

Characteristics and prognosis of alcoholic doctors

ROBIN M MURRAY

British Medical Journal, 1976, 2, 1537-1539

Summary

Five medically qualified women and 36 men who were being treated for alcoholism at a London postgraduate hospital were studied. Most were middle-aged and at an advanced stage of alcoholism. They had usually started drinking heavily in the wake of well-established drug dependence or other psychiatric disorder; as students or housemen; and in the armed forces. Thirty-six doctors were followed up for a mean of 63 months. Five doctors either killed themselves or died of cirrhosis, and nine persisted in almost continuous dependent drinking, while seven completely overcame their alcohol problem and 10 had only occasional relapses. Their prealcoholic careers had ranged from repeated failure to spectacular success, but of 29 doctors alive at follow-up only eight were practising satisfactorily.

Introduction

"Even the fact that doctors die of the very diseases they profess to cure passes unnoticed. We do not shoot out our lips and shake our heads, saying 'They save others: themselves they cannot save'."—BERNARD SHAW¹

British doctors appear to be particularly prone to alcoholism. First admission rates for alcoholism in Scotland are 2.7 times higher among doctors than among other men in social class I,² and the death rate from cirrhosis among doctors in England and Wales is 350% of that of the general population.³ Alcoholism is also the mental disorder most likely to bring a doctor before his professional disciplinary organisation.^{4,5} Nevertheless, Edwards⁶ believed that the problem of the alcoholic doctor was largely ignored, and declared: "Alcoholism in the medical profession is a subject which now requires to be brought out into the open." In an attempt to do this I have investigated the characteristics and prognosis of some alcoholic doctors.

Patients and methods

A search was made of the occupational records of all inpatients discharged from the Maudsley and Bethlem Royal Hospitals from January 1964 to December 1973. The case notes of all those recorded as having been medical practitioners were extracted, and those with a primary diagnosis of alcoholism or alcoholic psychosis were examined in detail.

These alcoholic doctors were followed up in late 1974 and 1975, and information on their progress up to December 1974 was accepted. The potential follow-up period therefore ranged from one year for those admitted in December 1973 to 11 years for those admitted in January 1964. A letter was sent to their general practitioners asking about their progress, and if this produced an unsatisfactory response their recorded next of kin were discreetly approached. The *Medical Register* and *Directory* were also searched for the latest addresses of

the alcoholic doctors, who were then contacted by letter or phone. Records from all hospitals they had attended were solicited and scrutinised. When information from these sources was incomplete an attempt was made to interview the doctors personally.

Results

Altogether 144 medical practitioners had been discharged from the joint hospitals during the 10 years. Five women and 36 men (29% of the total) had received a primary diagnosis of alcoholism or alcoholic psychosis. At admission these alcoholic doctors were aged from 24 to 65 (mean 44.5) years (table I). All but one had been born in the British Isles, and a surprisingly high proportion had graduated from Scottish (8 doctors) or Irish (4 doctors) universities. There was no consistent pattern in their undergraduate careers: seven had been awarded distinction at some time in their medical studies, while four had failed their finals at least once. Ten came from medical families, and seven had a family history of psychiatric disorder and 12 of alcohol abuse. Thirty-five had married, but in seven cases the marriage had broken down.

TABLE I—Ages at which the doctor patients started drinking heavily and were first diagnosed as alcoholic and their ages at admission studied. Results are numbers of doctors

Age (years):	<20	20-30	40	50	60	70
Started drinking heavily	2	15	10	9	5	
First diagnosed as alcoholic		5	10	13	12	1
Present admission		5	4	19	11	2

DRINKING HABITS

These doctors had most often begun to drink heavily in their 20s and 30s (table I). The commonest setting was that of drug dependence (in seven doctors) or other psychiatric disorder (in five); this was especially true among the women doctors, three of whom had been drug dependent and one depressed at the time they started drinking heavily. Five doctors started drinking when they were students, three when they were housemen, and five during service in the armed forces. In nearly a third (13) drinking had increased so insidiously that it was impossible to establish the setting in which it became pathological. The most common reasons that the doctors themselves gave in retrospect for their drinking problem were "underlying" psychological difficulties, overwork, and marital problems. The marital problems ranged from "incompatibility" to what one doctor called "the strain of keeping a wife and several mistresses on the go simultaneously." The drink of choice was spirits in 26 cases (usually whisky), sherry in five, and beer in only four. The length of time from the start of heavy drinking to alcoholism being diagnosed ranged from six months to 25 years.

Case 1—A 42-year-old doctor had begun drinking during army service and when he entered general practice usually had a few drinks after work. He occasionally got tight at parties or at the golf club, and his intake slowly increased until by his late 30s he was consuming a bottle of whisky daily. In the year before admission he was intoxicated most evenings and needed a drink before morning surgery to steady his hands. His breath always smelled of alcohol and the patients had noticed him swigging from a bottle between house calls.

