist, the addicted doctor can present with a variety of emotions including anger, bewilderment, distress and suicidal ideation. It is important at this first meeting to set out the remit for the encounter, exactly what will happen during the interview and what the next steps might be. Doctor–patients should be seen formally in an office (not the corridor or the canteen), and a full clinical history should be taken and recorded, in the same way as for any other patient. This will include a history of alcohol and drug use, self-medication, a collateral history and whether they are registered with a GP [31].

It is essential to uncover who is involved in the current situation. The NHS employer might be involved and also the postgraduate deanery, The National Clinical Assessment Service and the GMC. Does their partner know? The doctor may have withheld news of their suspension from their spouse and continued to leave home every morning for work, as if nothing had happened. It is possible to take a collateral history from work colleagues? It is usually helpful to obtain written consent to contact key individuals.

In assessing the addicted doctor, it is important to tease out whether the issue is one of health, competence and/or conduct. Often the issues are multiple. How long has the problem been going on? Is it an acute, chronic or subacute matter? What impact has this problem had on the competence of the doctor, their behaviour and/or interpersonal relationships? What is their perspective and degree of insight? Can one make an assessment of their personality? Are they motivated to change? Indeed what is their capacity for change?

In assessing the doctor, it is important to understand the subtext. The psychiatrist must get a sense of what is going on in the organization, but must also listen to (and hear) the doctor–patient’s perspective. It is critical to take a collateral history from the employer, from the occupational health physician and from colleagues and friends. The telephone is often very helpful in this regard. The taking of detailed contemporaneous notes is essential. Relevant reports should be read and leads followed up. For instance, the doctor–patient may have been performing extremely well until 12 months previously, at which time things began to unravel. Had colleagues or supervising consultants noticed this? Had the tenor of appraisals changed? Sometimes doctor–patients are given the benefit of the doubt. Previous episodes might have been considered a ‘one off’ and gone unreported. Has there been a relationship breakdown or divorce? Has a parent, sibling or friend become unwell or died? Has a child been in hospital or have there been difficulties in developing/maintaining childcare arrangements? Has there been a stressful incident at work? Throughout the assessment process, it is important to try to understand and conceptualize what is (has been) going on and to develop a working hypothesis. Often the issues are multiple, complex, overlapping and distorted. It can take some time to appreciate the complexities and it is probably sensible to pause and reflect before writing the first report. This ‘watchful waiting’ may delay the process somewhat, but may also pay dividends in a more complete insightful report.

The therapeutic relationship with the addicted doctor

Developing a therapeutic relationship with an addicted doctor can be difficult, particularly if the psychiatrist takes on a supervision role. Doctor–patients can be tetchy, irascible and arrogant and tend to use a number of ploys to avoid contact. They need to be treated with
a balance of respect and firmness. From the outset, the ‘treatment contract’ with the doctor–patient must be open, honest and closely defined. The commitment to help is made on the understanding that the doctor–patient accepts the relevant medical advice, gives up clinical responsibilities for the time being and makes recovery their first priority.

This work is time consuming. The treating psychiatrist must be meticulous and maintain an attitude of compassionate scepticism throughout. There is no rigid formula as to the period of abstinence required prior to returning to clinical duties (perhaps 6–12 months, sometimes less, sometimes more) and each doctor–patient must be considered individually. Advice should be firm and supportive, neither punitive nor harsh [26]. If the doctor–patient does not take the advice and a treatment contract can neither be set up nor sustained, then they will not be able to return to clinical practice.

There is no room for ‘cloak and dagger’ tactics when treating addicted doctors. The treating psychiatrist has a double responsibility to their doctor–patient and also to society.

**Back to work**

The psychiatrist can participate in setting up a back to work programme together with the occupational health physician, the deanery and the NHS employer. These programmes should ideally be individually tailored and have clear objectives. They also need to be structured, supported and managed, to be time limited and involve some assessment component. All too often, none of these requirements is available. The psychiatrist needs to understand the roles and responsibilities of the employing organization and make/facilitate contact with key players including the occupational health physician, the workplace supervisor, medical director and colleagues. While the psychiatrist will generally only report to the occupational health physician, they need to understand what is going on at an organizational level. For instance, is the organization trying to get rid of the doctor–patient? Is there a workplace drug and alcohol policy? Are they using the correct procedures?

The postgraduate deanery has an important role to play in facilitating return to work, particularly for doctors in training. They may require a ‘fitness to practise’ report from the psychiatrist and can advise employers on educational issues. They can also give independent advice, but their resources are limited. They cannot create posts and must work within their training capacity. The treating psychiatrist can help the doctor–patient to look for an independent coach or mentor who might help them draw up a realistic personal development plan to put to their employer. Often the British Medical Association’s industrial relations officer is the person who helps out with this. However, professional mentors can help with re-entry both from an individual and organizational perspective, are supportive and can help to build confidence and competencies.

