

# **THE WOUNDED HEALER:**

**Report on the First 10 Years of  
Practitioner Health Service**

If you build it they will come

## **Written by:**

Dr Clare Gerada, Medical Director, Practitioner Health Service MBE FRCGP FRCPsych

## **Contributors:**

Ms Lucy Warner, Chief Executive Officer, Practitioner Health Service

Mr Richard Jones, Clinical Director, Practitioner Health Service

Dr Zaid Al-Najjar, Deputy Medical Director, Practitioner Health Service

## **Acknowledgements**

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October 2018



GP Health Service  
Practitioner Health Programme

Doctors/Dentists come to us.  
They get well and **STAY WELL**  
in large numbers

# Practitioner Health Service

specialises in taking care of doctors and dentists with mental illness and addiction problems

## PHS A MULTI-AWARD WINNING SERVICE



"Without PHS I think I would have hung up my stethoscope or would not have been in this world."



"Access to PHS was quick, thoroughly supportive and empathetic - good links to other therapies."

WE LISTEN

CONFIDENTIAL

JOINED UP APPROACH  
TO PATIENT CARE

CONTINUITY OF  
CARE

EXPERT  
CLINICIANS

A TREATMENT  
SERVICE



"Absolutely brilliant. PHS have got me through really dark days. It has been really supportive, positive and encouraging which is essential for my confidence at the moment."

TRULY INTEGRATED

PATIENTS ARE PART  
OF THE CARE TEAM

We've come a

**LONG  
WAY**

in  
**10  
years!**

DAILY,  
MULTI-DISCIPLINARY  
TEAM MEETINGS



Our  
Award-winning  
booking  
App!



"My life has changed in its entirety. I am now healthy, happy and working as a safe and successful doctor. Without PHS this wouldn't have happened."

"Four months ago I was depressed, suicidal and felt my life had fallen apart. Now I am back at work full time enjoying life again and have a very sturdy support network."

PHS are first class and have likely saved my life."



**5000** patients in 10 years - **1000** doctors back in work

Our team . . .

Mental Health  
Nurses



GPs



Psychiatrists



Therapists

Specialist  
advisors



Operational  
team



Doctors suffer the highest  
rates of mental illness  
and suicide



Our service  
delivery  
costs  
less than  
£5 million pa

Have saved the  
NHS around  
£230 million -  
the cost of a  
medical school

Bipolar

Depression

PTSD

Anxiety

Undiagnosed schizophrenia

Addiction

SUPPORTING THE **HEALTH OF HEALTH PROFESSIONALS**

ARTWORK: [twovisualthinkers.info](http://twovisualthinkers.info)

# WELCOME

Welcome to this 10-year report on the work the Practitioner Health Service has done over the years caring for mentally unwell doctors and dentists.

PHS is a confidential, free, self-referral NHS service for doctors and dentists with mental illness and addiction problems. We see doctors and dentists nation-wide with all kinds of mental illness and are able to offer a wide range of pharmacological treatments and talking therapies. This report will describe these in detail.

Practitioner Health Service was launched in 2008, initially only for a two-year London pilot. The intention was to expand the service beyond London, if successful, to the rest of England.

Funding and other issues prevented this expansion at the time. Over the years, however, we have won new contracts for different cohorts of patients. For example, in 2015, we added the Trainee Doctors and Dentists Support Service (TDDSS) to our core offering, meaning that all doctor and dental medical trainees in London and the South East could receive a wellbeing support service. In 2017, given the particular pressures faced by general practitioners, a new service was commissioned to provide care to all GPs and GP trainees in England (GP Health Service [GPH]); we successfully won the contract to deliver this service. As of November 2017, more than 85,000 doctors can now access a confidential mental health and addiction service specifically designed to meet their needs and around 1,500 now do so every year. Sadly, 110,000 doctors across England still cannot access us directly.

Clinicians and managers from across the world have come to London to learn from what PHS provides and as a service, we have led the way in a host of clinical, operational and governance areas. It is the only NHS-funded service of its kind and is probably the largest practitioner health treatment service in the world.

We have influenced bodies such as the General Medical Council, many Royal Colleges, NHS England and other important organisations as to how mentally ill doctors should be treated.

The old saying that doctors make bad patients is true to a degree. Doctors are reluctant to come for help. They think that they are alone, the only ones ever to become unwell or need help. They describe being ashamed at having to admit to vulnerabilities and believe that in one way or another they are letting people down by being ill.

Over the years we have found that sick doctors, as with all patients, yearn to be treated compassionately – with sensitivity, sympathy, empathy and in a non-judgmental manner. All too often, however, mentally ill doctors are treated by trainers, employers and regulators as naughty schoolchildren or wrongdoers at having crossed the boundary from practitioner to patient.

Unfortunately, the needs of the doctor as a patient – a troubled, desperate and unwell patient – are ignored by most treatment agencies.

PHS is different.

We see the vulnerable patient behind the doctor. We understand their specific needs. However, even in the safety of a consulting room, doctors often start the consultation with a variation on 'I am so sorry to trouble you, sorry to be wasting your time'. Each doctor has their own story of pain and distress, and all have good reasons to seek help. Many have reached the end of their ability to self-sacrifice and to care, and their professional, personal and social lives are often in tatters. They have waited too long to seek help and when adversity strikes, they work harder in the belief that their problems will magically disappear. Some begin to self-prescribe, crossing a professional boundary which invites a host of other problems; others begin to use alcohol to address anxiety; some doctors present with disruptive behaviour which masks their mental illness.

We know that with the right support doctors not only make good patients, but excellent ones. They follow advice and respond to treatment. They are invested in their recovery and many thousands of the doctors attending PHS get better. Patients tell us how positive they are about their experiences and most report that their lives have improved after starting to attend PHS. They tell us they are happier, more relaxed, more self-confident or emotionally stronger; they talk about being able to rebuild their self-respect and improve their relationships with family members and colleagues.

An unexpectedly large number of patients have credited PHS with not only changing their lives but with saving them. Several believe they would not be alive had they not found the service. One said that the service was 'the best thing that ever happened' to them; another that finding PHS had led them 'to [discard] the idea of suicide'.

PHS is also often credited for saving careers, with practitioner-patients telling us that they believe they would no longer be working in medicine had they not accessed the service. One doctor said, '[without PHS] I think I would have either hung up my stethoscope or would not be in this world'.

Over the ten years we have won prizes (including The BMJ Mental Health Team of the Year in 2018); received accolades; been the focus of television and radio programmes and press reports. We have been the subject of a PhD, a MSC study and student dissertations, as well as TV, radio and print articles.

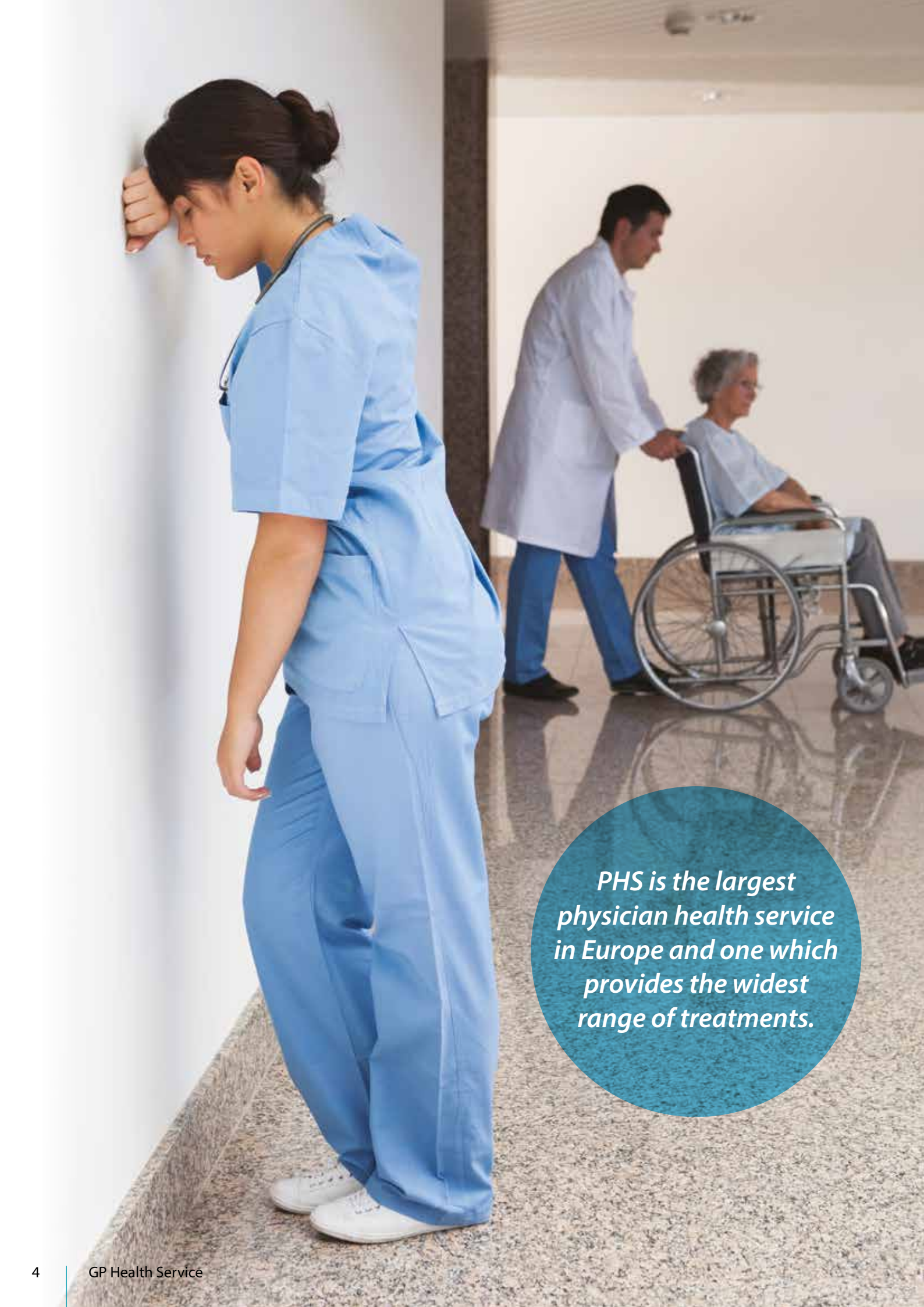
This report will describe how we operate and hopefully will help doctors in need to take the brave step of referring themselves to us or to a similar service. We hope it will provide the reader with an understanding of PHS, our statistics and evidence base and will encourage others to ensure that this important population group gets the healthcare support they need. Finally, it has been an honour treating my colleagues over the past decade.

The years have gone very fast and I am so proud that our service has gone from strength to strength in helping doctors in mental distress.

Thank you to all who have come to our service and to the staff who have cared for them.

Dr Clare Gerada

4th October 2018



*PHS is the largest physician health service in Europe and one which provides the widest range of treatments.*

<b>WELCOME</b>	<b>2</b>
<b>PART ONE: EXECUTIVE SUMMARY</b>	<b>8</b>
<b>SERVICE HIGHLIGHTS BETWEEN NOVEMBER 2008 - MARCH 2018</b>	<b>8</b>
Headlines	8
• Outcomes	9
• Feedback	9
<b>PART TWO: DOCTORS, MENTAL ILLNESS AND HEALTH SERVICES</b>	<b>10</b>
Background to PHS	10
Why do doctors need a specialist mental health service?	11
Risk factors linked to doctors and mental illness	12
Stigma and shame	13
Complaints	13
Barriers to doctors seeking help for mental health problems	15
Summary of mental illness and doctors	15
<b>PART THREE: THE NUTS AND BOLTS OF PRACTITIONER HEALTH SERVICE</b>	<b>16</b>
PHS: designed for doctors by doctors	16
What PHS does not provide	17
How PHS is different from other practitioner health services	18
Comparison of of PHS to US physician health programmes	19
European provider network	20
Our team	20
Service issues	21
Ensuring sufficient capacity	22
Education and training	22
Clinical	23
Education and liaison	23
Return to work	23
Other	23
Providing shared care	23
Summary of what PHS provides	24
How PHS works for the practitioner-patient	25
Booking app	25
The patient pathway	26
Medical record	28
Multidisciplinary team meeting (MDT)	28
Risk assessment	29
Ensuring coordinated care	30
Ongoing treatment	31
Talking therapies	32
Behavioural therapy	32
Supported, computerised CBT	33
Telephone-based CBT	33
Face-to-face CBT	33

Group therapy	33
Slow-open or closed groups	34
Drop-in groups	34
Time-limited groups	34
Monthly support groups	34
Support group for addiction	35
Residential rehabilitation	35
Managing exam stress workshop	36
Confidentiality	37
Consulting with a patient's own GP	39
Continuing care and discharge	40
Patient organisations and networks	41
<b>PART FOUR: HEADLINES OF OUR ACTIVITIES AT PHS</b>	<b>44</b>
Decoding our data	45
Summary of care from November 2008 – March 2018	46
Numbers seen	46
Basic demographic data	47
Age	47
Gender	48
Doctors in training vs consultant-grade	50
Additional equality monitoring – protected characteristics	50
Presenting problems	51
Mental illness	53
Common mental health problems	53
Complex mental health problems	54
Addiction and doctors	57
Treatment for doctors with addiction	60
Treatment outcomes for doctors with addiction	60
Residential rehabilitation	61
Work, regulation and addiction	61
'Other' mental health categories	62
Regulator/disciplinary involvement	62
How PHS helps doctors involved with the regulators	65
Work and training	66
Research and development	69
<b>PART FIVE: HIGHLIGHTS FROM DIFFERENT SPECIALTY GROUPS</b>	<b>70</b>
All doctors	70
General practitioners	70
Causes of GP distress	71
Practice meltdown	72
Too much too soon	73
The straw which breaks the camel's back	74
From sad to bad	74



Psychiatrists	75
Surgical specialties	77
Anaesthetists	79
Obstetrics and gynaecology (O&G)	80
Paediatricians	81
Dentists	83
Trainees and trainee doctors and dentists support service	85
International medical graduates (IMGs)	86
<b>PART SIX: OUTCOMES OF CARE AT PHS</b>	<b>88</b>
Patient wellbeing questionnaires	88
Clinical outcomes in routine evaluation outcome measure	88
Work and social adjustment scale	89
Global improvement and satisfaction self-rating scale	89
Work questionnaire	89
Psychlops ('psychological outcome profiles')	89
The Warwick-Edinburgh mental well-being scale (WEMWBS)	90
The perceived stress scale	90
Patient health questionnaire	90
Outcome from patients using PHS based on five psychometric instruments	91
Outcomes for patients receiving CBT therapy via efficacy	93
<b>PART SEVEN: OUR EXPERIENCE OF CARING FOR DOCTORS</b>	<b>94</b>
Caring for ourselves	97
When treatment doesn't work	98
<b>PART EIGHT: WHAT OTHERS HAVE SAID ABOUT PHS</b>	<b>102</b>
What our patients tell us	102
Patient stories in their own words	104
What our other stakeholders tell us	106
Awards	109
<b>PART NINE: SUMMING UP</b>	<b>110</b>
<b>PART TEN: BIBLIOGRAPHY</b>	<b>112</b>
<b>Additional reading: a selection of papers and resources by or about PHS</b>	<b>112</b>

The combined services of the NHS Practitioner Health Programme (PHP), NHS General Practitioner Health Service (GPHS) and Trainee Doctors and Dentists Support Service (TDDSS) are referred to collectively as the Practitioner Health Service (PHS).

For the purpose of this report, the term 'doctor' refers to both doctors and dentists.

The term practitioner-patient is used to designate a doctor who has become a patient of the service.

For the purpose of this report we refer to 'doctors' in the plural and will use 'they', rather than 'he or she' each time.

All case scenarios are composite cases unless otherwise stated.

We have included some key references and reading materials.

# PART ONE: Executive Summary

**I'm so glad I have found Practitioner Health Service! It took reaching crisis point to finally find help and I have my GP to thank for finding this service. More doctors need to be aware that there is specialist help out there that is available to us.**

A practitioner-patient

## Service highlights between November 2008 and March 2018

### Headlines

- Between 2008 and 2018, over 5,000 doctors have presented to PHS.
- 3,767 of these have gone on to have full assessments and become our patients.
- The remainder are: people who have sought advice from us and not progressed to full assessment; pharmacists; medical students; senior managers and other health practitioners seen on special arrangement; or doctors who have passed through one of our group activities (group therapy, Time-To-Think programme, reflective practice groups).
- From a London-based team of three in 2008, over the last decade we have grown to a network of over 300 clinicians, special advisors, clinical leads, therapists and operational staff across England.
- PHS is the only NHS-funded practitioner health service.
- PHS is the largest physician health service in Europe, providing all kinds of interventions (from community detoxification to residential rehabilitation; from individual to group therapy; from mental health to addiction treatment; from consulting room to back to work).
- Our delivery costs work out at around £54 per head for the population we serve.
- At the start of the service we saw slightly more men than women (M53% vs W47%) but by the end of the first decade women far outnumbered men (M32.5% vs W67.5%).
- Over the years, the service has seen a year-on-year drop in the mean age of doctors presenting for treatment, from 51.6 years in 2008 to 38.9 years in 2018.
- Not surprisingly, given the age of doctors we see, many are still training.
- The service saw a significant increase in self-referrals in 2016 which coincided with the NHS Junior Doctor strike.
- Overall, 430 doctors seen by PHS have been involved in regulatory processes (GMC, GDC).

