Protocol for Doctors Returning to Work after Illness

INTRODUCTION

This protocol is to be used in circumstances where a doctor is returning to work after a significant period of absence due to ill-health. In particular it should be used when the doctor in question has been absent due to stress-related illness, mental ill health or where the doctor has experienced trauma (either personal or work-related) resulting in significant emotional distress.

Absence of more than 4-6 weeks following physical illness should be referred to occupational health. In cases where the absence is due to stress- related illness or a mental health issue, an earlier referral should be considered and in all such cases, a doctor returning to work should be referred to occupational health.

This guidance should be used by doctors, employers, clinical directors, doctors' appraisers, and their employer and contracting agencies as well as the postgraduate training bodies. To place this protocol in context, it is important to remember that the quality of patient care depends on the people who are charged with delivering that care. Failure to care for health professionals when they are unwell may have a negative impact on the quality of patient care delivered by them.

It is important to reflect on the duty of care that all employers have towards their employees as well as their duty to provide a safe place of work (1). This includes the responsibility to identify and minimise workplace stressors which may be viewed under 6 headings: demand, control, support, role, relationships and change (2,3). Stigma and discrimination are still major issues and are particular barriers to doctors returning to work after mental illness. Employers, clinical directors and managers need to be aware of their legislative responsibilities in ensuring discrimination is avoided (4) and they should also be familiar with the HSE's policy on Dignity at Work (5).

Return to work is an important end point in recovery from illness and this is particularly so for doctors. Effective return to work and vocational interventions depend on (6):

- Healthcare which includes a focus on work
- Workplaces that are accommodating

Both are necessary and occupational health services can navigate the interface between the two. There is a strong scientific evidence base for many aspects of vocational rehabilitation. Transitional work arrangements can facilitate earlier return to work in those with musculoskeletal disorders and other common health problems. For those with mental health problems, work has the potential to be part of the recovery process.

Doctors as patients can be particularly concerned about confidentiality and occupational health professionals work to strict codes of professional ethics in this regard.

UNDERLYING PRINCIPLES

For this protocol to be effective a number of the basic principles must be adhered to:

- Doctors have a professional duty to seek independent medical advice promptly for physical and mental ill health and also to consider how their health problem may impact on their practice and on the quality of patient care.

- Notwithstanding an individual's professional responsibility, organizational responsibility for ensuring that an appropriate programme for return to work is in place and applied rests with the relevant line manager, usually the clinical director or hospital CEO or GM
- Best outcomes are achieved through a shared vision with the doctor returning to work having agreed a plan with the appropriate line manager e.g. clinical director or CEO/GM supported, when appropriate, by guidance from the relevant post –graduate training body
- Emphasis throughout should be on effective and considerate support for the doctor as s/he returns to work.
- All institutions are expected to respond positively to such a request under this protocol. Ultimately, as cases arise, this protocol will benefit all institutions, both HSE and Voluntary, and thus co-operation should not unreasonably be withheld.
- While the doctor is absent from work it is the responsibility of the clinical director or named alternative to remain in regular contact with the doctor in accordance with the HSE's Managing Attendance Policy (8)

The clinical director is required to ensure that the doctor is aware of his / her obligations regarding contact with the employer and also regarding compliance with the sick pay scheme. This may require the Clinical Director to organise a meeting between the Human Resources Manager and the practitioner.

In addition, where the doctor is returning from absence due to illness the following principles apply:

- The Clinical Director should be guided by the local Human Resources Department policy in determining the timing of referral to occupational health. Early referral is to be recommended, unless the doctor is hospitalised.
- The occupational health service of the institution should ensure that an experienced occupational physician (specialist) is involved in the care of the doctor /employee (7). The occupational physician (OP) will undertake a clinical assessment of the doctor which will include a risk assessment of potential risk to patients. Liaison with the doctor's treating clinical team will occur when appropriate and with the consent of the doctor.
- Following assessment of the doctor, the OP will set-out an agreed return to work programme with the doctor, will communicate the plan in writing to the clinical director and will monitor its implementation upon the doctor's return to work.
- Confidentiality should be observed at all times. Since doctors as patients can be particularly concerned about confidentiality, it should be possible for the doctor to request that the programme be co-ordinated through an alternative occupational health service within the region.

- In circumstances where it is not appropriate, advisable or possible for the doctor to return to his/her original place of work, it shall be the responsibility of the relevant HSE region to identify an alternative suitable post/location and to formally request that location to initiate the return to work programme with the doctor.

