Hong Kong Journal of Mental Health
2019, *45(1)*, 6-13

Mental Health & Well-being of Health Professionals

Prof. Dinesh Bhugra

Emeritus Professor Mental Health & Cultural Diversity,
Institute of Psychiatry, Kings College, London

Past President, British Medical Association (2018-2019),
World Psychiatric Association (2014-2017) and
The Royal College of Psychiatrists (2008-2011)

Thank you very much for that very kind introduction. I am grateful to the Association for inviting me and for the very kind hospitality, from Kimmy and William. A very very very happy 65th birthday and many many many happy returns. When one reaches 65, the clock starts to appear. The way our organization is growing I think you have several thousand years ahead of you.

For a number of reasons, I think when one reaches 65, you become grumpy. I certainly did, but I've always been grumpy; Prof. David Castle will certainly vouch for that. When you reach 65, you realize there is still a lot that needs to be done, and you can see the bigger picture, which you can't as you're going through your younger age. That is an advantage and also a disadvantage. It is an advantage because you can see the bigger picture, but it is a disadvantage because you can do very little about it. That is when you realize that you need partners, you need friends, you need colleagues, you need other organizations who can work with you to try to push the agenda forward.

Mental health among health professionals

What I am going to do is actually take a slightly different angle. Over the years various things in my working life have changed to create different areas. I came to public mental health quite late in life, and I think it is an absolutely vital part of good services to have public mental health on the agenda. How do we prevent psychiatric disorders? How do we encourage people to look after their mental health and well-being? How do we promote mental health? And subsequent to that, as you heard in my introduction, I have spent some time talking about the well-being of medical doctors and medical students. It became very clear that there are major challenges for people who provide services, people who provide health care. We know that when we talk about health professionals – and there is a range of people who provide services, from occupational therapy, physio-therapy, nursing, social work, psychology, psychiatry, general practitioners, and a whole range of other people. Each group has very specific stressors which affect their mental health and well-being.

Also, over 40 years ago when I graduated from medical school, the practice of medicine, practice of psychiatry and society were very very, very different. I will touch upon some of the sociological changes made in the last 40 years. Changes in the delivery of health care, changes in public expectations, changes

Transcript of Keynote Speech of 65th Anniversary Symposium on Mental Health on 10th December 2019.

in patient expectations have created a different set of issues and priorities which contribute to poor health and functioning of health professionals.

There was a survey in 2004, which showed that nearly all staff working in the National Health Service suffered from work-related stress. That has been fairly consistent, but if you look at the economic figures, in 2004, staff stress, staff mental ill health cost the NHS 300 million pounds a year. That figure is now touching about a billion. We know the rates of suicide among different health care groups are massive. We know, for example, pharmacists are 1.2 times more likely than the general population to commit suicide. Doctors are 1.87 times more likely. Chiropractors are one and a half times more likely and lawyers and judges are marginally more likely, but it's still a problem. The question is what is going on and what do we need to do.

I am going to focus on three groups mainly, talk a bit about nurses, a bit about psychologists, but most of my talk is going to be about doctors and medical students. It is quite clear that this is not a UK problem. This is not a developed world problem. It is not high income countries. This study published four years ago from Iran indicated that something like 83 percent of ICU nurses reported between moderate and high levels of stress. The percentage of mental disorders was 58.9 percent, somatic symptoms 60 per cent, etc. In the USA, a survey of nurses showed that nearly half reported drug or alcohol use while at work, again indicating that the extent of the problem is massive. I'll come back to that particularly in relationship to that of the doctors. Some years ago a survey published in the Nursing Times found that 70 per cent of nurses suffered from physical or mental health problems associated with work-related stress. Among psychiatric nurses, this is a particular problem. These included inadequate levels of staffing, managing acutely disturbed patients with risks of violence and self-harm, bed shortages, high occupancy rates of beds and unmanageable workloads. At least from one of my previous visits to Hong Kong, beds is not a problem, but the pressures and incidents are about the same. In a systematic review published 13 years ago, the rates of occupational stress related to working in acute wards, forensic wards, and general nursing wards, whether acute or health nurses, there were high levels of burn-out, low levels of job satisfaction and sickness. Violent incidents and potential risk of suicide among the patients, were identified as a key source of stress. Lack of support and lack of understanding from the organization were other key factors. I will come back to that because organizational factors are incredibly important in terms of the spaces within which we work. The support we get from managers and seniors and others around us can be problematic. This was a fascinating study, almost 20 years old. They compared the stress levels in Swedish nurses and English mental health nurses. They found English nurses rated their work environment higher but experienced lower levels of individual well-being, higher work loads and their self-esteem was much lower than the Swedish nurses. So obviously there is something in the work environment which is causing those problems. Swedish nurses recognized they had a higher status compared to their English colleagues and therefore had a higher self-esteem and lower work load leading to a more positive view.

