Mental health & wellbeing in the medical profession

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Executive summary

Objectives & methodology

The overarching objective of this research was to inform the development of policy solutions to promote wellbeing and maintain good mental health amongst doctors and medical students and improve available mental health support for those who need it.

Two phases of qualitative research were conducted including:

1) A total of 30 telephone interviews between 13th – 31st May 2019, most lasting up to 45 minutes. These included GPs (n=10), consultants and SAS doctors (n=10), medical students (n=5) and junior doctors (n=5). Included were those with a formal mental health diagnosis, those who had symptoms but no formal diagnosis and those without any symptoms or diagnosis of mental ill-health.
2) Two online focus groups on 29th May 2019, each lasting 90 minutes. One group was with medical students (n=6) and the other with junior doctors (n=5). These included those with a formal mental health diagnosis and those who had symptoms but no formal diagnosis.

As this is qualitative research, the sample was not designed to be proportionally representative of the original survey or the profession but chosen for the purposes of fulfilling the research objectives. In keeping with the principles of qualitative methods, this research has attempted to describe the range of subjects relevant to the individual and collective lived experience of participants in the study, rather than to quantify them. Importantly, while the research explores the broad range of topics discussed during in-depth conversations with students and doctors, it has not sought to attribute specific causality in cases of poor wellbeing or mental ill-health.

Main research findings

The in-depth conversations with doctors and students identified five potential groups of risk factors to which medical professionals were exposed throughout their careers and which could, in some cases, lead to the deterioration of their mental health.

These included:

1) **Systemic factors:** Issues which resulted from poor processes and systems including understaffing and rota gaps, lack of flexibility / poor work-life balance, demand in primary care, pressures to discharge in secondary care, and increased regulatory fears.
2) **Endemic factors:** Issues which were a necessary reality of a job in medicine, including learning to cope effectively with clinical risk, the rapidly evolving

pharmacological landscape and also dealing with traumatic events and unexpected outcomes.

3) **Interpersonal factors:** Issues that resulted from doctors' relationships with peers including issues related to hierarchy and bullying, the stigma around mental health, erosion of peer support networks and a perceived natural tendency of doctors to be type-A personalities (i.e. perfectionism, fear of weakness or being seen to fail).
4) **Environmental factors:** Practical issues, often linked to the workplace environment including a lack of basic workplace amenities, a lack of breaks, and the impact of training rotations on junior doctors.
5) **Sociocultural factors:** Wider contextual factors outside of the profession including the rise of patient self-diagnosis and increasing patient expectations along with doctors feeling increasingly undervalued by the public.

A combination of one or more of these factors led to some doctors being at risk of a deterioration in their mental health. Symptoms and diagnoses reported included anxiety, stress, depression, obsessive behaviours and burnout. Others, for whom these factors also existed and who operate in the same environment, were able to maintain good mental health. These doctors attributed this to supportive families, as well as supportive colleagues and workplaces.

There were a number of practical and perceptual barriers mentioned which meant that the doctors interviewed were often delaying proactively taking measures to maintain good mental health or seeking support for specific mental health issues. Practical barriers identified included lack of time, lack of awareness of services, fears over confidentiality combined with concerns about referrals to the regulator e.g. GMC, accessibility issues and line management issues. Perceptual barriers included stigma, guilt, so-called superhero syndrome and pride.

Doctors in the study reported frequently starting to manage their mental health with requests for more flexibility to try to self-manage their situation. Where these requests had been denied, the doctors were left feeling that their proactive attempts to help themselves were futile. During this window of time, any number of incidents linked to the five risk factor groupings may have led to mental health problems becoming more complex and difficult to cope with. At this point, the doctors experiencing mental health challenges tended to embark on a journey towards more reactive measures, commencing with seeking help from a GP, and resulting in extended periods of absence, or even resignation or retirement. Many considered this a less positive outcome for themselves, for their colleagues, and for the profession itself.

Doctors in the study with mental health challenges typically took extended periods of time off work and many had re-considered their career options during this time. Those doctors returning to work were not systematically offered formal modifications to aid the transition such as phased returns, reduced hours, workplace adjustments etc.,

particularly more senior doctors and those in primary care (e.g. GP Partners - as they were the ones who were responsible for providing these services in their workplace and there was no-one more senior to take this responsibility when they were ill). Those who did have access to these services, typically found them to be beneficial but too short-lived.

Experiences of interventions such as talking therapies, including counselling, psychotherapy and CBT, were scarce in this research. Amongst the minority where this kind of support was offered in their workplace, there was the feeling that the quality was not always adequate. There was some disparity between primary and secondary care in terms of occupational health provision. Many of the doctors in secondary care, who returned to work following a period of absence due to mental ill-health, had an occupational health visit but most found the experience disappointing due to poor communications. Occupational health services were less prevalent amongst GPs in this study, and appeared unavailable for locums without a consistent work base.