PROTOCOL STEPS

The protocol consists of a number of key steps:

STEP 1: Initiation

(a) Where the doctor is returning to the original post

When the doctor is deemed fit to return to work, either by the attending clinician or the occupational physician, s/he should initiate the process by writing to the clinical director indicating that this is the case.

The Clinical Director should then request the occupational physician to prepare the programme of return to work in consultation with the doctor, the Clinical Director, the CEO/GM and any other relevant persons, such as Department Head or other Clinical Leads.

It is expected that the doctor will have been referred to occupational health prior to the doctor's decision to return to work. All of the evidence points to the benefit of earlier referral to occupational health and early implementation of vocational rehabilitation.

SEE **STEP 2**

(b) Where the doctor is not returning to the original post

Circumstances may arise where it is not advisable or possible for the doctor to return to their original post or institution. Where relevant, this conclusion should be supported by independent medical advice (e.g. occupational physician), and agreed by the doctor, the clinical director and the hospital CEO/GM.

In this situation, the local Clinical Director should formally notify the relevant Group Clinical Director and Group CEO of the need to identify an alternative, suitable post - where possible within the Region.

It is important that the local Clinical Director and the doctor be involved in this process to ensure that the alternative post/location is appropriate to the professional qualification and experience of the doctor. The Occupational Health Service should be involved to ensure that the alternative post/location is in line with medical advice.

Following discussion with the alternative location, the Group Clinical Director and Group CEO will jointly formally request the Clinical Director and CEO/GM of that location to initiate the process of return to work, through the Occupational Health Service as at (a) above.

Issues relating to the financial implications of this transfer from one location to another should be dealt with by the RDO in consultation with the respective CEO/GM and Clinical Directors of both institutions.

SEE **STEP 2**

STEP 2: Programme Definition and Agreement

A structured programme for the return to work must now be developed. Certain elements of this will be determined at a management level by the Clinical Director and others.

- Details on appropriate professional supervision or retraining if required
- Clinical governance arrangements
- Contractual issues if necessary e.g. if returning to a different post or institution
- Evaluation milestones
- Communication
- End date of the programme

The occupational health report (written) should include the following elements:

- Timescale of return and likely duration of phased return to work programme
- Nature of duties to be undertaken and specific recommendations on restricted duties (e.g. call, night work, shift length when appropriate).
- Occupational health follow- up arrangements.
- Additional support deemed appropriate
- Incorporation of medical advice received regarding fitness to work and recommendations therein

Appendix one provides a template which can be used when devising the programme.

This programme, having been agreed between the Occupational Physician and the doctor should be signed-off by the doctor, the Clinical Director, and the CEO/GM.

It is particularly important that where the programme involves participation by third parties e.g. clinical departments in other hospitals for retraining purposes, their role should be clearly defined and agreed directly with them at the outset.

Step 3: Programme Implementation

This stage is largely dependant on the timescale, milestones, process and activities defined in the programme at Step 2.

Regular monitoring should be inbuilt. The Occupational Health Service is responsible for monitoring the return to work programme in so far as health impacts on work and work on health. The monitoring of clinical milestones should be monitored by the Clinical Director. Should it be considered by any party to the agreed programme that anticipated progress is not being achieved, it will be open to them to seek a review at any stage. It is then possible to modify the programme, with agreement.

