Guidance on standards of health for clinical health care workers

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Judgements about the health of clinical health care workers in relation to fitness to practice are made by a variety of doctors. These guidelines have been written to assist with such judgements and to facilitate equitable decision making in matters of employment.

Key words: Doctors; fitness to practice; guidelines; health care workers; nurses; standards of health.

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Introduction

In the nineteenth century, maintenance of personal health was a ‘fundamental duty and a matter of professional pride’ for nurses [1]. However, little appears to have been written about the health of doctors. Complaints about ill doctors were dealt with by the General Medical Council’s Conduct Committee until 1980, when a health jurisdiction committee was established on the recommendation of the Merrison Report [2]. The General Nursing Council (UKCC) followed with a similar health committee in 1983. More recently, the health of doctors and nurses has come under scrutiny with specific recommendations being made about standards of health for nurses in the Clothier [3] and Bullock [4] Reports. The Department of Health has also published guidelines for health care workers (HCWs) who are infected or may be at risk of being infected with the human immunodeficiency, hepatitis B or hepatitis C viruses [5–7].

This guidance has been written to facilitate openness and equitable decision making, and to ensure that all relevant employment issues related to health are taken into consideration when judgements are being made about the fitness of a clinical HCW to practice. It is not intended to cover every medical condition or to be proscriptive, and each case will need to be judged on its merits. We recommend that this guidance is drawn to the attention of student clinical HCWs before they enter training so that potential health problems can be addressed at as early a stage as possible. It has been formulated by doctors with an interest in fitness to work from a wide range of specialities. The recommendations are supported, where possible, by evidence from the literature and referenced, but where this was not possible, they are supported by consensus between the authors on what constitutes good practice. Implementation of the guidance can be audited internally by occupational health departments or externally by way of clinical governance.

The term ‘clinical health care worker’ as used here refers to a health care worker who treats patients.

Fitness to practice

Judgements about a practitioner’s health in relation to fitness to practice are currently made by various groups of doctors, including professional bodies, ‘three wise men’, managers and occupational physicians. Problems with performance, conduct or health should in the first instance be addressed locally, but if this fails and there is concern that patients are being put at risk, then the appropriate regulatory body must be informed [8]. On matters of health and safety, risk assessments should be made by ‘competent persons’ [9]. At the local level, we believe that specialist risk assessments of fitness to
practice should be undertaken by accredited specialists in occupational medicine, with advice from other specialists as appropriate. Nurses who undertake health assessments should have a qualification in occupational health and access to an accredited specialist in occupational medicine.

All HCWs should be registered with a general practitioner and also have access, either directly or by referral, to an accredited specialist in occupational medicine [HSG(94)51]. National services, such as the National Counselling Service for Sick Doctors, the British Medical Association [10] and the Royal College of Nursing counselling services, are also available to doctors or nurses. Model health questionnaires to assist with job placement and risk assessment have been published (HSC1994/064). For doctors in training, their health is currently screened at the start of each new job. This need not, however, be more often than at the start of the first pre-registration house job and thereafter at 3-yearly intervals up to and including their first appointment to a permanent post, whether consultant, staff grade or clinical assistant. A smart card is being developed to facilitate the recording of occupational health data for this process. Although this guidance was initially developed for doctors in training, the standards contained within it could be applied to all doctors as part of the 5-yearly revalidation process proposed by the General Medical Council.

Illnesses or conditions that are relatively common in clinical HCWs and that create specific occupational health problems for them or their patients are discussed below

**Depression**

Depression is common amongst clinical HCWs [11]. The nature of the work, degree of autonomy, absence of supporting factors, conflicts between personal life and career, and high levels of self-criticism or empathy have all been implicated in its development [12]. Recognition of the illness may be difficult for non- психiatrists, but valid and reliable instruments have been developed to assist with diagnosis [13–16]. For example, although untested in any study, a score of seven out of nine on the Goldberg depression scale and eight out of nine on the anxiety scale, in the absence of a physical cause for symptoms, is probably incompatible with safe clinical practice. In coming to such a judgement, co-morbid factors such as substance misuse, previous self-harming behaviour and medication need to be taken into consideration, as does the type of clinical work that is being undertaken. HCWs who have been sensitized to particular situations as a result of traumatic early life experiences, such as child abuse, may not be suited to certain jobs, e.g. paediatrics, particularly if there is a history of previous emotional breakdown whilst working under pressure. An increased emotional vulnerability to emergency work has been reported in individuals exposed to major physical trauma earlier in their lives [17]. Specialist psychiatric advice should be sought in such situations and individuals appraised of their increased risk, and if practicable given appropriate support, but relocated if necessary.

