PRACTITIONER HEALTH’S COVID EXPERIENCE

Meeting the mental health needs of doctors during the pandemic

October 2020 – March 2021

SUPPORTING THE HEALTH OF HEALTH PROFESSIONALS

www.practitionerhealth.nhs.uk
Written by:
Dame Clare Gerada, Medical Director, Practitioner Health MBBS FRCGP FRCPsych FRCP (Hons)

Contributors:
Ms Louisa Dallmeyer, Associate Director, Practitioner Health
Dr Helen Garr, Deputy Medical Director, Practitioner Health MRCGP
Mr Richard Jones, Clinical Director, Practitioner Health RMN
Ms Roma Soubry Gordon, Communications Officer, Practitioner Health
Ms Lucy Warner, Chief Executive, Practitioner Health
Ms Jessica Willis, Information and Data Analyst, Practitioner Health

Acknowledgements:
The authors would like to thank all of those who were involved in the production of this report; our wonderful patients who have given us the honour of caring for them during the pandemic, and our team of administrators, clinicians and therapists who make it all possible.

May 2021
# Contents

Summary of presentations to Practitioner Health pre- and during the pandemic 5

Introduction 6

Mental Health, Health Care Staff and Pandemics 8

The Service: Practitioner Health 8

Preparing for the Pandemic 11

Wellbeing Support 11

Pre-Pandemic 14

Overall Figures October 2019 – March 2022 15

The Lull Before the Storm 17

The Storm 20

Who are we treating? 25

Age 25

Gender 25

Geographical Location 28

Speciality 28

Non-Speciality Doctors, Including ‘Stranded’ Doctors 36

Work status 37

Ethnicity 38

Mental health characteristics of doctors attending Practitioner Health 42

Assessment tools 42

What troubles our patients? 44

Causes of mental illness and moral injury 46

Feedback from patients 48

Hope and Regeneration 48

References 50
This is the story of Practitioner Health (a confidential service for doctors and dentists with mental illness) and how our patients have experienced the COVID-19 pandemic. It uses data from doctors and dentists presenting between October 2019 – March 2021. It is important to add that we are not implying that the pandemic ended on 31 March 2021; this is simply a pragmatic cut-off date for the findings of this report.

Overall, and during the pandemic year whilst we have found a definite increase in the numbers of doctors and dentists presenting to the service, what is surprising given what health staff have been exposed to, is that more have not become unwell. This is their story.
Summary of presentations to Practitioner Health pre- and during the pandemic

- Nearly as many patients presented in the 12 month pandemic period (April 2020–March 2021) as in the first ten years of the service (4355 in last 12 months vs 5000 over first 10 years).

- Month on month, over the course of the pandemic an average of 46% more doctors presented during the pandemic compared to pre-pandemic.

- 105% more doctors presented in March 2021 compared to March 2020.

- Initial dip in self referrals at the start of first lock down (April, May 2020).

- Rising numbers from June 2020, peaking with start of second lock down (November 2020).

- Women far outweigh the number of men presenting (78% vs 22%); this is an increase from the first ten years where women represented 67.5%.

- Age has dropped from pre-pandemic, with the average age of men dropping more than the average age of women during the pandemic.

- All specialities have attended, and in increasing absolute numbers.

- Hospitalists, Accident and Emergency doctors, and Paediatricians had the largest percentage increase across the specialities.

- Psychiatry, diagnostics and surgery saw no percentage change in numbers presenting.

- General Practitioners saw the largest percentage drop as a proportion of the caseload but remained disproportionally higher than their speciality size.

- Doctors working in Intensive Care Units and anaesthetics, and foundation doctors saw a percentage decrease in proportion to the overall specialty mix.
It’s a truism that we are living in uncertain times. The COVID-19 pandemic has disrupted or derailed every aspect of our lives, both professional and private.

We all have a story to tell about living through this period – of our struggles with lockdown; of having to acclimatise to the sight of half faces as masks became mandatory; of loss and mourning; of postponed weddings and online funerals; or of meetings and trips – which seemed so important at the time – being cancelled. In increasing numbers, we have dealt with the illness itself and its lasting impact long after the acute infection has passed.

At the start of the pandemic there was a sense that we were all in this together and for the first few months this belief of solidarity kept us going. After a while, however, splits began to open up – between the young and old; between those in secure jobs and those with fragile employment, between those with family and friends to share lockdown and those who were alone. The pandemic exposed the disproportionate impact of COVID-19 especially on the poor and individuals from South Asian and Black Caribbean backgrounds. There were people who enjoyed the lockdowns, and others who struggled to cope through it. Some thrived as they used the time to declutter their lives, re-engage with their gardens, learn new skills, or just read, reflect and recuperate. But many, including those working in health care, have had to work harder than ever, readjusting their working lives and finding the divide between work and life to have vanished as their bedrooms became their consulting rooms.
# Timeline

Timeline of key moments during the pandemic, and the emotional impact this had on Practitioner Health patients

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Emotional Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2020</td>
<td>Lockdown starts</td>
<td>Anticipatory Anxiety</td>
</tr>
<tr>
<td>April/May 2020</td>
<td>PPE issues</td>
<td>Guilt, stress</td>
</tr>
<tr>
<td>June 2020</td>
<td>Stranded doctors</td>
<td>Isolation increase in IMGs</td>
</tr>
<tr>
<td>July 2020</td>
<td>Workplace return</td>
<td>Workload issues, overwhelmed</td>
</tr>
<tr>
<td>August 2020</td>
<td>Lockdown easing</td>
<td>Emotional exhaustion</td>
</tr>
<tr>
<td>September 2020</td>
<td>Local restrictions</td>
<td>Sleep issues and fatigue</td>
</tr>
<tr>
<td>October 2020</td>
<td>Tier System</td>
<td>Anxiety, self-doubt</td>
</tr>
<tr>
<td>November 2020</td>
<td>Second lockdown</td>
<td>Low mood</td>
</tr>
<tr>
<td>December 2020</td>
<td>Christmas ‘cancelled’</td>
<td>Relationship issues</td>
</tr>
<tr>
<td>January 2021</td>
<td>Third lockdown</td>
<td>Anxiety, stress</td>
</tr>
<tr>
<td>February 2021</td>
<td>Cases rising</td>
<td>Exhaustion, low morale</td>
</tr>
<tr>
<td>March 2021</td>
<td>Vaccines accelerating</td>
<td>Burnout symptoms &amp; anxiety</td>
</tr>
</tbody>
</table>
Mental Health, Health Care Staff and Pandemics

The COVID-19 virus outbreak was declared a pandemic by the World Health Organisation on 11 March 2020. Across the world, health care workers at the forefront of each nation’s response prepared themselves to address the (expected) massive demand from patients requiring care. Academics were highlighting the increased risk for health staff from the effects of the pandemic and anticipated mental health burden especially for those working on the ‘front line’. The largest impact on mental health was predicted to be an increase in cases of anxiety, depression, post-traumatic stress disorder and uncomfortable symptoms bracketed together as ‘moral injury or distress’, which include grief, loss, anxiety and guilt. This was the case with the outbreak of Severe Acute Respiratory Syndrome (SARS) in China 2002-2004. Up to half of health workers who worked through the SARS epidemic experienced significant mental health problems as a consequence of working with patients, with more than 10% having longer lasting problems. Up to 12% of these developing post-traumatic stress disorder. A study conducted in 2019 on health care staff working in China at the start of the COVID-19 pandemic found high rates of depression (50%), anxiety (45%), insomnia (34%), and psychological distress (71.5%). This study reported the psychological burden was felt especially by nurses, women, those working in Wuhan, and front-line health care workers directly engaged in the diagnosis, treatment, and care for patients with COVID-19.

