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Review of literature on the mental health of doctors: Are specialist services needed?

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Abstract

Background. Mental ill health is common among doctors. Fast, efficient diagnosis and treatment are needed as mentally ill doctors pose a safety risk to the public, yet they are often reluctant to seek help.

Aims. To review literature regarding risk factors and potential barriers to help-seeking unique to doctors; to consider the success of interventions by specialist services for doctors.

Method: Key phrases regarding the 'mental health of doctors' were entered into internet searches and journal databases to identify relevant research. When key authors were identified, author-specific searches were carried out.

Findings. There are contradictory reports about the prevalence of mental ill health in doctors but it is generally agreed that doctors face a large number of risk factors, both occupational and individual; and help-seeking is difficult due to complexities surrounding a doctor becoming a patient. Specialist services developed specifically for interventions for doctors with mental health problems tend to show promising results but further research is needed.

Conclusions. The unique and complex situation of a doctor becoming a patient benefits from specialist services; such services should focus on early intervention and raising awareness.

Keywords: *Mental health research, mental health of doctors, risk factors, obstacles to help-seeking, interventions*

Introduction

The research presented here forms a narrative review and is not intended to be a systematic review. We discuss research on the epidemiology of mental ill health in doctors – in terms of prevalence and risk factors – before considering obstacles to help-seeking unique to doctors, and whether specialist services for doctors are needed.

Epidemiology of mental ill health in practitioners

A wealth of research suggests that doctors have high rates of mental health problems including depression (Firth-Cozens, 2006), anxiety (Kroenke et al., 2007), addiction to

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alcohol or drugs (Bennett & O'Donovan, 2001; Brooke et al., 1993; Ghodse & Galea, 2006; Pilowski & O'Sullivan, 1989; Strang et al., 1988), misuse of prescription drugs (Forsythe et al., 1999; Vaillant, 1992), and emotional exhaustion or 'burnout' (Isaksson et al., 2008; Shanafelt et al., 2002). Suicide levels are also high for doctors (Firth-Cozens, 2006), particularly female doctors (Hawton et al., 2001; Lindeman et al., 1997).

Mental ill health in practitioners appears to be a global phenomenon. In the United Kingdom, for example, it has been suggested that between 10 and 20% of doctors become depressed at some point in their career and have a higher risk of suicide than the general population (Firth-Cozens, 2006). A survey sent round to members of the UK-based Doctors Support Network (Miller, 2008) found that 68% of 116 respondents had a diagnosis of depression; others reported diagnoses of bipolar disorder, anxiety, eating disorders and addictions. In Canada, a study using an objective measure of emotional exhaustion revealed that 80% of physicians were suffering from burnout (Thommasen et al., 2001). Burnout was also found to be common in doctors in Switzerland (Goehring et al., 2005). In the United States, studies have found high suicide rates in doctors (e.g. Frank et al., 2000) and high rates of prescription drug use, particularly opiates and benzodiazepines (Hughes et al., 1992). It has been suggested that approximately 10–12% of physicians in the USA develop a substance-use disorder (Flaherty & Richman, 1993), although this is similar to the rate for the general population. A large Canadian study showed that 23% of over 1800 practitioners had significant depressive symptoms, with female doctors twice as likely to be depressed (Hsu & Marshall, 1987). In New Zealand, it has been suggested that mental health problems are nearly three times as prevalent in general practitioners and surgeons than in the general population (Dowell et al., 2000). A study investigating psychological distress in hospital doctors in Auckland (Clarke & Singh, 2004) found that 29.1% of the doctors in the study showed psychological distress, higher than the general population.

There appear to be high rates of mental ill health in young doctors. Recent findings from studies of young doctors suggest that their own health care is poor (Baldwin et al., 1997) and that doctors with addiction problems in later life tend to manifest vulnerabilities at medical school (Marshall, 2008). In a study of the psychological characteristics of patients attending MedNet, a confidential consultation service for doctors and dentists in London (Garelick et al., 2007), the largest age group attending the service were young (30–39 years). This may suggest that the transition from trainee to having full consultant responsibility is a particularly stressful time. A prospective study (Sen et al., 2010) found a significant increase in depressive symptoms during medical internship, with over a quarter of the participants meeting the criteria for depression during internship compared to just 3.9% before the internship. There appears to be a need for support and monitoring from a very early stage of the doctor's career, with medical training emphasising clear pathways for help and increasing awareness of the vulnerability of doctors to mental illness (Hassan et al., 2009).