A liability to psychosis, mania, hypomania or major depressive illness, particularly if the HCW has poor insight into relapses of their illness, is incompatible with safe clinical practice. The person’s work may need to be adapted, e.g. by restricting surgical interventions, night work or the administration of medication, or, if practicable, by increased supervision. The potential effects of any therapeutic or prophylactic psychotropic medication on cognition or motor performance should also be taken into consideration.

**Substance misuse**

Alcohol or psychoactive drug misuse is incompatible with safe clinical practice. Employers should have a policy on substance misuse that has been agreed with staff representatives. Employers should also formalize arrangements for detoxification and rehabilitation, if necessary by making provision for extra- contractual referrals. We recommend that HCWs in whom alcohol consumption has led to problems with performance, the authorities or social life should, according to their degree of dependency, either abstain from or control their drinking [18] and that biological markers (e.g. gamma-glutamyl transferase, mean corpuscular volume and carbohydrate-deficient transferrin) be normalized before returning to work. For illicit drug misuse, abstinence and satisfactory witnessed urinary drug screening are essential before returning to work. Because of the risk of relapse, regular follow-up may be necessary. For individuals whose job allows unwitnessed access to controlled substances such as anaesthetics, a change in occupation may be advisable.

**Anorexia and bulimia**

These illnesses are relatively common in a mild form, from which most people make a full recovery. Occasional out-patient psychiatric support for someone with good insight into their illness need not be of concern when judgements about fitness to practice are being made. Individuals who are of particular concern are those with continuing symptoms of anorexia, particularly if their weight is unstable, they have a body mass index of <17 kg/m2 or intense dysfunctional beliefs of body image, or there is co-morbidity with addictive or self-harming behaviour. Bulimia with frequent vomiting and hypokalaemia is incompatible with safe clinical practice. Anorexia and bulimia may co-exist, and may be associated with psychosocial dysfunction or serious psycho-
pathology, such as a personality disorder. It has been recommended that applicants for nurse training with a history of self-harming behaviour, excessive use of medical facilities or counselling should not be accepted for training if they show more than one of these patterns of behaviour, until they have shown an ability to live an independent life without professional support and have been in stable employment for at least 2 years [3]. We believe that this is a reasonable precaution for all clinical HCWs, but each case should be assessed on its merits and specialist psychiatric advice sought to assist with risk assessment [19].

**Personality disorders**

Individuals may be attracted to health care work because of personal experience of serious illness in their families, neurotic drives or unresolved psychological problems from childhood [20]. Problems with emotions, interpersonal relationships and self-control will often adversely affect functioning in the workplace. Transient abnormal behaviour at times of stress is amenable to treatment, but repetitive problematic behaviour, such as recurrent self-harm or recurrent somatization, is indicative of a personality disorder and such an individual is not suited to clinical work.

Severe personality disorders of the paranoid, schizoid, antisocial, borderline, histrionic or narcissistic type are incompatible with safe clinical practice. A HCW who has been convicted (cautioned or conditionally discharged) for a serious sexual offence will have to disclose that conviction to their employer or prospective employer. Such a conviction is exempt from The Rehabilitation of Offenders Act 1974 (exemptions) Orders 1975 and 1986, and is incompatible with clinical practice. In addition, employers may seek information on pending prosecutions, cautions and bind overs through procedures agreed with their local police force. HCWs with substantial access to children may be subjected to a pre-placement criminal record check [HSG(94)43] or in due course asked to provide a criminal record certificate.

**Acute anxiety states, post-traumatic stress disorder and phobias**

Most acute neurotic states are short lived and treatable, but if they cause significant lapses in concentration or impair functional ability at work, then restriction of practice or relocation may be necessary until normal functional ability returns.

**Visual impairment**

Good visual acuity is necessary for most clinical work; however, adaptive computer technology, such as close-circuit television, voice recognition software and speech synthesizers, have greatly assisted the visually impaired. Severely impaired central vision or markedly restricted visual fields, which cannot be accommodated by reasonable adaptations, are incompatible with tasks that require detailed vision, such as reading drug charts, microscopy or surgery; however, some clinical work, such as psychotherapy or physiotherapy, may be permissible. Binocular vision is not essential for most clinical work, but stereopsis (three-dimensional vision) is essential for work that requires input from both eyes, such as microsurgery or stereotactic surgery. Diplopia that cannot be controlled is inconsistent with most clinical practice. If driving is a requirement of the job, then the DVLA standards will also apply [21].