- We believe we have the largest number of doctors with bipolar affective disorder being treated in a single service anywhere in the world.
- We believe we have the largest cohort of doctors being treated for addiction in a single treatment service anywhere in the world.
- Overall, most patients (83.5%) suffer from mental health problems; 10.1% have addiction issues and 6.3% have other diagnoses.
- Around 25% of practitioner-patients were not at work when they presented to us.

## Outcomes

- Over the decade, and across all services, we have had excellent outcomes with respect to:
  - Improvement in patients' mental health and social functioning
  - Numbers of health professionals returning to work or training
  - Reducing potential risk to practitioner-patients and the public
  - Excellent patient satisfaction scores and feedback
  - Evaluation scores demonstrate that all groups of practitioner-patients have improved regardless of age, gender or diagnostic category
  - Return to work
  - Abstinence rates for those with addictions.
- At discharge, approximately 76% of those not at work returned to work.
- Over the last 10 years we have returned more than 1,000 doctors back to the workplace.
- There has been a large drop in those involved with the regulator, from 33% (2008/9) to less than 5.1% (2017/18). Averaged out over the years 2008-2018, the figure is 11%.
- Over the years we have seen a marked drop in the percentage of doctors with addiction problems, from 36% (2008/09) to 10.1% (2017/2018).
- As a percentage of those presenting from specialties, anaesthetists, dentists and emergency practitioners are more likely to present with problems related to addiction than patients from other specialties.
- On all measures (using validated instruments), our patients improve with our care. PHS significantly decreases levels of distress and improves work and social functioning.

## Feedback

- PHS consistently receives positive written and verbal feedback from practitioner-patients and their families. Survey results from PHS patients show:
  - 93% are extremely likely/likely to recommend PHS to a friend or colleague
  - 88% say PHS has had a very positive or positive impact on their personal wellbeing
  - 81% say PHS has had a very positive or positive impact on their family life
  - 78% say PHS had a very positive or positive impact on their ability to work or train

# PART TWO:

## Doctors, Mental Illness and Health Services

*I can honestly say that I don't think I'd be alive without PHS. I wouldn't be as healthy and definitely not working successfully as a doctor, as I am now, without their unfaltering support, empathy, encouragement, tough love at times and general reliability. This service is amazing; please don't ever underestimate how important it is to the health of doctors.*

A practitioner-patient

### Background to PHS

The catalyst to secure the funding for the original service came after Dr Daksha Emson, a talented young psychiatrist with a history of bipolar affective disorder, killed herself and her three-month-old baby in October 2000. Though Daksha had a mental illness dating back to medical school, she managed to keep her diagnosis secret from those who should have known about it and for years had informal care from a consultant psychiatrist unconnected with her training institution, occupational health service or general practitioner. Daksha was terrified that if her mental illness were more widely known she would lose her job. What treatment she had was in the form of secretive, hurried consultations in hospital corridors. Most of the time, she was not treated at all. Before she became pregnant, she stopped her medication and, after the birth of her first child, she developed what we now know to have been a severe postnatal relapse of her bipolar affective disorder. Though her mental illness and the risk of a relapse following pregnancy were known to her health professionals, their care was tempered by her (and their) wish to keep her confidentiality intact. This meant that information was not shared as it should have been; notes recording the severity of her illness were downplayed; and child protection procedures were not implemented.

The subsequent inquiry into this extended suicide highlighted the barriers to receiving care embedded within the medical profession and reinforced by societies and the 'systems' (regulator, employer, media) view that doctors should not become mentally unwell, or that their illness should exclude them from working. As a result of her death, one of the recommendations from the inquiry was to develop services for doctors with psychological problems.

This issue was taken up by the Chief Medical Officer, Sir Liam Donaldson, whose report on medical regulation 'Good Doctors, Safer Patients' (2006)<sup>1</sup> was the starting point for the development of PHS. This report highlighted that:

- the insight sick doctors have into their condition and the impact that it has upon their performance may be severely compromised;
- illness in doctors may be poorly managed and appropriate assistance may not be sought for a variety of reasons;
- doctors may be able to disguise their illness from others (perhaps through self-prescription);
- where illness is recognised to adversely affect performance, there may be a reluctance to refer a doctor into a system that is perceived as 'disciplinary', particularly where there is a lack of knowledge about alternatives;
- an excessively stressful work environment may have a significant impact on doctors' health and wellbeing.

Following this report, resources were allocated for the first practitioner health service and the National Clinical Assessment Service (NCAS) led the development of the service specification and tendering for PHS. After a long, competitive process, this was won by the NHS general practice partnership, The Hurley Group.

## Why do doctors need a specialist mental health service?

Over the years, many have asked the obvious question: why do doctors need their own service? There is an assumption by some that providing a specific service just for doctors reinforces their 'specialness' and is therefore elitist. However, there are many reasons why doctors need to have their own service, elucidated in a paper by Brooks et al (2011).<sup>2</sup> Briefly, despite having higher rates of mental illness than the general population, doctors have poor access to healthcare, especially mental health services.<sup>3</sup> Doctors have a host of personal, professional and institutional barriers to accessing care when they need it. Some of these barriers are practical – even managing to make an appointment can be difficult due to long, irregular hours or registering with a general practitioner when regularly moving address. Despite working in the health system, doctors often do not know where to seek help. They also face emotional barriers – an unwillingness to admit to illness, instead presenting 'the stiff upper lip' and continuing to suffer in silence. Some doctors deliberately conceal their problems from family and friends and will even pretend to go to work rather than admit that they are unwell. Perhaps the biggest barriers for doctors when accessing care are concerns regarding confidentiality, the possible impact disclosing an illness might have on their career, and that any transgression might lead to a referral to the regulator. This is especially the case where addiction is the issue.

As a result of these problems doctors have a tendency to self-diagnose and self-treat. Where they do seek specialist help it more often than not takes the form of so-called

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<sup>1</sup> Chief Medical Officer. Good doctors: safer patients. London: Department of Health; 2006.

<sup>2</sup> Brooks S, Gerada C, Chalder T. Review of literature on the mental health of doctors: Are specialist services needed? *Journal of Mental Health*. 2011;20(2):146-156.

<sup>3</sup> Brooks S, Chalder T, Gerada C. Doctors vulnerable to psychological distress and addictions: Treatment from the Practitioner Health Programme. *Journal of Mental Health*. 2011;20(2):157-164.

'corridor' consultations – snippets of care carried out outside the consulting room.

Medicine is a small world with professional and personal circles creating a small community of doctors. This means it is difficult, particularly in small geographical areas or large Trusts, for doctors to consult with a stranger. The need to see a medical professional unknown to the practitioner-patient is all the more important where the sick doctor wants to discuss a sensitive issue.

When doctors do present for help, it is hard for caregivers to see beyond the professional to the patient and treat the sick doctor as the frightened and vulnerable individual they are. Doctors tend to treat sick doctors differently from other patients – they engage in medical talk, discuss academic papers or the latest research and go way beyond what the sick doctor really wants or needs.

The professional regulatory responsibilities placed on doctors also cause anxieties, where the caregiver or colleague may feel the need to alert the regulator to the doctor's illness and escalate issues unnecessarily.

All of these factors illustrate the importance of having an accessible and confidential service available for doctors, run by staff who understand the special needs of this hard-to-reach group.



## Risk factors linked to doctors and mental illness

Doctors may be more at risk of mental illness because they are chosen for those very personality factors which foster the antecedents of mental illness – perfectionism, obsessionism and altruism. Doctors occupy a privileged position in society; they have status, expertise, considerable power and are granted access to the most intimate parts of patients' lives. But with these privileges come darker consequences. Doctors contain some of most painful aspects of their patients' problems and enter 'the swampy lowland' with them – a place of confusing 'messes' for which there is no technical solution.<sup>4</sup> This can be a tremendous burden, and some, without the necessary support and spaces to reflect and talk about their work, may not be able to cope. Unrealistic expectations from patients, together with a constant fear of being named, blamed or shamed for any errors, adds an extra burden to an already difficult job. Easy access to prescription drugs and knowledge of how to use them is also a major risk factor for addiction, especially pertinent given the higher rates of addiction amongst anaesthetists, accident and emergency doctors and dentists. Finally, the heavy workload, long and unpredictable hours and sleep deprivation all add to the risks of developing mental illness.

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<sup>4</sup>Schon D. The reflective practitioner. San Francisco: Basic Books: Harper Collins; 1983.

## Stigma and shame

Daksha Emson wrote about the shame she felt about being unwell. Nearly 20 years after her death, sick doctors still continue to feel a dreadful sense of personal failure and inadequacy as they struggle to keep working. The stigma associated with doctors disclosing mental health problems also persists, often with tragic consequences. On 24th November 2015, Dr Wendy Potts, a general practitioner and mother of two, killed herself. Dr Potts suffered from bipolar affective disorder and kept a blog about her condition, about which a patient complained. As a result of the complaint, Dr Potts was suspended from clinical practice and later referred to the General Medical Council (GMC). The coroner told the inquest, 'it seems to me the suspension and investigation was something of a sledgehammer being used to crack a nut'. The theme of losing sight of the person behind the professional is echoed by Mahajan and Johnstone.<sup>5</sup> They describe how a doctor became 'lost in the system' and how this, in their view, contributed to his suicide. They emphasise the importance of addressing human factors in maintaining patient safety in the community.

## Complaints

As with the case of Dr Potts, complaints are a significant factor in doctors developing mental illness and can even lead to their suicides. Patients are encouraged to complain about the service they get from their doctor but for many doctors (who, after all, are perfectionists), a complaint can feel very personal, an attack on their core sense of self and on their vocational values. A doctor's response to a complaint is often similar to the stages of bereavement or to receiving a diagnosis of a terminal disease. For others, the complaint is felt with such force that they literally feel a heavy weight on their chest wall.

Research has shown that for doctors, a complaint can lead to future defensive action, depression, anxiety, suicidal thoughts and sadly even suicide. In 2012, the GMC found that there were high rates of suicide among doctors going through their processes,<sup>6,7</sup> and whilst correlation does not mean causation, their findings must nevertheless be taken seriously.

At the time of writing, PHS has prepared advice for doctors who are facing a complaint, and we are now drafting a Code of Conduct to outline the process and support which should be in place for doctors when a complaint is made about them. Hopefully, in time, this will become operational.

For more information on complaints, visit our website:

<http://php.nhs.uk/resources/complaints/>

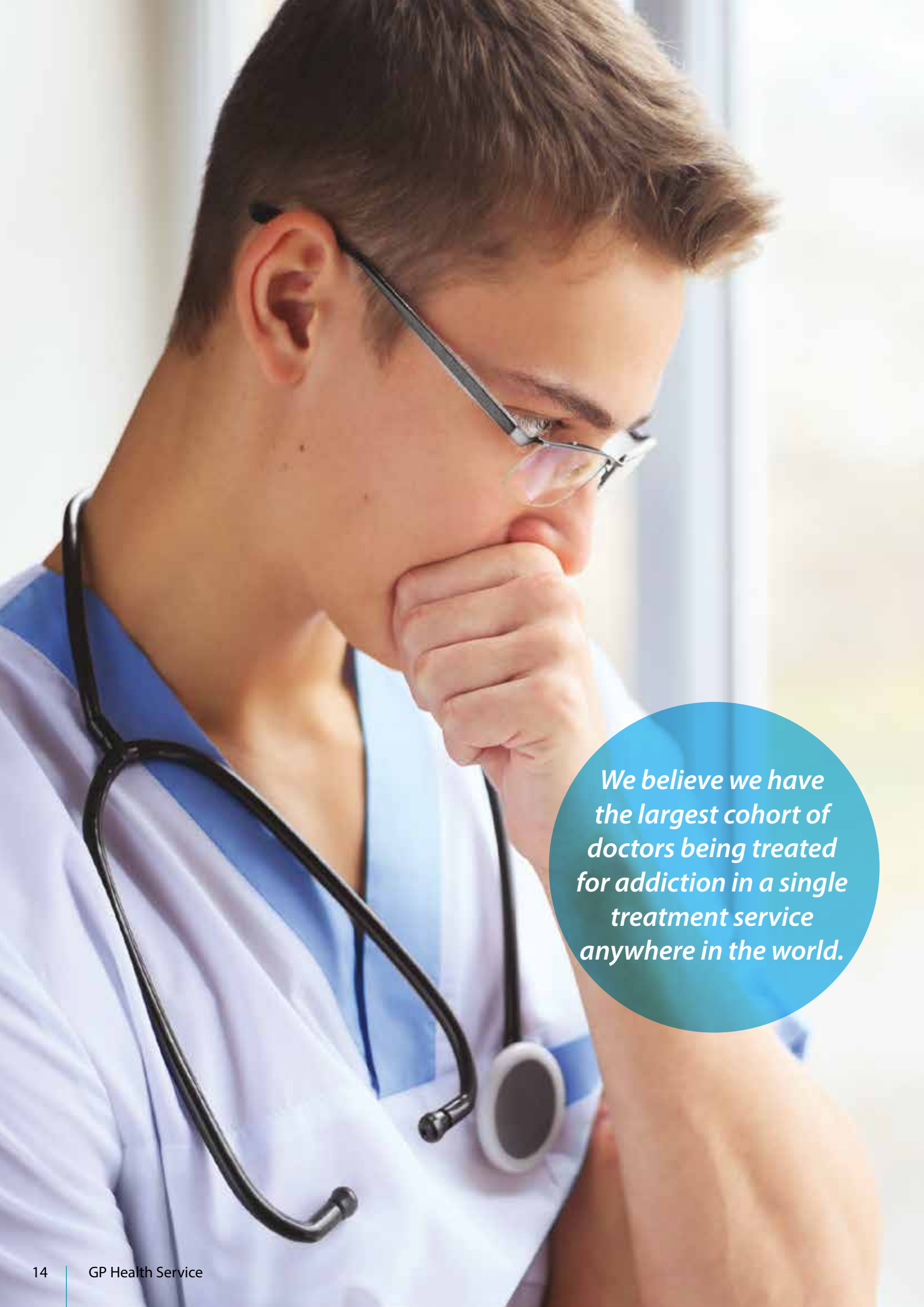
This report will describe many of the features which make the PHS accessible, confidential and a place where doctors can take off their metaphorical white coat, replace it with the patient's gown and receive the care they so badly need.

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<sup>5</sup> Mahajan S, Johnstone C. Human factors in suicide prevention. *InnovAIT: Education and inspiration for general practice*. 2017;10(11):679-686.

<sup>6</sup> Bourne T, Wynants L, Peters M, Van Audenhove C, Timmerman D, Van Calster B et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ Open*. 2015;5(1):e006687-e006687.

<sup>7</sup> General Medical Council. Doctors who commit suicide while under GMC fitness to practise investigation: Internal Review. 2014. Available from: [https://www.gmc-uk.org/-/media/documents/Internal\\_review\\_into\\_suicide\\_in\\_FTP\\_processes.pdf\\_59088696.pdf](https://www.gmc-uk.org/-/media/documents/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf)



*We believe we have the largest cohort of doctors being treated for addiction in a single treatment service anywhere in the world.*



## Barriers to doctors seeking help for mental health problems

- Fear of lack of confidentiality;
- Embarrassment and even shame at having to disclose mental health problems;
- Guilt at taking time off work, related to presenteesim;
- Fears that their career will be compromised if illness is disclosed;
- Personal knowledge and the wish to self-manage rather than seek help.

## Summary of mental illness and doctors

- Mental illness is common amongst doctors;
- Suicide rates are higher than for most other professional groups;
- The culture of medicine and dentistry is not generally supportive;
- Personal, professional and institutional stigma exacerbate mental health problems amongst doctors;
- Patient complaints are a significant factor leading to mental illness and suicide amongst doctors;
- Prevalence of addiction disorders is similar to the general population;
- Some groups, such as anaesthetists and international medical graduates (IMGs) have additional risk factors.