There is clearly much research suggesting that doctors have high rates of mental ill health. However, most of these studies are cross-sectional studies using self-report data to focus on a particular group of practitioners, and there are conflicting figures about how mental ill health in doctors compares to the rest of the population. What is generally agreed upon is that it is important that doctors receive help quickly in order to protect the safety of their patients, and that young doctors need to be made aware of where to seek help in order to treat problems at an early stage, and not much later in their career when they may be much worse. We will now examine literature on the particular risk factors involved with being a doctor before moving on to consider

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obstacles to seeking help and the potential problems involved with being a patient which are unique to doctors.

Risk factors

The job of a doctor is a high-pressure one, with many stressors involved in the profession (Gerada et al., 2000). Risk factors can generally be divided into two categories: occupational risk factors (risks associated with the job itself; this can be further divided into clinical and structural aspects of the job) and individual risk factors (personality traits and psychological vulnerabilities which may interact with occupational risk factors to create psychological distress).

Occupational risk factors (clinical)

The emotional demands of working with patients can be a major stressor (Persaud, 2004). For example, doctors are routinely faced with breaking bad news (Schildmann et al., 2005) and are in frequent contact with illness, anxiety, suffering and death (Bennett & O'Donovan, 2001). Other patient-related stressors may include patients' high expectations about the power of medicine putting unrealistic pressure on doctors (Edwards et al., 2002) and even aggression (both verbal and physical) from patients (Hobbs & Keane, 1996). A doctors' relationship with patients was found to be a key predictor of depression in GPs (Firth-Cozens, 1998).

Another occupational risk factor may be the easy access to prescription drugs. As noted in the first section of this paper, misuse of prescription drugs is common in health professionals, likely related to ease of access; doctors are in regular contact with a wide variety of drugs, and possess the knowledge of how the drugs work, what they do, and how to administer them (Bennett & Donovan, 2001; Brooke et al., 1991; Christie et al., 1998; Merlo & Gold, 2008).

Occupational risk factors (structural)

The heavy workload and working hours involved in the job can also be risk factors: long shifts and unpredictable hours (and the sleep deprivation associated with these) can cause psychological distress (Defoe et al., 2001; Firth-Cozens & Cording, 2004).

The psychosocial work environment may be another risk factor. It has been suggested that doctors frequently experience problematic relationships and conflicts with colleagues (Garelick & Fagin, 2004); workplace bullying (Quine, 2002); and lack of cohesive teamwork and social support, leading them to work individually (Firth-Cozens, 2000), whereas working in teams is associated with being better able to cope with stress (Sexton et al., 2000). All of these factors may contribute to psychological distress.

Many of these occupational risk factors are intrinsic to the job. Even those which could be modified (such as workload and hours worked) may lead to greater tension with other members of staff.

Individual risk factors

Firth-Cozens (1997) suggests that the difficult and emotionally demanding job of a doctor frequently leads to doctors being self-critical. The typical personality traits of many medical professionals, such as perfectionism, can lead individuals to become increasingly self-critical

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which can increase stress and lead to depression (e.g. Brewin & Firth, 1997; McManus et al., 2004). Some practitioners have unhelpful coping strategies (e.g. emotional distancing, rather than actively dealing with stressors) which may add to psychological distress (Tattersall et al., 1999). Other psychological vulnerabilities common in physicians have been identified, including an excessive sense of responsibility, desire to please everyone, guilt for things outside of one's own control, self-doubt and obsessive compulsive traits (Vaillant et al., 1972).

Interaction between occupational and individual risk factors should be considered (Harvey et al., 2009), as it may be a combination of workplace stressors and psychological vulnerabilities which produce psychiatric disorder. Mental ill health in doctors cannot simply be due to occupational stressors as if it were, a much greater percentage of healthcare professionals would be mentally ill. It may be the case that workplace risk factors can lead to mental ill health *in vulnerable individuals* – in other words, occupational risk factors combine with pre-existing personality factors to create psychological distress.

