BMA

Personal stories of doctors in training with experience of mental illness

Doctors in training are dealing with mental illness, in some cases caused or exacerbated by the pressures of the job. Negative attitudes towards mental ill-health stop doctors seeking the help they need for fear of being seen as weak, and prevent them from taking sick leave when they know they are too unwell to work.

Doctors worry about the impact of disclosing mental ill-health on their future career and struggle to access appropriate support services. The lack of comprehensive occupational health services adds to the difficulties doctors experience in taking time off and returning to work.

It is clear that there is much still to do to improve the working lives of doctors with mental illness. This paper looks at the lived experiences of a group of doctors in training and makes recommendations for change.

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Introduction

There is some uncertainty in existing literature as to whether mental illness is more common among medical students and doctors than in the general population (Mata et al., 2015; Brooks et al, 2011). It is certainly true that maladaptive behaviour in young doctors when ill has been reported for over 20 years (Baldwin, Dodd, & Wrate, 1997) and a number of self-report studies show an increased prevalence of mental illness among doctors compared to the general population (Brooks, 2015). A systematic review and meta-analysis found the prevalence of depression among doctors to be 28.2%, ranging from 20.9% to 43.2% depending on the instrument used (Mata et al., 2015). Yet the evidence is not conclusive. There is, however, a consensus that it is imperative for the safety of their patients that mentally ill doctors can access immediate effective medical care (GMC, 2014).

Much has been written about the factors that contribute towards doctors becoming mentally unwell, somewhat less about the factors that aid their recovery, and the barriers they encounter in seeking support when needed. To address this, a team at Swansea University Medical School undertook a study which aimed to identify factors and barriers that influence the recovery of doctors in training who experience mental illness, drawing on a review of the literature, interviews with stakeholders, focus group interviews with trainee doctors, and narrative interviews with trainees who had personally experienced mental illness.

This paper is based on those narrative interviews and gives unique insights into what it is like to experience mental illness during a doctor's trainee years. It attempts to understand the factors, specific to their occupation, that may have contributed to their illness, the barriers they faced in seeking help, and the factors that influenced their recovery. This report draws on these experiences to develop a series of recommendations designed to improve the support available to doctors experiencing mental illness. Personal information has been omitted from the quotes to preserve participants' anonymity.

Key findings and recommendations

There are specific pressures on doctors in training

All of the participants were doctors in training, most of whom were in their mid to late twenties. As would be expected with people in this age range, they were commonly experiencing significant life events such as meeting a life partner, getting married, buying a home and the arrival of and caring for young children. What being a doctor in training appeared to add to this was the need to do a highly pressurised job where the consequences of error were grave. Some specific factors can impact on the mental health of younger doctors, including transition from medical student to trainee doctor and from trainee to full consultant responsibility, having to make life and death decisions and working shifts (Baldwin et al., 1997; Brooks, Gerada, & Chalder, 2011; Dyrbye, Thomas, & Shanafelt, 2005). At times the combination of major life events and doing the job while feeling unsupported was overwhelming.

'Oh, God. I have to do something to fix this situation, and I don't know what to do and I don't know who I should ask to find out what to do and this person is weight bearing on their hideous fracture and I don't know how bad that is.'

Doctors work when they know they are unwell

A number of the participants had knowingly continued working even though they knew they were ill and sometimes after they had been diagnosed and advised to take sick leave. They describe doing the bare minimum to get by, being unable or unwilling to engage with patients and failing to remember the basic knowledge needed to practice. For the most part, they had sufficient insight into the consequences but felt they had no alternative but to continue working.

Crucially, having a mental health problem interfered with doctors' ability to carry out one of the most fundamental tasks for any doctor – the ability to listen to and communicate with patients effectively. It also affected some doctors' cognitive function.