# PART THREE:

## The Nuts and Bolts of Practitioner Health Service

*Slowly and imperceptibly, my enjoyment of life in general – and work in particular – had been diminishing. The burden of professional life weighed down almost intolerably on my shoulders; my colleagues and my patients began to suffer the fall-out from this downward spiral. One patient wrote to me following a consultation, saying ‘...you made me feel as if you were in a hurry, that I was your last consideration, and that you basically wanted me out of your room as quickly as possible...’ To say that I was shattered by this is an understatement – I had gone from someone whose pigeonhole frequently contained cards and gifts from grateful patients to someone who radiated antipathy towards the very people I was supposed to be caring for. This hand-written letter, sent to me personally, was the catalyst to take action. Within a week of contacting PHS, I was assessed and commenced on a programme combining pharmacological and talking therapy. The relief was overwhelming. I will feel forever grateful for the compassionate response I received. This allowed me to regain control, enjoyment and effectiveness at work without taking any time off or feeling stigmatised for having sought help.*

Dermatologist, abridged from version published on PHS website

***PHS has been a vital part of my recovery and return to a contented life.***

A practitioner-patient

### **PHS: designed for doctors by doctors**

Practitioner Health Service (PHS) specialises in treating doctors and dentists with mental illness. It helps doctors make the transition from doctor to patient. We work in the unique interface between health practitioners as regulated professionals and as patients with a mental illness, and as such are experts at the interface between regulation, employment and mental illness and addiction.

PHS understands the special needs of doctors with mental illness, how their condition might impact on their work and potentially their own patients. We are skilled at helping doctors return to work or training. We see and treat practitioners with mental health conditions such as depression, anxiety and obsessive-compulsive disorder.



We also see doctors with more severe illnesses, such as bipolar affective disorder, personality disorders and psychosis.

Everything about the service has been designed with the needs of doctors in mind. For example, the original service was (and still is) located in the heart of a general practice setting in Vauxhall, South London.

Many of the locations around the country are also in general practice settings. This feels familiar for doctors and mirrors the contact they may have had with the health service in the past.

We want to make sure that each patient feels safe and our team understands the issues that health professionals face in crossing that boundary from carer to patient.

PHS has been led since the outset by a general practitioner with training in psychiatry. As such, the service acts as a hybrid between a mental health service and a primary care service. We provide what any mental health service would as standard – a range of talking therapies, pharmacological interventions and case management; we also provide services which would be routine in any GP service – issuing fit-notes, brief intervention therapies and liaison with external agencies (with patients' consent). Practitioner Health Service also has access to residential rehabilitation services for patients with addiction problems.

## What PHS does not provide

It is important to say what we do not provide.

PHS is not a specialist mental health service. This is a subtle but important distinction. We do not limit our care to any particular mental health disorder (such as depression

or addiction), nor any patient demographic.

PHS is also not an occupational health service. We help with returning doctors to work and have occupational health expertise within the service, but we do not carry out return to work assessments, or assessments which might be required to formulate reasonable adjustments.

PHS is not a replacement for mainstream NHS services, nor designed to offer a second opinion for mental or occupational health, nor is it a shortcut to obtaining a medico-legal opinion. Doctors who are currently supported by NHS mental health services are encouraged to remain with their local team, though we are happy to offer guidance on particular aspects of care or support them for their return to work. This means that patients with, for example, acute psychotic illnesses, patients with severe eating disorders, or patients who require assertive outreach or home/in-patient treatment must be seen by local services.

PHS plays no part in managing professional standards and has no role in overseeing doctors in disciplinary processes, supporting investigations into their practice or informing performance assessment processes.

We are not an emergency or urgent service but try to be as responsive as possible where doctors are in crisis.

We do not provide drop-in services, or directly treat patients' physical health problems.

Notwithstanding all of the above, we are a comprehensive, integrated service providing care across the physical, social and psychological domains.

## How PHS is different from other practitioner health services

We are proud that there are certain aspects of PHS which are unique, not just in England but across the world.

For example:

- It is a national service delivered through a central hub.
- It is run by a general practitioner, who leads a multidisciplinary team of specialists, GPs, nurses and therapists.
- It delivers holistic care treating the individual's personal, social, mental health and addiction needs within the same service and by the same clinician.
- It is an integrated service – the clinical team share the care of all patients, with communication that does not rely on the exchange of letters (or emails) but on talking and sharing information, use of a single electronic record system and daily multidisciplinary team meetings (dial-in or face-to-face).
- Where needed we can prescribe medicines.
- We offer a range of group work.
- We offer remote, face-to-face and web-based therapy.
- Our secure booking app enables the choice of clinician, location and time.
- There is no cost for patients who use the service.

## Comparison of PHS to US physician health programmes

Other physician health programmes (PHPs) exist across the world. Perhaps the most established of these are in America.<sup>8</sup> American PHPs have the dual role of helping addicted physicians attain sobriety and personal recovery while also providing assurance to colleagues, hospitals, insurers, licensing boards, and the general public that these physicians can practise safe care.<sup>9</sup> The processes used by these programmes include clinical assessment, referral for treatment, and support and monitoring after treatment.

This table outlines the some of the common differences between England PHP and USA PHP, although individual state programmes may differ in their approaches.

PHS England	PHPs USA
<b>Treatment:</b> Treatment options are discussed with patient and multi-disciplinary team. Patient can choose whether to take up the treatment offered.	<b>Treatment:</b> Usually a mandated treatment programme. Medical board can place a treatment requirement on the doctor which they may be required to sign up to.
Treatment provided by PHS is through a network of clinicians and therapists linked to PHS.	Treatment usually provided via referral to a third party.
Complete abstinence achieved through different modalities, based on individual circumstances.	Abstinence based on the 12 steps model is the norm.
No cost to the patient.	Patient usually expected to fund treatment.
<b>Transparency:</b> Patients able to review and comment on facts in letters and reports about them before sending.	<b>Transparency:</b> Doctors may not have access to medical reports written about them and presented to the medical board and are not usually given the opportunity to comment.
Letters and reports done only with the consent of the patient (unless mandated by law).	Doctors do not usually have the right to challenge what is written about them.
<b>Regulatory links:</b> No formal link with GMC or GDC, Memorandum of Understanding which enables an anonymised discussion to take place.	<b>Regulatory links:</b> Formal link with the Medical Board.
Support for self-disclosure when required. Often if a doctor is seeking appropriate treatment the regulator does not wish to be involved.	Doctor required to sign and comply with treatment programme. Non-compliance with treatment or abstinence threatens the doctors licence.
Therapeutic testing can be offered.	Testing and monitoring is a requirement.
<b>Outcomes:</b> 77.6% abstinence at 12 months.	<b>Outcomes:</b> Around 80% abstinence rates.

<sup>8</sup> State Programs. Federation of State Physician Health Programs [Internet]. Fshp.org. 2018.

Available from: <https://www.fshp.org/state-programs>

<sup>9</sup> McLellan A, Skipper G, Campbell M, DuPont R. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ*. 2008;337(nov04 1):a2038-a2038.

American PHPs are seen by some of their critics as punitive, unmonitored, and depriving doctors of due process rights, preventing doctors from challenging diagnoses they disagree with. However, they do have success rates of around 80%,<sup>10</sup> although some suggest this hides the fact that there are large numbers of doctors who want or need help but are afraid to ask due to fears concerning confidentiality and impact on their career.<sup>11</sup> Some states such as Maryland have brought in voluntary confidential programmes operating separately from the medical board.

PHS in England is different to the physician health programmes operating in the USA. The key difference is with respect to monitoring which we see as well outside the remit of PHS. We deliberately do not have any formal links with the regulators (though we do have meetings and reviews with them about processes).

## European Provider Network



In December 2017, we established a European Practitioner Health Provider Network (PHPN) which provides the opportunity to share practice, understand variance between different services and define a common Europe-wide service specification for practitioner health services. This includes outcome measures, such that we can build evidence of what works in this area of care across Europe. We believe a strong network can also act as an advocate for the improvement in physician health and might help create a cultural shift in how doctors are treated (well or unwell). To date, membership of the network includes providers from:

- France
- Ireland
- The Netherlands
- Belgium
- Germany
- England
- Spain
- Malta

## Our team

From only three staff in 2008, over the last decade we have grown to a network of more than 300 clinicians, special advisors, clinical leads, therapists and operational staff across England. This photo is just a few of us, taken at our 2018 away day.

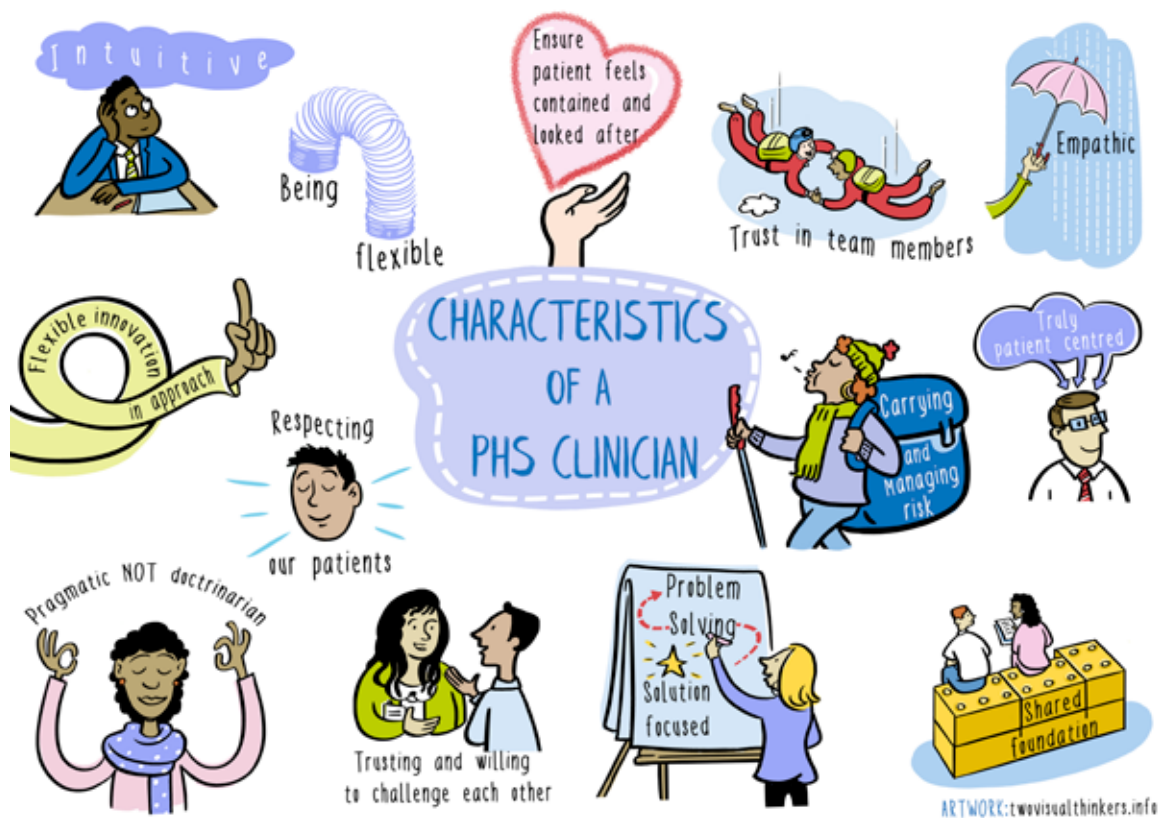


<sup>10</sup> Lenzer J. Physician health programs under fire. *BMJ*. 2016;;i3568.

<sup>11</sup> Tjia J, Givens J, Shea J. Factors Associated With Undertreatment of Medical Student Depression. *Journal of American College Health*. 2005;53(5):219-224.

The core team includes: consultant psychiatrists with expertise in areas such as liaison, forensic and addiction psychiatry; general practitioners with special interest in occupational health, regulation, addiction and eating disorders; specialist mental health nurses with expertise in psychopharmacology and behaviour treatment; and other clinicians with psychotherapy training. Our operational staff bring expertise from general practice, regulation, revalidation and much more. Our wider team is scattered across England. Each provides the same standard of care and the same dedication as the initial team back in 2008. The staff work hard to make sure each patient feels that they are personally cared for and this is the reason our outcomes are so good and why patients value what we do so much.

This diagram illustrates the qualities of our staff.



## Service issues

From the outset we knew that the success of PHS would be enhanced by:

- Ensuring sufficient capacity within the service programme to deal with unmet needs;
- Providing treatment within the framework of shared/integrated care;
- Ensuring that we listen to and respond to the voice of our patients;
- Continuing to develop through research and development.

## Ensuring sufficient capacity

In 2008, once we launched our service and patients began to come in large numbers it was clear that we rapidly had to increase the number of clinicians we had in the team. At the time we were just London-based and easily recruited more clinicians. The need to expand our clinical team was especially urgent once the service extended to cover the rest of England. We ran a recruitment campaign and were overwhelmed by the number and diversity of clinicians expressing an interest to work with sick health professionals. PHS is constantly recruiting new staff to help meet the gaps in provision across England.

## Education and training

In 2010, in order to help maintain standards across the whole service and to ensure doctors who are doing the doctoring do it well, we developed a specialty-based competency framework, called the Health for Health Practitioner framework. The framework was developed and adopted by the Royal College of General Practitioners,<sup>12</sup> the Royal College of Psychiatrists and the Faculty of Occupational Medicine. In 2018, we reviewed and updated the framework to combine the knowledge and skills for all health professionals in the identification, treatment and management of mentally ill doctors – ‘Guidance and Competencies for the provision of services using practitioners with a special interest – Health for Health Professionals Practitioner’. This provides the competencies for clinicians (doctors and nurses) joining our service and also highlights any learning needs they might have. Other clinicians not working with PHS can use this framework to identify areas where they might want further training. More than 120 PHS clinicians have now been recruited and trained using this competency framework.

The competencies we have defined are as follows:

### Clinical

- Good understanding and implementation of self-care and competence in advising practitioner-patients on self-care
- First contact care and assessment for practitioner-patients referred for care
- Continuing care and signposting to provision of a range of clinical interventions as appropriate, such as individual behavioural therapy, group therapy and mentoring
- Management of common mental health and addiction problems as far as individual expertise allows
- Referral for specialist assessment or treatment
- Case management

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<sup>12</sup> GP Health Service/Practitioner Health Programme. Guidance and competencies for practitioners with a special interest: Health for health Professionals Practitioner. 2018. Available from: <http://php.nhs.uk/wp-content/uploads/sites/26/2018/08/HHP-framework-Final-August-2018.pdf>



## Education and liaison


- Provide advice and liaison to other practitioners through non-face-to-face or face-to-face contact, in the management of those problems/conditions within their expertise
- Provide support and training to other health and related practitioners in areas related to a) prevention b) identification and c) brief intervention of mental health/addiction problems in health professionals, and d) self-care and wellbeing
- Participate in education and training activities
- Liaise with other practitioners involved in the care of practitioner-patients

## Return to work

- Supporting a return to work programme
- Writing relevant reports

## Other

- Patient advocacy



*PHS saved my life  
and probably my  
career.*

## Providing shared care

The original Practitioner Health Programme in London was designed to be two distinct services: PHP1, a first contact service offering assessment and limited therapeutic intervention; and PHP2, a secondary care service providing specialist outpatient, in-patient and day care services. PHP1 was expected to be delivered by GPs, and PHP2 by specialists, mirroring what happens in the rest of the NHS. However, from the start we felt that this would create unnecessary transitions in care, was too fragmented and that the patient would have to tell and retell their story to multiple different clinicians. It also increased the points where patients could experience delays and confidentiality might be more easily compromised. We wanted PHS to be joined up and for the patient to feel they belonged to the whole service, not just the individual parts with which they had contact at any particular point in time. We therefore designed PHS to combine the best of primary and secondary care, drawing together GPs, psychiatrists, nurses and others into a single service (called integrated or shared care). London clinicians work together on a single site, sharing the same electronic patient record, systems, learning, policies and practices.

We are one service.

Our patients belong to all of us.

Our definition of shared care is very simple. It is communication which goes beyond the simple exchange of letters or emails, ideally involving clinicians using a shared electronic record, shared budget and shared space. PHS meets this definition. We believe that the success of PHS is due in part to it being a shared care (integrated) service.

## Summary of what PHS provides

- Telephone advice
- First contact assessment, formulation and treatment planning
- Fit notes
- Multi-professional approach to care
- Brief intervention, cognitive behaviour therapy, relapse prevention, brief psychotherapy
- Community-based detoxification and access to in-patient drug and alcohol detoxification
- Substitute medication for opiate addiction
- Therapeutic blood, urine and hair testing as part of treatment
- Access to in-patient rehabilitation
- Report writing
- Attendance at employment tribunals or other work-related hearings
- Referral for benefits advice via links with the Royal Medical Benevolent Fund and the Cameron Fund
- Speaking and teaching engagements
- Specific interventions, such as behaviour therapy for exam failure
- Direct liaison with defence organisations/barristers/case management
- Liaison with educational supervisors/training programme directors where necessary
- Contact with GMC/GDC supervisor
- Attendance at GMC/GDC hearings
- Work-related therapy, with a focus on return-to-work strategies
- Group work (including for suspended doctors, addiction, reflection)
- Expert help for doctors out of work for long periods (e.g. due to illness or erasure from work)
- Peer support
- Advice to commissioners
- Advice to responsible officers and appraisers
- Referral to occupational health
- Support in returning to work
- Outreach and health promotion
- Mentoring and specialist appraisal

In the early days of PHS, with a limited team, we referred patients for in-patient care for mental health problems (such as bipolar affective disorder and eating disorders). However, over time we have found that we can manage the majority of these patients without admission, whilst those who are ill enough to require admission are better served by the skills of mainstream NHS services and with coordination from the patient's own GP.

