Doctors in crisis: creating a strategy for mental health in health care work

This article is based on the Ernestine Henry lecture given at the Royal College of Physicians on 15 March 1994 by **Roger Higgs** MBE, MA, FRCP, FRCGP, Head of Department of General Practice and Primary Care, King's College School of Medicine and Dentistry, London.

Doctors seem more likely to become depressed and to kill themselves than do equivalent colleagues in other professions; moreover, there is a consistency between the high depression rates and the alarming figures for alcohol and drug use, and the high divorce rates. There is widespread unhappiness particularly amongst junior doctors [1], of whom a quarter to a third may suffer from clinical depression [2].

The new arrangements in hospital and general practice increase the stress and make doctors feel confused when changes are introduced which make no sense to them. The appearance of new institutions with strong marketing profiles make distress more likely but the reporting of it less so.

What can be done to offset these problems?

A strategy for mental health

Several areas have been identified for urgent support:

- Proper anticipation of risk
- Practical organisational improvements
- Appropriate confidential and professional help for those in distress
- Regular reflection time for learners
- Supervision for clinicians at all stages
- Development of processes of 'internal supervision'

Prevention of risk

The main thrust of any strategy to prevent ill health must consist of a determined attempt to anticipate major risk and provide protective measures where that risk cannot be avoided. In the daily practice of medicine, this entails looking the stresses and crises in the face, and developing within individual professionals and health care organisations, at all levels, ways of containing and reducing damaging work stress. Thought must be given to enable doctors in training to acquire not just the medical knowledge required but also the everyday work skills and attitudes which they will need at each stage of their career. These are part of routine training in other fields. Medical training should ideally include practical instruction in those personal transferable skills which some find so difficult, such as dealing with paperwork, writing reports and so on. But there are deeper processes to be considered as well. Career progress and development for a professional may entail loss as well as gain. A busy houseman must be prepared not only to do the job effectively but also for the loss of spare time or social life, at least temporarily, or changes in his/her personal schedule. Many training jobs reduce a doctor's control over his or her own work and personal life. At King's, my colleagues Clare Vaughan and Shirine Pezeshgi have developed a successful preparation course on these lines for final year students before their house jobs. At the very least, orientation time should be provided for hospitals and practices at the beginning of new clinical work, with space in these courses for trainees' own personal needs to be addressed.

Practical organisational improvements have been suggested. These may include modernising and pruning the curriculum in medical schools, proper holidays in the clinical period of training, improved canteens and places to meet for hospital workers, with a reasonable environment for those who have to sleep overnight. On the educational front, we are just beginning to see the creation of proper educational contracts, which at the very least ought to cover the following areas:

- Agreed educational aims
- A named supervising consultant
- The existence of an educational plan
- Formative assessment
- Study leave
- An induction booklet
- A checklist or log book
- Protected educational time
- Satisfactory living conditions.

However, the missing key to unlock the area of mental health remains an increase in the quality and quantity of reflective time throughout the medical career.

If we are correct in sometimes viewing medical work as risky, doctors as vulnerable and unprepared, motivation for the work as being mixed, and current coping strategies not always appropriate, there remains a very large amount of work to be done throughout the profession.

A counselling service for doctors

Health care workers are just as likely as the general population to meet problems which they are unable to solve without professional help. Yet there is a huge stigma attached to the doctor who cannot cope. This means that doctors are likely to try to work through problems on their own, or turn to drink or drugs. The model of post-traumatic stress disorder suggests that work experiences may compound this need for help. A national system is available for doctors who are very ill and there are groups who work with addicted doctors, but the middle ground is still not covered. Doctors need an opportunity to discuss problems when they begin to perceive that they are in difficulties, not when these difficulties have become overwhelming and when shame and guilt make disclosure impossible. To be useful, such a service must be accessible, relevant, available to all, with a reasonable waiting time and absolutely confidential. It is possible that such a service could be part of a general counselling system but experience suggests that to be effective, the counsellors would need special preparation and skills.

Why don't we have one?

Reflective time

The main need in a coping policy is to develop a reflective process throughout a doctor's career. Justification for this is as old as Hippocrates: 'if treatment is good, treatment after thought must be better'. The doctor's job has changed in many ways: in particular away from the master/apprentice model to a much more public, complex and multi-faceted role, where the newcomer is largely expected to stand on his own feet and relationships are covered by contract. There is every pressure for an organisation to get the most work out of an individual that it can. But workers under pressure may respond in a routine and uncreative way and apply damaging therapy when the patient refuses to get better, and this incurs extra costs for both the organisation and for patients. In all these situations a doctor needs to think with colleagues on the best way forward. This is not likely to occur unless time for reflection is provided as part of work. Other helping professions such as psychotherapists, nurses or social workers have seen this process as vital, whether it is called supervision, review or mentoring.