MEDICAL PRACTICE

The specialties of all 144 doctors treated at the joint hospitals are shown in table II, but the figures should be interpreted with caution. The numbers of general practitioners and administrators recorded as

Institute of Psychiatry, London SE5 8AF

ROBIN M MURRAY, MD, MPhil, research worker, (now Lilly international fellow, Section on Clinical Neuropharmacology, Laboratory of Clinical Science, NIH Clinical Center, 10/35229, Bethesda, Maryland 20014)

TABLE II—Specialties of 144 doctors treated at Bethlem and Maudsley Hospitals

	No of doctor-patients (all diagnoses)	No with primary diagnosis of alcoholism	% Alcoholic
General practice ..	46	17	37
Medicine ..	22	3	14
Psychiatry ..	16	1	6
Surgery ..	15	5	33
Laboratory specialties ..	15	5	33
Anaesthetics ..	10	2	20
Administration ..	8	4	50
Obstetrics ..	5	1	20
Others ..	7	3	43
Total	144	41	29

alcoholic were inflated by the inclusion of doctors who had left other specialties because of drink-related problems. Only 6% of psychiatrists received a primary diagnosis of alcoholism compared with 33% of surgeons, but this might have reflected not more alcoholism among surgeons but a higher incidence of other psychiatric disorders among psychiatrists.

Although 13 doctors had achieved consultant and one professorial status, 25 thought that drinking had seriously affected their careers. Most admitted that alcohol had at times impaired their care of patients; this ranged from inability to do house calls or ward rounds when drunk to causing the death of a patient through negligence.

ALCOHOL-RELATED DISABILITIES

Seventeen doctors had been in trouble with the law, the offences ranging from drunken driving to forging prescriptions and attempted murder. Several others had escaped prosecution only through the indulgence of local police. Twelve doctors had attempted suicide but, perhaps because of their knowledge of the lethal dose of drugs, this was rarely accepted as a "cry for help." One doctor stated that he had taken an overdose "to make my wife more sympathetic. It didn't work—she just laughed at me."

Most were at a fairly advanced stage of alcoholism, and disease of the central nervous system was not uncommon. Nine had experienced delirium tremens, seven had had convulsions, four had neuropathy, and two had Korsakoff's psychosis. Both physical symptoms and outrageous social behaviour had often been attributed wrongly to organic disease, with resultant unnecessary investigations.

ASSOCIATED PROBLEMS

Twenty-eight doctors had undergone previous psychiatric treatment, and in 15 cases conditions other than alcoholism had been diagnosed. Depression, anxiety states, and drug dependence were the commonest. In all, 23 doctors abused drugs: eight took mainly barbiturates, six mainly amphetamines, and one pethidine, while the remainder used a variety of drugs. In 13 cases the psychiatrists in charge considered that a personality disorder underlay the alcoholism. This was particularly so for those diagnosed as alcoholic before reaching 40 years of age. Eight of the 15 diagnosed before that age were considered to have an abnormal personality compared with five of the 26 diagnosed later in life. This was a significant difference ($\chi^2=5.1$; $P<0.05$), but some psychiatrists apply the label of personality disorder more readily to young patients.

REFERRAL AND TREATMENT

Only six doctors had sought psychiatric help entirely of their own accord. Sixteen came on the advice of colleagues, seven on account of their families or friends, and four on instruction from their employers. Three came from other psychiatric hospitals, and five were transferred from general hospitals for reasons such as self-poisoning or delirium tremens.

Case 2—A 50-year-old doctor developed a tremor after a routine operation and on the third day claimed that he was surrounded by threatening figures who had electrified his bed. He became delirious, had a convulsion, and was subsequently discovered to have been drinking nearly a bottle of vodka daily for several years.

Invariably the cause of concern was not the alcohol consumption itself but the adverse consequences of that consumption. Patients were often amazingly tolerant of behaviour that included falling asleep during a surgery. Colleagues acted mainly because of obvious danger to patients. One referral came after an anaesthetist had refused to start an operating session because the surgeon was so dysarthric and ataxic.

Inpatient psychiatric care lasted from six days up to six months. Although most doctors co-operated in their treatment, six could never accept that they were dependent on alcohol. A typical explanation in the latter group was: "My boss thinks I've been drinking too much. What, in fact, is wrong is that I've had a major upset with my wife." Six doctors drank surreptitiously while they were inpatients.