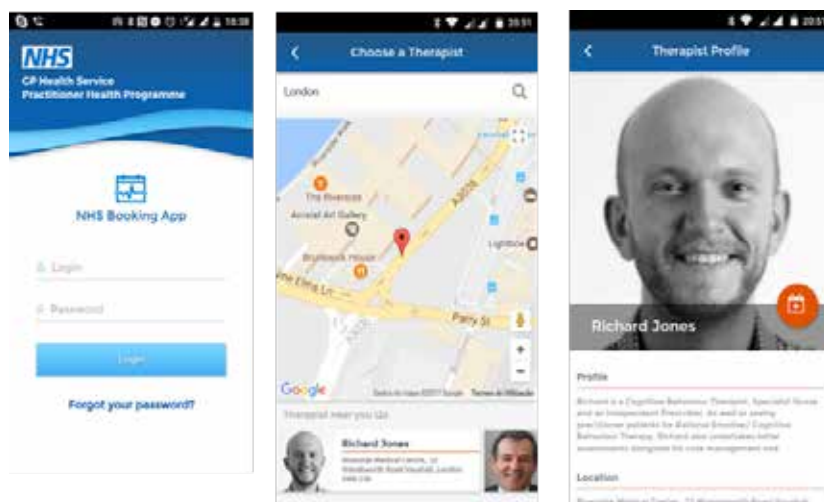
## How PHS works for the practitioner-patient

We encourage doctors to make contact with us even if just to seek general advice. Doctors can contact us via text, phone (020 3049 4504, 0300 0303 300), email ([gp.health@nhs.net](mailto:gp.health@nhs.net) or [england.phpadmin@nhs.net](mailto:england.phpadmin@nhs.net)), web ([www.php.nhs.uk](http://www.php.nhs.uk) or [www.gphealth.nhs.uk](http://www.gphealth.nhs.uk)), or letter (PHP Riverside Medical Centre, St George Wharf, Wandsworth Road, London SW8 2JB).

We only accept self-referrals but do provide advice to family members, employers, responsible officers and in fact anyone who contacts us (of course never breaching confidentiality in the process). Third parties can contact us if they are worried about a colleague, employer or relative, but they cannot force a doctor to come to see us. Once a doctor contacts us, we try and respond within the working day. A face-to-face appointment for the first in-depth assessment is offered within ten working days. Whilst we are unable to deal with emergency problems, if a doctor contacts us with an urgent issue (a recent complaint or referral to the regulator, for example) we see them as soon as possible.

The service is open between 8am to 8pm weekdays (excluding Bank Holidays) and between 8am and 2pm Saturdays. Appointment times fit in with busy clinicians' schedules and we offer flexibility in terms of place, time and clinician.

## Booking app



As soon as we confirm eligibility for the service, control passes to the patient with respect to who they see, and where and when they are seen for the first in-depth assessment. This is usually via an NHS booking app, specifically developed for the PHS service. This gets over the problem of the patient accidentally being booked in with a friend, relative or work colleague. This means patients can directly book with the clinician of their choice. The app allows patients to cancel and reschedule

appointments to suit them and to directly message their clinician or therapists regarding the appointment arrangements.

## The patient pathway

When a doctor makes contact we send them a set of registration forms to complete. We also send a number of wellbeing and mental health questionnaires (Psychlops,<sup>13</sup> Warwick-Edinburgh Mental Wellbeing scale,<sup>14</sup> Perceived Stress scale,<sup>15</sup> PHQ-9<sup>16</sup> and GAD-7<sup>17</sup>) which allow us to pick up any severe distress or potential risk before their first assessment. Once the doctor has sent the forms back they can then book their first full assessment. Whilst some doctors may be anxious about taking this step we try hard to encourage them to proceed and make an appointment to see one of our clinicians.

Even though our patients come from all over England we try to ensure no one has more than two hours to travel to their first assessment (unless by their choice) and no more than 30 minutes for any therapy. Where travelling distances are difficult, the clinician will offer to travel closer to the practitioner-patient.

**Below is a map of the location of our current clinicians and therapists** (the different colours refer to whether the doctor is a clinical lead, clinician or therapist)



<sup>13</sup> Psychlops [Internet]. Psychlops.org.uk. 2018. Available from: <http://www.psychlops.org.uk/>

<sup>14</sup> Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) [Internet]. Warwick.ac.uk. 2015. Available from: <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/>

<sup>15</sup> Cohen S, Kamarck T, Mermelstein R. A Global Measure of Perceived Stress. *Journal of Health and Social Behavior*. 1983;24(4):385.

<sup>16</sup> Kroenke K, Spitzer R, Williams J. The PHQ-9. *Journal of General Internal Medicine*. 2001;16(9):606-613.

<sup>17</sup> Spitzer R, Kroenke K, Williams J, Löwe B. A Brief Measure for Assessing Generalized Anxiety Disorder. *Archives of Internal Medicine*. 2006;166(10):1092.

If preferred, the patient can have their first full assessment via video-link or telephone.

We understand and are sympathetic that it might take sick doctors several attempts to have the confidence to make contact with us, and we allow a great deal of flexibility in terms of times and days of the week (including Saturdays), meaning that rates of those who do not attend (DNA) are extremely low. We allocate around 90 minutes for the first assessment.

We have clinicians within the service who might be more experienced at managing patients with particular problems (for example addiction, bipolar affective disorder, or complex regulatory issues), but all PHS clinicians are able to carry out full assessments irrespective of the problem the patient presents with. Internal referrals (PHS clinician to PHS clinician) can and do occur if needed. We use each other at our daily multidisciplinary team meeting or in the spaces between patients to ask for help with particularly difficult problems.

For many of our patients, when they attend for their assessment it is the first time they have told their story. More often than not the doctor starts by apologising for coming and remarking that others must be in more need. We quickly disabuse them of this view. We encourage our patients to tell us in their own words what they think their problem is and why they have needed to come to the service. Between us we try and piece together what we think has been the cause (or indeed number of causes) of their distress.

Even though many of our patients present with illnesses similar to those of non-practitioners (depression, anxiety, post-traumatic stress disorder), the context in which their problems sit is different. So often the underlying cause of their illness is due to a combination of work-related stresses, family difficulties, a recent life event, a complaint or adverse outcome at work. As such we take a detailed history of the doctor's work, training and other professional issues.

Our assessment includes:

- Personal and family history (including other doctors in the family)
- Past medical and psychiatric history, including any addictive behaviours
- School, postgraduate and medical school history; training and work history (including reason for choosing specialty, exam history)
- Breaks in training or service and why these have occurred
- Current work (including NHS, private practice, academic work)
- Involvement with complaints, significant events, referral to regulator
- Any financial problems

The assessment may include a physical examination and further investigations, such as routine haematological or liver function tests and we might ask consent to access any supportive or collateral information where appropriate. Where we see addicted doctors, we ask to involve a third party – the practitioner-patient's relative, friend or close colleague. This is important in aiding the practitioner-patient's recovery – from experience addiction can be a family illness needing a family response to improve

outcomes. We appreciate the sensitivity of this but feel it is best practice and safer for patients.

At the end of the assessment we formulate what the issues are, taking into account any predisposing, precipitating, perpetuating and protective factors there might be for each individual doctor.

At registration we also ask for an In-Case-of-Emergency (ICE) contact (must be someone residing in the UK), which will only ever be used in exceptional circumstances. We also ask for consent for us to write to the doctor's general practitioner.

## Medical record

Our practitioner-patient clinical record is cloud-based and operates on any computer with internet access. Outside London, clinicians can only access their own caseload and we are able to restrict access to records if the patient is personally known to a member of the clinical or operational team. The record is for PHS purposes only and does not form part of any electronic shared NHS record.

## Multidisciplinary team meeting (MDT)




All clinicians at PHS work together, as a team. Our patients belong to us all, though each patient will have a case (or key) manager. After the first assessment, patients are discussed at the next multi-disciplinary team meeting (MDT) – held daily, either face-to-face or remotely – and this gives the team the opportunity to create a personalised plan for each practitioner-patient based on the specific issues they present with. The MDT is an integral part of PHS and we believe part of its success. The London MDT is attended by all the London PHS clinicians and is where new cases and important follow-ups are discussed. Outside London, the MDT is done remotely and chaired by London clinicians, with clinicians from across England dialling in to present to the team. In time, PHS will move towards local regional hubs (this is already happening in the West Midlands), and remote MDTs will be replaced by face-to-face meetings.

It is at the MDT where we code diagnoses, determine any risks (see below) and record treatment plans. We also write a brief summary of what the issues are.

## Risk assessment

The risk assessment of our patients is multifaceted and includes not only making an assessment about the practitioner-patient's safety and wellbeing but also about any risk for their own patients or organisation.

At the MDT we decide the level of risk the patient is posing – to themselves, their own patients or their organisation. Depending on the problem and severity, patients are risk-rated as either green (lowest), amber or red (greatest). The risk category determines how often the patient is seen and how proactive we are at following them up. The process of ascribing a risk-status to our patients ensures that we look in depth at their special issues and how these might impact on their behaviour (e.g. suicide risk or risk of breaking down at work).



*Thank you to all  
the people behind the  
scenes who keep it  
running*

An important aspect of the first full assessment is to make sure that the practitioner, if unwell, is safe to continue working.

*Dr Hasan lived in hospital accommodation. He had recently started work in this hospital as a maternity locum in accident and emergency. His family live in Kuwait and he came to work in England a few years ago. It is hard now for him to return. Dr Hasan had recently been suspended after a complaint from a patient who said he had been rude to her and shouted. He denies this, saying he had been upset as the patient had been racist to him and had said she didn't want to see a foreign doctor. Even before this, he had noticed how irritable he had become and had lost interest in most things. All he seemed to do was work. He had no friends, no family in England and no real social network. He started to cry. He said he would be better off dead.*

Dr Hasan was rated as the highest risk, red. He lives alone, in hospital accommodation. He was socially isolated and undertook his primary medical qualification overseas – he is an international medical graduate (IMG). He was depressed and now had a major risk factor in the complaint and his subsequent suspension from work. We would make sure that we kept close contact with him (at least weekly) and offered treatment, most likely including antidepressants, cognitive behaviour therapy and a place, if he wanted it, at our group for doctors under suspension. We would also offer support around the complaint. We would analyse it in great detail, hopefully de-personalise the issue and help him see the complaint in perspective.

If a doctor has received a complaint, we take this very seriously and consider a complaint to be a major risk factor for depression and even suicide.

Risk Assessment Group (RAG) rating	Examples (by no means complete)
RAG Risk Green Reviewed as and when	Mild to moderate symptoms Good social and/or family network Other factors (for example, no major financial issues, partner supportive) Work involved but supportive
RAG Risk Amber Reviewed monthly	Bipolar affective disorder, in contact with other services but still acutely unwell Mental illness with other issues which might cause problems (e.g. waiting on the outcome of a regulatory determination) Few social supports Financial issues, but still able to pay bills
RAG Risk Red Reviewed weekly or more often	Bipolar affective disorder and not in contact with any other service Severe depressed mood BMI < 16 Intravenous drug use Anaesthetist who uses any drugs Anaesthetists with depression Serious complaint or referral to regulator Lives alone, especially if in hospital accommodation Previous suicide attempt International medical graduate

## Ensuring coordinated care

All patients have a case manager – usually the clinician who did their first assessment. It is the case manager who helps provide continuity of care. Case management involves guiding the doctor through their treatment with us at PHS, helping them with any professional difficulties, coordinating the provision of care and support and aiding them to recovery.

The case manager's role includes the following responsibilities:

- Coordinating and facilitating communication between the patient and PHS and between the patient and outside agencies
- Being the first point of contact for the practitioner-patient



- Devising a formulation of their problem
- Creating a treatment plan
- Responding promptly to relapse and identify prodromal factors indicative of relapse
- Providing the multidisciplinary team meeting with a review of a treatment plan, and a review of the Risk Assessment Group status
- Writing any necessary progress or advocacy report for third parties
- Liaising and referring to occupational health as necessary

## Ongoing treatment

No two practitioner-patients are alike and as such their ongoing contact with PHS will be different depending on their individual circumstances and the problems they present with. We may offer treatment via our therapists, or an admission for detoxification and rehabilitation in addiction cases. Others may only require ongoing support with their case manager. We might offer any one, or a combination, of the following:

**Advice with no further PHS action:** in these circumstances we provide an 'open-door' policy whereby the patient can contact the service whenever they feel the need. Some patients require a 'light touch' only, such as a short 'burst' of behavioural therapy.

**Prescribing:** we have developed a PHS pharmacopeia and are able to prescribe on NHS prescriptions. We have had to modify what we can prescribe and for how long without involvement from the patient's own GP. This means we are unable (unless in exceptional circumstances) to prescribe long-term complex medication regimes or medicines which need careful monitoring such as lithium. This is for patient safety reasons, as it is important that if patients are on complex medication regimes that their own GP knows what these are. In exceptional circumstances, we have made arrangements to register the doctor as an out-of-area patient at the co-located GP practice in London or with our other PHS GPs across England.

**Community detoxification:** we provide domiciliary alcohol detoxification; opiate stabilisation; detoxification; long-term opiate maintenance treatment (for a small number of patients); and, on a case-by-case basis, relapse prevention therapies.

**Referral outside PHS:** on occasions where patients cannot be managed by PHS, we refer, with consent, to outside organisations or services. This is usually via the patient's GP. This is necessary where assertive outreach, home care, in-patient mental health care or admission under the Mental Health Act is needed, or where an assessment is required which is outside the expertise of PHS (e.g. assessment for autism spectrum). Even if a patient is referred out, we continue to offer what we call 'wrap around' care. This usually involves supporting a return to work, help with regulatory issues or complaints, and in some cases provision of talking therapies. We won't let our patients fall through gaps.

**Planning return to work:** whilst we are not a workplace occupational health service, with the patient's consent we liaise with employers and an occupational health physician. We understand the importance that employment has for doctors' sense of wellbeing and will work with our patients to help wherever possible.

## Talking therapies

*I am so grateful for the services of PHS. The therapy I received has hugely improved my ability to cope with life, and the clinician has been understanding and supportive. At one very dark point I was constantly fighting intrusive thoughts and feeling suicidal on a regular basis. I don't know where I would be without the support of PHS - thank you!*

A practitioner patient



As PHS has grown, so too has the need for talking therapies. We provide a range of talking treatments, from individual to group therapy, behavioural to short-term psychotherapy. Talking therapies are a major part of PHS treatment. Patients can choose between face-to-face therapy, telephone, and supported online therapy. These are delivered via a network of nearly 200 independent and in-house therapists across England. All therapists, whether in-house or commissioned externally, are trained to deliver care according to the strict standards and criteria laid down by PHS. They especially have to respect our confidentiality agreements.

## Behavioural therapy

Our mainstay of treatment is cognitive behavioural therapy (CBT). As well as therapists who are directly employed, we also commission a large provider, Efficacy, to help us deliver CBT across England. They have seen over 1,200 of our doctors over the years.

CBT is based on the concept that one's thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap the individual in a vicious cycle. CBT aims to help deal with overwhelming problems in a more positive way by breaking them down into smaller parts.

PHS provides an interchangeable choice of three options for cognitive behaviour therapy - each is discussed in person during a telephone-based assessment with a

senior clinician to make sure the patient makes a choice that is clinically appropriate and suits their personal needs.

The options are as follows:

**Supported, computerised CBT:** We use *SilverCloud* which achieves exceptional outcomes for patients in excess of published outcome data which is in itself very positive.<sup>18</sup>

**How it works:**

A link is sent via email to the patient that includes modules that are suitable for the initial diagnosis (best for depression, anxiety disorders, managing stress). The therapist calls the patient to book them in with a therapist for a telephone appointment. The patient then works through exercises and records thoughts, feelings and behaviours. The patient has a weekly telephone appointment with their clinician who discusses their work and records of the week and supports their progress throughout treatment. The patient has 12 months' access to their own confidential *SilverCloud* platform and can review lessons and relapse plans to support staying well for the future.