The Service: Practitioner Health

A free and confidential service for health and care professionals working or looking to return to clinical practice who are suffering with mental health or addictions issues

CONFIDENTIALITY  NATIONALLY CONSISTENT OFFER ACROSS ENGLAND  EASY TO ACCESS THE SERVICE  THE SERVICE DOES NOT REPLACE NHS AND IS NOT AN OH SERVICE

Our specialist and unique role is that we occupy and address the complex interface between mental health, regulation and work
The NHS Practitioner Health (PH) is the largest publicly funded physician health programme in Europe. It was established in 2008 after the suicide of a young psychiatrist, who also killed her three-month-old baby. The subsequent enquiry into their deaths highlighted the barriers doctors face in receiving confidential care for mental health problems. Despite a host of protective factors (secure, highly respected job; flexibility; good social networks) doctors have high rates of mental illness, yet low rates of attending treatment services. As a result, many suffer in silence or present for treatment late, following a crisis at work. Reasons for this are multifactorial and well documented in a number of studies. Briefly, on one hand, there are structural factors (actual difficulties in finding time to see a doctor; frequent changes of address making it hard to have continuity of care); on the other, stigma and shame are endemic among doctors, who feel they must be invincible and that any sign of perceived ‘weakness’ is seen as negative.

Practitioner Health operates in the unique space where there is a crossover between the professional and regulatory environment in which a health professional works, and their mental health treatment needs. The expertise of the service lies in managing the confidentiality associated with accessing care, taking responsibility for the safety of the patient accessing the service, but also the professional and patient responsibilities and risks associated with the health professional’s role. Our understanding and experience are in the mental health presentation of health professionals especially where there is a risk of suicide, and the specialist support they may require to return to safe, effective practice.

Detailed analysis of Practitioner Health was produced for its 10-year anniversary and covered 5,000 presentations over the period 2008–2018. At this time the service was England-wide only for General Practitioners and London-wide for all other doctors. Since October 2019 the service has been available to all doctors and dentists across England and, from January 2021, is now available to all health and care staff in Scotland and all health staff in England. To address the impact of the pandemic we have used data from October 2019 onwards. This allows us to compare October 2019 – March 2020 ‘Pre pandemic’ with April 2020 – March 2021 ‘Pandemic’.
Practitioner Health is a self-referral service only. The eligibility for the service is broad, with very few exclusion criteria. Historically, patients attending Practitioner Health have had the same level of psychiatric morbidity as patients attending a standard NHS outpatient department. Care is delivered via a team of general practitioners, psychiatrists, mental health nurses, therapists and other support staff. The clinical team share the care of patients, with communication that does not rely on the exchange of letters (or emails) but on talking with each other and exchanging information, use of a single electronic record system and daily multidisciplinary team meetings (dial-in or face-to-face). Where needed the service can prescribe medicines. There is no cost for patients who use the service.

At registration doctors/dentists provide information about basic demographics (age, gender, locality), work (training grade, substantive post, speciality, complaints etc) and health specific questions. They complete a number of validated questionnaires to determine levels of anxiety, depression and perceived stress, as well as the WHO-validated questionnaire PSYCHLOPS questionnaire. PSYCHLOPS is used to measure mental health outcomes as a quality-of-life measure.
Preparing for the Pandemic

In March 2020 and knowing that there was going to be a significant impact on mental health of staff, Practitioner Health set to work to make sure all 300 or so clinical, operational, management and support staff were prepared. As with other services, we had to rapidly adapt to remote working and develop new policies, practices, systems and operating procedures to meet the challenges of online provision and expected increase in numbers. Fortunately, the operational aspects of the service fitted neatly into allowing remote working. Our Booking App already allowed patients to choose their therapist; remote systems for prescribing, electronic medical records, therapy, multi-disciplinary team working, and remote consultations were already in place and being used. These just all needed to be scaled up to create a seamless transition between the real and virtual world.

Wellbeing Support

As well as expanding treatment services, Practitioner Health also established a suite of new offerings to address wellbeing. We used a combination of virtual large and small groups, webinars, educational and topic specific events and podcasts. They were largely open access (attendees did not have to register with the service, nor be a doctor, nor be located anywhere specific).

These interventions were aimed at all health professionals, not just doctors and dentists.

All told, from April 2020 – March 2021, Practitioner Health ran 421 webinars with nearly 8000 attendees. Events ran morning and evening, seven days a week to allow staff working shifts to attend. Groups were not therapy but ran on psychotherapeutic lines – all were led by trained facilitators able to identify individuals who might need further support and where needed draw them into a separate breakout area for one-to-one support.
Wellbeing Events: Highlights

APRIL 2020

MAY 2020

JUN 2020

JUL 2020

AUG 2020

SEP 2020

OCT 2020

NOV 2020

DEC 2020

JAN 2021

Campaigns & Awareness Days

Feedback from attendees

“Liked the discussion approach, felt gained knowledge. Good to connect with like-minded individuals.”

Female
GP

“Recently struggling with mental well-being, I’ve attended previous helpful webinars organised by Practitioner Health”

Female
Trust Doctor

“The whole session was set on a positive note and gave some really useful tips to cope in the current climate.”

Male
Dentist
The web resources attracted more than 460,000 users over the twelve ‘pandemic’ months. In comparison to the six ‘pre-pandemic’ months, where 64,000 users used the resources. The most commonly used materials were the wellbeing resources.

During the pandemic we offered:

**Virtual Common Rooms**

These provided a confidential space for any health professional to be part of an informal chat, have the opportunity to reflect or to support one another. Each common room was run by a trained host to help guide the chat and signpost attendees to other offers of help or support.

**Webinars**

A series of webinars entitled ‘Caring During COVID - Caring for You’ were led by wellbeing experts and provided a platform to enhance the wellbeing of NHS staff. The monthly topics were tailored to reflect topical issues and concerns of the health professionals presenting to the service.

**Newsletter**

2020 saw the introduction of our monthly newsletter, sharing topics related to the wellbeing of health care staff, posting invitations to our wellbeing events and a monthly blog outlining the latest issues facing the NHS, patients, health care workers and our service.

**Support and Resources**

We provided a dedicated webpage on our website with links to offers of external support and resources.

**Joint Working**

In July 2020, we held the conference The Wounded Healer in collaboration with the British Medical Association. We also worked with the charity Doctors in Distress to provide on online groups for doctors with Long COVID, and a separate one for ‘Black Medics’, a group for doctors who identify themselves as being of Black Caribbean origin.
**Wellbeing App**

We launched a wellbeing app aimed specifically at the needs of health professionals, featuring an individualised wellbeing plan and articles, tools and resources tailored to the needs identified in the plan.

**Pre-Pandemic**

Before the pandemic there had been concerns about rising levels of mental illness in the medical profession, with burnout endemic and levels of distress, mental illness and suicide all at levels of concern. Even pre-pandemic, burnout (although not a mental illness per se) was reported in up to 50% of UK doctors, with some studies suggesting even higher levels. There was a rising feeling that ‘something needs to be done’ yet little was being done on the ground. Those interventions that were offered tended to focus on the individual rather than the system with, ‘resilience and wellbeing’ programmes being the most common interventions. Experience tells us that burnout only happens when organisations are ‘on fire’, and interventions focussing solely on the individual do not work.

Intensity of workload and the lack of attention to the basic needs of practitioners (food, rest, somewhere to hang one’s coat, personal safety) were largely ignored and contributed to doctors’ sense of worthlessness, hopelessness and eventually to burnout and doctors leaving the profession.

**Heavy workload leaves 40% of GPs facing mental health problems including PTSD**

Two in five GPs have experienced mental health problems including depression, anxiety and post-traumatic stress disorder (PTSD) - with heavy workload a key factor, a survey has revealed.