Follow-up

One consultant refused permission for his two doctor-patients to be followed-up. Satisfactory information on the progress of 36 of the other 39 (92%) was obtained up to December 1974. The actual length of follow-up ranged from six to 132 (mean 63) months. Seven doctors had died, two certainly and two almost certainly from suicide, one from cirrhosis, and two of causes unconnected with their alcoholism.

Drinking habits—Five doctors subsequently remained totally abstinent and two returned to apparently normal social drinking (mean follow-up period 37 months). Ten drank intermittently with less than one relapse a year and 10 with more than one relapse a year (mean follow-up period 72 months). Nine continued almost constant dependent drinking (mean follow-up period 62 months).

Psychiatric treatment—Seventeen doctors required further inpatient psychiatric care for periods of a few days to three years, and another seven had further outpatient care.

Ability to practise—Of the 29 doctors alive at follow-up, eight were practising satisfactorily and six with varying degrees of incompetence. Three had retired voluntarily and two under compulsion, and eight appeared unemployable. Two had taken other jobs, one as a shop-keeper and one as a cinema projectionist. Four had appeared before the disciplinary committee of the General Medical Council, and the names of five did not appear in the 1974 *Medical Register*.

Prognostic factors—Subsequent drinking habits could not be related to any particular demographic or clinical factors. Whether they concurrently abused drugs did not seem to affect outcome, and neither did the degree of co-operation they had shown during treatment on their psychiatrists' predictions at discharge.

Discussion

A smaller percentage of the doctor-patients treated in the Maudsley hospital were alcoholic than the 39% I recorded among male doctors admitted to all Scottish psychiatric hospitals,⁷ a fact no doubt explained by the greater prevalence of alcoholism in Scotland.⁸ One possible explanation considered in my Scottish study for the greater incidence of alcoholism among doctors than among their social and economic equals was that the doctors might have presented at an earlier stage of illness because of their easier access to psychiatrists. The picture presented by the alcoholic doctors studied here suggests that this is unlikely. On the contrary, the drink-related disabilities described in this paper point to a group of individuals whose lives had already been seriously affected by their drinking.

Many of these alcoholic doctors had similar characteristics—for example, age, frequency of marital breakdown, and personality disorder—to those noted by Edwards *et al*⁹ in their study of all alcoholics admitted to four hospitals in the London area. There was, however, one important difference. Only 3.5% of all the doctors studied by Edwards *et al* had a secondary diagnosis of drug dependence, whereas 56% of the alcoholic doctors had abused drugs. Doctors are, of course, known to be especially prone to use¹⁰ and abuse psychoactive drugs.¹¹

The prevalence of alcoholism varies considerably among various occupational groups.^{12 13} To understand such differences fully we need to know factors such as the leisure habits, moral attitudes towards drinking, and occupational responsibilities and frustrations of the groups under study. Such data are not

available in a statistically valid form for doctors. Nevertheless, an examination of the major settings in which heavy drinking began may provide some clues on why doctors have a high risk of becoming alcoholics. In seven cases abnormal drinking began in the wake of well-established drug dependence, which suggests that doctors' increased access to drugs may predispose them not only to drug dependence but also to later alcoholism: the addicted doctor suspected of overprescribing for himself may substitute alcohol for drugs. As any reader of Richard Gordon knows, an ability to hold one's liquor is supposed to be almost mandatory for medical students. That eight of the alcoholic doctors had started their abnormal drinking as undergraduates or housemen suggests that attempting to measure up to this caricature is not without risk. Service in the armed forces can also be a significant factor in the aetiology of alcoholism,¹⁴ but, since doctors had to spend no more time in the services than other men, it is difficult to relate this to their greater liability to alcoholism.

Once heavy drinking patterns are established they may be reinforced by the social and economic milieu in which doctors live and work. A further factor may be the surprising ignorance of the dependent doctors about how much it is safe to drink day in day out. In a recent epidemiological survey Cartwright *et al*¹⁵ found that below a level of 60 cl of absolute alcohol per week there was no relation between consumption and drink-related problems, but above that intake increased consumption led to more and more problems. This level represents an average daily consumption of just over eight single whiskeys or four pints of beer—amounts considerably below those which the dependent doctors in this study had thought it safe to drink. Medical colleagues, too, had rarely showed concern about the amounts these doctors had been consuming. Indeed, colleagues, patients, and, at times, even police appeared to collude with the drinking doctor to prevent his dependence being recognised and treated. This natural reluctance to interfere only too often allowed the dependent doctor to proceed unhindered down the road to professional and social ruin.

The suicide rate of English doctors is 176% of that of the general population,³ while that of all alcoholics admitted to hospital is about 25 times the expected rate.¹⁶ The high risk of suicide among the alcoholic doctors in this study is, therefore, hardly surprising. That so few completely overcame their dependence on alcohol is, none the less, disappointing since their successful completion of medical training indicated that they once had considerable resources of personality and intellect.