**Telephone-based CBT:** This is popular amongst some patients who want the flexibility that a remote service can provide. This permits patients to manage their treatment around shift work, family life and other commitments. It can also offer the anonymity of treatment being delivered out of their local area.

**How it works:**

The patient is contacted to set up the first telephone appointment and then has a weekly 50-minute call on the telephone or skype (as per their preference) with their therapist. The patient continues to be treated weekly via telephone or skype for as many sessions as are clinically indicated.

**Face-to-face CBT:** This is the mainstay of treatment modality and allows the practitioner-patient to work through their issues with the therapist and follow up with homework between sessions.

**How it works:**

The patient is contacted to set up the first appointment based on their local clinician's diary availability and then has weekly 50-minute appointments face-to-face. The patient continues to be treated weekly for as many sessions as are clinically indicated. Patients can move between the different modalities as their circumstances or illness changes.

## Group therapy:

Group psychotherapy is a form of therapy in which one or more therapists treat a small number of patients together as a group. The term can legitimately refer to any form of psychotherapy delivered in a group format, including CBT, interpersonal therapy and psychodynamic therapy. Group work is provided for PHS largely through the Institute of Group Analysis ([www.groupanalysis.org](http://www.groupanalysis.org)).

We have also provided access to Balint groups ([www.balint.co.uk](http://www.balint.co.uk)) which provide structured, facilitator-led, reflective groups based on psychoanalytical concepts

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<sup>18</sup> Silvercloud. Making Space for Healthy Minds [Internet]. Silvercloudhealth.com. 2018. Available from: <https://www.silvercloudhealth.com/research/publications>

exploring the doctor-patient relationship. PHS has held a number of Time-To-Think reflective practice events, mindfulness courses and more structured events addressing organisational issues in the workplace.

Groups help reduce the isolation of sick doctors and allow them to overcome the barriers to becoming a patient and of disclosing their issues. Once in a group, doctors find them extremely beneficial and therapeutic. Our ambition is that over the next five years all doctors will have the opportunity to become part of a reflective practice or professional development group. These peer support style groups are currently being established across England and around 20 are now in place.

#### **How it works:**

Across all of PHS we offer the following group interventions:

**Slow-open or closed groups**, lasting one year: if the PHS treating clinician and the patient feel group therapy might be helpful, the doctor is interviewed by a group therapist prior to starting the group. They might have up to six sessions on a one-to-one basis before starting the group. The therapist is qualified in providing group psychotherapy. The group usually has six to eight members, meeting for 90 minutes once a week for 40 weeks. It is either a 'slow-open' group (so new members can join if there are spaces) or a closed group (no new members join once the group is formed).

**Drop-in groups**: weekly groups with an open invite to all eligible doctors/dentists. This intervention is supportive in its nature, with some psychoeducation solutions offered by the facilitator.

**Time-limited groups**: typically lasting eight weeks, these are goal-orientated groups for specific cohorts with similar issues, or those wanting to learn a new therapeutic approach (e.g. mindfulness).

**Specific groups**: we occasionally hold groups for specific issues. For example, we held a group for international medical graduates to explore their unique issues and how we can best address them. We have held workshops examining how GPs can create the space to think about their own needs. In July 2018 we held a group for those who had been bereaved by a doctor's suicide or sudden accidental death. This group will be meeting again and in time we hope it will become a support group for those involved.

**Monthly support groups**: long-term groups offering mutual support and guidance for patients experiencing similar issues (e.g. suspended doctors' group). This group is run by a psychotherapist and helps doctors survive suspension, undertakings, conditions or even erasure. The group is open access and held monthly, for 90 minutes. As with all the groups, clear boundaries of confidentiality and respect are requirements. In the meeting new doctors are invited to say briefly what has brought them to the group. Older members update the group on their progress since the last group meeting. The focus of the group is to try and understand the thoughts and feelings underlying the general and individual experiences whilst unable to work; to think about how best to manage the unwanted feelings affecting them; and to reflect on how they have come to be in their current situation.

**Support group for addiction:** we call this the *Garden Group*, named after Vauxhall Gardens. It is a self-help group for any PHS patient with a substance misuse problem, held at PHS Vauxhall office every fortnight and facilitated by a psychiatrist. Group work in addictions can make a huge contribution to recovery. The experience of being included in a group reduces isolation and stigma. Members share their experiences of recovery, and those in established recovery model success for people just starting out. The group adopts an alcoholic or narcotics anonymous (AA/NA) philosophy because many of the group members have come through recovery using this model. We endorse the use of the 12 Step Programme. However, the Garden Group has participants who have adopted multiple different paths into sustained recovery. Along the way, they have used the support of the group to be more curious about themselves, confident that it is a safe space for shared reflection.

In other parts of the country we link patients to local British Doctors and Dentists Groups (BDDG). The British Doctors and Dentists Group are doctors and dentists who are recovering from or wish to recover from addiction to and dependency on alcohol and other drugs. It is based on the AA 12 steps model. Their meetings focus on individuals sharing their journeys and difficulties, both personally and professionally and what has helped them along the way.

## Residential rehabilitation

Over the last decade we have established strong links with Action on Addiction, a charity running Clouds House which provides an abstinence-based twelve-step programme over a six-week residential stay. Clouds House is in the middle of beautiful Wiltshire countryside, in a converted mansion house. This setting provides a welcome respite from daily life, allowing residents to fully engage in their recovery in a beautiful protected environment.

Most of the treatments we deliver at PHS are for doctors/dentists only and do not include members of the general public as patients.

When deciding who should provide our addiction residential treatment we considered whether we should commission doctor-only programmes, programmes for health professionals in general or programmes which take patients from all walks of life. In discussion with Action on Addiction (and other potential providers) we came to the view that for those in need of residential treatment for addiction, the main issue to be addressed is the doctor's addiction, and not their professional background. We came to the view that a doctor starting their recovery journey firmly attached and defended by their 'white coat' would have less of chance of success at sustaining their recovery. The feedback we receive from graduates of the Clouds programme often touch on the value of the 'levelling out' experience, enabling them to realise that, whilst the context of their lives may be quite different from others, the overall themes of their addiction are common.

### How it works:

Every in-patient admission begins with a physical and psychological assessment to establish if a period of drug or alcohol detoxification (or both) is needed before any rehabilitation can begin. This detoxification period is included within the overall six-

week admission and is usually complete within four to seven days.

Our experience has shown us that the most useful recovery work occurs in the latter four weeks of admission. Shorter admissions often see patients focusing only on their detoxification process with little attention being paid to their triggers, life story exploration and recovery-sustaining skills, which in turn increases their risks of relapse.

Once in the six-week residential treatment programme at Clouds, patients will be expected to attend all group and one-to-one sessions, and work in partnership with their lead counsellor on personal issues that arise during the programme. The PHS lead clinician remains in contact with both the patient and their key worker throughout their stay and actively plans how best to support them once they leave. Typically, the patient will be offered a follow-up appointment with their PHS clinician within 72 hours of discharge from Clouds.

Patients describe the first three days post-discharge as a shock to their system after the intensity of admission to Clouds. It is in the immediate discharge period when they face the prospect of returning to work, the sadness of maybe never being able to, and the challenge of maintaining recovery in their community.

Obviously, each patient's needs are different, but we will typically suggest either 30 abstinence fellowship meetings (e.g. Alcoholic or Narcotics Anonymous and BDDG) in 30 days or 60 meetings in 60 days. We encourage patients not to rush into returning to work until their recovery is more established. Those who do rush back tend to do less well, and struggle with the demands of their work, taking over their need to stay connected with their fellowship.

Part of the overall Clouds treatment package open to all is the option to attend weekly follow-up groups in either Wiltshire or Central London for up to a year with other Clouds graduates. The involvement of a significant other is key to recovery being a success.

The period between discharge from Clouds and returning to work is where PHS clinicians will really begin to address the issues faced by doctors in recovery. Patients may need support in disclosing issues to occupational health departments, and in some cases the GMC/GDC and others who may need to be involved. This period may also see the emergence of more understanding as to what led the patient to their addictive patterns and behaviours. They may need some enhanced support to deal with these often-painful issues.

## **Managing exam stress workshop**

*I have managed to succeed in passing my exam which was a huge hurdle, having failed it twice, which was one of the contributing factors to the initial deterioration in my mental health. I am progressing well at work and my confidence and self-esteem has flourished.*

### **A practitioner-patient**

A specific workshop we have run over the years is one aimed at managing exam stress. This workshop is targeted at doctors who have failed examinations on many occasions and provides an introduction to how stress and anxiety impact on their ability to pass

exams. Through the use of cognitive and behavioural techniques, the workshops give trainees the skills and strategies to understand and manage their stress and anxiety, particularly in relation to exams and work.

The underpinning principle of these workshops is to help the doctor understand that the exam itself does not have the power to make them feel anxious (or to feel anything for that matter). Instead, it is the doctor themselves who hold the power to control the emotion they feel about the threat of the exam. It is important that the doctors on these workshops do not feel they are to blame for the anxiety that they are feeling, but instead feel empowered to change their anxiety into a more functional and adaptive emotional response. The feedback from this course, including those who go on to pass their examinations is very good.



## Confidentiality

*I was very happy that the team was able to fully understand the difficulties of having a mental illness while being a psychiatrist. Once I realised PHS was confidential and that I didn't have to spend time explaining my circumstances, I was able to concentrate on my recovery.*

A practitioner-patient

We understand how important confidentiality is for doctors and how they fear the loss of confidentiality more than anything else. The 'Frequently Asked Question' [FAQ] concerning confidentiality is the most looked-at question on our website. Doctors must trust our service and really believe that they will be treated in confidence.

We have a series of measures to ensure confidentiality is secure, including:

- All electronic correspondence uses the patient's registration number, not their name.
- We avoid paper correspondence wherever possible.
- Doctors can register using a pseudonym (we recommend using their mother's maiden name).
- All staff have to adhere to our confidentiality policy.
- A patient has a right to bar any PHS clinician from seeing their records or being present at discussions about them (medicine is a small world).
- We are mindful of, and mark the notes accordingly, where we might have members of the same family or close friends/colleagues also attending the service (which often happens).
- We send reports in draft form to the patient for approval.

- We use a specific medical electronic record system not linked to the NHS Spine.
- We do not disclose records to any third party except where required by law (this means we do not disclose to the GMC/GDC even if there is signed consent by the patient).
- We work on the principle that there is 'nothing about me without me'. This means that, bar exceptional circumstances, what is said in the service stays in the service and the doctor's confidentiality is paramount.
- How to maintain confidentiality is part of our training and induction process.

Of course, as doctors treating doctors we have to follow the professional regulatory framework. The quote below is from the General Medical Council (GMC) website and is reassuring, stating that where doctors are getting the right support, following advice and there are no patient safety issues surrounding the doctor's patients, the GMC does not need to get involved.

*If, with the right support, you are able to manage a health problem so that the care that you give your patients is not affected, then your fitness to practise won't be affected. So, there will be no need for us to be involved or even to know about it.*

General Medical Council, 2018

From the start of Practitioner Health Service, we created an agreement (Memorandum of Understanding [MOU]) with the General Medical Council<sup>19</sup> and the General Dental Council<sup>20</sup> and updated it as we expanded the service (see our website for copies of the MOUs and confidentiality policies). The MOU sets the parameters for when we, PHS, must disclose an issue to the GMC/GDC. It allows us some flexibility and confirms that for the vast majority of patients we do not need to share information with the GMC and GDC. It also allows us, in confidence and without disclosing identifying information, to seek advice from the GMC-appointed employment liaison officers (ELAs).

The exceptions where we might need to report, or breach confidentiality are: where a doctor might be placing their own patients at risk; where they are not engaging with treatment or adhering to our advice; or where they are continuing to engage in illegal activities (including drug taking).

We work to the principle that a practitioner-patient should never be worse off being part of PHS than not attending us. This acts as a guide for us when, in exceptional circumstances, we do need to breach confidentiality. Any breach of confidentiality is treated as a significant event and discussed at a team meeting.

Having to disclose without consent has occurred in a very small number of cases over the 10 years, and only ever after much discussion within the multidisciplinary team.

Examples of where we have had to do this are:

- Where a patient with delusional beliefs could not reassure us that they would take time out of work and we felt it important to contact the patient's general practitioner and Responsible Officer to inform them of our concerns.

<sup>19</sup>NHS Practitioner Health Programme. Memorandum of Understanding between the NHS Practitioner Health Programme and the General Dental Council. 2009. Available from: <http://php.nhs.uk/wp-content/uploads/sites/26/2013/11/Memorandum-of-Understanding-with-the-GDC.pdf>

<sup>20</sup>NHS Practitioner Health Programme. Memorandum of understanding between the NHS Practitioner Health Programme and the General Medical Council. 2009. Available from: <http://php.nhs.uk/wp-content/uploads/sites/26/2013/11/Memorandum-of-Understanding-with-the-GMC.pdf>



- Where we were concerned about a doctor's suicidal thoughts and needed to speak to their GP.
- Where a doctor would not stop working despite our advice to do so.
- Where a doctor was continuing to use illegal drugs.
- Where a patient continued to drive whilst under the influence of alcohol.
- Where we have had serious concerns about a patient being out of reach, we have been in touch with their GP, ICE contact, and on rare occasions, the police.

In some cases, we recommend that the patient self refers to the regulator and that it would be in their best interests to do so. In these situations, we help the patient draft the email or letter to the regulator. In our experience, self-disclosure is always better than disclosure by a third party. Wherever possible we advise that the doctor seeks legal advice beforehand, either through their medical defence organisation or a solicitor. One example among others where self-disclosure would be in the best interests of the doctor would be after any criminal conviction.

Further information is available on our website:

<http://php.nhs.uk/resources/self-disclosure-of-a-health-issue/>

## Consulting with a patient's own GP

At registration we ask for consent to write to a doctor's general practitioner. This is simply to inform the GP that the doctor has made contact with us and is now under our care. Where there might be a need to prescribe complex medications or medicines needed on a repeat basis, it would usually be necessary to give the GP more information, but again this is always with consent.

We are aware of doctors' (especially GPs') concerns about being registered with a GP who might know them personally (or be a relation/friend). Doctors can therefore opt out of communication and we would honour this. There is a consent form for practitioner-patients who do not wish us to liaise with their general practitioner and we ask that the patient signs this.

There are certain instances, however, where we insist on communication with a GP.

These would be where:

- We are concerned about the patient's risk to themselves and where we cannot reduce this risk through PHS treatment and intervention.
- The patient's care needs to be transferred to local services – for example, for assertive outreach, in-patient care or day-care services.
- There are ongoing prescribing requirements, such as the long-term prescribing of antidepressants, anxiolytics or medicines required for alcohol and/or drug maintenance.
- We might have safeguarding concerns for dependent children or adults.
- There are concerns that the patient is unstable with a severe mental condition which might require GP/community intervention.

In exceptional situations and where no other option is available, the practitioner-patient can register with Riverside Medical Centre or with one of our PHS GPs across the country as an out-of-area patient.

This might be required:

- Where a doctor is registered with a close friend or relative.
- Where confidentiality issues are paramount and cannot be assured by their existing GP (e.g. they might live in small village).
- Where the doctor has no fixed abode.
- Where the doctor is constantly changing address.
- Where the doctor is so high profile they are anxious not to have to disclose a serious mental illness.

We do not routinely write a discharge letter to the GP. Where we do need to communicate, for example with the patient's therapist, this is using the anonymous clinical record number, not name.


## Continuing care and discharge

Whilst we discharge around two-thirds of our caseload every year, the remaining one-third continue to remain active patients beyond a year.

Patients stay registered with us for longer than a year for many different reasons. For example:

- Training-grade doctors who are on frequent rotations might find it difficult to register with a local GP and maintain continuity of care.
- Doctors referred to the GMC/GDC might need to wait years until their cases are heard at a Fitness to Practice hearing. This is a particularly difficult and high-risk time for them and we like to keep our patients close during this stressful period.
- The treatment pathway for serious addiction involves years of close monitoring.
- Patients might need to remain under the care of PHS as part of their GMC/GDC or Performers List conditions or undertakings. PHS does not encourage the regulator to make it a condition to be part of PHS as we are not a probation service. Nevertheless, in some situations it is in the patients' best interest.

Any patient who is discharged from PHS can re-engage with the service at a future point.



*Over the last 10 years  
we have returned more  
than 1000 doctors back  
to the workplace.*

## Patient organisations and networks

Mentally ill doctors are a largely hidden group – hiding due to personal, professional and institutional stigma. Whilst this is changing, mental illness amongst doctors is perhaps the last taboo. At PHS we have worked hard to get their voice heard. We encourage patients to write what we call, 'little stories' to post on our website talking about their illness (we remove any identifying information).