There is both qualitative [22] and experimental [23] evidence that severe protan (red) or deutan (green) colour-deficient vision may disadvantage doctors in microscopy. We recommend that medical students and trainee doctors in selected specialities are screened for colour-deficient vision, together with tests for severity, so that individuals can be made aware of potential limitations in their powers of observation, be guided in their choice of career and adopt safe systems of work so as to avoid potential harm to patients. We recommend that if a doctor has a severe colour deficiency, then he or she should not work in histopathology, endoscopy or ophthalmology unless able to adopt a safe system of working.

**Hearing impairment**

Mild-to-moderate hearing loss should not create problems with clinical practice, provided the HCW has been appropriately rehabilitated with adaptive technology. Such technology includes a hearing aid, loop system, telephone amplifier, vibrating bleep, transmitter and visual alarms. In the absence of a functional test or relevant research, it would seem prudent to recommend that a clinical HCW who undertakes auscultation as part of their job, with a mean hearing threshold loss of >35 dB in the frequency range of 500–4000 Hz, should use an electronic stethoscope.

Severe hearing loss will create difficulty with tasks such as taking a history from a young child, communicating with a very ill or infirm patient or auscultation, even with an electronic stethoscope. Emergency situations, intensive therapy units, areas where there is a lot of background noise and operating theatres where masks have to be worn are areas of practice where patient care is likely to be compromised. A successful cochlear implant may re-establish safe clinical practice in these situations. Someone whose primary mode of communication is sign language is unlikely to be suited to training as a clinical HCW except in a very specialized area such as a school for the deaf.
**Eczema and psoriasis**

Because of the need for regular hand washing and frequent changes of gloves, contact irritant and contact allergic dermatitis are relatively common in clinical HCWs. Careful choice of antiseptic hand washes, correct hand washing techniques and regular use of emollients will prevent most irritant contact dermatis. Patch testing may be required to identify contact allergic dermatitis, and specific IgE measurements or skin prick testing to identify latex allergy. Staff with latex allergy should work in latex-free areas. Such individuals should not be excluded from clinical work or be recommended for early retirement. Good infection control requires that staff with a rash or broken skin that cannot be satisfactorily covered should not undertake clinical procedures [24].

Individuals who have had severe eczema in childhood—particularly if it involved the hands—are more susceptible to contact irritants. Eczematosus lesions are frequently colonized in high concentrations by staphylococci or streptococci. We recommend that staff with active eczema or broken skin on their hands should not undertake high-risk clinical procedures such as those involved with wounds, immunocompromised patients or neonates. HCWs with endogenous eczema of the hands that has responded poorly to treatment are not suited to work that requires repeated hand washing.

Psoriasis is associated with increased shedding of scales and the dispersal of skin organisms. Mild psoriasis can probably be safely ignored as a cross-infection risk. However, extensively distributed psoriatic plaques or plaques affecting the hands or scalp are associated with high bacterial counts, which will be dispersed on scales shed into the environment and thereby pose an increased risk of infection to vulnerable patients. A severe outbreak of surgical sepsis has been reported from a HCW with widespread psoriasis [25]. Clinical HCWs infected or colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) should be suspended from work and treated in accordance with previously published guidelines [26]. Individuals with a skin condition which makes them vulnerable to repeated infection or colonization with MRSA are not suited to clinical work.

**Tuberculosis**

Clinical HCWs in the UK, especially nurses and those working in mortuaries or microbiology laboratories, are at an increased risk of catching tuberculosis (TB) compared with the general population [27,28]. Such staff should be advised of their increased risk, told the symptoms of TB and told to report relevant symptoms to the occupational health department. The risk of infection with TB is reduced by BCG vaccination [29], which is recommended in the UK for non-immune clinical HCWs [30,31]. Pre-placement health screening should include questions for symptoms of TB, as well as BCG scar inspection and, for those who do not have an adequate BCG scar or validated BCG vaccination, a Heaf test. Clinical HCWs from countries where TB is endemic (annual incidence >40 per 100 000 of the population) should be screened for symptoms of TB, given a Heaf test if there is no BCG scar (unless there is a past history of TB) and a chest X-ray [31]. Those with relevant symptoms, a grade 3–4 Heaf test or an abnormal chest X-ray should be referred to a respiratory physician.