'I'd kind of be okay if it was like a senior ward round, I could just go and do the jobs. But if I had to have any autonomous thinking and it was you know, I think it was the first time I did my own bit of the ward round. And I just couldn't, I couldn't my thoughts weren't very coherent because I just felt so panicked. I just thought "well I can't do this anymore" like I just felt so overwhelmed by it and I felt like 'well this is such a responsibility, like what am I doing here?' And I just remember feeling like really, really anxious'

'...not really being able to read or comprehend or retain any information which was tricky.'

'...it got to the point where I was almost catatonic in my room all the time. I was making it to work, just doing what is required and then coming back but I wasn't making any advancements in anything else in work I was just doing my on calls, turning up doing the list'

Recommendation:

Special provision should be made for doctors in training with mental illness, who face particular challenges due to their stage of life. This is imperative because, as this study shows, doctors with mental illness, at best, are unavailable due to sick leave and, at worst, are practising when their ability to do their job is impaired. This has serious implications for the quality and safety of patient care.

The recently announced expansion of the Practitioner Health Programme is a welcome development. Care must now be taken to ensure the Programme can cater for the specific needs of doctors in training alongside other groups of doctors.

Doctors in training are reluctant to take sick leave

Sick leave, and the decisions it forced the participants to make when they were unwell, caused a great deal of distress. The need to take sick leave was a source of major conflict. One participant was even told at induction not to take sick leave.

Most participants did take a period of sick leave. Almost all had resisted this and, in several cases, a third person, a friend or relative had intervened and persuaded them that they must take sick leave.

'So, she made me phone in sick on Monday. I told them I had a temperature and that I was unwell and that I couldn't come to work and she made an appointment for me. So my mum took me to the GP and she took one look at me, gave me a sick note for six weeks that said stress and I think started me on an antidepressant there and then.'

For some participants it was their own perception of taking sick leave and it being associated with failure that kept them at work.

'Yeah of course, so I managed not to make any major mistakes that I know of but just I couldn't think. I thought it would be a complete failure to have to have time off work'

However, negative views of mental illness among doctors were aired freely in the workplace by senior colleagues.

'Like the department I was in before there was about five trainees off sick around the time that I was with mental health problems and there was so much public chat amongst the consultants about how these days trainees just can't cope with the stress and they go off sick and as soon as they go off sick we should half their pay, that would stop them going off.'

Several participants took sick leave only when the clinician looking after them said they would inform their employer that they were not well enough to be at work.

'...he said that you either don't, you either go on sick leave now or I am calling the hospital and telling them that you are not going to be allowed to go to work.'

When they did take leave, it sometimes still took second place to the needs of their unit. One doctor, having been taken to their GP and given a medical certificate for two weeks, did not start the sick leave for another two days as there was nobody else to do their shifts.

'I was signed off for two weeks as well but I still had two more on calls to do like the following day so I still went and did those. So probably not the most sensible thing to do but I thought well we won't get anyone.'

Being on sick leave was a shock for these doctors. It meant being away from the career path and the professional identity that they had been working towards for many years, and which formed a central part of their sense of identity.

'...my identity was extremely bound up in my you know my profession and like it had been ever since I started medical school you know immediately once you start university you are one of the medics... It's not just a job is it.'

Participants talked about feeling like a fraud when they were on sick leave and pushed the doctors caring for them to permit them to return to work before they were ready.

Doctors are concerned that their illness will be disclosed

Fear of disclosure manifested itself in a number of ways. One doctor was sufficiently afraid of the effects of disclosure on her career that she consulted a psychiatrist privately.

'By that time I knew I was really poorly. With records and now I don't, I've not consented for any record, any GP record sharing, so I didn't want my notes potentially accessible....I didn't want my notes there, I didn't want them recorded for time indefinite....I was worried about fitness to practice issues. I didn't want to stop work. I didn't want long-term consequences. I didn't really want anybody to know what was going on.'

Most participants, if they could avoid it, did not disclose their illness to their educational supervisor or anybody else who might have any influence over their career progression (and this included sources of potential support within the deanery). The outcome of this ongoing lack of disclosure was that, at times, some participants were judged to be performing poorly, disengaged or rude, when in fact their behaviour related to mental illness.