In 2017, we formed a Patient Participation and Volunteer Network (VN). The VN is the forum where key stakeholders, other service providers and patients meet to discuss, reflect and advise on mental health, addiction treatment and psycho-education support services for doctors provided by volunteers. We believe this is the first group of its kind anywhere in the world. This network has been important in shaping policy and practice more widely. It provides a voice in the development of services and support for practitioners within and outside our service. The group now meets on a monthly basis and includes patients from across all of the Practitioner Health Services.

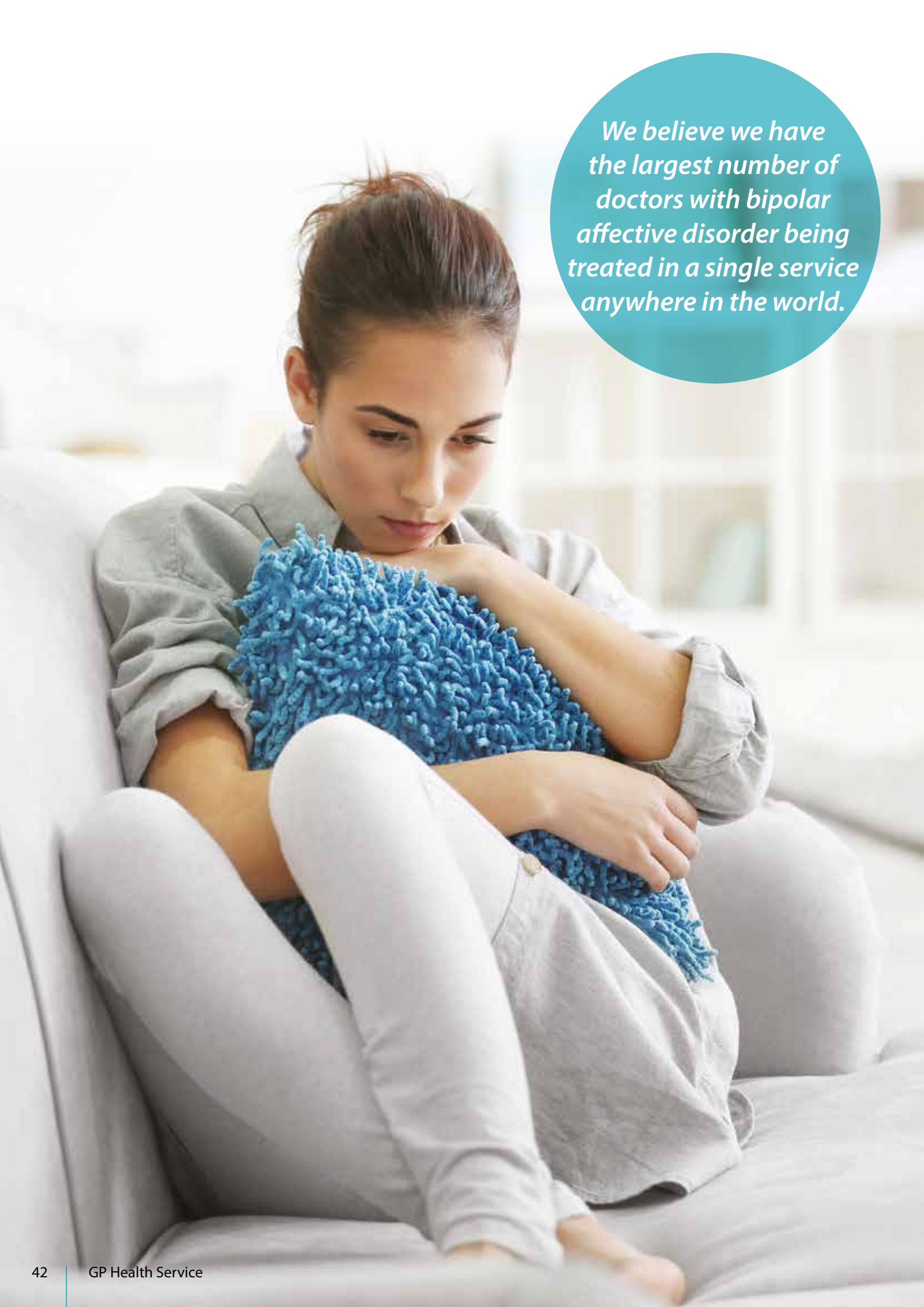
They have agreed key purposes of:

- bringing together practitioner-patient voices and experiences;
- allowing practitioner-patients at various stages of recovery from mental illness, support groups and NHS England to come together to share information and act as a collective voice for change;
- raising awareness of the key issues affecting the management, support and processes for doctors who become unwell;
- exploring the barriers to seeking help and the gaps in service provision;
- providing input and expertise for events/groups/working parties outside PHS.

Practitioner-patients have already been instrumental in shaping GMC policy when a group of them contributed to the design of the health declaration for revalidation purposes, as well as to the development of the GMC's resources to support doctors with health conditions.

The group is now designing an information leaflet to provide necessary information for doctors seeking help at difficult times. A longer-term aim is to produce a step-by-step guide to help doctors passing through a disciplinary process. This would in essence create a roadmap for doctors to navigate the journey from initial complaint through to investigation, sanction and then a return to work. The idea will be to create a personal development plan and structured compendium of evidence to demonstrate to employers, regulators or even themselves that the doctor had done all that was required.

There is a huge enthusiasm and willingness among doctors who have faced difficulties themselves to share that experience and knowledge with other doctors who may face similar problems.

A woman with her hair in a bun is sitting on a light-colored sofa. She is wearing a grey long-sleeved shirt and white pants. She is hugging a large, blue, textured blanket. The background is a bright, out-of-focus room with a bookshelf.

*We believe we have  
the largest number of  
doctors with bipolar  
affective disorder being  
treated in a single service  
anywhere in the world.*

We have close links to many practitioner-patient charities. These include:

The **Louise Tebboth Foundation** (<http://www.louisetebboth.org.uk>), a charity founded by Gary Marson whose GP wife, Louise, killed herself during a depressive illness. The foundation aims to provide financial assistance to projects and services which support the mental wellbeing of doctors in England and Wales and initiatives assisting the bereaved families of doctors who have died by suicide. The Foundation has provided a grant to support the VN in its initial phase.

The **Doctors Support Network** (<http://www.dsn.org.uk>) has since 1996 independently championed positive mental health within the medical profession. It provides a confidential peer support network for doctors and medical students with concerns about their mental health. DSN provides input and advice on many areas of PHS, including through an expert advisory group.

The **Cameron Fund** (<http://www.cameronfund.org.uk>) is a GP charity which supports GPs who are in financial need through ill health, disability or death. The Cameron Fund has supported PHS from the beginning, offering travel costs for doctors attending the service in London from other parts of the country and in supporting those needing to access rehabilitation care.

The **Royal Medical Benevolent Fund** (<https://www.rmbf.org>) is a medical charity for doctors, medical students and their families, helping them through the stages of their career including offering financial advice when in difficulty. The RMBF help our patients by providing a benefits clinics and advice.

## PART FOUR: Headlines of our activities at PHS

*I never expected that we would win the service to provide the first NHS-funded physician health service in England. After all, I was a GP and they were bound to award the contract to specialist mental health providers. But I did win, helped by Lucy Warner (who is still part of the service a decade later), and Jane Haywood, a mental health nurse with expertise in addiction. The first few months trying to get ready to see our first patients was hectic, to say the least. Everything had to be designed from scratch. Staff, systems and all operational procedures (including, importantly, our confidentiality processes and Memoranda of Understanding) had to be put together. We had to design and launch a website, which included choosing a new phone number, web address, and logo. We had to develop marketing material and come up with a communication strategy (after all, we needed to make sure doctors knew about us).*

*After this mobilisation stage, PHS opened for patients in November 2008. Jane and I waited with excitement for the first patient to present to us. I can vividly remember him: a complicated middle-aged doctor who had many problems with his mental health, clinical practice and other issues. After him followed other doctors, almost all older and male, and mostly with addiction issues, especially alcohol. These early patients had long-standing problems which they had never disclosed to anyone until they came to PHS. Jane and I would discuss each patient every week and wonder in astonishment at the stories they told us, secretly hoping that the next patient would not be so complicated. Of course, what we were seeing was enormous unmet need – patients who for years had bottled up their problems, too ashamed to present them to anyone. Over time our patients have become younger, slightly less complicated but still as in need of the confidential service we provide as those doctors we saw a decade ago.*

Clare Gerada, Medical Director, PHS

## Decoding Our Data

Over the years we have prepared reports for our various commissioners, presenting data on who is attending, why and what their outcomes are. We have also drilled down further into various areas and issues and have published a number of papers on topics such as: surgeons and mental illness; women and medicine; bipolar affective disorder and the impact of work on doctors' mental health. In addition, the first 200 patients attending the newly opened PHP service were subject to a detailed independent study.<sup>21</sup>

For this report we analysed the data over our first 10 years and tried to make some comparisons between different specialities, genders and levels of seniority to find differences and trends across the decade.

However, analysing data across years and specialities and using the analysis to make comparisons is a very inexact science. The baseline with respect to who we can see has changed, and the numbers of doctors able to access PHS has increased over time – the new Trainee Doctors and Dentists Support Service (TDDSS) and General Practitioner Health Service (GPHS) contracts mean we are now commissioned to see more trainee doctors and GPs than we were before.

There is also no current information about how many doctors on the GMC or GDC register live in London, making it difficult to have an accurate denominator when comparing one specialty with another.

Another problem is the defining of specialities. There are many specialties and subspecialties, and if a doctor is with us for any length of time it's entirely possible they might change speciality during the course of their treatment.

For the purposes of our coding, we take the speciality at presentation, and have collated these into 11 main areas:

- I. General practitioner: (includes partners, salaried, and others e.g. academic GPs) general practitioner trainee (includes ST3, ST4); general practitioner vocational training hospital post (ST1, ST2)
- II. Physician (includes acute medicine, cardiologist, core medical trainee, dermatologist, endocrinologist, gastroenterologist, geriatrician, GUM, nephrologist, neurologist, ophthalmologist, rehabilitation medicine, rheumatologist)
- III. Surgery specialities (includes orthopaedic)
- IV. Paediatrics
- V. Obstetrics and gynaecology
- VI. Pathology (includes virology, immunology, microbiology, haematology)
- VII. Foundation trainee irrespective of current specialty (any foundation year doctor)
- VIII. Dentist (including dental trainee)
- IX. Anaesthetist

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<sup>21</sup> Brooks S, Gerada C, Chalder T. Doctors and dentists with mental ill health and addictions: Outcomes of treatment from the Practitioner Health Programme. *Journal of Mental Health*. 2013;22(3):237-245.

- X. Emergency Department
- XI. Other: (includes occupational health, public health, radiologist, sport and exercise, interventionist and doctors who do not define themselves as having a particular specialty)

When describing the level of training or role within the medical hierarchy we have used the following definitions:

- I. Trainee: any doctor with a training number. This includes doctors undertaking an out-of-programme placement, on sabbatical or working outside their area of training, but who still have a training number. This does not include Foundation Trainees.
- II. Staff and associate specialists: any doctor who has not obtained a completion of Certificate of Specialist Training (CCST) in their given specialty
- III. Specialist: any doctor who has a CCST in their given area of training
- IV. Locum vs substantive: over the years the number of doctors (especially general practitioners) who work as locums has increased considerably. GPs can work in salaried, locum and partnership positions in their professional life. We took the definition of locum as given by the patient indicating that they mainly worked peripatetically.
- V. International medical graduate: any doctor who undertook their primary medical qualification overseas.

Given all of these imperfections, the following section gives information on the patients presenting to PHS from November 2008 to March 2018. Unless otherwise stated, the data we are using for this final report is based on information contained in our case notes on 31 March 2018.

## Summary of care from November 2008 – March 2018

*'If you build it, they will come'*<sup>22</sup>

This section will present the headlines of who has attended, for what reason and any important outcomes.

### Numbers seen

In total, around 5,000 new patients have made contact with PHS from November 2008 to March 2018. Of these 3,767 have gone on to have a full assessment and become new patients of PHS. Of the others, 290 doctors have attended our prevention groups (Time-To-Think, Therapy, Reflective Practice); we have given advice to a further 600 doctors/relatives/employers. The remainder includes other patients such as pharmacists, medical students, practice managers, NHS managers and others we have seen through special arrangements.

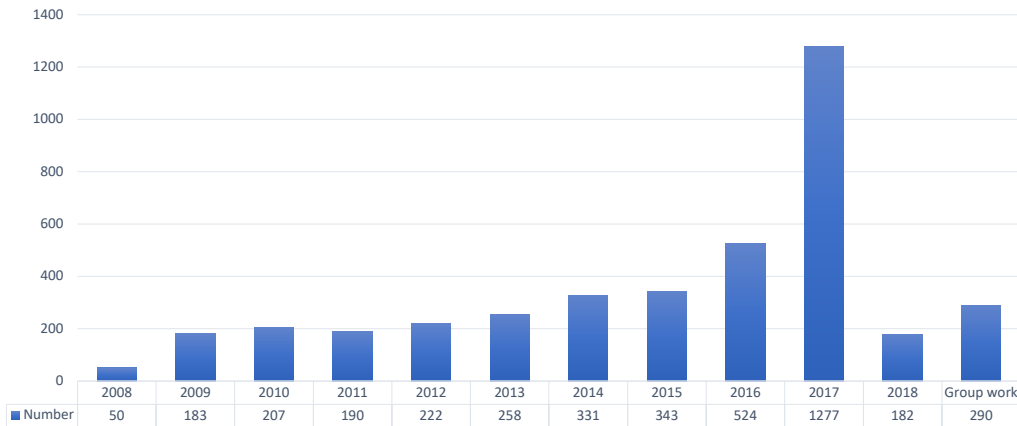
We have had a steady but consistent year-on-year increase in the numbers presenting for care.

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<sup>22</sup> Field of Dreams. 1989.



# Number of new patients 2008-2018



This is of course related to the new contracts we have taken on, particularly with the start of GPHS in 2017. However, even before the start of GPHS (which increased our potential patients from around 35,000 to 85,000), we saw a significant spike in numbers of patients accessing the service in 2016. This was across all specialties, including general practice. A possible explanation of the spike could be the junior doctor strike which occurred in 2016. Whilst during this period junior doctors had a sense of camaraderie, one could also surmise that many felt distressed due to the cognitive dissonance between having made a pledge to ‘serve humanity’ (as in the Geneva Declaration<sup>23</sup>) and removing their care from their patients.

## Basic demographic data

### Age

#### Average Age (years)

Years 1-2: 2008/9	51.6
Year 2017/2018	38.9
Years 1-10: 2008-18	41

Over the ten years our patients have become younger, and more female (see below). The average age has dropped from 51.6 years (2008/9) to 38.9 years (2017/2018); across the ten-year period, the average age is around 41 years. The age of doctors presenting for care has ranged from 24 years old (newly qualified doctors just days from starting work), to those at the other end of their career (recently retired doctors, in their early to late 70s). The steady drop in age is likely to be for a number of reasons. The younger generation might be more willing to seek help for mental health problems. Better training and more empathetic attitudes to mental health may also have helped to reduce the stigma and shame that doctors feel when admitting they have mental health problems. Younger doctors might therefore feel more comfortable

<sup>23</sup> The World Medical Association-WMA Declaration of Geneva [Internet]. Wma.net. 1948. Available from: <https://www.wma.net/policies-post/wma-declaration-of-geneva/>

presenting for help. PHS is certainly seeing some doctors who present early, before their issues have become entrenched. But this is not the whole story. Our experience is that, by and large, most doctors experience months of distress and disability until their condition is noticed by friends and family, or more likely their employers following a crisis at work. So, it is likely that the younger age group is not just related to them being more willing to present.

There are other factors going on.

Could it be that younger doctors have less of a threshold for containing distress and coping with the job? Put bluntly, is the current generation not 'tough enough' to survive the rough and tumble of a career in medicine? There is no evidence for this or that there has been any change in the personality or resilience of students choosing, or being selected, to study medicine.

Doctors have always been required to be adaptable and flexible, able to move between different clinical settings, work stressors and teams. As such, medical professionals are perhaps some of the most resilient individuals in the workforce. They work long hours, have to move between intensely traumatic events (such as the death of a child) to more mundane and routine tasks, and have to show leadership in the most difficult times.

Resilience is a process, not a personality trait, and dependent on an interplay between the individual, their environment and wider socio-cultural milieu. Given enough environmental pressure, everyone has their breaking point, beyond which they can go no further.

It is the working environment, not doctors' personalities or psychological makeup, which have changed considerably over the decades. Workload, intensity and patient complexity have magnified in the last few years. What has also changed over the years is the time and space doctors have to re-charge their batteries by talking to one another, gaining support from each other and learning how to cope with each other. These factors, much more so than the change in the selection criteria for medical students or the lack of 'mettle', 'toughness' or 'resilience' of younger doctors is to blame for the rise in mental illness we are seeing amongst the younger generation of doctors.