So many issues emerged with various studies looking at the mental health and well-being of psychologists. More than half, nearly two-thirds, reported a lived experience of mental health problems with depression and anxiety presenting as much more common. There were obviously high levels of stigma perceived, which really stops people from seeking help. Of those who had experienced a mental health problem, 10% did not tell anyone that they were suffering, so they were suffering in isolation and by themselves. Two-thirds reported talking with their family and friends with only 44 percent talking about it

in their work setting. Of course once you've declared and shared the stress, you start to feel better. But if you express to the employee, you get much better medical response. That goes back to the organisational factor that I've touched upon and I will come back to that.

Overall, again, like many other health professionals, clinical psychologists did not have a positive attitude towards asking for professional help. But another study showed that at least two thirds of psychologists had at least one episode of clinical depression and most participants had been in therapy. Now I am not saying that if you go into therapy you are mentally ill. When I was training as a psychiatrist in Leicester, we had an expectation that every psychiatrist in training would undergo personal therapy. I did 18 months of personal therapy, and I'm not sure whether it made me a better person but certainly it made a lot of difference to my clinical thinking in terms of understanding transference and counter-transference. What a patient does to me? Why am I feeling like this with this patient but not with this patient? And understanding why some patients get attached to me and others don't. I think that's a very helpful way of looking at relationships.

And again, in another survey of over 1,000 randomly selected counselling psychologists, 62% self-identified themselves as having depression, and 42% reported some form of suicidal ideation or suicidal behaviour. In a survey 10 years ago, American Psychological Association found that 40-60% of practitioners who responded to the survey reported at least a little disruption in professional functioning due to burnout, anxiety or depression. A few acknowledged that they had had suicidal ideation. An anonymous on-line survey with about 700 respondents showed that two-thirds had experienced mental health problems themselves. Again, I want us to bear in mind that the definition of burnout and mental health problems, mental health issues, mental health concerns vary, so we need to be slightly careful. But, this indicates that there is a problem in the profession that we need to be addressing. Again, perceived mental health stigma was much higher than external and self-stigma. So it is the perception which also creates the problem which stops us from seeking help.

Doctors' health

Moving on to the third part of my talk, which is about doctors and medical students. In 1978, one third of doctors scored above the threshold for General Health Questionnaire compared to 18% for workers outside the health profession. Doctors were almost twice as likely, 2.75 or whatever. In 1994, a study by Caplan reported 47% doctors had reported stress, 29% reported anxiety and 27% reported depression. 27% reported psychological morbidity. Among consultants, again 27% psychiatric morbidity using a general health questionnaire and 28% doctors showing work-related stresses.

Among general practitioners, 50% were reported being at high risk of burnout and 14% at very high risk. 45% of GPs had resigned or thought of resigning or thought of resigning over work-related stress. 58% reported their personal or family life suffered because they chose medicine as a career. I don't know what it is like in Hong Kong, but certainly in the UK lots of the children of doctors are choosing not to go into medicine. They see what is going on with their parents and think why would I want to do that? I want to come back to that because it is an absolutely crucial point.

65% of NHS staff reported that they had not taken time off work despite feeling ill enough to do so. That indicates their professionalism that in spite of being unwell they carry on going to work. But are you functioning to your best ability at that level? Your body is present but the mind and everything else is not. The British Medical

Association runs a counselling service called DocHealth which is open to any doctor. It was set up about three years ago jointly funded by the Royal Medical Benevolent Fund and the BMA and the service is already getting 3,000 calls per year so on average ten calls a day. The number is rising. This is completely anonymous. People ring up. They get advice on the phone. Some will be seen in person for a number of sessions. Others will be seen by Skype. Very clearly there are differences across gender, across ethnicities and across specialities.

