The (mental) health problems faced by medical students and doctors:

Disclosure and help-seeking

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Overview

Medical students and doctors

• What do we really know?

• Should/ Could OH do more?

• Could we be more effective?
Mental ill health in doctors and medical students
Stress, burnout ... what's out there

Welcome to Health For Health Professionals Wales

This is the HHP Wales counselling service.

The NHS Practitioner Health Programme is an award winning, free and confidential NHS service for doctors and dentists with issues relating to a mental or physical health concern or addiction problem, in particular where these might affect their work.
Health For Health Professionals Wales

...Support for doctors with health problems

This is the HHP Wales counselling service.

PULSE

GMC to introduce 'emotional resilience' training after finding 28 doctors under investigation committed suicide

these might affect their work.

Physician Resiliency Training
Fitness to Practise
(Medical Students)

Maintaining a high standard of professional behaviour
Your studies will bring you into contact with patients and members of the public, who can be physically and emotionally vulnerable. Because of this, and the fact that you’ll be joining a trusted profession, we expect, you to understand that there is a difference in the standard of behaviour expected of students on courses that bring them into contact with patients and the public.
Specifically, your behaviour at all times, both in the clinical environment and outside of your studies, must justify the trust that patients and the public place in you as a future member of the medical profession. We and your medical school will support you in your journey from student to doctor, which includes teaching and assessment on professionalism.
Medical Students and their Mental Health

- Medical students display significantly higher incidences of common mental health problems than the general population.

- The reasons are complex and relate to the intensity and the nature of the course and the personalities that are both attracted to and recruited into medical training (Tyssen 2000, 2007, Firth Cozens 2001).

- Problems are exacerbated by learnt behaviours and the hidden curriculum where ill health is minimised and resilience is an expected outcome (Chew-Graham et al, 2003, Hillis et al, 2010).
Students and mental ill health in UK (n =1122)

• 30% (343) declared they had experienced or received treatment for a mental health condition while at medical school.

• 80% of those who disclosed thought the level of support available to them was either poor or only moderately adequate.

• 15% (167) revealed that they had considered committing suicide at some point during their studies.

Billingsley, 2015 Student BMJ
Depression and stress amongst undergraduate medical students

*Qualitative study based on essays in year 3 students:*

- The burden of becoming a role model
- The impact of newly acquired medical knowledge and experience of patients’ illness on the students’ perspective on their own health
- The relationship between wellness and professional identity

Ludwig et al 2015 BMC Medical Education, 15:141,
Doctors and mental ill health in UK

- Doctors have higher rates of mental disorder than the general population
  \(^1\)
- Doctors are more likely to have work related mental ill health than others in the working population
  \(^2\)
- Understanding of doctors’ attitudes to disclosing their own mental ill health has improved but many assumptions are still made about their perceived obstacles to seeking help
  \(^1\)

\(^1\) Department of Health 2008, \(^2\) Health Policy and Economic Research Unit 2007,
Suicide and Addictions

• Risk of suicide amongst doctors is higher than in many other occupations.

• Anaesthetists, community health doctors, GPs and psychiatrists had significantly increased rates of suicide compared with general hospital doctors.

• Doctors often find themselves under extreme pressure when being referred to the General Medical Council (GMC) in relation to a complaint or investigation of health concerns.

• The British Medical Association (BMA) has estimated that 1 in 15 doctors have some form of drug or alcohol dependency at some point in their career.
What has been done so far?

Governance and training
Standards and Care Pathways

Standards for ‘Health for Health Professionals’ services in the UK

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**Background**
Doctors are more likely to suffer from work-related mental ill-health than other professions in the UK and internationally. Services to support doctors with health problems are emerging in the UK and have diverse models of delivery and funding. Services should be able to demonstrate standards of practice for those who wish to commission, develop or access them.

**Aims**
To develop consensus about standards for ‘Health for Health Professionals’ (HHP) services in the UK through a modified Delphi study.

**Methods**
We conducted a two-stage Delphi study over 6 months. The questionnaire development took place during the UK Association of Physician Health (UKAPH) meeting in London in 2012, an invited meeting for clinicians with a specific interest in the area of physician health. The final questionnaire was disseminated via the UKAPH database.

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Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study

Max Henderson,1 Samantha K Brooks,1 Lilliana del Busso,2 Trudie Chalder,1 Samuel B Harvey,2 Matthew Hotopf,1 Ira Madan,3 Stephanie Hatch1

**Abstract**
Objective: To explore the views of sick doctors on the obstacles preventing them returning to work.

Design: Qualitative study.