Obstacles to help-seeking

There are many reasons why doctors may not seek help for mental health problems, and this section discusses the various barriers to help-seeking experienced by doctors.

Lack of knowledge about where to find help

There are various practical reasons – first, the fact that many doctors do not know where to go to seek help. In the early years of one's career in health there is often a great deal of moving around during training and placements – this may make it difficult to know where to seek help. A study of young doctors (Baldwin et al., 1997) found many were not registered with a GP and were unsure of the role of occupational health services.

Professional implications

Practitioners may have concerns about how their professional future might be affected by seeking help for mental health problems (Iversen et al., 2009). For example, they may be worried about having to take time off work (Wrate, 1999) which can be troublesome in the short term (they may feel guilty and that they are letting people down by taking even a day-off sick) and especially in the long term, where they may worry that it will be hard to get back to work if they need an extended period of leave. Doctors report high levels of 'presenteeism' (attending work even when not feeling well enough to do so). Studies have suggested that doctors tend to take very little time off work even when unwell (Baldwin et al., 1997; Forsythe et al., 1999). It has also been found that medical students are reluctant to seek help due to the worry that the stigma attached to a mental illness may affect the progression of their career (Chew-Graham et al., 2003).

There may also be concerns about the implications of disclosing an illness, particularly where illegal activities such as substance misuse are involved. It is important to note that medicine is a regulated profession, where doctors' health is of interest to the regulators as well as performance. Doctors may hide illness specifically to avoid potential disciplinary action, such as suspension or General Medical Council involvement, which could lead to a long period of stress and confusion due to the lengthy investigations that take place when doctors are suspended (Marshall, 2008; Strang et al., 1998).

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Difficulties with disclosure

It is common for doctors to self-diagnose and self-treat, and even self-prescribe (Baldwin et al., 1997; Davidson & Schattner, 2003; Hem et al., 2005). Watts (2005) suggested that doctors tend to be secretive and reluctant to disclose mental health problems. It may be that doctors are worried about confidentiality, with anxieties about this often leading to minimisation and even denial of symptoms (Kay et al., 2008). It is possible that doctors could end up getting treatment from someone they know in a professional context (Barrett, 1995), making it difficult to establish a normal doctor–patient relationship. A study of doctors' attitudes to becoming mentally ill (Hassan et al., 2009) asked respondents who they would disclose to if they were to become mentally ill and what factors might influence this. About 73.4% of 2462 respondents said they would disclose a mental illness to a friend or family member rather than a professional, with most suggesting that career implications were their biggest concern regarding seeking help, as well as professional integrity and stigma. They concluded that there is a stigma surrounding mental health which is prevalent in doctors. Even when health problems are disclosed, it is common for doctors to have informal discussions with colleagues rather than formal consultations (Baldwin et al., 1997). Even if formal consultations are sought, doctors are often treated as colleagues and not patients (Strang et al., 1998).

Psychological barriers to help-seeking

There are also psychological and psychosocial factors which may add to practitioners' reluctance to seek help – for example, feelings of shame and embarrassment (Davidson & Schattner, 2003; Thompson et al., 2001). It has been suggested that mental ill health may be seen as a weakness (McKevitt & Morgan, 1997) and that there is a pressure for doctors to appear healthy (Thompson et al., 2001) – doctors may feel that they are letting down themselves, their patients, and their colleagues by becoming ill and needing to seek help and potentially take time away from work.

It appears to be hard for a doctor to become a patient (McKevitt et al., 1997), with many frequently resisting the 'role reversal' involved (Thompson et al., 2001). It should be noted here that it is also extremely difficult for the doctor *treating* the doctor–patient (Strang et al., 1998) – they may over-identify with the patient and there are certain to be boundaries and control issues, difficult for both the doctor–patient and the doctor treating them. Waring (1974) suggests that doctors are very difficult patients and they receive inadequate treatment from colleagues.

Given the amount of risk factors doctors face and the number of unique and complex factors making it difficult to seek help, doctors may benefit from specialised services – developed specifically for doctors and other health practitioners – where confidentiality is assured and rapid, efficient diagnosis and treatment can be provided. We will now go on to consider some of the services that are available around the world and whether such interventions have been successful.