Again, when we look at suicide rates among doctors in the U.K., they are between two and five times those of the general population. Anaesthetists are followed very closely by psychiatrists, and this is largely because they have access to a number of drugs that they can use. Psychiatrists partly because of the stress of managing risk, assessing risk in the patients and not being able to deal with that.

Nearly a quarter of the doctors in an Australian survey, had had suicidal thoughts in the previous year and thoughts of suicide were significantly higher, say about 25% had thoughts compared with the general population which was 13% and other professionals, which was again about 13%. Physicians' relative suicide rates are again much higher for women compared with those for the general population and only marginally higher for men too. Anaesthetists and psychiatrists in the U.K. but in Australia anaesthetists followed by general practitioners followed by psychiatrists appeared to be at slightly higher risk.

This was an interesting survey carried out by the American College of Surgeons. Anonymously nearly 7,900 respondents and the response rate was only 31.7%. Six percent reported suicidal ideation during the previous 12 months, much more common in older surgeons. These levels of suicide reports were between one and a half and three times more common compared with the general population. This is frightening – only a quarter of the surgeons had considered seeking help for their suicidal ideations. This is worrying for a number of reasons. If you are feeling suicidal and you are operating on someone, what are the potential factors which may come into play and what occurs then?

We did a survey of burnout in north India over ten years ago, and the rate of burnout was very low. We wondered why that should be the case. We explored it further and of the samples, virtually almost all the samples were in private practice, so they could choose how many patients they saw, how much they charged, how much control they had over working life. That goes back to the organisational issue I was mentioning earlier on. We need to confirm that subsequently.

The other issue is that quite often the rates of depression and anxiety and burnout are much higher in the first year after graduation. Here we can discuss why that should be. Factors like family background, personality traits, neuroticism and self-criticism, coping by wishful thinking that I am a doctor and I should be able to cope creates unnecessarily high internalized pressure.

When you look at doctors' health, you are dealing with physical and emotional health 24 hours a day. You never really switch off. Even when you are on a flight, you can sometimes worry if there is a call, "Is there a doctor on board?". What will you do? If you had two drinks, are you in a fit state to advise the pilot or the stewards. What does that mean? You are never stress-free. You are giving emotionally all the time, but who gives to you? That is a key question.

I don't know what it's like in Hong Kong, but I think you're probably better off in

getting some positive feedback. In the U.K. you never get positive feedback as a doctor; you get complaints. And you get complaints and you get complaints. So when things go wrong, you're in the frontline. And when things go right, nobody says it. Particularly in psychiatry, it is a major issue. One of my M.Phil. students had done a study comparing gift-giving to doctors and physical patients in King's College and psychiatry patients. Guess what? Physicians were much more likely to get chocolates and cakes and flowers. Psychiatrists don't.

Quite often you are working in isolation when teamwork is important. Long hours, poor family relationships. Work-life balance doesn't work. Increasing and changing expectations put a lot of pressure. On the one hand we are supposed to be empathic and on the other we are expected to maintain a professional distance. The two are incompatible. If you hold somebody's hand, you're always worried that, "Is he or she going to report me to the General Medical Council and I'll have a hearing then?". Or if you don't hold their hand and somebody is crying, what do you do? Do you just sit there? Is it not my problem? And that tension creates a lot of problem in lack of support and lack of praise. So there are issues in physician-personal factors, and I will come back with that with a look at some of these personality traits that we all as health professionals carry an exaggerated sense of responsibility.

In many countries you may have seen the patient for half an hour a year ago and something else goes wrong. A year later and you have had no contact but you are still held responsible. It's also about everything else should be perfect. But life never is. So there is an inherent double bind. To be a good doctor you need to be able to relate to patients, capable of empathy and humanity, and yet to survive emotionally you have to have detachment, an emotional distance from patients and their families. And there are also higher levels of self-criticism. You never switch off. You go home and you think, "Drat! I forgot to ask that question." Or, "I didn't do all of that test or I did not do A, B or C". You are expected to be self-critical and expected to be obsessional so again that creates a double bind.