Compared with qualified doctors, the medical students in this study generally felt well-supported by their medical school/university in terms of preventative measures and initiatives, and as such felt they may enter the workforce with fewer perceptual barriers to seeking support if they needed it at some stage in their career. Peer-to-peer networks were often set-up during the student induction process and most students had been offered wellbeing services including mandatory wellbeing conferences, workshops on stress reduction, as well as free on-campus meditation and yoga classes to promote individual wellbeing. Students in the study also felt that more formal services such as counselling and CBT were well sign-posted and available when needed. Although students identified that wellbeing and mental health was high on the agenda of their place of study, some expressed concerns around whether these services would cease when they progressed into the role of junior doctor. Taken together with junior doctors' less positive experiences, assumptions of sustained improvements to both access and attitude to support cannot be taken for granted, as students enter the workforce.

In terms of the types of support and services that doctors in this study would like to see in the future to support the profession, these corresponded to the five factors outlined as potential drivers for deterioration in medical professionals' mental health.

1) **Systemic changes:** Doctors from this study believed that the most significant improvements would result from substantial systemic, structural changes to working practices and priorities, that would give doctors more time to spend on their 'main role' of patient care. Identified examples from this research included increasing GP appointment times, reduction of administration burden and increased staffing levels. More flexibility in working hours and patterns were also considered to be beneficial to improve doctors' feelings of self-control over their work/life balance.
2) **Support to face endemic challenges:** Doctors in this study believed that the most effective way to help them throughout some of the more difficult moments

of their career in medicine, was through peer support, both formal and informal. Participants mentioned talking groups for doctors after traumatic events to help them deconstruct in a professional environment. Junior doctors requested more formalised peer support structures whilst on rotations, along with junior doctors being paired with a named doctor when on rotations.

3) **Promoting camaraderie:** Many doctors in this research would like to see better coverage of mental health issues within university lectures, as well as within inductions and workplace workshops, to help to reduce stigma within the profession. To prevent further erosion of peer relationships, the provision of peer-to-peer support groups was considered highly beneficial for doctors at all levels, including Schwartz rounds[1], Balint groups[2] to help reduce the risk of isolation, and also provide doctors with more opportunities for socialising. Doctors also requested the introduction of mental health 'buddies' who they could turn to in times of need.

4) **Environmental improvements:** Doctors in this study highlighted a range of environmental factors that could be improved to help the promotion of happy, healthy workplaces. Examples included protected lunchtimes and coffee breaks to help to reduce professional isolation and raise morale. Other practical environmental changes were considered helpful in allowing doctors to feel more valued by their place of work including the provision of showers and dedicated socialising space.

5) **Responding to sociocultural change:** These were identified as macro environmental factors, such as rising patient expectations, the increase of patient self-diagnosis or negative perceptions of the medical profession. There was thought to be a role here for the BMA, and other stakeholders, to lobby government for an honest and open conversation with the public about what can and cannot be realistically delivered with resources available. Also, it was suggested that improvements in the other four areas listed above would ultimately leave doctors feeling better supported to respond to wider sociocultural evolutions.

The main research findings can be found in a separate document titled 'Mental Health and Wellbeing in the Medical Profession_Report'.

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[1] Schwartz rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare. Definition taken from the General Medical Council. https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/schwartz-rounds

[2] Balint groups have been established in the UK for over 50 years and provide an effective setting for health professionals to reflect on their practice. Definition taken from the General Medical Council. https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/balint-groups

Recommendations

Based on analysis of conversations with participants in this study, the following recommendations are made to support wellbeing and, where appropriate, the mental health of medical students and doctors:

1. The most radical improvement to life as a doctor will come from systemic changes, which will need to be **driven by revised governmental and NHS priorities and policy**. Systemic changes will in turn allow for more time and better peer relationships to promote good mental health amongst doctors and ultimately, improved patient care and outcomes. **The BMA and other organisations should continue work to lobby government to protect the long-term interests of doctors with specific focus on increased time and resource to practice.**

2. Shorter-term improvements to environmental factors will nonetheless have a significant impact on morale. The BMA is also well-positioned to develop and promote **a wider wellbeing charter** to generate commitment to providing healthy, happy workplaces. This could include a set of minimum standards for the provision of adequate facilities for doctors, especially in secondary care. These include, for example: staff lockers, doctors' mess, parking for night shifts, rest rooms, canteens, kitchens.

3. The BMA and other key medical professional bodies all have a role to play in terms of **raising awareness of and signposting** to available support for wellbeing and, even more critically, mental health, with a particular focus on primary care, where GP partners, GPs and locums are often unsure how to access support.

4. Impartial BMA resources such as the wellbeing service's confidential **helpline** are extremely valuable to doctors. The BMA should also work with Trusts and other organisations across the country to investigate how more localised resources can be delivered to the profession to improve access.

5. Junior doctors and students appear more inclined to engage with the subject of mental health in the workplace. This presents an **opportunity for the future**, and the BMA and other stakeholders should consider how to capitalise on this cohort of doctors to better understand and meet the needs of medical professionals in the future.

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