A HCW who refuses to have a Heaf test should have a chest X-ray. If this is normal, it should be recorded in their occupational health notes that their immunity to TB could not be assessed as they declined tuberculin skin testing. If the Heaf test is grade 0–1, the HCW should be offered BCG vaccination unless there is a contraindication to vaccination, such as pregnancy or immunosuppression [30]. A HCW who is immunosuppressed, or who refuses BCG vaccination, should not work in areas where the risk of catching TB or transmitting it to vulnerable patients is high [32]. In practice, such areas vary geographically, but probably encompass general medicine, paediatrics, obstetrics, mortuaries and microbiology laboratories. The HCW should have his or her practice restricted, their manager advised in writing of the recommended restrictions and a note to this effect entered in the occupational health records. A HCW who is non-immune to TB but chooses not to undergo a BCG vaccination should sign a Form of Acknowledgement (to be kept in the occupational health records) that they are aware of their increased risk of catching TB but have declined an offer of vaccination. An alternative practice is for the HCW to have regular (annual) health surveillance with tuberculin skin tests and chemoprophylaxis or treatment as appropriate if skin reactivity increases by two or more grades. A Form of Acknowledgement to this effect should also be signed.

Transmission of TB from HCW to patient is uncommon [33–36]; however, HCWs with infectious TB should not work with patients. The risk of transmission of pulmonary TB is low after 2 weeks of chemotherapy unless the mycobacteria are multidrug resistant, in which case the HCW should not work until they have completed a course of treatment and remain culture negative from sputum. HCWs with positive cultures for environmental mycobacteria pose no risk to patients.

**Asthma**

HCWs with current asthma may have impaired lung function and, if also sensitized by way of their work to, for example, aldehydes, latex, enzymes, ispagula or acrylics, then their disability will be enhanced. Workplace control of the hazard or, where this is not possible, relocation of the asthmatic HCW away from the sensitizing agent should be feasible in most health care settings.
**Bronchiectasis and cystic fibrosis**

HCWs with bronchiectasis or cystic fibrosis and significant production of daily sputum may be colonized or infected with *Pseudomonas* sp. or MRSA. There is evidence of patient-to-patient spread of *Pseudomonas* sp. in health care settings [37–39], but no published report of spread from HCW to patient or from patient to HCW. It would seem prudent, however, for reasons of good infection control, to restrict HCWs with diseased lungs and chronic sputum production who have been colonized with MRSA, *Pseudomonas aeruginosa*, *Burkholderia cepacia* complex or *Stenothrophomonas multiflora* from working with neonates or immunocompromised patients. It would also seem prudent for HCWs with bronchiectasis or cystic fibrosis to avoid treating patients with *Pseudomonas* sp. or MRSA so as to reduce the risk of cross-infection and further damage to their own lungs.

**Blood-borne viruses**

The regulatory bodies for doctors, dentists and nurses have advised on the professional responsibilities of practitioners infected or who have placed themselves at risk of infection with the hepatitis B virus (HBV) or human immunodeficiency virus (HIV). HCWs undertaking exposure-prone procedures (EPPs) should have evidence of immunity or non-infectivity to HBV [6]. All non-immune clinical HCWs should be vaccinated against HBV, and following successful immunization, it is recommended that one single booster of vaccine only should be given after 5 years [30]. HCWs who are non-responders to vaccine and who are non-immune should be advised in writing of their immune status and the need for post-exposure prophylaxis with specific hepatitis B immunoglobulin after a high-risk inoculation incident. Because of recent reports of transmission from doctor to patient [40], it is now a requirement of the Department of Health that HCWs who are hepatitis B antigen-negative carriers of the virus and who undertake EPPs or work in renal dialysis units must have <10^3 genome equivalents/ml viral DNA (HSC 2000/20).

Current Department of Health guidelines still permit HCWs who are hepatitis C antibody positive to perform EPPs although transmission from doctor to patient has been recorded in these circumstances [41–44]. Affected clinicians should, if appropriate, be offered treatment, but advised that these guidelines are under review and may change. Those in training should be advised to consider changing to work that does not involve EPPs.

Transmission of HIV from HCW to patient has been recorded now on two separate occasions [45,46]. Clinical HCWs who are HIV antibody positive, confirmed in two independent laboratories, must not perform EPPs [5]. As with other immunosuppressed patients, clinical HCWs who are HIV seropositive, or at high risk of being positive, should not be vaccinated with BCG. This is because the efficacy of the vaccine is unknown in this situation and there is a risk of inducing disseminated TB in the vacciné. A clinical HCW who is Heaf test grade 0–1 but who has a past history of TB, immunity to TB, or is from a country where TB is endemic, should be counselled about the possibility of HIV infection and, if appropriate, tested with consent for HIV antibodies. If consent is not given, the HCW should be restricted as if immunosuppressed (see section on TB). HCWs who are HIV seropositive or who have the acquired immune deficiency syndrome are at increased risk of catching TB and may therefore pose a risk of cross-infection [47]. It would seem prudent to restrict their practice from high-risk situations.