While numbers presenting to Practitioner Health might fluctuate depending on seasonal variation, annual leave and transition from medical school to foundation training - highest in March and September and lowest in August and December - overall the service averaged **249 new referrals per 30-day month**.
Overall Figures October 2019 – March 2022

As we moved into the pandemic registration numbers initially dipped, but from early summer they began to rise again and have maintained at higher levels than before. It is important to note that the differences in numbers and patterns of presentation during the pandemic might be due to a host of factors independent of COVID-19. These may relate to the continued rise in mental health problems seen before the pandemic, or due to a greater awareness of the service as it became more accessible to non-general practitioners outside London. However, while correlation does not imply causation, given the changes seen and their relationship with the rising levels of infection, it is likely that the changes were (largely) related to the pandemic.

Number of new presentations per month

The diagram above gives the headline changes pre and during the pandemic based on the new presentations during the periods October 2019 to March 2020 and April 2020 to March 2021.
### Headline demographics of patients presenting during the pandemic

<table>
<thead>
<tr>
<th></th>
<th>Oct 2019 – Mar 2020 Pre-Pandemic</th>
<th>Apr 2020 – Mar 2021 Pandemic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Number of Presentations</strong></td>
<td>1492</td>
<td>4355</td>
</tr>
<tr>
<td><strong>Average Per Calendar Month</strong></td>
<td>249 Per Month</td>
<td>363 Per Month</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oct 2019</strong></td>
<td>[Image: Male 34%, Female 65.6%, Other 0.4%]</td>
<td>[Image: Male 25.4%, Female 73.6%, Other 1%]</td>
</tr>
<tr>
<td><strong>Mar 2021</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>[Image: Male 43 Years 40.6 Years Old, Female 39.7 Years Old]</td>
<td>[Image: Male 40.8 Years Old, Female 38 Years Old]</td>
</tr>
<tr>
<td><strong>Average Age</strong></td>
<td>40.6 Years</td>
<td>38.8 Years</td>
</tr>
</tbody>
</table>

*Notes:*
- The data for Oct 2019 - Mar 2020 period is labeled as pre-pandemic.
- The data for Apr 2020 - Mar 2021 period is labeled as pandemic.
The Lull Before the Storm

The first case of COVID-19 was reported in China in November 2019. Cases accelerated across the world during the winter months. It first began to really hit the UK in late February 2020, ostensibly carried by holiday makers returning from skiing breaks in Italy. During January and February 2020 there was already rising anxiety fuelled by daily reports of increasing deaths and overwhelmed intensive care units in parts of Europe and New York in the United States of America. The Medical Director of Practitioner Health returned from New York in early March, where she herself had contracted COVID-19 – she was one of the first doctors to be known to have the infection in the UK. As cases across the world rose, and even before the full facts were known, leaders acted. Some took decisive action and adopted the precautionary principle of ‘better safe than sorry’ and favoured the ‘go hard, go early’ approach. Others decided to ‘wait and see’, essentially a ‘do nothing’ approach. The NHS did the former and went into action. With growing urgency, staff went into planning mode, dusted off pandemic-disaster plans, built in April 2020 a temporary hospital at Excel London in the first wave, arranged for staff to work at home if needed, moved care online and waited. Hardly surprising therefore that even before the first case in the UK, doctors were already experiencing anticipatory anxiety, waiting for cases to start presenting.

Inside of the Nightingale Hospital, London
The first lockdown in England began on 23 March 2020 and by April there was a reduction in the number of health professionals presenting to Practitioner Health compared to pre-pandemic months: 148 presented in April 2020; 211 presented in May - a clear drop compared to previous months. This represents a decrease over these two months of 28% compared to months before.

Presentations dropped by 28% in the first two months after the start of the pandemic

The drop in presentations in April and May 2020 initially seemed unusual and surprising. In retrospect, however, the reduction was understandable. In these first few week’s doctors were busying themselves being retrained, redeployed and engaged in the looming crisis. At the start there was a sense of teamwork in a crisis. Massive public support bolstered the morale of NHS staff and they were thanked repeatedly for their help and dedication. The weekly ‘Clap for Carers’ began on 26 March and calls were made for NHS staff to be financially rewarded. This was unprecedented compared to previous pandemics.

For Practitioner Health there was an urgency to set services up, recruit staff to meet anticipated demand, and contact thousands of current patients to reassure them we were still available, and that care was being moved online. New online consultation software was put in place and laptops, screens and speakers shipped out across the country to our staff. We were overwhelmed with and touched by offers of support and help from psychologists, psychotherapists, counsellors and volunteers wanting to help. This led to us quickly establishing a directory of provider resources for any health professional to access. We also created a cadre of peer supporters to provide a listening ear for health professionals accessing the service.

One of the benefits of online working was the ability to connect as a team more frequently. We scheduled daily catchups, peer-led ‘tea and listening’ sessions, and weekly and regular whole team events. Over time the frenetic pace created through this urgency to ‘get things done’ changed and some normality returned. Shared learning, reflections on practice and speedy communication through message groups and online meetings have and will all continue once we return to face-to-face working.

The first 2 months of the pandemic saw referrals drop by over 1/3rd from pre-pandemic
Early in the pandemic, adaptation in the face of new needs was driving the whole health system, not just Practitioner Health. For general practitioners, for example, this meant moving approximately one million daily consultations done face-to-face online (e-consultation, telephone, video). Retired doctors were returning and being retrained; medical students were being drafted in to work earlier than expected.

Every service had to reorganise their teams and ensure infrastructure was in place (IT facilities, logins, computers, remote access); where necessary, personnel were moved to other parts of the health system; managers needed to arrange for necessary personal protective equipment to be available; and much more. There was, to put it bluntly, no time to be unwell, no time to address one’s own needs. There was also a sense of excitement in dealing with the unknown. Overnight, normal working practices changed and many of barriers which hindered innovation were removed. For some, the workload decreased by up to 60% compared to before lockdown\textsuperscript{16} as routine practice and any work deemed to be non urgent\textsuperscript{17} and large amounts of non-clinical care was suspended.

In the NHS, the need for the annual appraisal, revalidation and inspection of health professionals were paused and systems put in place for fast-tracking the reinstatement of doctors to clinical practice.
There were also changes in how doctors were cared for. In some organisations, for the first time in years doctors reported having workplace support, debriefing after difficult shifts and for some, hot food available throughout the day and night; junior staff had access to senior support and a real sense of belonging. Doctors in certain areas of the NHS had many of their wellbeing needs addressed almost overnight. These had been identified following an independent report conducted for the General Medical Council (GMC)\textsuperscript{18} and included: being able to have control over one’s working life and to act consistently with work and life values; to be connected to, cared for, and caring of others in the workplace; to feel valued, respected and supported; and able to deliver valued-based care. These were put in place during the early days of the pandemic. Many hospitals, for example, re-created ‘doctors’ messes’, decompression or welfare rooms where all staff could go. Some of these were indistinguishable from first class airline lounges and run by air stewards on furlough. Now staff had not only a place to hang their coat but also a place to rest their head between shifts. Gone were the shifts where no one communicated, now there were team briefings and staff ringing their junior to ask how they were. Gone was the anonymity where trainees were only known to their consultants through their absence – that is if they didn’t fill a shift. Doctors reported how their team members knew each knew each other by name. It seemed staff really cared for each other. Existing Practitioner Health patients, as with Jane below, told us that they had rediscovered their vocation and purpose in being a doctor. Their mental health improved and there was sense of exhilaration at being able to do the job they had trained for in an environment of reduced bureaucracy, managerial support, realistic workloads with built in break times and a focus on staff wellbeing.

---

\textbf{Jane had been coming to Practitioner Health for depression. Soon after the start of the pandemic she described how, for the first time in years, she now had the time, space and opportunity to be the doctor she had always wanted to be.}

---

\textbf{The Storm}

As the numbers of people with COVID-19 grew and more restrictions were placed on everyday life, morale began to fall across the whole population. Social distancing, uncomfortable personal protective equipment and fatigue added to the distressing experiences doctors faced. Whether working on the so called ‘front line’; behind the scenes managing their patients remotely, or in leadership roles, everyone began to struggle. As the pandemic progressed, any excitement present in the early days was replaced by an intense and overwhelming tiredness and irritability.