British Medical Association health and mental well-being survey

When I took over the presidency of the British Medical Association, I said one of the things that we have to do is to look at the health and mental well-being of doctors and medical students. On World Mental Health Day in 2018, BMA launched this on-line survey. We used burnout definition as feeling constantly exhausted and disengaging from work. One can lead to the other, we need to bear in mind. We focused very much on high scores of exhaustion, which may lead to disengagement. We had 4,500 some responses, of which 4,300 were complete, and we used that for the final data analysis.

80% of doctors and student doctors were at high risk of burnout with junior doctors most at risk. More than a quarter were diagnosed with a mental health condition at some point and 7% in the past year. 40% were currently suffering from a broader range of psychological and emotional conditions. Those working longer hours were most likely to say they were currently suffering. 90% placed the blame on the working, training or studying environment to a significant or partial extent. Again, going back to the organisational question.

Similarly for general practitioners. One third of doctors were using alcohol or drugs to function, an absolutely horrific finding. Older doctors were much more likely to use alcohol or drugs or self-medication, self-prescribing to cope with their condition. The junior doctors had the highest rates. Those who were older and working less than 20 hours per week were less likely to report burnout. So working less is good for your mental health.

Again, if you compare medical students, junior doctors, staff grades, there are clear differences. But I want you to bear in mind that when we look at medical students and junior doctors, they are generally in that age group where people are more likely to develop psychological disorders anyway. Again, that is something which we need to bear in mind.

Women are more likely than men. Ethnicity, if you were non-white, much more likely than white British. If you had graduated from the U.K., you are marginally more likely. I don't want to put too much emphasis on these findings because they have different implications. Junior doctors, medical students, staff grade are fairly high and then general practitioners, it starts to go down. Again, age-wise, 35 to 44 high. 51 hours plus, high rates. Again, women much more likely. When you access support, medical students are much more likely to access support, and they are also much more likely to get it within three weeks of asking support. Junior doctors fare very badly in accessing support. Even when they access it and ask for support, they did not get it, for the simple reason that quite often the rotation is four months or six months. They don't want to disturb this and so they will say that he, or she, will be somebody else's problem and we don't need to do anything. This goes back to the organisational factor that I was touching upon. The older you are, the less likely you are to get help. What is really fascinating is that the doctors who are coming up for retirement are seeking help but not getting it. Therefore they are retiring and creating further problems.

We followed up by qualitatively interviewing over 60 randomly selected doctors and medical students to try and understand what was going on. These were the five key factors which emerged: systemic, occupational, interpersonal, environmental and socio-cultural. Systemic factors were under-staffing and rota gaps. If you are a perfectionist, you will go to work because you want to do the right thing. You know that so-and-so is on long-term sick leave and you are carrying on the work of two doctors, so you go and you get even more stressed. Poor work and life balance. You are over-stressed. You are working long hours. Your relationships and friendships suffer, and the blame culture is really taking wing.

We are following in the example of the USA in a number of ways, and the blame culture is one of them. If you ask junior doctors, they are spending between one third and two thirds of their time on administrative matters, being taken away from patient care. About six or seven years ago, when I finished my term and went back to service, I had a meeting with a manager who said, "Welcome back. Delighted to have you back. You can start with new patients under your clinic." Until then I'd avoided seeing new patients because continuity was a problem. I said, "fine", and she said, "How many new patients a day?" "Six or seven?" Her jaw dropped. "Six or seven new patients a day?!" And I panicked and said, "Is it too few?" She said, "No. It's too many". I said, "Why?" She said, "You need two hours for each patient". "Why do I need two hours?" "One hour to see the patient and one hour to fill in the assessment forms." I said to her, "Are you sure that is very good use of my very expensive time? Why can't the clinic administrator or my peer fill in the forms? I'll do the assessments but they fill in the forms. I type with two fingers and it takes me about five times to fill in things which can be done by somebody else who is efficient." "No. That is not acceptable because we need 95% compliance and it has to be done by clinicians." If as an organisation you cannot get your priorities right, is it any wonder that clinicians and health care specialists feel under stress?