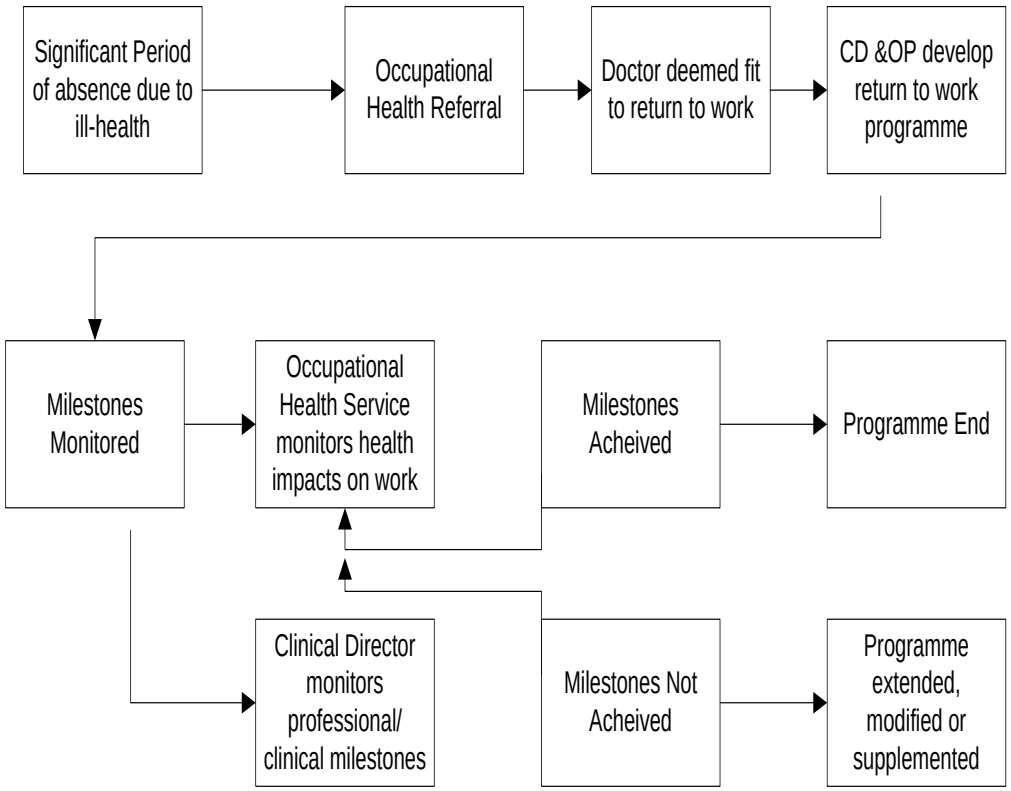
Monitoring of the programme should not be confused with existing clinical governance arrangements, which should be applied as normal.

Step 4: Programme End

On completion of the programme of return to work the Clinical Director and the doctor should jointly evaluate the programme. The Occupational Health Service is responsible for ensuring that final evaluation and closure of the programme occurs.

Where anticipated outcomes are not achieved or are unclear, the programme may be extended, modified or supplemented.

If it is agreed that the outcomes have been achieved, and that the return to work is successful, the programme is closed.



Appendix 1

A Doctors Return to Practice – Recommended Questions and Actions[1]

The following checklist of questions is recommended to be used post-absence in order to help with identification of issues and facilitate support planning.

1. Was a pre-departure plan developed? (If so, this should be reviewed.)

2. How long has the doctor been away?

3. Has the absence extended beyond that which was originally expected? If so, what impact has this had? (If it was an unplanned absence, the reasons may be important.)

4. How long had the doctor been practising in the role they are returning to prior to their absence?

5. What responsibilities does the doctor have in the post to which they are returning? In particular are there any new responsibilities?

6. How does the doctor feel about their confidence and skills levels?

7. What support would the doctor find most useful in returning to practice?

8. Has the doctor had any relevant contact with work and/or practice, during absence e.g. 'keep in touch' days?

9. Have there been any changes since the doctor was last in post? For example:
    - The need for training such as for new equipment, medication, changes to infection control, health and safety, quality assurance, other new procedures, NICE guidance, or anything that the doctor needs to learn
    - Changes to common conditions or current patient population information
    - Significant developments or new practices within their specialty
    - Changes in management or role expectations. What time will the doctor have for patient care?
    - Are there any teaching, research, management or leadership roles required?

11. Have any new issues (negative or positive) arisen for the doctor since the doctor was last in post which may affect the doctor's confidence or abilities?

12. Has the doctor been able to keep up to date with their professional competence whilst they have been away?

[1] Checklist was adapted from the Academy of Royal Colleges document *Return to Practice Guidance.* http://www.aomrc.org.uk/doc_view/9486-return-to-practice-guidance

13. Is the doctor having a graded return to work on the advice of Occupational Health?

15. Are there other factors affecting the return to practice or does the doctor have issues to raise?

16. Is a period of observation of other doctors' practice is required and/or does the doctor need to be observed before beginning to practise independently again?

17. Will the doctor need training, special support or mentoring on return to practice? If so, are there any funding issues related to this which need to be considered?

Signatures

Doctor Date

Clinical Director Date

CEO/GM Date

On behalf of the organisation Date

References:

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7. DOH UK 2008 Mental Health and Ill Health in Doctors, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083066
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