Interventions

Although there are certain factors which may lead to the development of mental health problems, it is not always possible to predict who will suffer from mental health and who will not. According to Tyssen and Vaglum (2002), there are no reliable predictors of mental

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health problems and therefore the focus should be on early identification and treatment of problems.

Fast and efficient diagnosis and treatment benefit not only the sick doctor but also those they treat: untreated mental health problems in doctors may lead to poor performance, professional misconduct and an inadequate quality of care for their patients. In order to ensure patient safety and sustain public confidence in doctors, it is essential to identify and treat mental health problems in doctors as quickly and efficiently as possible so that their quality of care is not compromised.

Interventions should be straightforward and efficient in order to make the treatment process as effective as possible. However, there are often many official bodies and individuals who become involved when a doctor becomes sick – for example, supervisors, occupational health teams and deaneries. The amount of people involved in treatment and monitoring, especially if there is conflicting advice given or a lack of communication between parties, may lead to confusion for the doctor–patient.

In many countries, specialist services for health professionals have been set up, where practitioners can get support and treatment in an environment designed specifically for doctors. We will now consider some of the interventions which have already been established.

In the USA, Physician Health Programmes or 'PHPs' were developed in the 1970s to provide professional support and monitoring for healthcare professionals and for early detection and intervention for healthcare professionals with substance misuse disorders. The PHPs carry out assessments and facilitate treatment elsewhere (often in 'residential' inpatient programmes), and monitor the practitioners over time – their purpose is to provide referrals and long-term case management, rather than to give treatment. A contract between the PHP and patient is developed, and the patient's family, employers, colleagues and regulatory bodies are kept informed throughout (DuPont et al., 2009). A study examining 5-year outcomes for practitioners across 16 PHPs (McLellan et al., 2008) found that those who failed the programme (19.3%) usually did so early on. Of those who did complete treatment, over 80% had no positive urine tests for drugs or alcohol at the 5-year follow-up. Around 78.7% of the doctors were working after 5 years, and 95% were still licensed. It was concluded that approximately three quarters of the professionals in the study had favourable outcomes after 5 years, and that positive outcomes are more to do with the long-term nature of the treatment and monitoring rather than to specific modes of therapy. Another evaluation of PHPs (DuPont et al., 2009) found that treatment for physicians with substance-use disorders is different from the treatment provided to the general population, in terms of intensity and duration of care; outcomes of PHP substance misuse programmes are superior to outcomes for the general population involved in drug treatment programmes in terms of high abstinence rates over a long period of time (Domino et al., 2005).

In Spain, the Program for the Integral Care of the Ill Physician (PAIMM) provides care specifically for physicians with psychiatric disorders or addictions, and appears to have been successful (Bosch, 2000). In Ireland, the Sick Doctor Scheme (Irish Medical News, 2009) promotes early intervention and prevention and provides practical support to doctors with substance abuse, though there is little research on outcomes. In Norway, a counselling intervention aimed at self-reflection and acknowledging needs (Tyssen, 2007) was investigated and it was found that emotional exhaustion was significantly reduced at the 1-year follow-up (Isaksson et al., 2008). In the UK, several specialist services for doctors exist, though these are not nation-wide and generally do not have long-term funding for a secure future. Such services are less closely linked to regulatory bodies than the American PHPs, although patients are encouraged to self-disclose where appropriate. The London-

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based Practitioner Health Programme – an integrated, comprehensive service developed specifically to help doctors and dentists with mental health and addiction problems – is funded by the Department of Health for a pilot stage of 2 years. Research on patients presenting at this service so far suggests that doctors and dentists often have very serious problems before they present for help – they are not getting the early intervention that is needed to protect both themselves and patient safety (Practitioner Health Programme, 2010). Other London-based services such as MedNet (Garelick et al., 2007) have not yet been running long enough for long-term evaluations to be carried out.