## Gender

The gender breakdown of doctors qualifying has changed considerably over the years since PHS has been in operation. For the first year, 53% of all our patients were men, this has dropped to 32.5 by 2017/2018. Currently women make up around 67% of our patients.

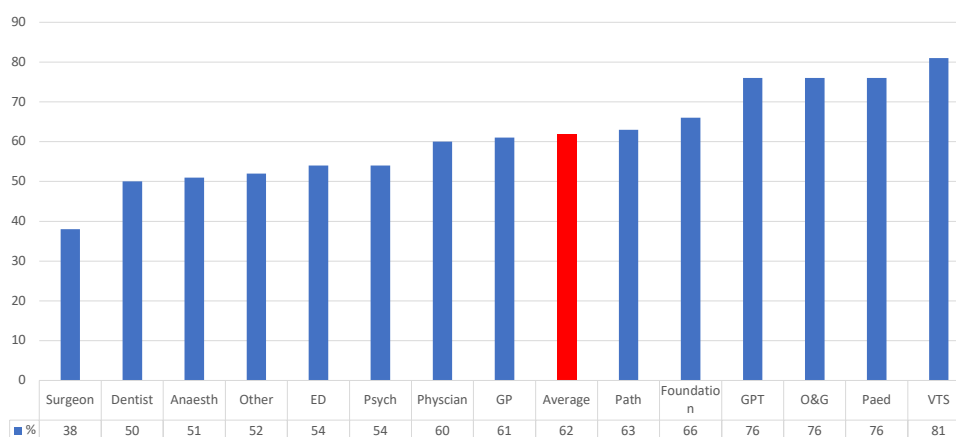
Men vs Women presenting per year	2008/2009	2017/2018
Men: Women	53% vs 47%	32.5% vs 67.5%

Across the health service, between 2009 and 2017 the number of female hospital and community doctors increased by 11,000, whilst the number of male doctors over the same period rose by just over 4,000. In 2017, 41% of all doctors were women compared to 35% in 2009. The percentage also varies across different specialties – 51% of all psychiatrists are women compared to only 27% of surgeons, for example.

General practice has a higher proportion of women compared to hospital medicine, both at career grade level and at the specialty training/registrars level.

At PHS we have seen a change in the proportion of women attending and differences across specialities. As with the national figures, we have seen more male surgeons than female (60% vs 40%); paediatrics, obstetrics and gynaecology, and those on vocational training GP schemes also have significantly more women than men (around 80% vs 20%). However, women attending PHS are still over-represented within these specialities. For example, only 27% of surgeons are women yet they represent 38% of surgeons presenting to PHS.

## Females: across each speciality (%)



Women doctors have also been found to be more likely to have mental health problems elsewhere. In research carried out in Australia, female doctors reported higher rates compared to male doctors of: current psychological distress (4.1% vs. 2.8%); high likelihood of minor psychiatric disorders (33.5% vs. 23.2%); and current diagnoses of specific mental health disorders (8.1% vs. 5.0% for depression; 5.1% vs. 2.9% for anxiety).<sup>24</sup> Young female doctors were more likely to have thoughts of suicide and to have attempted suicide. Female doctors also have higher rates of completed suicide. They also reported greater work stress and were more likely than male doctors to report having experienced stressful life events in the past year.

The reasons why we are seeing more female doctors is again likely to be multifactorial. It might be that we are attracting those into medicine who might be more at risk of mental illness – those who are more self-critical, high-achieving perfectionists. It might also be that women have more of these characteristics. There is little evidence to substantiate this. What we do know is that women tend to have more responsibilities outside the work environment than their male counterparts (e.g. childcare, caring for

<sup>24</sup> Beyond Blue. National Mental Health Survey of Doctors and Medical Students. 2013. Available from: [https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report\\_web](https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web)

elders and so forth). This might leave them little time for rest, recuperation and self-care. Women can experience significant difficulties at different stages in their medical careers. These include conflict between work and family life, part-time hours, lack of role models and having little time for leadership on top of clinical and personal commitments. All of these can contribute to mental ill health.

The corollary to women being more at risk of mental health problems is that male doctors might be under-reporting their problems. For men, depression is more closely linked to drug misuse and at PHS we certainly see more men using drugs than women. Men are also generally less likely to seek medical attention for depression and rather than seek help, are more likely to 'tough it out'. They might also try to self-medicate with alcohol and/or drugs. It is telling that in specialities which are more male dominated (e.g. surgery) we see fewer doctors presenting for care.

### **Doctors in training vs consultant-grade**

Given the younger age of the doctors presenting for care, it is hardly surprising that over half of the doctors attending PHS (54%) have not yet completed their speciality training. This is the case for every specialty other than general practice (this reflects the much shorter training for GPs [three years] compared to all other specialties).

Consultants and general practitioners are more likely to present with complex mental illnesses than their younger counterparts still in training. These issues cross a broad range of mental health, financial and work areas.

Late presentation amongst the older, more senior members of the medical profession might be due to the fact that stigma associated with mental illness is greater amongst this generation (compared to younger doctors), meaning that they present later and therefore have more entrenched and complex problems. Many of them, especially the older GPs, have 'held on' for many years in a deteriorating situation and finally come to a point where they can no longer offer the care they believe they should. This can cause huge distress. Those with addiction issues also tend to be younger than those with mental health issues. Again, these doctors tend to present in crises and often with multiple problems across different areas.

### **Additional equality monitoring – protected characteristics**

In line with the Equality Act 2010 we collect data in relation to the nine protected characteristics:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

Some of these categories (such as age and gender) are discussed elsewhere in the report.

In relation to the other categories, our caseload over the last ten years has identified that:

**Disability** – only 8% of those who have registered with PHS have identified as having a disability. Patients are not asked to distinguish between physical or mental disabilities.

**Gender reassignment** – less than 0.5% of patients identified as male to female or female to male gender.

**Marriage and civil partnership** – the majority of PHS patients identified as being in some form of relationship. When asked, 44%, recorded that they were married, and 1% that they were in a civil partnership. In addition, 10% identified as in a relationship and 9% were co-habiting; 28% identified as single, whilst 2% were divorced and 1% widowed. Only 1% of PHS patients did not identify their status in this category.

**Pregnancy and maternity** – we do not record pregnancy as a registration status but do identify where this is impacting on work status. Only 1% of our caseload are on maternity or paternity leave.

**Race** – we collect information on race, broken down into seven categories. Of the patients who have registered with PHS over the last ten years, 62% have identified themselves as White, 22% Asian or Asian British, 4% as Black or Black British, 4% as Mixed race, 2% as Chinese and 2% as 'Other'. When asked, 4% of PHS patients did not identify their race.

**Religion or belief** – this item has eight categories. When asked, 33%, identified themselves as Christian, 31% as 'other' and 26% as 'no religion'. Other religions recorded were Muslim (9%), Hindu (7%), Jewish (2%), Sikh (1%) and Buddhist (1%).

**Sexual orientation** – of those patients who have registered with PHS the majority have identified themselves as heterosexual (88%), 4% as a gay man, 1% as a gay woman/lesbian, 1% as bisexual, 1% as Other; and 5% indicated that they would prefer not to say.

## Presenting problems

In this next section we will look in more detail at the type of problems we have been seeing and whether there have been any significant changes over the years we have been in operation.

One of the functions of the daily multidisciplinary team meeting is to assign a diagnosis to each patient. Diagnoses are grouped into four main categories based on the presenting issue and its severity. Patients can have more than one presenting problem and as such the category is the one which best describes the patient's most serious problem. These categories are Common Mental Health Problems, Complex Mental Health Problems, Addiction and Other.

**Common Mental Health:** Includes mild to moderate depression, anxiety, post-traumatic stress disorder, mild to moderate obsessive-compulsive disorder, burnout, adjustment disorder.

**Complex Mental Health:** Includes bipolar affective disorder, personality disorders, severe depression/anxiety/post-traumatic stress disorder/obsessive compulsive disorder,

psychotic disorders, eating disorders and complex co-morbidities (e.g. depression and physical health).

**Addiction:** Includes any problem drug or alcohol use, gambling, sex/pornography addiction.

**Other:** Includes physical health problems, complaints and patients wanting advice around specific issues related to work (bullying, whistle-blowing).

Year	Mental Health category of presenting problem		
	Mental Health (Common and Complex)	Addiction	Other
2008/09	62% (114) Common 61% [70/114] Complex 39% [44/114]	36% (67) Alcohol 77% [51/67] Drugs and other 23% [16/67]	2% (3)
2008/18	83.5 (3146) Common 82% [2577/3146] Complex 18% [569/3146]	10.1% (381) Alcohol 75% [285/382] Drugs and other 25% [95/381]	6.3% (240)

Over time, the sort of problems doctors present with has stayed more or less the same – anxiety, depression, obsessive compulsive disorder, alcohol and drug addiction. What has changed is the proportions of each. During the first year more than one third of all doctors (36%) presented with problems related to either drug or alcohol (mainly alcohol) misuse. This figure for the ten-year period (2008-2018) has dropped to 10.1%; currently for 2017-2018 only around seven per cent of doctors are presenting with addiction issues. These addictions are mainly to alcohol (over 75% of cases) but also include addiction to drugs, gambling and, for a small number of doctors, pornography or online gaming.

Of those with mental health problems, 82% have problems with anxiety, mild to moderate depression, mild to moderate obsessive-compulsive disorder or adjustment disorder; the remaining 18% have serious (or major) mental health problems, mostly eating disorders or bipolar affective disorder, and a few have personality disorder or psychosis.

## Mental Illness

### Common mental health problems

*Dr Khan is a 28-year-old ST1 paediatric trainee. She was always a high achiever at school and later at medical school. But she is struggling with severe anxiety. During her FY1 post, she worried constantly that she had forgotten to hand things over or had missed obvious signs in sick patients. She managed by seeking reassurance and checking the same results with different staff members.*

*Her next post as an ST1 she described as a 'baptism of fire'. She began to stay late to make sure everything was completed and also to come in early to make sure she could check results that had arrived overnight. Six months earlier, she received one negative comment on her 360-degree feedback form (amongst all other excellent comments). The comment said that she took too much time to complete her tasks and often sought advice from different staff before taking action. The anonymous review reported that this was disrespectful and annoying. She felt devastated and now worried she would be removed from her training.*

*On top of everything else, she had recently been involved in caring for a child who later died from sepsis. She had been asked to write a report for the Trust. She now feels anxious all the time; her heart pounds and she feels constantly sick. She wants to leave medicine as she does not feel good enough to be a doctor. She feels she has let everyone down and doesn't know where to turn for help. She feels hopeless, is finding it difficult to sleep at night, has lost weight and has increasingly persistent suicidal thoughts.*

Most of our patients fall into this category, most commonly with a diagnosis of depression and/or anxiety, which have probably been present for some time.

A large number of doctors present with a self-diagnosis of 'burnout'. When we assess them, however, quite often they have a diagnosis of depression (low mood, poor sleep, nihilistic thinking, feelings of helplessness and suicidal thoughts) which has been present for some time, with burnout probably being present earlier.

Whilst we categorise these conditions as 'common' this does not in any way underestimate their severity or complexity. Doctors tend to present late, often when their mental illness is beginning to impact on their work or when compelled to do so by their regulator. This means that it is not uncommon for doctors to receive a complaint, or have concerns raised at work about their performance or behaviour, which acts as a trigger to seeking help. Treating these doctors means unpicking and then addressing the host of problems they present with and trying to reverse any damage they might have done to their professional standing whilst being unwell.

Dr Khan illustrates a doctor with long standing anxiety traits and perfectionism. She coasts through medical school but starts to find, as many young doctors do, the real-life experience of treating patients difficult as problems patients present with do not often fit into the neat textbook descriptions. Compromises have to be made and the ability to manage risk and uncertainty learnt. She is already suffering some features of an anxiety disorder before her mood begins to dip following the death of the child. Unsupported and with the fear of the coroner's case, her anxiety begins to

be compounded by depressive features. Like many junior doctors she feels isolated, ashamed and unsure where to go for help.

Dr Khan may well need a combination of antidepressants and behavioural treatment. From a psychological perspective her difficulties can be addressed in a number of ways:

**Letting go of the quest for 'perfect' and accepting 'good enough'.** Dr Khan will take some persuading, but once she realises that her quest for perfection is in fact making her more likely to make mistakes, she will recover more quickly.

In a clinical environment doctors often legitimise their anxiety, claiming it is necessary and useful in 'keeping me on my toes' or 'keeping me motivated'. In fact, true anxiety is very unhelpful in problem solving and working effectively. PHS would work with Dr Khan on establishing a new emotion to experience instead of the anxiety she is currently feeling. This new emotion needs to acknowledge the inherent threat of errors/ mistakes, but be qualitatively different from anxiety, which is inherently dysfunctional and maladaptive due to the thinking and behaviour it generates – panic, catastrophising, avoidance, reassurance-seeking etc.

**Emotional responsibility.** Doctors like Dr Khan find it helpful to know that (with practice and guidance) they can begin to experience more helpful emotions in place of low mood and anxiety, without there being any fundamental changes in their environment/workplace or colleagues. To start we help them understand that their emotions are exactly that – theirs. They can then begin to modify them and take more control of their emotional responses. If they are responsible for their emotions, then they can be empowered to change them. One caveat here, though, is that a doctor should never feel blamed for their anxiety or low mood and should instead be taught that with some re-framing they can take back control and change it.

**Practise makes... good enough.** Once a doctor has been shown the theory of emotional change, they need to practise, practise, practise.

**Addressing self-defeating core beliefs.** High achievers often have crippling core beliefs. These core beliefs operate as quiet but constant whispers about being unlovable, inadequate, or useless. Doctors often set themselves overly high expectations to disprove these core beliefs, even though there is no objective evidence to support them whatsoever. The reassurance we all get when we disprove these core beliefs feels good. It is intoxicating, but never enough and we need more and more reassurance. At PHS we help doctors accept that they are fallible like everyone else and are allowed to make mistakes. Dr Khan will be a healthier, happier and a better doctor, who is less likely to make mistakes once she accepts that she is imperfect, but still has inherent self-worth in light of her human imperfection.

## Complex mental health problems

Doctors with bipolar affective disorder (BPAD) or any psychotic illness, severe depression or personality disorder are placed in this category.



Our colleague Dr Daksha Emson suffered from bipolar affective disorder (BPAD) and we are always reminded of her when a patient presents with this diagnosis. Over the last 10 years, 107 patients have had a diagnosis of bipolar affective disorder, around 19% of the complex mental health category.

This is a large number and we believe we have the largest number of doctors with BPAD in a single service anywhere in the world.

People with bipolar affective disorder have periods of depression (feeling very low and lethargic) and periods of mania, where they feel very high and overactive (the less extreme form of mania is known as hypomania). Each extreme episode can last several weeks (or longer). The high and low phases of bipolar affective disorder are often so extreme that they interfere with everyday life.

*Dr McArthur was appointed to his first substantive consultant surgical post a year ago. He was a graduate entrant into medicine after studying chemistry, then going on to do a PhD. He abandoned this in the second year, instead using inherited money to start a business. His business failed, and he sank into a depression. His first year as a consultant has not been what he expected. He says he hates his job at the moment. He reports that each year he notices that he becomes depressed but that it lifts in the summer. He then makes up for lost time by going out socialising and dating. He needs less sleep, blaming the light in the morning for waking early but makes the point of stating he's not manic, and wonders if he might suffer from Seasonal Affective Disorder (SAD). He has tried several anti-depressant medications via his GP but they either make him feel worse or do nothing at all. During the assessment it becomes clear that since his late teens he has had at least one period of high mood every 12-18 months, characterised by: increased sexual behaviour and activity; decreased need for sleep; increased alcohol use; sudden huge life/career direction changes; and some poor financial activity. These periods are always immediately followed by a deep depression that fails to respond to medication. At least one antidepressant medication that he tried in his twenties appears to have triggered a sudden-onset hypomanic episode. He leaves the initial assessment worried about the potential diagnosis of BPAD but does agree to take a look at some websites and resources. At the next appointment he is more open to a possible bipolar affective disorder diagnosis, also wondering if his father may have been so, too. He fears being referred to the GMC and is visibly relieved to be told this is not necessary and that there is no reason why this diagnosis should negatively impact his career at all.*

The average age of doctors with BPAD at presentation is 44.5 years with a gender split of almost exactly 50:50.

As with Dr McArthur, an area of concern for many practitioner-patients is whether or not they should inform the regulator of their diagnosis. Whilst the percentage of those with BPAD and regulatory involvement is higher than for other doctors with major mental illness (21% vs 15%), overall 79% of doctors with BPAD do not have any regulatory involvement at all.