The impact on healthcare staff was overwhelming. For some it meant moving out of their home and spending weeks on end in hotel rooms unable to visit their families for fear of transmitting the virus to them. Staff, particularly nursing staff,
were concerned about their own safety as reports of verbal and physical abuse by the public emerged. These included individuals being spat at and labelled ‘disease spreaders’ amid COVID-19 fears and misinformation. Staff were advised through social media to make sure their NHS passes were not visible as increasing numbers were mugged for them as the public wanted to access some of the benefits being made available to NHS staff.

Other staff were assaulted by COVID-19 deniers.

As the weekly clapping stopped after 28 May 2020, the feelings of resentment and anger rose, and staff felt demoralised and unappreciated for the sacrifices they were making. Even fifteen months on we are still seeing examples of misinformation on the risk of infection and distrust of health professionals, with a cosmetic company initially refusing to treat NHS staff when they reopened in April 2021.

As the distress and numbers infected grew, so too did the numbers of doctors who presented to Practitioner Health.
A graph showing the numbers of health professionals presenting to Practitioner Health in the period October 2020 - March 2021, compared to the same six-month period before the pandemic, along with the percentage increase.
Over the pandemic year (April 2020 – March 2021) there were **4,355 new registrations**, an average of **363 new registrations per month** (30 days), in comparison with **1,492 presentations** in the previous 6 months, an average of **249** per month. This is an increase of **46%** when comparing total numbers presenting pre-pandemic. The third lockdown started on 5 January 2021. By the end of March 2021, the numbers of health professionals presenting to us have not returned to pre-pandemic levels and are at more than **100%** higher than in March 2020.

**Average number of presentations pre and during pandemic**

The reasons for the change in numbers presenting will be discussed in the following sections.
Who are we treating?

**Age**

In October 2019, the average age of all doctors presenting was **40.6 years**; for women it was **39.7 years** and **43 years** for men.

The average age of doctors presenting during the pandemic dropped to **38.8 years**. There was a decrease in the average age of both men and women; for women it was **38 years** while the average age of men fell slightly more to **40.9 years**.

This age drop would be expected. It is those in the middle age bracket (30-45 years) who are most likely to juggling responsibilities at home (children, older parents) and work. Given the additional pressures brought on by the pandemic it is not surprising that this generation of doctors struggled more. It might also be that older doctors have felt unable to admit vulnerability and seek help from friends or colleagues – instead, feeling that they have had to soldier on.

**Gender**

There have always been proportionally more women than men presenting to the service, and the differential has grown year on year. For the month of October 2019, **65.6%** of presentations were women, this rose to **73.6%** in March 2021. Women make up around **46%** of the GMC registrants though it is likely that they account for less of the actual workforce, as a greater proportion of women than men will be on maternity/paternity leave or working part time at any one time.
The reason why we have seen many more women than men is likely to be multifactorial. Across the world, and as the pandemic took hold, research suggests that women have been disproportionately affected,\(^\text{22}\) and there is no reason to suggest that female doctors have not been similarly so. In our analysis of the first ten years of Practitioner Health, we found higher levels of women attending than men and attributed this to the additional caring responsibilities women doctors are more likely to have outside the work environment. The pandemic has added to these responsibilities and pressures on maintaining stability in their own homes with the added constraints brought about by emergency pandemic legislation. Even the simple act of shopping for food has become harder as shops have limited numbers allowed in stores. Women from all walks of life and age groups have been affected by unemployment, income loss and a reduction in paid working hours. Their share of unpaid care and domestic work has also increased\(^\text{23}\) - with more time spent looking after and teaching children (as schools were closed) and attending more often to elderly relatives (all the more difficult in a pandemic).\(^\text{23,24}\) Creches have been closed and help from informal carers, such as grandparents, has not been available. Even with schools open to key worker children, the lack of after school provision impacts on childcare arrangements. All of this means that for women, the unpaid domestic and care workload that disproportionately falls to them has increased, arguably more so for younger women.\(^\text{25}\)
Looking back, I realise I had been struggling since before the pandemic, but without the usual wraparound childcare and the massive new demands of working from home, home schooling and battling Wi-Fi with my consultant surgeon husband it all became too much. I had so much guilt, that I was letting down my children by not giving them enough attention, putting the family at risk on the days I did go into the practice and having to stay away from my elderly mother, who was shielding – I could see her mental health deteriorating and felt hopeless that I couldn’t seem to help.

I was constantly anxious, exhausted and overwhelmed. When I was working, I didn’t find time to eat or even go to the lavatory. I felt decision making was getting harder by the day and I constantly worried about missing a diagnosis when consulting online. In our small team of GPs many were shielding so I was also doing my best to see all those patients who needed face to face appointments.

There was no way to rest or relax – the housework was piling up, endless meals to be cooked, children and dogs at my side at all times. I felt like I was letting everyone down, my patients, my family, my work colleagues, and with arguments brewing with my husband all the time I had nowhere to turn to support.

A glass of two or wine each night seemed fine to help me relax and get off to sleep. There were wellbeing offers everywhere but I had neither the time nor inclination for self-care. I was waking up each morning wondering how I would get through another day. As I drove to the practice, I started to have intrusive thoughts of driving my car into a wall, I didn’t want to die or leave behind my children, but I was just so exhausted and anxious and wanted it all to stop.

Laura, GP
Geographical Location

The proportion of doctors presenting to the service across the country was roughly that expected based on numbers of doctors in areas, except London, where proportionally more doctors attended during the pandemic. As the first cases of coronavirus began to emerge, initially in York, followed by significant numbers in London we saw a pattern emerge with new registrations mapping the covid outbreaks in each area of the country.

In every region the number of registrations has exceeded the expected numbers with London and the North West showing increases of 89% and 71%. Those areas least impacted by COVID-19, South West and East, have seen the smallest increases.

Change in the number of doctors presenting compared to a pre-COVID-19 baseline (the final quarter of 20-21, January – March 2020) shown by NHS England region

Speciality

Working in ICU in a pandemic is not all bad. It was a shock to the system at first and yes it’s grim and yes it’s really hard work. I’m exhausted, but we’ve really bonded as a team and the other redeployed staff are such a great help. It’s not work I want help with really, it’s that I miss my family.

My wife and young daughter have moved in with my mum and dad as they’re shielding and need help. It’s the right thing to do, but I miss them so much. The hours I work are ludicrously long, and I often miss my daughter’s bedtime, and my wife looks exhausted when we speak. I’ve not held my daughter or hugged my wife in 6 months. Sometimes I go back to the hotel at night and just sob. It’s a nice hotel, and I’m glad the Trust is paying for it, but it’s not my home and I miss my family.

I really shouted at someone at work the other day I feel dreadful. People in the department often say I’m like the father of the unit as I’ve been there so long, and I don’t feel I can tell them how I’m feeling. I also don’t want to burden my wife as she has a lot on her plate too. I feel like I’m losing my mind sometimes and I just feel so alone.

Krish, Hospital Consultant
Doctors attending Practitioner Health work in a multiplicity of roles and working patterns – full time, part time, substantive, training, locum, in and out of hospital, patient-facing and non-patient-facing, research, leadership, policy, medical journalism, private and NHS practice, within charities and medico-legal roles. Medical roles therefore encompass many different specialities and subspecialty groups which for the purpose of this analysis (and for simplicity) we have grouped into 13 categories. Some of these categories contain multiple subspecialities which again we have grouped for ease of analysis and to maintain confidentiality where the speciality has only a few presentations.