With consultations and problems, quite often when you are working on the ward,

there are traumatic events and there is no de-briefing and no recognition of the impact on the individual. Also, how do you keep your skills up-to-date if you cannot take time off work because there are so many interpersonal factors, stigma, both in terms of seeking help? If there are gaps, not having friends or support systems creates problems, inter-generational differences in terms of work-life balance and isolation. Quite often you hear doctors say that in the U.K. you do not get breaks. It is only in the last few years that the BMA has managed to persuade the Department of Health to invest in junior doctors' messes, where they can sit and relax, have a cup of tea without having to run around and get chocolates and horrible coffee from the machines. Those kinds of values of being appreciated or there is a lack of appreciation by the organisation and by the general public and patients are important for wellbeing.

A lot of problems are created, especially with patients. Printouts from the Net about their diagnosis and about their medications, about the side effects – sometimes they are right but sometimes they are not. To have that dialogue creates further stress. Stress is about all engagement. It is about your energy factor, creating burnout, disengagement, a sense of helplessness and hopelessness and feeling trapped, that I can't get out of it. Then feeling detached and depressed.

With burnout you are more likely to make errors. It will contribute to reduced patient satisfaction because your mind is somewhere else and you're just kind of listening but not listening. You're not tuning in and that increases absenteeism, depression and suicidal ideation, not answering your calls, unexplained absences during the day, being late, frequent sick leave, bursts of anger, shouting matches with patients or administrators or others, or reacting badly. As doctors we should be good at managing not only our own anxieties but also others around us. We should be good at managing ambiguity, but if you're burning out, you can forget all that. That leads to failure in your exams and promotion, etc.

These are the figures for the BMA services. Psychiatry fairly high, medicine one-third, surgery quite low, general practitioners fairly high, and largely junior doctors compared to seniors. As I said earlier, the sense of insecurity and litigation and complaints. Medicine has become a commodity, certainly in the West where you can buy health. If you are not getting what you think you paid for, you get more angry and frustrated.

What the organisation and the individual must do

Organisational pressures start at the top. Government pressures, NHS executives who have the maximum power. It follows down on trainees who have the minimum power in the system to be able to do anything. Consistently we don't seek help because of fear and stigma. Sometimes we know how bad the care is, so why would we want to go and seek help? It's difficult being a patient. How do we look after ourself and peer support?

What organisations need to do, what each hospital needs to do, is to make sure the support is widely advertised, accessible, available and confidential. For trainees particularly working with other pc's in Balint groups, Schwarz rounds and other health care professionals, a recognition that there is a problem.

Individuals need to look after themselves as they are being used in support organisations, being very clear about seeking help, sharing problems with families, friends and colleagues, admitting vulnerability. One of the major changes in the U.K. was in June 2013, when 26 members of Parliament stood up in the House of Commons and one by one talked of their own personal experience of mental illness. The Chair of the Parliamentary Group for Mental Health, Charles Walker, stood up

and talked about his own obsessive compulsive disorder, and he said that his children called him a fruitcake. Then other MPs talked about their alcohol problems, post-natal depression, depression, etc. That changed the dialogue by admitting vulnerability, so we need to be thinking about that.

We subsequently did a survey of medical students in 12 countries looking at burnout. Hong Kong was one of the centres. To our horror we found that 95% of medical students were reporting a sense of exhaustion and disengagement. That is remarkable but not that different from other countries. The general variation of burnout among medical students, who are bright, young, energetic, enthusiastic people, varied between 80 and 95 percent. So there is something that we as a profession are doing wrong that we need to address. Is it the training? Is it our selection? Is it something else that we are doing to these bright young people? We need to think about that.

My hope is that the Mental Health Association of Hong Kong can start to take the lead in creating those links in terms of providing information and services to medical students. It is absolutely critical that we need to look after ourselves, we need to seek professional confidential peer support if it is available. We are human beings, likely to be stressed, likely to be anxious, likely to be depressed. As long as we can function. That acknowledgement makes us a better doctor.

A few years ago, NHS decided that appointing health care staff in the NHS, 10% of places would be reserved for people with psychiatric disorders. I remember being on an interview panel and a consultant admitted to having used drugs was given the appointment. Not only was she a better candidate but also there was that degree of positive discrimination. So I think we as a Society need to think differently, we need to think outside the box. We need to look at what the social contract with patients, with government is and how do we deliver on that.

Once again my thanks to the Association for inviting me and for your support and very kind hospitality. And thank you very much for being here and thank you for giving me the opportunity to open the conference. Thank you.