Despite the fact that specialist services for doctors are beginning to emerge, there are still unmet needs; practitioners are still reluctant to seek help; self-treating and self-prescribing are still common (Forsythe et al., 1999). Oxley (2004) agrees that doctors have diverse needs which have not yet been met. Clearly something more needs to be done, and we will discuss potential future research and intervention strategies in the next section.

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Conclusions

The mental health, psychological wellbeing and functioning of doctors is an important issue, which should be considered separately to mental health issues of the general population.

Literature reviews yield contradictory reports with varying figures about the prevalence of mental ill health in doctors compared to the non-health professional population. However, researchers *do* tend to agree that it is important for doctors to be helped quickly and efficiently in order to protect their own patients; that there are many risk factors associated with the job; that it is difficult for doctors to seek help; that the situation where a doctor becomes a patient is a unique one which needs to be explored and understood so that the right treatment can be delivered. Focus should therefore shift from the epidemiology of mental health in doctors and on to the best ways to minimise the risk of doctors developing mental health problems and how to treat those doctors who a*re* mentally unwell.

Should doctors have specialist services?

As we have discussed, doctors have great occupational health risks associated with their job, and there are many complex issues which can arise from a doctor seeking help for mental health problems. We have discussed the difficulties involved in help-seeking for doctors, and complexities involved when a doctor does become a patient. Therefore it seems logical to suggest that doctors may benefit from specialist services which take these unique issues into account. For example, we discussed earlier that career concerns may make doctors reluctant to seek help. This suggests that a service is needed which will ensure confidentiality and which will not report patients without their knowledge but will, if GMC disclosure is necessary due to the doctor posing a threat to patients, advise the patient if and how they need to self-disclose and ensure that they are supported during the process. Practitioners may see help-seeking as leading to a potential threat to their career, financial situation and future prospects, but a specialist service could in fact give them the advice and support needed to ensure that they do what is best for themselves and the patients they treat.

A unique kind of support is needed in order to make the transition from doctor to patient as problem-free as possible: practitioners treating other practitioners need to acknowledge and respect their patient's role as a doctor as well as their needs as a patient. These may be difficult to reconcile, and special training may be required to make both parties comfortable with the situation. It is imperative that the treating practitioners strike the right balance

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between respecting their patient's position as a health professional and listening to their own ideas about their treatment plan, and also being firm about what is best for the doctor–patient. They must also be aware of possible issues that might arise: the doctor–patient being embarrassed, or feeling that they know more than the doctor treating them or being reluctant to take advice from a peer.

We have also discussed the difficulties facing medical students and newly qualified doctors, who may require help settling in and knowing where to go for help should problems arise. It is important that advice, treatment and support are made available to practitioners from an early stage in their career. The recent concept of 'mentoring' (Alliott, 1996) – involving a more experienced doctor acting as a 'role model' for a younger doctor, providing support and advice and encouraging self-reflection and career development – may be of benefit (Iversen et al., 2009). Other pathways might include induction for new healthcare professionals, with clear information about risk factors and where to seek help; directors and leaders being made aware of risks and particularly vulnerable times (e.g. transition periods) and encouraged to monitor practitioners; staff being encouraged to help monitor their colleagues; and clear information about where to seek help being provided on medical school websites and in NHS and GMC documents. Awareness should be raised during medical school and training, addressing not only how to seek help but also the psychological obstacles to help-seeking – emphasising that the same worries are shared by many, and that it is still important to seek help, may encourage help-seeking. Education on stigma is also needed, as reducing the stigma attached to mental illness in doctors may mean there is less 'shame' involved in help-seeking.

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Future research

More prospective – rather than retrospective – studies on risk factors are needed, where risk factors in the population are examined first and then followed up. It would also be useful to explore the interaction of occupational risk factors and individual risk factors, to more reliably predict who might be vulnerable to mental ill health. In terms of interventions, it may be useful to investigate whether doctors of different ages, genders and specialities may experience different risk factors and if therefore they may benefit from different aspects of intervention.

There is a lack of evaluation studies of many of the specialist services which exist around the world, due mostly to the anonymity and confidentiality that such services promise. If possible, it would be useful for more findings to be published, as long as anonymity of patients could be preserved. There also need to be more longitudinal evaluations of the specialist intervention services, as little is known about the long-term benefits of many of these services.

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