For the purpose of this report, we have grouped specialties into the following:

- **‘Hospitalists’** includes any medical subspeciality where the doctors work predominantly in a hospital environment.
- **Diagnostics** includes areas of work such as radiology, pathology, haematology, microbiology and virology.
- **Surgery** includes maxillofacial surgery, trauma and orthopaedics, ophthalmologists, and all areas of subspeciality surgery.
- **Obstetrics and Gynaecology** includes genitourinary medicine.
- **Foundation doctors** include FY1, FY2 and FY3.
- **General practitioners** include salaried GPs, partners, locum GPs, academic GPs and ST3/4 GP trainees.
- **Non-speciality** includes doctors such as locums, doctors not in training positions and also a cohort of doctors who came to the UK from overseas early in the pandemic to sit their English Language medical examinations.
- **Non-hospital medical speciality** includes those working in areas such as occupational medicine, pharmaceutical medical, public health, sports medicine and clinical research.

While all specialties saw an increase in the actual numbers presenting to the service during the pandemic, there were differences in their proportions within our total patient cohort. Overall and across the life of Practitioner Health, general practitioners have always been the majority of attendees, disproportionate to their numbers on the medical register. Pre-pandemic, general practitioners represented 55% of all presentations. The reasons why general practitioners are overrepresented (they only represent around 30% of all registrants) have been explored in the ten-year report and in the book on doctors and mental illness, edited by the Medical Director of Practitioner Health. Briefly, given their position at the ‘front door’ of the health system, general practitioners are probably bearing a disproportionate burden of workload against diminishing resources. Workload has increased considerably over recent years without a corresponding rise in the work force. It is hardly surprising therefore that general practitioners are often top of the list for mental distress
and burnout in the medical profession. This is translating into increasing levels of dissatisfaction, anxiety, chronic stress, depression and suicidal thoughts. This level of distress became exaggerated during the pandemic as behind the scenes general practitioners continued to see patients, increasing their workload. Far from being applauded, however, general practitioners were often at the brunt of criticism from patients and national leaders.

Doctors working in the hospital medical specialities – ‘hospitalists’ – also presented in greater numbers - proportionally the largest increase from pre-pandemic levels (4.7% increase, from 7% of all doctor’s pre-pandemic to 11.0 % during the pandemic).
## Numbers of different specialities presenting for care

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>820</td>
<td>1995</td>
<td>2815</td>
</tr>
<tr>
<td>Hospitalists</td>
<td>97</td>
<td>486</td>
<td>583</td>
</tr>
<tr>
<td>Anaesthetist &amp; Intensivist</td>
<td>92</td>
<td>243</td>
<td>335</td>
</tr>
<tr>
<td>Non-Specialty</td>
<td>54</td>
<td>199</td>
<td>253</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>74</td>
<td>246</td>
<td>320</td>
</tr>
<tr>
<td>Surgery</td>
<td>66</td>
<td>222</td>
<td>288</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>40</td>
<td>163</td>
<td>203</td>
</tr>
<tr>
<td>Foundation doctor</td>
<td>71</td>
<td>192</td>
<td>263</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>40</td>
<td>169</td>
<td>209</td>
</tr>
<tr>
<td>Dentist</td>
<td>58</td>
<td>159</td>
<td>217</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>32</td>
<td>129</td>
<td>161</td>
</tr>
<tr>
<td>Nonhospital medicine</td>
<td>7</td>
<td>24</td>
<td>31</td>
</tr>
<tr>
<td>Obs &amp; Gynae</td>
<td>41</td>
<td>128</td>
<td>169</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1492</strong></td>
<td><strong>4355</strong></td>
<td><strong>5847</strong></td>
</tr>
</tbody>
</table>
When I heard we would be fast tracked to work provisionally as doctors I was excited, but that soon passed when I found myself on the wards feeling like a fraud. I felt like I had not really earned my place and I was constantly doubting my skills and abilities. My elective to Fiji was cancelled but I understood, and I was proud to be able to work for the NHS.

Some days felt like a baptism of fire, I felt totally out of my depth. My consultant said I had seen more death in my first 6 months than he saw in the first 5 years of his career. I had heard about the legendary camaraderie of being a junior doctor – the doctors mess nights out, the social life. Yet with that all cancelled I never felt so isolated and alone.

Jack FY1

What does Practitioner Health Offer?
Each time I held an iPad to the face of a dying patient I felt a little bit more broken. At no point in my career had I been prepared for this, it felt so wrong. I tried to imagine how it would feel to watch my own relative die by Facetime and the only way to cope was to stop thinking about it. I think they call this moral injury. Most of my team have been deployed to help from other areas. They look to me for guidance and support – I can barely keep my own head above water. Others have it far worse than me, I should be able to cope.

My family stood outside their house clapping each week yet when they met in the garden I was not invited, they were worried I was too risky. I feel like a social pariah, when I get home at night and my children run to greet me, I shout to not touch me while I strip and run to the shower to scrub away the risk I carry. My hair is like straw and my hands so dry from all the washing.

Rebecca, Medical Registrar

While the actual numbers of different specialities increased, there was a difference in the percentage increase across different specialities. From April 2020 the percentage of general practitioners presenting compared to other specialities actually decreased from 55% to 46% of all presentations, though given the increased numbers attending this was still 22% more GPs presenting over the course of the pandemic than before.

Doctors working in Accident and Emergency (+1.2%), non-specialty doctors (+1%) and paediatricians (+1.1%) had increases in presentations over the course of the pandemic. There was also a slight decrease in percentage of dentists (-0.2%), foundation doctors (-0.3%) and those working in anaesthesia/intensive care (-0.6%). The figures shown are the change in overall percentage of all presentations.

The reasons for seeing the change in proportions of specialities presenting over the pandemic are likely to be varied. They might relate to an actual increased risk of mental illness (for example, due to exposure to repeated trauma or disruption of training or work); for those where proportions are lower, this could be down to better psychological protection and support. It might also be that some speciality areas had better access to more local support while others, predominately those working in non-acute settings, had poorer access.

Drawing on experiences of previous pandemics and the available literature cited earlier in this report the expectation was that Intensive Care Unit (ICU) staff would be most at risk of mental illness. To this effect, there was a focus on their wellbeing from the outset of the COVID-19 pandemic. From our dialogue with different parts of the health system what was clear was that ICU staff had frequent debriefing sessions, close team working, prominent leadership, and easy access to wellbeing support.
Resources (staff, supplies, support) were also drawn from the rest of the hospital to meet the needs of ICU staff. This is not to say that those working in ICU are not at risk of mental health problems but that they had greater psychological protection to help them cope with their massive increase in workload and exposure to trauma. Our patients told us that in the main, ICU staff were the one group who had adequate PPE which was not always the case for other specialities.

For others, the risk of mental illness was less obvious and their distress less visible. For example, doctors whose work moved predominately online (including most non-acute medical specialities, general practitioners and psychiatrists) lost the personal contact with colleagues, and told us how this made them feel isolated, and given the changing nature of the work (almost all dealing with COVID-19 queries), concerned about their own knowledge and skills.

The guilt was overwhelming. My medical condition meant I needed to shield and work from home, but I felt such a failure and unable to pull my weight. It took weeks to get the IT set up, I knew my colleagues were struggling in the practice and here I was at home unable to help. I became aware that one of the admin staff had complained that it was unfair I was working at home. I cried for what seemed like days after that. My main contact with work was our staff WhatsApp group but I left as felt so embarrassed and ashamed, but it just made me feel even more lonely and out of touch.

I carried on my usual clinics over the telephone, it was so draining. My back and my eyes hurt, and the work was taking me so much longer than usual. When the clapping happened each week, I closed the curtains and hid. I started to think about giving up work as a doctor all together.

Rachel, GP

They faced a computer screen all day and missed not being in close contact with peers who could provide informal support and advice. Added to this was the fear of making errors and missing serious underlying disease among the ‘noise’ of COVID-19.