**Influenza and other infections**

Clinical HCWs who are febrile, with symptoms of cough, sneezing, diarrhoea or vomiting, should not be in contact with neonates or immunocompromised patients. There is increasing evidence that vaccinating HCWs who work with elderly patients against influenza is associated with significantly reduced patient mortality [48,49], probably by the prevention of nosocomial transmission. We recommend therefore that HCWs at high risk [30], or who work with the elderly (>70 years) or immunocompromised patients or in nursing homes, should be vaccinated against influenza. To avoid the risk of transmitting rubella to non-immune pregnant patients, seronegative clinical HCWs (both male and female) should be vaccinated with rubella vaccine [30]. HCWs who work with pregnant women, neonates or immunocompromised patients should have their immunity to varicella ascertained and those who are seronegative must follow infection control guidelines when in contact with a case of chicken pox [30]. Staff who are in contact with varicella specimens in laboratories or mortuaries should also know their varicella status.

**Epilepsy**

A liability to epileptic fits or attacks of altered consciousness is not normally a bar to clinical work—unless the attacks occur without warning or in a way which might put the patient or HCW at risk. Such a situation may arise when the HCW has sole charge of a patient or is performing an invasive procedure, e.g. during surgery, giving an anaesthetic or nursing a baby.

A continuing liability to further seizures by reason of a structural lesion or electroencephalogram suggesting subclinical seizures increases the risk of recurrent attacks. Co-morbid factors, such as substance abuse or depression, need to be taken into consideration, as does compliance with treatment and the side-effects of medication. If driving is a requirement of the job, then the medical standards of the DVLA will apply [21]. Once reasonable
control of seizures has been achieved, epilepsy should not prevent training as a clinical HCW, although night work which leads to sleep deprivation may cause a deterioration in seizure control [50]. HCWs with seizures that have occurred only during sleep should not be restricted in their work unless the HCW is on call that night or if the symptoms persist during the following day.

A HCW liable to uncontrolled attacks of narcolepsy, cataplexy or disabling vertigo should be restricted in the same way as a HCW with epilepsy. Untreated sleep apnoea will also interfere with concentration and performance, and is not therefore compatible with safe clinical practice.

Disabling neurological conditions

Occupational problems may occur with any chronic degenerative neurological condition that impairs motor, sensory or cognitive functions, such as multiple sclerosis, dementia or Parkinson's disease. Because much of the work of a clinical HCW is safety critical, the functional ability of an affected individual should be kept under review by an occupational physician, in liaison, when necessary, with the general practitioner and treating specialist. A particular problem occurs with cognitive deficit that may not be appreciated by the affected HCW; in which case, additional information from a third party such as a colleague or spouse may be helpful.

Obesity

A body mass index of >30 kg/m² is associated with increased mortality [51], increased morbidity [52] and more disability pensions [53]. Severe obesity in certain circumstances may create difficulties with manual handling and also with health education, which may need to be taken into consideration at job placement.

Employment law

HCWs who are at increased risk of illness or injury as a result of their work must be given information, instruction and training on how to reduce such risks. Clinical HCWs who contract an illness or who suffer an injury as a result of their work are entitled to NHS Injury Benefit (form AW13) and may be entitled to Industrial Injury Benefit from the Benefits Agency. Doctors who are asked to provide information about patients for the purpose of employment should release information in accordance with the Access to Medical Reports Act (1988) [54]. The provision of such information falls within category 1 of the Terms and Conditions of Service of Hospital Medical and Dental Staff (appendix 3, sections 36 and 37) for which no fee is payable.

The Disability Discrimination Act (1995) requires that employers make suitable and reasonable adjustments to the workplace to accommodate an employee who has substantial and long-term physical or mental impairment that prevents that person from carrying out normal and everyday activities [55]. Financial help for employers is available from the Employment Service via the Disability Employment Advisor.

An employer can only make adaptations if they are aware that a HCW has a disability or medical condition relevant to employment, and pre-placement health screening or periodic health surveillance is one way in which this can be facilitated. In most situations, safe clinical practice can be achieved by workplace adaptations, safe systems of work, careful rehabilitation or redeployment, and openness by both the clinical HCW and the employer.

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