The fact that doctors are unable or unwilling to disclose their illness to their line manager or supervisor is of concern. The implication is that doctors assume disclosing a mental illness will be seen as failure and could harm their career. The fact that trainees are working in a culture that allows negative attitudes about sickness to go unchallenged serves to compound this problem.

Concealment of illness is closely linked to presenteeism. A 2015 survey found that doctors take one-third of the amount of sick leave of other healthcare workers (Workforce and Facilities Team, 2015). Yet this is at odds with data illustrating the prevalence of mental illness amongst this group (Mata et al, 2015). Factors already identified – attitudes in the workplace, a strong work ethic and sense of identity as a doctor, not wanting to add to colleagues' burden by being off sick – contribute to presenteeism among doctors who are not always fit to work.

Interestingly, despite their reluctance to disclose their illness, several interviewees reported that their educational supervisors were very helpful and supportive once they became aware of their difficulties. This echoes findings from a previous study of medical students (Grant et al., 2013). This work found that fear of the effects of disclosure was a major issue but also that those students who did disclose to their medical school, without exception, received good support. It's clear that there is a mismatch between the perception of what will happen when illness is disclosed, and what actually happens. This mismatch needs to be made much clearer to doctors, to encourage them to seek help at an earlier stage.

Recommendations:

— Employers must take steps to tackle the stigma of mental illness among the medical profession so doctors feel able to seek help when they need it — the view that mental illness is equal to weakness is still commonly held. One way to do this would be include information about the prevalence of illness among doctors, including mental illness, at induction sessions. Inductions should also be used to raise awareness about the signs that could alert doctors to mental illness in themselves and their colleagues. Employers should instigate regular awareness raising sessions for all staff, covering mental health and suicide risk, with information on how to get help.

— Employers should have comprehensive health and wellbeing strategies in place covering all NHS staff — a 2014 audit of NICE workplace guidance found that this was the case in only 57% of trusts in England. To ensure that health and wellbeing strategies work, staff at all levels should be encouraged to be involved in their design and implementation.

— Creating the right conditions to tackle stigma about mental illness requires leadership from the very top of every organisation. Doctors are unwilling to seek help for mental health problems, so board members and senior managers need to show engagement and leadership on the issue. This will help to foster more open and supportive cultures that encourage doctors to seek help and to support each other. Doctors who supervise or line manager other doctors also need help to develop the skills required to support more junior staff who may be experiencing mental illness.

Doctors can struggle to access support

Access to appropriate support was impeded for the interviewees in a number of ways. As well as cultural barriers created by the overt expression of negative attitudes towards illness, some reported being purposefully prevented from accessing appropriate clinical care and facing difficulties in negotiating time away from work for appointments.

Support units in postgraduate training bodies, which are in place to support trainees with a wide spectrum of problems including mental illness, were perceived to be too close to employment and disciplinary processes, and referral to them was seen as punitive by some.

In rural and semi-rural areas doctors in training were more likely to be known to local practitioners such as psychiatrists. Perhaps understandably, they did not wish to consult current or former colleagues about their mental illness. For those who chose private psychiatric help to ensure confidentiality, there were significant financial implications.

These sorts of barriers may contribute to the temptation peculiar to members of the medical profession to treat themselves when they become ill (George, Hanson, & Jackson, 2014), a behaviour which of itself raises questions of efficiency if not risk.

Recommendations:

– To encourage staff to access services at an earlier stage, employers should tackle the stigma that surrounds accessing support services. This should include regularly raising awareness of mental health and suicide risk amongst healthcare workers with information on how to get help. The confidential nature of occupational health and other support services must be also be stressed.

– Doctors in training should have access to a senior colleague, tutor or mentor to whom they could turn if they needed support. A previous study examining support for medical students with mental illness found that all the participants had access to a personal tutor (Grant et al., 2013). This should be replicated for doctors in training.

