Doctors accessing mental health services: An exploratory study

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All authors declare that the answer to the questions on your competing interest form are all No and therefore have nothing to declare

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Abstract

Objective: To develop a more in-depth understanding of how doctors do and don't access mental health care from the perspectives of doctors themselves and people they have contact with through the process.

Design: Qualitative methodology was used with semi-structured interviews transcribed and analysed using Grounded Theory. Participants were eleven doctors with experience as patients of psychiatrists, 4 doctor and 4 non-doctor personal contacts (friends, family and colleagues) and 8 treating psychiatrists.

Results: Participants described experiencing unrealistic expectations and a harsh work environment with poor self care and denial and minimisation of signs of mental health difficulties. Doctor contacts described particular difficulty in responding effectively to doctor friends, family and colleagues in need of mental health care. In contrast non-doctor personal contacts were more able to identify and speak about concerns but not necessarily to enable accessing adequate mental health services.

Conclusions: Three areas for further research have been identified: (i) processes to enable doctors to maintain high standards of functioning with less use of minimisation and denial (ii) informal doctor to doctor conversations about mental health issues among themselves (iii) role of non-doctor support people in identifying doctors' mental health needs and enabling their access to mental health care. Findings in all these areas have potential contributions to improving doctors' access to appropriate mental health care.

Declaration of Interest: None

Article Summary

Article focus:

Doctors' accessing adequate mental health care is less than optimal.
Family and community contacts have an important role in accessing mental health care.
Our understanding of the processes related to doctors accessing mental health care can be improved by exploring perspectives of doctor patients, their support people and treating psychiatrists.

Key messages

Doctors' unrealistic expectations of themselves and associated minimisation and denial of a range of self care needs may function as a barrier to accessing mental health care.
More research is needed as to how doctors respond to other doctors in informal conversations indicating mental health care needs.
Further exploration is needed of the potential contribution of non-doctor support people in enabling doctors to access appropriate mental health care.

Strengths and limitations

This is the first study of its kind and generates new insights in an important area.
Because of challenges in recruiting doctors with experience as patients of psychiatrists, a hard to reach group, the sample is small with significant potential bias.

Introduction

Living in a culture where doctors are seen as healthy people who treat sick patients creates a paradox for a doctor moving into a patient role. Accordingly many doctors do not make use of usual channels for accessing health care and continue to treat themselves despite guidelines to the contrary (1). Moving into the role of a patient with psychological illness has been described as particularly challenging (2). There is increasing concern about doctors' mental health and effectiveness in accessing mental health services (3-5).

Out of this concern a literature documenting and recommending interventions for medical students and doctors is emerging (6-9). The research base is limited. Individual case information has been made available (10-11). Questionaire surveys give important information about attitudes (12-13) but the depth and complexity they are able to contribute to our understanding is limited. We need more understanding about how doctors do and do not access mental health care.

Because family and community contacts have an important role in facilitating access to mental health services (14) this paper explores the process of doctors accessing mental health care from the perspective of the doctor patients themselves and others they have contact with in the process. The data presented in this paper are drawn from a more wide ranging multi-perspective qualitative study on doctors as patients of psychiatrists.

Participants

Recruitment was challenging. We sought information rich participants, doctors with experience as patient of a psychiatrist who were fluent in English and had capacity to consent. Initially we approached 6 doctors who were known to the researchers through personal or professional contact as having had experience as patients of psychiatrists. Four agreed to participate. Formal channels such as the Medical Council and support providers to doctors declined to participate because of concerns about confidentiality. One of the researchers (PR) had been actively involved in developing a support network for doctors with mental health issues and 5 potential participants were identified via this role. Four agreed to participate. She also put out an invitation to participate in the study to members of a currently developing local internet site for peer support for doctors. One member specifically declined and there were no other responses. Two were identified and referred to the researchers by other participants. One self identified to the researchers following listening to a presentation of preliminary data. One was referred by a treating psychiatrist.

