General Medical Council

European Association for Physician Health meeting 28 and 29 October 2009

Case studies for discussion.

The following vignettes assume that the doctor has contacted you in your role as an experienced provider of support and/or treatment to sick health care workers.

Dr Parmar

Dr Parmar is a single handed GP who has been working in a mixed urban and rural demography for 25 years. Originally he was a partner however the Group Practice was dissolved 10 years ago following a partnership dispute and he has been working alone since then, with a part time practice nurse and receptionist.

He says his audit outcomes are all within normal range and he has a good reputation with his patients, his immediate colleagues and his employing authority. His list size is around 2000 patients and growing.

He was recently convicted for driving with excess alcohol in his bloodstream and fined £750 (a large fine) and had his driving licence revoked for 2 years, as opposed to one year which is normal for a first offence. He was 3 times over the legal limit. This was not notified to the GMC by the police. The police should normally contact the GMC if a doctor is subject to a caution or a conviction but this does not always happen.

He has been asked to see you by the employing authority as a condition of assisting him with providing cover for home visits etc now that he has no driving licence. He tells you he has a troubled relationship with alcohol.

Issues for debate:

- How concerned should you be by this doctor's alcohol use?
- What support does this Dr need from you?
- How is ongoing patient risk assessed? Who should do the assessing?
- Should this doctor remain in single handed practice? If not, what mechanism can the employing authority use to change the working arrangements?
- Should this doctor self refer to the GMC? Should you notify the GMC about this doctor?

Dr Thornton

Dr Thornton is a junior doctor in paediatrics. He has significant chronic mental and physical illness problems including depression, sleep apnoea, clinical obesity and a serious long term life threatening viral infection. His Medical Director is trying to negotiate him into a different job plan that "works to his strengths" – part time and no on call - however he is suspicious that there is an underlying desire to force him into a position where he has to leave his job.

He has problems with concentration. Getting to work early or leaving late can be difficult – there have been many absences from work and lateness episodes because of this. He has poor personal organisational skills. His family has ill health problems also (mother has terminal illness) and he has no social support.

He has been referred to Occupational Health, who state he is fit to work despite his Medical Director remaining sceptical of this. The issue seems to be about what kind of work he can manage.

This doctor is clearly extremely bright and clinically very able. So far all the arrangements made to accommodate this doctor's needs have been informal, made between Medical Director and him. However he tells you that now the Human Resources Director has sought a meeting with him to discuss his absences. He is concerned about his general health and the pressure that such a meeting is putting him under.

Issues for debate:

- How is ongoing patient risk assessed? Who should do the assessing?
- What support does this doctor need from you?
- Are there any reasons for GMC involvement with this doctor at the moment?
- If there are, what is the most appropriate route to GMC involvement?

Dr Smith

Dr Smith is a 64 year old GP working in an inner city group practice of 4 partners. He has been involved in an ongoing dispute with a Local Councillor regarding the provision of family planning clinics for some years, which has involved verbal threats by the Councillor to refer the doctor to the GMC in respect of his deteriorating health. He rings you wishing to speak to someone in confidence.

He tells you he was diagnosed with Parkinson's disease 6 years ago. The employing authority are aware of this diagnosis and have been content to allow him to remain on the Performers List** and as a GP. He has a tremor which varies in intensity. He is under neurology care, and reports no problems at work, few patient complaints etc, although he does refer work

requiring significant manual dexterity to his partners, who are supportive of him remaining at work.

Issues for debate:

- What support does this doctor need from you?
- Is this doctor's health a matter which should concern the GMC?
- Is there anything that could be done locally to support this doctor?
- How would you advise regarding the threats of referral to the GMC?

*** Performers List – in the UK, medical practitioners may not perform any primary medical services, unless they are general medical practitioners **and** their name is included in a medical performers list in the same country as they are performing those services.*

Dr Poynter

Dr Poynter is a specialist in anaesthetics. Whilst working in Theatre in May this year Dr Poynter collapsed, disconnecting tubing carrying anaesthetic gases to the patient. Dr Poynter had to be resuscitated in theatre. On recovery he vomited, and subsequent analysis of the vomit showed the presence of remifentanil, a drug that had been administered to the patient in theatre shortly before Dr Poynter collapsed.

Dr Poynter has been referred to you by his employing authority. He has also been excluded from work pending an occupational health assessment and a report from you.

He tells you that he did use remifentanil in the situation described above. As an anaesthetist he was fully aware of the very profound and rapid effects of this drug. He is clearly extremely low and appears to have suicidal thoughts.

Issues for debate:

- What support does this doctor need form you?
- Can you assist him with a return to work? Should you do so?
- Should the GMC be informed of this matter?
- What ongoing role might you have in relation to any referral to the GMC?