Those working at home could be more at risk of mental illness than those actually travelling to a real space and being with real people. The physical transition from a home to working environment appeared to give greater purpose to their days compared with those who moved the few feet from bedroom to living room.

Those not working also experienced distress. Feelings of guilt and of ‘not pulling one’s weight’ were prevalent in those who were shielding – even if they had been redeployed to virtual or telephone work. Some were also working remotely and home schooling one or more children as well as doing their ‘day job’.
Proportion of different specialities presenting for care

October 2019 – March 2020

April 2020 – March 2021
Non-Speciality Doctors, Including ‘Stranded’ Doctors

Attention should be drawn to a small but important subgroup, that of non-speciality doctors. While over the course of the pandemic the average proportion of non-specialist doctors rose by only 0.1%, this belies the massive fluctuations in their numbers over the pandemic months. This group included more than 200 doctors (mainly from South Asia and Africa) who came to England in March 2020 to sit their Professional and Linguistic Assessments Board (PLAB 2) test. Their March examination was cancelled and for many so too was their ability to return home. They were unable to work and earn money in the UK and also had to face the additional costs of obtaining a new visa to sit the rescheduled exam, and being unable to leave the country. This added to the financial and other difficulties these doctors found themselves in, far from the families, friends and support networks and the distress of watching the pandemic play out and not being able to return home to help. A number of these doctors sought help from Practitioner Health which may have accounted from the increase in numbers of non-speciality doctors during April 20 – June 20.

International medical graduates (those whose primary medical qualification was obtained overseas) also struggled more during the pandemic. Where between lockdowns, and when restrictions allowed, others were allowed to meet families, IMGs could not in the main leave the UK – often finding their home country on a ‘banned list’ or with strict travel restrictions in place. They also had to watch from afar as their family, friends and colleagues suffered and died in their home country, unable to help.

Number of Non-speciality doctors (IMG’s, locums, non assigned, PLAB doctors)
Work status

In October 2019 approximately **75%** of doctors presenting to the service were working (as opposed to being on sick leave, maternity leave etc.).

---

*I’ve been depressed before, but this felt different. Before, I just couldn’t find any motivation to do anything but this time it was the anxiety that really affected me. I still felt low, but I was also panicking all the time too. I’ve not got long now before finish my training and I love Emergency Medicine, but this last 6 months has been like nothing else I’ve ever experienced. I’ve not seen my family or many of my friends for ages, and I can’t even date any more, and I feel quite alone when I’m on my own at home. Keeping in touch on zoom just isn’t the same.*

*I hate wearing PPE, but in the last month or so it has had some odd advantages. I found myself crying at work a few times, but the PPE meant nobody could see and I was just able to get on with things but still crying. How strange is that! I’m still working with my team whom I love, but it’s just not the same. You can’t have banter or nuanced chat or jokes when you look like you’re ready for a moon landing!*

*I’ve started to drink pretty much every night. I’m not getting drunk, but I know it’s not good for me. I just really want some time off. The department is already on its knees and I just don’t feel I can. Thank god for my Dr autopilot, but I’m just not sure how much longer it’ll last.*

Adam, Hospital doctor

---

At the start of the pandemic in April 2020, the number of medical professionals presenting to the service who were currently working dropped to **66%** and continued at that level until July 2020. Then the number began to rise again, reaching **76%** in employment by March 2021 and **18%** of the remainder were on sick leave.

Doctors have low rates of absenteeism, with presenteeism (that is turning up for work even if unwell) more of a problem compared to other occupational groups. This is likely to be the case here, given the high levels of stress which doctors were presenting with and the fact that the proportion still working increased. It is a reasonable assumption to make that by continuing to work – absorbing pressures, dealing with their home responsibilities and caring for patients – individuals were denying their own needs. This is illustrative of medical professionals’ strong moral obligation to continue working despite personal distress. Doctors often feel a moral and ethical duty to work, even when unwell, they have concerns about professionalism – they feel nothing can disrupt their duty to provide care to patients and work is central to their lives. Doctors are often unsure about the threshold for taking sick leave and whether their symptoms are severe enough to warrant sickness absence. Other reasons include fear of increasing the burden on others and avoiding...
feelings of guilt by staying at work despite being unwell. These reasons are likely to have been amplified when, in the height of the pandemic, reports of a third of staff being on sick leave or absent due to shielding or enforced isolation were common and doctors were asked to cover for absent nursing and medical colleagues.

**Ethnicity**

Over the course of the pandemic there was a slight decrease in the proportion of those who identify themselves as White, with an increase in those who identify themselves as Asian.

**October 2019 – March 2020**

- **White**: 66.4%
- **Asian**: 21.9%
- **Black**: 3.5%
- **Mixed**: 4.8%
- **Other**: 3.3%

**April 2020 – March 2021**

- **White**: 62.4%
- **Asian**: 25.4%
- **Black**: 3.6%
- **Mixed**: 4.5%
- **Other**: 4.2%

---

I couldn’t stop watching the news, it was obvious almost from the start that most of the doctors who were dying of covid were of BAME backgrounds. Early on a colleague of mine was told off for wearing his own mask at work – he was told it was scaring the patients. The rules about PPE seemed to be changing each day, I was worried the PPE I had was not enough to protect me. My family back home rely on me and I have a wife and young children to support. I literally could not afford to die.

I was terrified, I was too frightened to tell anyone, too scared to ask to work in a less risky area. I didn’t want to look like I was causing a fuss. I had spoken up in the past about something and got reported for being rude, yet when my white colleague raised the same issue people listened. I had to keep my head down and pray I would get through this with my life.

Rashid, Emergency Department doctor.
Some of the UK doctors who have died of COVID-19[^34]
As the pandemic unfolded with it came the deaths of health care staff. Picture montages in memorial to those doctors who had lost their lives began to appear in the media and the predominance of those from Black, Asian and minority ethnic (BAME) backgrounds was striking. It became clear that minority ethnic staff were disproportionately affected by COVID-19 and their risk of dying was significantly higher than their white colleagues.

Compared to those of White British ethnicity, people of Bangladeshi ethnicity had approximately twice the risk of death. Those of Indian, Pakistani, Caribbean, Chinese, other Asian and other Black ethnicity had between 10 and 50% higher risk of death, this even after adjusting for confounding factors.

Overall, 63% of deaths among health and social care workers were in Black and Asian staff, yet they account for only 21% of the NHS workforce and 94% of doctors and dentists who have died from COVID-19 are from a minority ethnic background.

Black, Asian and minority ethnic healthcare professionals faced a far greater threat from COVID-19 and lived a different experience compared to their white colleagues. There are many reasons for this disparity in risk between minority ethnic doctors and dentists and their white counterparts and include issues related to health (prevalence of diabetes, hypertension, coronary heart disease and obesity) as well as working conditions. A large proportion of minority ethnic doctors work in staff grade, specialist, and associate specialist roles, which are crucial, patient-facing roles and hence place the doctor at greater risk of contracting the infection. A survey found that minority ethnic doctors were twice as likely as white doctors to feel pressured to see patients in high-risk settings without adequate personal protective equipment.

Practitioner Health provided culturally diverse virtual common rooms, a therapeutic space for staff to come together to share and be supported in their experiences and we continue to place paramount importance in ensuring our service remains inclusive and accessible and is responsive to the needs of doctors and dentists of Black, Asian and minority ethnic backgrounds.
It’s feeling under threat all the time that I’ve been finding so difficult. I’ve experienced racism and micro-aggressions ever since I moved to the UK to study medicine. I’m from China and feel like I’ve worked hard to integrate into UK life, but when the pandemic started, I began to feel people in the street were looking at me differently due to my Asian appearance. It really hit hard when I heard about an international student (also East Asian) that had been attacked on Oxford street in broad daylight, purely because he was east Asian, and blamed for the virus.

The Black Lives Matter movement also made me reflect more on earlier experiences that I’d tried to bury.