Eleven doctors, 5 men and 6 women were interviewed. Age range was 32 to 54. Years since graduation were 5 to 28. Diagnoses identified by the doctors themselves were Depression, Psychotic Depression, Bipolar Disorder,

Generalised Anxiety Disorder, Brief Psychotic Episodes, Bipolar disorder with a differential diagnosis of Schizophrenia, Borderline traits, and Poly Substance Dependence.

Nine were working in clinical medicine at time of interview, five as specialists. Six were working in psychiatry, two as specialist psychiatrists, four as generalists with a special interest in psychiatry. One was working in General Practice. At the time of initial identification of mental health needs only two were working in psychiatry. Six were working in General Practice, two in specialist training positions, one was a house surgeon, one was a student and one was a specialist. Range of time off work due to illness was up to two years.

Psychiatrists with experience of treating doctors as patients were recruited separately. Eleven were approached. They were selected by the researchers to provide a range of orientations and practice type. Three declined interview. Eight were interviewed. Range of years since qualification as a psychiatrist was 12 – 39 years. Estimated numbers of doctors treated ranged from 8-12 to 60-70. All had private practice experience and most, but not all, of their experience of treating doctor-patients had been in the private sector.

Eight contact people (friends, family or colleagues) were identified by the doctors with experience as patients. Four of these were themselves doctors, two of whom had also been recruited as doctors with experience as patients of psychiatrists. In total 25 participants were interviewed.

Procedure

Participants were interviewed individually by the two researchers together for one or two interviews of up to 90 minutes each. The interviews were initially open. The participant was invited to choose a place to begin. Most told their story. This part of the interview was not time limited and a second interview was scheduled when needed. Participants were encouraged to range broadly over their experience, with prompt such as, 'Can you tell us more about that?' Questioning in the interview was focused towards bringing forward the experiences, thoughts, values etc of the participant. Eg "How did you decide to …?", "How did you experience/understand that?", "What were your hopes/fears when you …?"

A checklist of relevant issues was developed initially from published personal accounts, personal and clinical contact with doctors with mental health issues, seminars for psychiatrists treating doctors. These were revised and developed in accord with ongoing data analysis of interviews. Mostly they were covered in the open part of the interview. If not they were specifically inquired about. Prompts relevant to this paper included managing vulnerability, other people knowing, identifying mental illness, stigma, role of the Medical Council.

Ethical approval was obtained from the Ministry of Health Ethics Committee (No AKY/04/12/344).

Data Analysis

The interviews were transcribed verbatim from recordings by a typist and reviewed by one of the researchers (JS). Identifying data were removed. A grounded theory approach to data analysis was used (15). The transcripts were closely read by each of the researchers individually and independently coded using the Qualitative Solutions and Research NVIVO computer software (QSR International Pty Ltd, Doncaster, Victoria, Australia). The two sets of codes and themes were then extensively and continuously discussed and compared. Convergence and divergence in accounts were both explicitly sought with particular emphasis on exceptions. Emerging themes and higher level codes were fed into the ongoing interviewing process. This process was repeated, at times in part and at times in whole, through the data collection process. In returning to the transcripts the recoding was focused on both confirmation and disconfirmation of hypotheses and evolving analysis of themes. Additional depth to this process was contributed by comparing and contrasting accounts from different groups of participants.

Researchers

Both researchers are doctors with decades of experience working in psychiatry across a range of disorders and service types. One of the researchers has personal experience of psychosis and depression (PR). Both researchers have experience as network members of doctors engaging as patients of psychiatrists and limited experience in engaging with doctors as patients. One of the researchers is working as a child and adolescent psychiatrist, using biological as well as psychological approaches and compulsory care (JS). The other researcher is working psychologically with people with severe and chronic psychiatric disorder (PR). Both are committed to working creatively and reflectively, developing strategies for empowering and enabling people who are using mental health services http://www.collaborativepsychiatry.com.

Results

Accounts of male and female participants did not generate differences in coding. Where an indication of gender is used in presenting the data these are assigned randomly, irrespective of the gender of the person making the comment.