The treating psychiatrist will have less contact with the workplace supervisor, usually a senior doctor who reports to the medical director, deanery and possibly into the GMC procedures. The workplace supervisor will set objectives, advise on a personal development programme, identify training needs and advise the doctor on how to meet them. They also manage the structured clinical situation within which the retraining doctor works, usually under restrictions, carry out assessments of the doctor and give regular feedback.

While many doctors do well in recovery and return to work successfully, some only recover after ‘a prolonged and stormy passage’ [26] and others do not make it. It is possible, at an early stage, to predict the doctors who are likely to ‘make it’. They have a capacity to engage in the therapeutic process, to understand and accept what is required of them. With support, they are able to embark on a shared therapeutic journey which is often painful but ultimately enlightening and ‘liberating’. One of this writer’s doctor–patients, now back in unsupervised clinical practice put it like this: ‘I am living a life beyond my wildest dreams’.

**Support for the treating psychiatrist**

Treating psychiatrists will usually be attached to an institution, have local continuing professional development networks and other supports. Supervising and treating addicted doctors can be extremely burdensome, so it is important that treating psychiatrists learn to pace their work and have access to support.

**Prevention and early detection**

It is clear from the literature that many doctors who go on to develop addiction problems later in their careers were already manifesting vulnerabilities at medical school. There is a strong case for surveillance and support at medical school and provision for early identification. Addictions should be on the curriculum and there should be clear pathways for help.

Different stressors emerge in the first few years post-qualification and young doctors need support in their early working years. Young doctors are now exposed to a wider range of recreational psychoactive drugs, which are frequently combined with heavy alcohol consumption [32]. Those who develop anxiety and depression are at risk of self-medicating with alcohol, benzodiazepines or opiates, even with illicit drugs. Occupational health services are well placed to intervene at this point, but as a group, doctors do not self-refer to these services.

A Norwegian study has shown that job stress is related to mental health problems among young doctors in their
first postgraduate year [33]. In this study, the most important stress factor was that of emotional pressure/demands of patients.

**Implications for policy**

Medical schools, postgraduate and continuing medical education programmes should put addiction studies higher in the curriculum. Medical students and doctors must be warned that they are at high risk for drug misuse. Medical schools and employing authorities should all have a drug and alcohol policy. All doctors should have access to a comprehensive occupational health service.

All doctors should be encouraged to register with a GP. Doctors should avoid self-prescribing of any sort. Once doctors have developed an addiction problem, they have to cope with the stigma of failure which acts as a barrier to recognition and effective help [16]. Colleagues often wait far too long before intervening. Where a problem is suspected a frank, concerned attitude is needed. Referral for treatment should be facilitated, confidential and accessible. Local arrangements should be clear.

**North American models of care**

The management of the ‘impaired physician’ in the USA and Canada is proactive, confidential, robust and non-punitive, with each state/province organizing a ‘physician health programme’ which facilitates specialist treatment and long-term monitoring [4,34,35,43]. Similar programmes have been set up in Spain and in one state in Australia [36–38]. These programmes assess, monitor and support the addicted physician, ensuring compliance with treatment and practice restrictions. They do not provide treatment services themselves but facilitate referral to appropriate specialist treatment services. Key components of this model include therapeutic drug monitoring, attendance at self-help groups and management through an independent treatment programmes independent from the regulation board [3,39,40].

**Treatment systems in the UK**

Are there adequate treatment systems in place in the UK? The answer is no, for the moment [42]. Although there have been improvements over the past decade, it is still possible for a doctor with an alcohol problem to elude detection until a late stage. Once a problem has been detected, there is no ready referral system for treatment. Occupational health services, employers and the GMC depend on the goodwill of psychiatrists to assess, treat and supervise addicted doctors. In addition, there exist a number of confidential telephone counselling services, signposting services and self-help groups. While voluntary organizations such as the Sick Doctors Trust have a role to play, they cannot single handedly provide an organized and comprehensive treatment system for doctors with serious drug and alcohol problems, in particular long-term monitoring and support. Treatment works. A recent 21-year follow-up study of 100 alcoholic doctors in England reported a 73% recovery rate for 17-year average duration over the follow-up period. There was a strong relationship between initial recovery (6-month abstinence) and attendance at self-help meetings which included Alcoholics Anonymous and a regional doctors and dentists group [30].

The recent White Paper made a recommendation that the NHS set up a service to treat addicted doctors [41]. Components of a specialist treatment system are set out in Table 2.

**Conflicts of interest**

None declared.

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