There was lots of chatter at work about healthcare staff being treated like cannon fodder without proper PPE. I work in respiratory medicine and I knew it was risky, but I also felt I had to stay at work. I usually stay sane by trying to maintain a good work life balance, but every time my phone beeped it was something to do with work or Covid or a relative asking me questions about the pandemic or their health or risks. My nanny left without notice and moved back to Spain, and my husband and I were fighting over arrangements for childcare. I couldn’t even watch the TV without constantly being reminded of Covid, death, unrest on the streets. I started to feel like I couldn’t switch off and it all ended with me having what I think was a panic attack at work. I was so ashamed, as everyone else seems to be coping better than me. I just needed to talk to someone who understood.

Mai, Respiratory Consultant
Mental health characteristics of doctors attending Practitioner Health

Doctors presenting during the pandemic had:
• Moderately high levels of anxiety
• Moderately high levels of depression
• High levels of stress
• Low levels of wellbeing
• Lower reported levels of alcohol and/or drug misuse
• High levels of moral distress

Assessment tools

This section shall now look at what doctors coming to the service presented with, and their overall diagnosis. In coming to a view, we use three sources of information. The first is by asking the patient in their own words why they need help, through a self-completed free text form.

The second is through a number of validated questionnaires looking at anxiety, depression, stress and wellbeing. Third, we carry out a detailed assessment of the patient. These have all helped build up a picture of the problem’s doctors have faced before and during the pandemic. All self-referring patients also undergo an extended assessment, typically lasting 90 mins to determine the formulation and best treatment plan for them. These are undertaken by GPs, psychiatrists and specialist nurses. All new patients are discussed at a weekly multidisciplinary team meeting.

The table below summarises the questionnaires used on the patients who register with Practitioner Health, the cut of scores for Caseness and the average score for the doctors attending the service. As with the other assessment processes used, the results found that overwhelmingly the doctors attending suffered from moderate to high levels of anxiety, depression, poor wellbeing and stress.
<table>
<thead>
<tr>
<th>Questionnaires used</th>
<th>‘Caseness’</th>
<th>All doctors average scores during pandemic April 2020-March 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generalised Anxiety Disorder (GAD)</strong> measures anxiety disorder. A score greater than 9 indicates a probable moderate anxiety disorder; a score greater than 15 indicates probable severe anxiety disorder.</td>
<td>10+</td>
<td>12.1</td>
</tr>
<tr>
<td><strong>Patient Health Questionnaire (PHQ-9).</strong> A score greater than 9 indicates probable moderate depression; a score greater than 19 indicates probable severe depression.</td>
<td>10+</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>The Perceived Stress Scale (PSS)</strong> is the most widely used psychological instrument for measuring the perception of stress. It is a measure of the degree to which situations in one’s life are appraised as stressful. Items were designed to measure how unpredictable, uncontrollable, and overloaded respondents find their lives. The assessed items are general in nature rather than focusing on specific events or experiences. The scale also includes a number of direct queries about current levels of experienced stress. The higher the score the greater the level of perceived stress. A score of 14 indicates significant stress.</td>
<td>14+</td>
<td>25.9</td>
</tr>
<tr>
<td><strong>The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)</strong> is a 14-item scale where all items are worded positively. The higher the score the more positive the response. It covers both feeling and functioning aspects of mental wellbeing. The WEMWBS questions align well to feelings of loss, interest, fear and energy, all symptoms of distress.</td>
<td>&lt;40</td>
<td>36.2</td>
</tr>
</tbody>
</table>
What troubles our patients?

- more than one third of patients presenting to the service cited anxiety as their main complaint.
- another third of doctors presenting to service cited work, work-related stress and burnout as their main problem.
- 17% of patients presenting to Practitioner Health cited depression as their presenting problem.

Doctors presenting to Practitioner Health have high levels of mental illness, in particular, anxiety, depression and work-related stress (feeling overwhelmed and burnt out) and there is of course considerable overlap between these conditions. One third of doctors stated anxiety was their main reason for seeking help at registration. Following assessment, nearly 90% of doctors (88.5%) were given a diagnosis of a ‘common mental health problem’. This category includes depression, anxiety, stress and post-traumatic stress disorder (which was diagnosed in 91 patients attending the service).
That doctors had high levels of anxiety is not a surprise. Surveys done in the early stages of the pandemic found that anxiety was the predominate symptom.44

There is a strong overlap between post-traumatic stress disorder/syndrome (PTSD/S) and anxiety. While only a small number of patients reported symptoms of PTSD when registering, it may be that further cases of PTSD emerge as we go forward, especially for those working in intensive care.

Moral injury (which includes guilt, fear, dread) was the cited as the reason for attending by 6.5% of all new patients. Moral injury, a term that originated in the military can be defined as the psychological distress that results from actions, or the lack of them, which violate one’s ethical or moral code. Moral injury is itself not a mental illness, though the uncomfortable emotions can increase the risk of anxiety, depression, PTSD and even suicide1.

The proportion of patients presenting with addiction dropped slightly from pre-pandemic levels, from previous 4% to 3% of the overall cohort. This drop was surprising given that many of the doctors who presented for treatment admit to drinking more alcohol than they normally do – trying to numb either the pain of their work or the boredom that their lives have now become. While doctor-specific studies on alcohol consumption during the pandemic are yet to emerge, across the UK there are reports of increasing alcohol use in the general population, especially in older adults. Alcohol sales increased by 30% just before lockdown started as people stocked up for fear of shortages – 15% of individuals who drink alcohol are drinking more than before lockdown. For medical professionals, homeworking, frequent moves across different wards or services and the facial coverings demanded by the pandemic all make it easier to mask the effects of heavy drinking. At the very least it is harder to smell alcohol on the breath with a mask on. Lower levels of presentation might actually be due to alcohol misuse now being better hidden rather than true lower numbers.
Causes of mental illness and moral injury

It is hardly surprising Practitioner Health saw a rise in presentations after the start of the pandemic given that doctors were directly involved with every aspect of dealing with the effects of the infection. The British Medical Association\textsuperscript{26} has been conducting tracker surveys of their (doctor) members throughout the pandemic, and our findings mirror theirs. Nearly 65\% of doctors responding to one survey in November 2020 were ‘quite or extremely’ anxious about work in the coming months and 40\% felt their levels of stress, anxiety and emotional distress had got worse since the pandemic began.

There are many reasons for this and given that 76\% (March 2021) of our patients were working at the time of presentation, it is likely that work was a significant contributor. Long working hours in unfamiliar settings, intensified conditions, worries about personal protective equipment, fear of contracting and passing the infection on to loved ones, losing high numbers of patients, seeing bereaved families, and a sense of isolation. These multiple stressors were part of the daily diet of doctors during the pandemic and each individual has had to change and adapt to deal with the crisis of the pandemic.