– Mental health provision for doctors with mental health problems needs to be far enough away from their workplace to enable them to get the medical care they need without having any concerns about their illness being disclosed to anyone associated with their work, unless they choose to make that disclosure.

Going back to work can be difficult

Returning from sick leave was difficult for a number of respondents. The length of the period of sickness made a difference to the most likely concerns on returning to work. Where the participant had been on leave for a short period of time there was uncertainty how much their superiors at work knew or wanted to know about the nature of their illness. In a number of cases formal back to work interviews with line managers were not held.

'I went back, nothing was said of it. There was no back to work meeting, there was nothing. Even though I had had to send the sick form up to the department, you know nothing more was said about it.'

Occupational health advice was not always available, meaning there was no liaison between the employer and the doctor's psychiatrist or GP. In the absence of any contact with their employer one participant took the initiative and made contact with the occupational health unit only to be sent an appointment for six months' time.

'I self-referred to occupational health... and on the referral form, I detailed that...I had suffered from low mood and was having a lot of confidence and anxiety issues. And I basically got sort of a generic letter back giving me an appointment for May. And I was due to go back in February.'

For doctors on a training rotation taking time off usually meant that they would not return to the job they had been doing when they started sick leave and, in many cases, that they would join a different cohort. Sometimes this caused awkwardness with the doctor and their former contemporaries.

Some of those who took a long break from their career were required to take further exams before they were allowed to restart practising as a doctor.

Recommendations:

— Any doctor returning to work after a period of sick leave should receive a back to work interview with their line manager or supervisor. For doctors in training, this should include discussion of their feelings about returning to a different cohort or job.

— Occupational health advice should be another strand of this more rigorous return to work process. Doctors with any health problems need access to an occupational health unit, where they can get advice on any aspect of their health in relation to work. An occupational physician can advise a doctor on when to return to work and whether this should happen gradually over a period of time. It is essential to determine whether a phased return with or without a period of working in a supernumerary capacity is necessary. The occupational health unit can also act as a conduit of information between the doctor's own GP and/or psychiatrist.

These services should be free, comprehensive and meet the individual needs and requirements of doctors and staff working across all settings. Access to services should be consistent and easily accessible for all doctors and other staff, with timely access to assessments to prevent absence or delays in training.

Methods

The study was concerned with developing an understanding of the experience of doctors in training with mental illness. Participants were asked about an episode of illness and the authors wanted to encourage them to tell their story in their own words. The biographical narrative interviewing method (BNIM) was chosen because it is designed to give the interviewee maximum encouragement to tell their story in narrative form (Wengraf, 2001, 2008). It enables the participant to tell their story (narrative) without the use of an interview guide, and without any interruption by the interviewer (Wengraf, 2008). The interviewer asked the participant a single question to induce narrative (SQIN) then listened in silence, taking notes while the participants told their story (Appendix 1).

Further questions were developed based on information arising from the narrative relating to the participant's recalled: Situation, Happening, Event, Incident, Occasion, or Time ('SHEIOT') (Wengraf, 2013). These questions encouraged participants to explore their narrative in more depth.

Thirty doctors in training volunteered to be interviewed. The researchers took a purposive sample, aiming to get responses from a wide selection of specialties and grades within the constraints of time and budgets, and selected the 10 participants who gave us the most comprehensive sample. The parameters that were used were: level of seniority, specialty and gender.

The researchers interviewed ten doctors in training from England and Wales across a range of specialities, and were able to include doctors in training across various levels of seniority from F2 (foundation year 2, second-year post-graduation) to ST5 (at least fifth-year post-foundation training). These doctors displayed a range of mental health conditions, including symptoms of anxiety, depression and psychosis.

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Acknowledgements

Appendix 1:

The SQIN for this study was:

'As you are aware I am interested in the experience of doctors in training who have personal experience in mental health problems. In particular I am interested in whether you being a doctor contributed to your illness or whether being a doctor made a difference to accessing health care or support once you began to experience problems. I will listen without interrupting but will take some notes'