Doctors as Super people

All of the doctor participants described elements of a culture of unrealistic expectations of themselves and one another, needing to “know everything about everything”, and not able to make “any mistakes”.

> you have a particular way that you think that doctors are meant to act … be calm, cool and collected and … having everything together. … dealing with life and death and being in control. … putting yourself on the back burner and just fighting for your patients.

To show vulnerability was to risk losing respect of peers and seniors. Some described having empathy for a patient in distress being associated with the risk that you might "reveal your own emotions and vulnerability".

Participants described some variability in the whole heartedness with which they took up this idea. One described thinking it was, "Ok to be vulnerable" but you "did not show it". Another described awareness of a discrepancy between the expectation that they be "kind, caring and compassionate" towards other people but "not to have that for yourself". Another described how medical students "tried to be accepting" when a class member developed a psychotic illness. One described awareness of these expectations but <u>not</u> having a sense, himself, of patients needing to see him as invulnerable.

Pressure in the workplace

Bullying and lack of emotional safety were described in the workplace, particularly in years following graduation but continuing through later practice.

> there was that absolute sense of "can't cope, sling your hook, off you go, you're obviously not made for it, you're obviously not good enough"

Treating psychiatrists spoke of competitiveness, criticism and harshness among colleagues in medicine from their own experience and listening to other doctors.
Most doctor participants described not taking care of basic needs such as for sleep, or even a coffee break. Some described becoming more able to do this over time.

Maintaining the myth

Some of the participants spoke about how difficult it was to maintain the myth of being a super-person and the cost of this.

> I've got this dichotomous view of myself; at one level I do think I'm very careful and I do generally deal quite well with patients. um But on the other hand if there's any hint of criticism I suddenly think I'm no good.

Failing to identify signs of illness

Several participants described actively denying and minimising awareness of difficulties and early signs of illness.

> I managed to keep convincing myself that I was quite capable and I managed to convince a lot of other people [doctors]

The commonest response to a perceived difficulty in functioning was to just "keep going".

> I'd be dragging myself around. I remember at the end of the day I had to lie down for about an hour before I could drive home.

Initiating help-seeking

Even once the recognition of need for help was acknowledged the decision to see a psychiatrist was a last resort for most participants. Several described self treating with medication, exercise, relaxation, etc until a point of crisis or desperation was reached.

> It was just getting so bad, like I was just, things were becoming so unmanageable in my life

Doctor contact people - friends, colleagues and family who were also doctors

Six of the eight treating psychiatrists and five of the 11 doctor patients described experiences as doctor contact people in addition to the four doctors identified as contact people. Thus 15 of the 21 participants who were doctors described experience as contacts with doctors with mental health issues. They were in a range of roles including friend, partner, colleague or supervisor. The coding of their descriptions of experiences in all these roles overlapped substantially and therefore were analysed together. There was little overlap with the descriptions of the 4 non-doctors identified as personal contacts.

Some of the doctors described difficulty in perceiving need for care, "particularly mental health" in doctor friends and colleagues with a tendency to over or under-estimate the seriousness of issues. One participant described being approached for a prescription for benzodiazapines and feeling "off-guard", "completely dis-empowered".

> wanting to be helpful but … I felt so much on the defensive being asked for something and not delivering it that I didn't sort of think, think more broadly … obviously she may be in some sort of trouble

Another described failing to respond usefully to a phone call from a colleague asking for information around treatment of depression.

> I didn't hear the asking for help in it. … I heard his uncomfortableness. … how I dealt with the uncomfortableness was to draw away, you know, rather than to step in. And again it was this fear of stepping in where I wasn't wanted, of his feeling humiliated

> because of me finding out about his vulnerability and the fact that he was a mess.

Several doctors described identifying signs of illness in friends or colleagues and not speaking about them.

> I can pick up on an intuitive level that they [other doctors] are depressed and I struggle to know what to do about it because you can't sort of say, "I've been there and I can see that you're struggling, do you want to have a little talk to me?"