In general practice training, the reflective process has been used for many years as a powerful tool in an educational plan, both on an individual and a group basis. A three year educational practice training programme includes two years in hospital posts and one year in general practice. Throughout this time, successful programmes run a weekly release course, where trainees meet with a trainer as supervisor and group leader. In the year in general practice trainees have, in addition, individual sessions of two and four hours per week with their trainer once or twice a week. The general practice system is mandatory within the training framework: trainers who did not offer this to their trainees would lose the training positions.

Trainees learn to:

- Identify their own feelings and manage them
- Identify and manage other sources of difficulty
- Check patient/doctor distance
- Check perceptions of others, especially patient
- Care system and colleagues

These may be straightforward instruction around an agreed programme, review of consultations by video or audio-tape, dicussion of cases or case notes and audit projects, and open discussion of difficulties or 'hot topics' based on the needs perceived by the trainee or the supervisor. The educational programme is negotiated between what is agreed nationally to be the curriculum, and what each individual feels he or she requires.

The triangle of doctor, patient and supervisor provides a safe place where a professional may examine the context within which he or she is working. Some of this may be advanced by broadening an understanding of the background of the patients, or of the complaint itself. Examples of this are provided by the public health perspective espoused by Tudor Hart [3], or the approach to everyday ethics of Campbell and Higgs [4]. But the central issue is to examine the relationship between doctor and patient, particularly when there are difficulties. These difficulties may relate to skills or knowledge but often concern feelings or attitudes. Reflection time allows the doctor to understand the personal dynamic in that relationship, and to allocate feelings to the right place [5]. The perspective of different people, particularly that of the patient, can be examined without embarrassment or fear. As a result, the person supervised can begin to understand his/her own feelings, and manage them—and the consultation—more effectively.

Adding the process of reflection to an individual's professional life creates immediate possibilities. At different stages the doctor as learner has different needs. A GP trainee may often have difficulty in reaching or allocating a formal diagnosis; a student at the start of clinical work may have trouble balancing need to obtain information from the patient with listening to what the patient is saying; a colleague ten years into his work may realise that he is beginning to stop caring and feels worn out; another in mid-life, facing organisational change may need help with coping with a management role while retaining her own sense of independent professionalism. Thus, reflective individual or group sessions closely link our needs to learn in the three areas of skills, knowledge and attitudes, or with hands, head and heart; these three areas are, in turn, connected with other aspects of the education or training process. We need summative assessment to plan career progression; and formative assessment asking creative questions about educational gaps; and

restorative work to look at personal needs. There are linked areas of work around quality control, clinical audit, personal learning and career guidance.

But if this is necessary, is it effective and can we afford it? Its effectiveness has been demonstrated in the year allocated to general practice training. As to cost, the answer is linked to the methods used. There is no doubt that a trainee or supervision group under skilled leadership can achieve a great deal if the leader's skills are harnessed to enable the group to tackle individual issues, supporting, challenging, reflecting, or informing. But some work is too personal for such a setting, and the choice of trainer, supervisor or mentor for personal work is key. A personal tutor is needed, especially wherever there are difficulties or major changes; but these relationships should be part of the way in which our work is organised, and costed accordingly.

Internal supervision

This sort of reflective time is not only needed in training, but probably also throughout the rest of one's medical work. Ultimately a doctor needs to develop what Patrick Casement has called 'internal supervision', a process of reflection on work which does not need an outsider [6]. This is very close to what we hope to develop in ethics teaching, the internalisation of skills and approaches to checking out our work, examining the values we are working to, the concerns and challenges we face or asking the broader questions—'what is best here?', 'what is right?' [7]. Doctors have to balance many competing claims on the limited resources at their disposal, whether it be money, time or their own enthusiasm and patience. Doctors must be able to say 'no': they must not allow themselves to be pressed beyond the boundaries of what they think is right in their work by anyone, be they importunate patient, desperate manager, or controlling government with little understanding of the delicate ecology of health care. If we develop proper internal and external supervision, we learn many things: in particular, for the sake of our patients and our own integrity to refuse to do too much work, to provide too much treatment, to reflect too little or to change too fast with too little preparation. For healthy health care, we need real people, not stereotyped heroes. We need a new culture in which professionals look after themselves within a defined strategy which promotes their own health—in a practical, therapeutic and reflective way.

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Address for correspondence: Professor Roger Higgs, Department of General Practice and Primary Care, Kings College School of Medicine and Dentistry, Denmark Hill, London SE5 9RS.