There were no reliable predictors of outcome, and the two consultants who specialised in alcoholism were no more successful than their colleagues in making a prognosis. They did, however, take a more realistic view of their doctor-patients' competence to practise medicine, and one regularly recommended that his patients should be sober for six to 12 months before returning to medical practice. The Merrison Committee¹⁷ has concluded that the present constraints that prevent mentally sick doctors from practising are inadequate. Several incidents when alcoholic doctors returned to practice against medical advice with disastrous consequences highlighted the inadequacy. In particular, the ease with which drinking doctors could take on and then lose a succession of general practice locums was disquieting.

I am grateful to the consultants at the Maudsley and Bethlem Hospitals for their permission to carry out this study, to the doctor-patients for their co-operation, and to Dr D L Davies and Dr Griffith Edwards for helpful advice.

References

- Shaw, G B, *The Doctor's Dilemma*, preface. London, Bodley Head, 1931.
- Murray, R M, *Lancet*, 1976, **2**, 729.
- Registrar-General's Decennial Supplement 1961. *Occupational Mortality Tables*. London, HMSO, 1971.
- American Medical Association, Council on Mental Health, *Journal of the American Medical Association*, 1973, **223**, 684.
- General Medical Council, *Annual Report*. London, GMC, 1974.
- Edwards, G, *Lancet*, 1975, **2**, 1297.
- Murray, R M, *British Journal of Psychiatry*, in press.
- Dight, S E, *Scottish Drinking Habits*. Office of Population Censuses and Surveys. London, HMSO, 1976.
- Edwards, G, Kyle, E, Nicholls, P, *Quarterly Journal of Studies on Alcohol*, 1974, **35**, 499.
- Vaillant, G E, Brighton, J R, and McArthur, C, *New England Journal of Medicine*, 1970, **282**, 365.
- Modlin, H C, and Montes, A, *American Journal of Psychiatry*, 1964, **121**, 358.
- Murray, R M, *Journal of Alcoholism*, 1975, **10**, 23.
- Plant, M, *British Journal of Addiction*, in press.
- Carney, M W P, and Lawes, T G G, *Quarterly Journal of Studies on Alcohol*, 1957, **28**, 59.
- Cartwright, A K J, Shaw, S J, and Spratley, T A, *Designing a Comprehensive Community Response to Problems of Alcohol Abuse*. London, Maudsley Hospital, 1975.
- Nicholls, P, Edwards, G, and Kyle, E, *Quarterly Journal of Studies on Alcohol*, 1974, **35**, 841.
- Committee of Inquiry into the Regulation of the Medical Profession, *Report*. London, HMSO, 1975. (Merrison Report.)

SHORT REPORTS

Herbal cigarettes for kicks

The anticholinergic effects of *Datura stramonium* have been recognised and utilised for centuries. The dried leaves, in powder or tobacco form, are still the basis of some traditional asthma remedies. Several instances of poisoning from the misuse of such preparations have been reported in the USA,¹⁻³ but only one has been recorded in Britain.⁴ We report here two further cases.

Case reports

Case 1—A 25-year-old art student was admitted to hospital after collapsing on a bus. At the time no other information was available. He was uncommunicative and made jerky, uncoordinated movements. The skin and mucous membranes were warm and dry, the pulse was 110/min, and the bladder was distended. The pupils were widely dilated and unresponsive to light, and there was rotary nystagmus. All tendon reflexes were exaggerated, and the plantar responses were extensor. The clinical features were consistent with poisoning by an atropine-like compound. During recovery he experi-

enced visual hallucinations and was sedated with diazepam, but he was rational within 12 hours of admission. He then admitted eating one and a half Surama herbal cigarettes.

Case 2—Ten days after case 1 a 16-year-old girl was admitted with a six-hour history of bizarre behaviour. She was seen by the casualty officer, a neurosurgeon, and a psychiatrist before the possibility of poisoning was considered on the clinical presentation of an acute psychosis with disorientation. She was agitated, talking incoherently, and plucking at the bed-clothes. The skin and mucous membranes were dry, the pulse was 110/min, and the bladder was distended. The pupils were dilated and reacted sluggishly to light, rotatory nystagmus was present, and the tendon reflexes were hyperactive with flexor plantar responses. Her agitation was controlled with diazepam, and within 24 hours of admission she was rational and admitted eating two Surama cigarettes. She described vivid and frightening hallucinations of dead babies and of a satanic black mass. Two friends also ate some of the cigarettes but were not referred to hospital.

Comment

D stramonium, known as the Jimson-weed or thorn-apple, is distributed worldwide. The leaves and seeds contain hyoscyamine,