Participants described finding it hard to know "how much to probe" in a context which is "sort of professional" and "more a social [conversation]".

> the sense of paralysis around "what the hell do I do?" and being tied up with just the complexity of it all.

Some of the doctor contacts described regret at having responded to hearing experiences described by a doctor friend in terms of symptoms rather than an example of a range of ordinary experience.

> As a friend who wasn't trained you wouldn't see it as a symptom, you'd just go "that's [x]".

Some of the doctor patients described how unhelpful it had been when doctor friends had responded to them by identifying symptoms or recommending mental health services rather than hearing and responding as to an ordinary human concern.

One doctor spouse described concern that her being a doctor delayed rather than facilitated access to care as both she and doctor colleagues avoided accessing "to protect his identity and his career".

> Anyone else would have dialed 111 and the ambulance would have been there and he would have been admitted

In contrast to the above accounts, one of the doctor colleagues who had felt unable to be helpful was described by the doctor patient as having been "enormously" helpful in seeing the size of the problem and "putting the flag up".

Several of the doctor contact people described feeling they had learned from these and other experiences and would feel more able to respond effectively in the future.

Non-doctor contact people – friends, colleagues and family who were not doctors

Non-medical network members described identifying difficulties and the need for help in their partners but not necessarily identifying these as mental illness.

> I was aware that she was a bit down and that things weren't right, you know. The Wordsworth poem; 'Some natural sorrow, loss, or pain, that has been, and will be again'. It felt like that kind of situation to me.

Another described being aware of her partner being "grumpy" and knowing that something needed to happen but not having the knowledge to identify depression. Their personal knowledge was overshadowed by the medical knowledge of their partners leaving them disempowered in this context.

> [Her being a doctor] just made it very hard for me to convince her um that she might need help because she's the expert.

Some described feeling that their loved one's concern about confidentiality impeded accessing care. Some of those who did take an active role in calling a crisis team or ambulance described difficulty getting an adequate response and then facing their partner's anger and rejection of what was offered.

Treating psychiatrists

Treating psychiatrists described delays in doctors accessing treatment. They described most doctor patients as self referring, some sent by their employer and some by the Medical Council. Referral via General Practitioner was less usual. They described doctors self referring in response to concern about their work performance and associated fear of complaints to the Medical Council rather than presenting as having a mental illness.

Summary of main findings

1. Doctors described having a culture of unrealistic expectations of themselves and each other.
2. These expectations were associated with denial and minimisation of need for self care, vulnerability and early signs of illness. In this way they formed a barrier to help-seeking.
3. Doctor colleagues, friends and partners, whether recruited as doctor patients, doctor contacts or treating psychiatrists described experiences of considerable difficulty in identifying concerns and speaking about these to other doctors.
4. Non-doctor personal contacts described being able to identify difficulties and speak about them but not necessarily to enable effective help-seeking for the doctor.

Discussion

Strengths and Limitations of study

This is an in-depth study of an information rich group in an area where more understanding is acutely needed. Including the perspectives of the doctors themselves as well as doctors and non-doctors with whom they had contact in the process has given the opportunity to generate new insights.

Challenges in recruiting have meant there is a self selection bias. Most participants were recruited via personal knowledge or recommendation. In the current climate this personal knowledge may be necessary to create the safety for agreement to participate.

Doctors working in psychiatry are over represented and currently working in General Practice under represented. The small number of non-doctor personal contact people is of particular significance as the study indicated a marked difference in the contribution of doctor and non-doctor contact people to doctors accessing mental health services. This has not previously been identified.

Implication of findings

The culture of unrealistic expectations of doctors described here has been previously identified (10) (3). Clearly doctors cannot know everything, cannot be infallible and will have a range of health issues. Unless doctors are able to acknowledge realistic limitations and vulnerability they will need to deny and minimise. Denial and minimisation have been identified in doctors (16) (17). Potential adverse effects of such defences were demonstrated by Wu et al (18). They found that doctors who took responsibility for making an error experienced more distress but were more likely to engage in constructive remedial processes. Finding a way for doctors to function consistently at a high level and cope with intense stress without this denial and minimisation may be important for their health and quality of functioning.