Setting: Single participating centre recruiting doctors from all over the UK.

Participants: Doctors who had been away from work for at least 6 months with physical or mental health

**Article Summary**
- Doctors have rates of mental illness, drug and alcohol misuse and suicide at least as high as the general population, though many doctors have difficulty accessing appropriate mainstream healthcare, often due to fears about
Competency frameworks

Health for Healthcare Practitioners

Enhanced competencies for Occupational Physicians caring for Healthcare Practitioners
A few things...

- What about Burn Out?
- Do symptoms equate to disorders?
- Disclosure – what we now know, or still don’t know
Burn Out

• A three-dimensional syndrome that measures:
  • Emotional exhaustion
  • Depersonalisation
  • Personal Accomplishment

It is not unidimensional, not just emotional exhaustion and is syndrome related to the workplace environment
It is not a diagnosis
Comparison of self-report and clinical interviews. Do students over report anxiety?

Comparison of HADS and clinical interview data in 50 medical students
Aims

• Is Hospital Anxiety and Depression Scale (HADS) an accurate screening tool for depression and anxiety in medical students?

• Would alternative cut off points for this population be appropriate?
Method

• Recruited medical students from Cardiff University

• Students were offered a £10 voucher for taking part

• Students were invited to complete HADS and then undertake a clinical interview.

• Clinical interview and HADS data compared
Clinical Interviews (SCAN)

• Schedules for Clinical Assessment in Neuropsychiatry (SCAN) clinical interview technique.

• The SCAN clinical interview data is used to derive clinical diagnoses according to ICD-10.
HADS

• Hospital Anxiety and Depression Scale

• Two subscales: Anxiety and Depression

• Optimum cut off “caseness” for each subscale = 8 (probable presence)
Results

50 students recruited across all year groups at School of Medicine (Cardiff University)
Conclusions

- HADS self-report questionnaire may be an appropriate questionnaire for screening for anxiety and depression in medical students.

- Users may wish to consider whether to:
  a) Reduce HADS-D subscale cut-off to ≥7
  b) Raise HADS –A subscale cut-off of ≥13

Caution with interpreting items.
Symptoms don’t equate to disease!
Disclosure

Disclosure: what do we really know and what might make a difference?

Positive next steps...
Obstacles

• **Lack of knowledge** about where to find help and the professional implications of seeking it.

• **Long work hours and shifts** can impede access, and this problem is exacerbated in isolated geographic locations.

• **Age and level of experience**

• **8% of doctors surveyed would choose not to turn to anyone for treatment of mental illness, preferring to self-medicate or have no treatment at all.**
Aims

Research programme (3 Stages) to develop a simple ‘tool’ to support doctors and medical students in their decision to disclose their own mental ill health.

Work already completed:
Stage 1: A UK wide survey
Stage 2: Qualitative interviews with 46 doctors and medical students across the UK

Work underway:
Stage 3: Development and pilot of a ‘tool’ (decision aid) to enable earlier disclosure
Stage 1 Survey

An anonymous online survey with 1,946 UK doctors, both with and without a history of mental ill health.

Key Findings:
• For all doctors, what they think they would do is different to what they actually do when they become unwell.
• Doctors not fully aware of their disclosure options or use established support pathways
• Age and speciality are a risk (younger and hospital doctors more at risk)
Who would you tell first in the workplace?

(Those without history of mental ill health, n=570)
Qualitative Interviews

Aims:
1. To further understand the thought processes and ‘tipping point’ to disclosure
2. To determine views on a potential tool
Focus of the interviews

• Reasons to disclose rather than not to disclose

• Drivers to disclose

• What factors contributed to their decision-making
Help seeking

• Seeking treatment, diagnosis or support for mental ill health

  Initial primary disclosure then often enabled subsequent and further disclosures

• Patient safety

• Some only went to family or friends.
Disclosing at ‘crisis point’

- Psychotic episode
- Feeling suicidal

Some participants did not seek help until they were at the crisis point.

An act of kindness
Tool development – where we are now

• Support earlier disclosure

• Target most at risk populations

• Acceptability

• Confidentiality
How can OH be more effective?

How can we:

• Reach those at risk earlier

• Influence service provision- evidence based

• More proactive
Thank you

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