Given the extraordinary circumstances which health professionals have been working under, it is hardly surprising that a number of them have developed mental illness as a result. There is a multiplicity of other aetiological factors at play – for example concerns about being exposed to the infection, fear of taking the infection to loved ones at home, fears about their own lack of knowledge to deal with unwell patients. If there is one word to describe the universal experience of the pandemic it is loss. This might be the loss or separation of a loved one, a colleague or friend, or the actual death of a friend, colleague, relative or patient. Before COVID-19, death was hidden from sight, in nursing homes, hospitals and hospices. Now it fills our lives, every day. Each evening we have had a daily tally of the number of people who have died. Images of coffins, shrouded bodies and grieving relatives fill our TV screens. There are photos of the dead in newspapers, reminding us of the real human cost of this disease. People announce on social media the death of their loved ones and we increasingly receive personal communications about the death of friends, relatives and colleagues and attend virtual and real funerals. Doctors have commented on seeing more death in patients in a week than in all of their previous working lives, of witnessing their patients dying alone, holding their hands through PPE as their family members are not allowed to be by the bedside. Doctor’s report needing to communicate end of life messages back and forth through mobile phones and the worry of having to withdraw treatment prematurely due to lack of resources to save lives. There have been other losses. Almost without exception the working lives of medical professionals have been disrupted, whether through interrupted training or moving teams, jobs and even hospitals. There are also fewer tangible experiences, more ambiguous losses: loss of status when having to move across work boundaries; and loss of certainty, as none of us can be truly sure of what tomorrow will bring.
Loss and grief are interconnected and dealing with grief has been difficult. Grief is a complex process – its duration, intensity and the impact of the loss, are all unique to the individual, but generally speaking, shared grief is grief abated. Many of the doctors presenting to the service talk of their overwhelming feeling of guilt. Guilt is an intrusive emotion which is a common finding among the doctors presenting to Practitioner Health and triggered by the pandemic. If pervasive, guilt can undermine mental wellbeing. It involves self-criticism about harm done to self or others. Grief can become maladaptive when individuals develop an exaggerated sense of responsibility for events that occur out of their control, or when reparation is not possible. COVID-19 has afforded many opportunities for health professionals to feel guilty and to exaggerate their part. For example, lack of PPE led to health staff contacting COVID-19 and spreading it beyond the confines of the hospital and into communities. The researchers Brooks et al write in their review of the effects of quarantine, that the prolonged uncertainty and constant alert related to COVID-19, combined with a fear of infecting others, can lead to maladaptive guilt with disruptive consequences for mental health. All these emotions, and the risks they pose in leading to mental illness are compounded by fatigue. The initial eagerness to play one’s part in the crisis, to get ‘stuck in’ and to make a difference has been replaced by an intense and overwhelming fatigue. Fatigue has also been experienced by those not working. Some staff, such as those shielding or recently returned after retirement, may not have been run off their feet, but found the perpetual state of waiting just as exhausting. Others have been working long shifts in face-to-face clinical practice. Staff have worked hard, extremely hard. An overwhelming memory of the leader’s group we run, was when one member told how she had broken her chair by sitting in it for six weeks for every hour of the day she had not been sleeping. The work was generated by the urgent need for new policies, practices, guidelines and standard operating procedures. Fatigue compounded the problems faced by those working in health care.

Despite being repeatedly told ‘this is not a sprint but a marathon’ (in fact several marathons back-to-back is a better way to describe the intensity of the work), working 16-hour days appeared to be the norm. Remote working, with no natural breaks for travel or even moving between rooms compounded the problem for those at home. Each virtual meeting appeared to have an urgency to it not there when meeting face-to-face; gone are the pleasantries at the start of face-to-face meetings, the sharing of each other’s day-to-day experiences or the ritual distraction of asking for coffee or tea orders. Instead, we get stuck in straight away, sometimes not even able to see each other as the faces appear or not (apparently randomly) across ever-shifting screens.
Feedback from patients

Each year we ask our patients for feedback on the service, their experience of accessing care and the impact that Practitioner Health has had on their work and personal lives. This is an important tracker for us to know that we are meeting the needs of our patients and that we are contributing to the wellbeing of the workforce. Given the major upheaval for the service in the last year, the rapid growth to meet demand, changes in care delivery and the challenges every healthcare organisation and individual have faced, we were not sure how many patients would complete the survey or how the results would read.

Over 1700 patients responded and the results were upbeat and positive, with over 94% saying they were likely/very likely to recommend the service to friends and family.

The positive impact on wellbeing, personal life, and ability to continue work or training were all upwards of 78%.

| Likely/very likely to recommend PH to friends and family | 94% |
| Believe the service is confidential/very confidential | 93% |
| Believe the service has had a positive/very positive impact on wellbeing. | 90% |
| Believe the service has had a positive/very positive impact on personal/family life. | 83% |
| Believe the service has had a positive/very positive impact on ability to work/train & return to clinical practice. | 81% |
| Believe the service has had a positive/very positive impact on intention to keep working as a doctor/dentist. | 78% |

I don’t think I would still be working as a doctor if it was not for Practitioner Health. I hit many lows and always knew I had a place to turn to and support without which I am unsure if I would still be here today.
Practitioner Health Patient

I was and am still grateful that the NHS appeared to care about its workforce for the first time in my 30-year history of working in it.
Practitioner Health Patient

Hope and Regeneration

For most who work in health the last year has been very difficult. All have had to deal with their unexpected changes to ways of working, some needing to work in isolation without support from teams, others having to learn new skills or revisit roles long left behind. There is no doubt the anxiety and stress has been intense, though mixed with moments of joy and satisfaction.

But hope is now in the air.

At the time of writing (May 2021), the UK is heading towards herd immunity and over 60% of the population have received at least one dose of a vaccine. Shops have
reopened and gradually social restrictions are being removed. Doctors are beginning to take stock of what they have been through and prepare to deal with the backlog created through delayed activity caused by the pandemic. However, it is important that they, as with all health staff, have time to recuperate and recover from this unprecedented time.

The NHS is still facing a massive uphill challenge, like Sisyphus forever pushing his boulder up hill, patients keep coming and the waiting lists continue to grow. This may look daunting, and staff can be forgiven for feeling overwhelmed with what they have just been through and what will come next. COVID-19, however, has shown us that NHS staff can adapt and step up to do what is needed. The success of the vaccine campaign is testament to this and the huge efforts of so many who have taken on the task to ensure it is rolled out as quickly and efficiently as it has been.

After this year it is not surprising that staff will be feeling demoralised and for morale to be low. Some might be considering their career choices or leaving the profession. Yet the annual staff survey,49 capturing the opinion of more than half a million staff, indicates that morale is actually improving; hospital managers are taking an interest in the health and wellbeing of their workforce and more options are opening up for flexible working, including home working.

The pandemic has brought positive changes to working cultures: the team reflections which enable sharing after difficult shifts; the connectivity of colleagues who have come together to learn from one another, share experiences and build on good practice; the opportunities for new ways of working that have enabled people to both work and be there for their families. We will need all of these on the road to recovery if that boulder is not going to slip back and crash into us again. In the long run healthcare staff will recover but for some the last year will have opened old wounds, exposed difficult feelings and left them needing external support. Their recovery may need some help – that’s where NHS Practitioner Health comes in.

NHS staff across England can now access mental health support, either by self-referral or via signposting from their local hub. Regulated health and care staff in Scotland can also self-refer, meaning the service is now open to more than 1.6 million health and care staff if and when they need it. www.practitionerhealth.nhs.uk

We commented at the outset of this report that whilst we have found a definite increase in the numbers of doctors and dentists presenting to the service during the pandemic, what is surprising given what health staff have been exposed to, is that more have not become unwell. There is no doubt that our collective COVID-19 experience has been a challenge like no other and it remains to be seen whether the ongoing effects will bring a deluge of healthcare staff needing future support. As always, NHS Practitioner Health will be here - ready to care, support, hold and treat them.

As we all begin our journey on the road to recovery, if you are one of the people who may need some additional support to get you back on track, or you know a colleague or friend who could, please signpost them in our direction.
References


18. Iacobucci G. Covid-19: all non-urgent elective surgery is suspended for at least three months in England. BMJ. 2020;368:m1106. doi:10.1136/bmj.m1106


32. Rimmer A. Overseas doctors stranded by cancelled exams can stay in UK without extra visa costs. BMJ. 2020;370:m3177. doi:10.1136/bmj.m3177


34. Gerada C. Work is central to doctors’ identity, and those unable to work need support. BMJ. Published online April 21, 2016:i2014. doi:10.1136/bmj.i2014

35. Remembering the UK doctors who have died of covid-19 | The BMJ. Accessed May 9, 2021. https://www.bmj.com/covid-memorial


SUPPORTING THE HEALTH OF HEALTH PROFESSIONALS

www.practitionerhealth.nhs.uk