The difficulty described by doctor friends, colleagues and partners in identifying and speaking about mental health issues with other doctors has not previously been demonstrated in research. Thompson et al (2) found that GP's played down evidence of colleagues being physically unwell.

This is an important area for further research. All doctors are potential participants so that recruitment would not be as challenging as for a study of doctors who have sought or accessed mental health care. If the results of this study are replicated then improving the quality and effectiveness of informal doctor to doctor conversations may be an area where a difference can be made in improving doctors' access to mental health services. This may also be of benefit for doctors' general health.

Further research is needed to validate the descriptions from this study of non-doctor contact people being able to identify and speak about mental health issues with doctors. Some support exists for the importance of their role in that doctors have described themselves as more likely to disclose a mental health issue to a non-doctor contact than a professional (13). Increasing awareness of the value of the perspective of the non-doctor contact people may also contribute to helping doctors access optimal mental health care.

References

1. Forsythe M, Calnan M, Wall B. Doctors as patients: postal survey examining consultants and general practioners adherence to guidelines. BMJ. 1999;319:605-8.
2. Thompson WT, Cupples ME, Sibbett CH, Skan D, Bradley T. Challenge of culture, conscience, and contract to general practioners' care of their own health: qualitative study. BMJ. 2001;323:728-31.
3. Department of Health. Mental health and ill health in doctors 2008 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083090.pdf
4. Houston D. Psychological distress and error making among junior house officers. Br J Health Psychol. 1997;2:141-51.
5. Taylor C, Graham J, Potts H, Candy J, Richards MA, Ramirez AR. Impact of hospital consultants' poor mental health on patient care on patient care Br J Psychiat. 2007;190:268-9.
6. Amy I, Kirsty F. The competent novice: How to handle stress and look after your mental health. BMJ. 2009;338:1139-44.
7. Krasner M, Beckman H, Suchman A, Chapman B, Mooney C, Quill T. Association of an Educational Programme in Mindful Communcation with Burnout, Empathy, and Attitudes Among Primary Care Physicians. JAMA. 2009;302(12):1284-93.
8. Shanafelt TD. Enhancing Meaning in Work: A Prescription for Preventing Physician Burnout and Promoting Patient-Centred Care. JAMA. 2009;302(12):1338-40.
9. Cox CC, Cambre KM, Wolf TM, Webster MG, Hooper J. Trends in the number and administrative characteristics of medical school health promotion programmes. Med Educ. 2001;35:173-4.
10. Jones P. Doctors as Patients. Oxford: Radcliffe Publishing; 2005.
11. Emson D. Daksha Emson. BMJ. 2004;328:291.
12. Mukherjee R, Wijetunge M, Surgenor T. The stigmatisation of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital. Psychiat Bull. 2002;26:178-81.
13. Hassan T, Ahmed S, White A, Galbraith N. A postal survey of doctors' attitudes to becoming mentally ill. Clin Med. 2009 9 327-32:327-32.
14. Lincoln C, Harrigan S, McGorry P. Understanding the topography of the early psychosis pathways. An opportunity to reduce delays in treatment. Br J Psychiat - Supp. 1998;172:21-5.
15. Glaser BG, Strauss AL. The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine Publishing Company; 1967.
16. Sexton JB, Thomas EJ, Helmreich RL. Error, stress and teamwork in mediine and aviation: cross sectional surveys. BMJ. 2000;320:745-9.
17. Mizrahi T. Managing medical mistakes: Ideology, insularity and accountability among internists-in-training. Soc Sci Med. 1984;19(2):135-46.
18. Wu AW, Folkman S, Mcphee SJ, Lo B. How house officers cope with their mistakes. West J Med. 1993;159:565-9.

Role of researchers.
Both researchers have been actively involved in all aspects of planning and carrying out the study and writing the article.