It is also possible to work with a diagnosis of BPAD. Whilst only 38% of doctors presenting to us with this diagnosis were at work, by the end of treatment with PHS this figure increased to 73%.

We now have a clear treatment pathway for patients with BPAD. What we do essentially is augment NHS services. We make sure that wherever possible we involve their general practitioner – especially so if the doctor needs a complex medication regime. We make sure the doctor is on the correct medication, that they are receiving psychological treatments, and we support the doctor's return to work or training. One of the problems associated with doctors and mental illness is that they frequently move address, moving to a different community mental health team catchment area in the process. Even moving across the road might mean that the doctor changes team and needs a new referral, which might take a long time to put in place. PHS makes sure that the doctor does not fall through any nets. We care for the doctor during their move from one service to another.

Overall, when doctors with BPAD receive the right treatment, their mood improves, and they are able to return to work, with or without reasonable adjustments being made.

This 'complex' group also contains doctors who have a multiplicity of issues.

Typically, they might have had a low mood for a while, with deteriorating ability to function at work (e.g. minor errors, coming in late, being sharp with staff). Their fear of being 'found out' to have a mental illness and general lack of insight into the change in their behaviour – or their fear of professional repercussions if others should ever learn of their difficulties – might lead to them to compensate in unhelpful ways. They often describe a working life that is lived in a constant 'flight-or-fight' mode. A relatively minor event, such as being handed the wrong surgical instrument, or having an extra non-scheduled patient slotted in by reception staff will lead to an explosion at other people, or an implosion into tears, self-harm or drug use. Instead of seeking help earlier, they try to work their way through this low mood – working harder and harder in the magical belief that it will help. Of course, it doesn't. What tends to happen is the doctor becomes increasingly depressed, which will then lead to an error at work. In the throes of altered cognitions due to their depressive illness they might try and cover up the error, for example by altering the medical records. Alternatively, the doctor might lash out at a colleague or member of staff at work and be accused of bullying. Both scenarios might result in the doctor being suspended and referred for investigation (especially if it appears this is a recurrent episode).

Doctors in difficulty will often 'keep going' at work, seeing their marriages break up, their friends disappear, and their interests dwindle. They hold onto their professional role in the view that this is the one domain in their life in which they can exert the most influence and control and receive the validation they may perceive to be lacking elsewhere – an understandable conclusion to arrive at given the power that doctors can exert. Where these doctors run into difficulty is when the sole source of their validation as a doctor (and in their view as a human being) is threatened.

## Addiction and doctors

*Case One: Dr Allan, an anaesthetist, works in a large teaching hospital and in a private pain clinic. He was finding it increasingly hard to get to sleep when not working but felt too anxious to see his GP. Instead he decided to try a small amount of Fentanyl left over from his list. The drug worked; in fact, he felt much better. He repeated this for the next few nights, always careful not to overdo the amount. Unfortunately, he found that if he didn't take the drug he couldn't function, and his use was escalating. Over the next months he found that he was taking increasing amounts of the drug home with him, together with needles and syringes. He was also taking diazepam ampules from the anaesthetic room. One day he was asked to see the Medical Director who confronted him about his behaviour at work and suggestions that he might be removing Fentanyl from the anaesthetic room. Dr Allan felt his life was over.*

*Case Two: Dr Maritos is a dental practitioner. The previous week he had tried to hang himself. He had survived as the knot had slipped. During the assessment he described how he had begun to drink heavily to help deal with insomnia relating to his shift-working. He was now regularly drinking a least 10 units of whiskey every day, including on his way to work, and topping up during the day. His alcohol use had been creeping up over many years and he cannot remember the last time he had an alcohol-free day. He admits to getting the shakes in the morning and having to start most days with a small drink. Faced with the wreckage of his life, Dr Maritos felt suicidal and began to cry.*

These doctors are typical of those attending PHS and as they illustrate, a medical degree does not offer immunity to addiction to drugs or alcohol.

Over the years, around 10.1% of doctors attending PHS (381) have had problems with addiction – mainly alcohol addiction. Others presenting with addiction have problems with drug misuse and behavioural addiction (internet pornography and gambling). The drugs include opiates, stimulants, club drugs/legal highs and prescribed or over-the-counter medications.

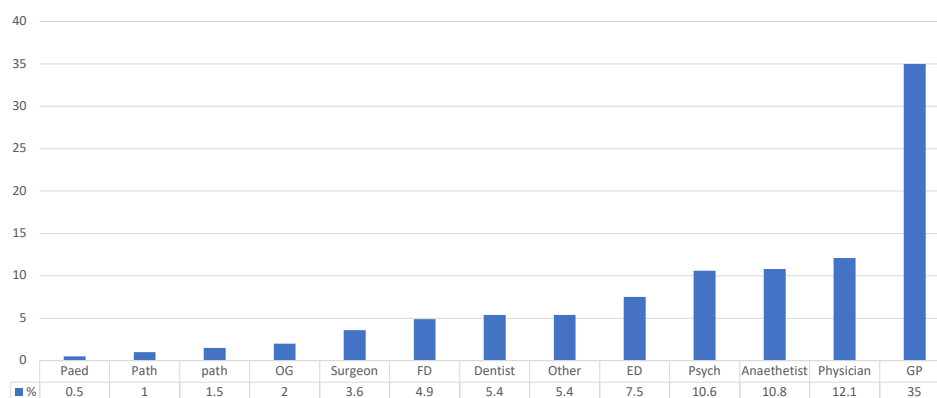
We believe that this is the largest cohort of doctors being treated for addiction in a single treatment service and are proud of our outcomes.

We have seen a significant drop in the number of doctors presenting with addiction issues, from 36% in 2008/9 to 7% in 2017/2018. This may be that we are reaching out to doctors earlier and providing them with care before their use of alcohol or drugs becomes problematic and entrenched.

Consistently over the years men have outnumbered women presenting with addiction problems by three to one. All age ranges have doctors with addiction though it is more common in doctors aged 35-45 years old.

In general, younger doctors are more likely to use drugs, and older age groups are more likely to be addicted to alcohol.

## Addiction: percentage in each speciality



In actual numbers, and across all specialities, general practitioners were most likely to present with problems related to addiction (35% of the total), but this is related to the higher number of GPs able to access PHS. However, when weighted according to the numbers presenting from each specialty, anaesthetists, emergency department doctors and dentists have the highest percentages presenting with problems related to addiction.

### % of each speciality with addiction disorder

Paediatrician	<1
GP Trainee	3.4
Foundation Dr	8.4
GP	8.7
Physician	9.7
O&G	9.8
Surgeon	9.8
Pathology	9.8
Average	10.5
Others	11.7
Psychiatrist	12.5
Dentist	19.3
Anaesthetist	19.8
Emergency	20.2

In 2017, an anaesthetist was jailed after stealing codeine to fuel his addiction to opiates.<sup>25</sup> The trial judge accepted that the doctor's problems were genuine but 'as a doctor, he should have known where to get help'. However, for a host of reasons, doctors with addiction do not know where to seek help, have very poor access to confidential, accessible and supportive care and there are special features of doctors' dependency which makes them stand out from other addicts.

For example:

- Addicted doctors have to endure negative professional attitudes from colleagues;
- Isolation contributes to late presentation as addicted doctors do not share their issues with fellow addicts, nor do they identify as addicts until their recovery starts, seeing status and occupation as differentiators or protecting factors;
- Although depression is well recognised in addiction, the level of low mood and suicidality is striking amongst the population of addicted doctors;
- With treatment, addicted doctors have excellent outcomes compared to non-medical addicted patients;
- There are very high rates of complete abstinence in successfully treated doctors compared with much higher use of opiate substitute treatments for non-medical addicts.

Addicted doctors therefore stand out as a special group compared to other non-medical addicts. Perhaps the most important feature that sets them apart is the nature and pattern of their use. In our experience of doctors attending the service, few use drugs every day and most use sporadically – when on holiday or off duty. It is very unusual for them to use at work, though some do. Their pattern of use can be unusual and related to their rota. So even where a doctor might have alcohol dependency (craving, withdrawal, escalation of use, salience), they might 'only' use when not on duty or when not working the following day. This is much more akin to binge-drinking than the pattern of drinking we see in more typical alcohol dependence. However, any illegal drug use, even sporadically, is by definition problem use, given that it is out of line with good medical practice. As doctors, using any substance which is illegal, illegally obtained (perhaps through prescribing in a patient's name) or, if legal and legally obtained, is causing problems, should be considered as problematic. As such, at PHS and in fact across most physician health services we use the terms dependency, problem use and addiction interchangeably. The same holds for alcohol dependence.

Returning now to Dr Allan and Dr Maritos: both doctors, once in treatment, as with the vast majority of doctors attending PHS, will have an excellent outcome in terms of abstinence and improvement in mental health. We treat all our addicted doctors with a combination of psychological and pharmaceutical interventions (alcohol or drug-assisted detoxification, antidepressants if necessary) and case management. All doctors are followed up, monitored where necessary (including testing urine and blood tests) and are encouraged to attend a mutual self-help meeting such as Narcotics/Alcoholic/Cocaine Anonymous, a British Doctors and Dentists Group or our own PHS addicted doctors' group, the 'Garden Group'.

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<sup>25</sup> Dyer C. Anaesthetist is jailed after stealing codeine from hospital where he no longer worked. *BMJ*. 2017; j4841.

## Treatment for doctors with addiction

We know how hard it is for doctors with addiction to seek help, to overcome their deep-rooted sense of shame and humiliation and admit they have crossed the boundary into dependency. Using drugs often involves dishonesty and crossing other professional boundaries. Addicted doctors face the biggest barriers to accessing timely help. They include: feelings of guilt, stigma, shame and denial of the problem; fears about negative response from colleagues and employer; and mistrust and real fear of the General Medical or Dental Council. Unwell practitioners delaying seeking help is of great concern and a missed opportunity, since early and appropriate intervention produces excellent outcomes. More often than not doctors' late presentation is not a deliberate act but due to a lack of insight secondary to their addiction.

With respect to Dr Maritos (case two), not only does he have an addiction issue, but he also has depression – the two, of course, often go together. He also is a significant risk to himself given that he attempted to hang himself. We can offer him a place at a six-week residential alcohol and drug rehabilitation unit or a community detoxification programme. If he wants the latter, then we would need to involve a close family member to supervise the community detoxification. For a community detoxification, we would see him on a daily basis initially, reducing to once or twice a week and then weekly as his mood improved and he moved out of the acute phase. Alcoholism is not something that needs to involve the regulator unless he has been under the influence whilst at work or drink-driving. As long as he removes himself from clinical work whilst unwell, the GDC would never need to know of his case or be involved.

It is important to note that PHS is not designed to monitor doctors to the same degree of scrutiny as the GMC/GDC can. For example, we do not do hair testing, random unannounced testing or carbohydrate deficient transferrin (CDT) (test for alcohol use) unless required for clinical rather than regulatory purposes – i.e. it has to be in the patient's best interest for the test to be performed.

## Treatment outcomes for doctors with addiction

In 2017, we looked in detail at our first 255 addicted doctors attending the service and at longer-term outcomes, including abstinence from drugs and/or alcohol. At discharge (usually <5 years) or 12-month follow-up (for newer patients), complete abstinence was achieved by 77.6% of doctors, and a further 14.6% had achieved controlled use of alcohol. All doctors with behavioural addictions achieved abstinence. Of the 20 patients who had not achieved abstinence, 10 were still in treatment with us. This meant that of the overall cohort of patients only 10 doctors had relapsed to problematic use. Even where doctors do relapse, most of these doctors go on to full recovery. This compares very favourably with other physician health services, in particular in the United States, and is much better than for the general population, where it is expected that only between 10-30% of those addicted to alcohol and/or drugs will become abstinent.

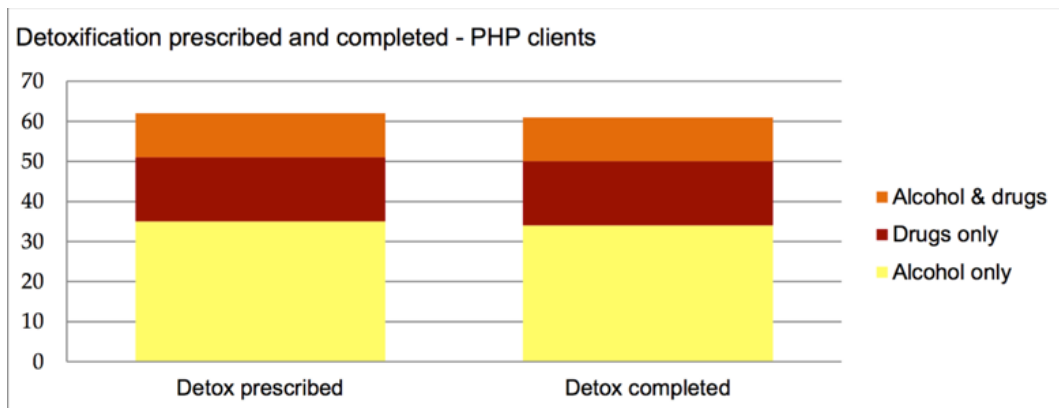
Whilst we follow an abstinence-based model, in some circumstances we prescribe (or supervise the prescribing of) opioid substitute medication or the drug disulfiram (a

drug which produces unpleasant effects when taken with alcohol). For a very small number of doctors we allow controlled drinking, though this is rare as for the vast majority of patients' complete abstinence is necessary.

## Residential rehabilitation

We have also compared the outcomes of our patients who have chosen admission into our rehabilitation unit and those who have not. Overall, 100 doctors out of the 381 addicted doctors have been admitted (this resulted in 104 treatment episodes as a few patients have been admitted more than once). Doctors are able to choose, dependent on their own circumstances, whether to go into residential rehabilitation. Admission is sometimes encouraged by us or a family member but fundamentally the patient chooses. It is not therefore related to severity of dependence, and rather to social, family and work factors. Outcomes are comparable for the two groups.

Of the 104 rehabilitation treatment episodes (between 2009 and 2016), 74 were men and 29 women. The vast majority (89%) of all admissions for this period successfully completed their treatment programme. Female patients showed a slightly higher completion rate than men, with 93% of the 28 women completing compared to 87% of the men. Of those admitted, 40% did not need a detoxification regime. Of those who did (62), 57% were from alcohol only, 18% were from alcohol and drugs, and 26% were from drugs only. Almost all (61 of the 62) prescribed detoxification regimes were



successfully completed, giving an overall detoxification completion rate of 98%.

## Work, regulation and addiction

Dr Allan's (case one) employers are suspicious of him and that he is using drugs. As an anaesthetist he is high risk for escalating addiction and accidental or deliberate overdose and death. To help him, it is important that he accepts that he cannot work until his addiction is under control and that it would be in his best interests to self-disclose to the GMC about his use (PHS would help him in this disclosure). It may take time for any regulatory or disciplinary processes to be completed but PHS will be alongside our patient throughout. At presentation around half (51%) of all doctors with addiction problems are already involved in regulatory and/or disciplinary proceedings upon entry to treatment. Of the remainder, 44% required no regulator involvement at any point. Only a small minority (five per cent) were recommended by PHS to self-refer to the GMC/GDC and/or disclose to their employer because of patient safety concerns, ongoing illegal or harmful activity or where it was in the best interests of the health practitioner.

Doctors with addiction issues often have problems in the workplace – even if their addiction is not noticeable, issues such as arriving late for work, frequent days off sick and erratic moods often lead to concerns being raised and action taken, including exclusion from work.

It is therefore not surprising that at presentation less than half (42%) of addicted doctors were working. After treatment at PHS this increased to 82.4% and the percentage of doctors on sick leave fell from 25.9% at entry to 2.4% after treatment. Likewise, those who were unemployed dropped from 14.1% to 2.6% and those suspended from work fell from 11.3% to 3.1%. With respect to referral to the regulator: addiction accounts for 38% of those involved with the GMC/GDC; Complex Mental Illness 19%; Common Mental Illness 38%; and others around 5%.

## 'Other' mental health categories

This group contains doctors who might have physical health problems affecting their mental health – doctors have presented to us with new diagnosis of neurodegenerative problems or cancer, for example. Some doctors want advice about disclosure of certain illnesses (such as HIV) or how they might approach local occupational health services for further help. This group also contains patients who are in 'a mess'. They may have problems in many areas of their lives – including financial difficulties, work-related problems and problems with relationships. It also contains doctors who have been bullied, are whistle-blowers, or in some cases who are involved in high profile cases which have made the news. They all need our support.

## Regulator/disciplinary involvement

*In the early hours of a warm day in 2008, I had a choice. It was the morning of my surgical exam viva and I was in a hotel room, shaking uncontrollably, retching and generally feeling like death. Something's wrong when you need half a bottle of spirit before 6am to prepare for the day. Something's wrong when you dread an on-call, not because of sleep deprivation or the stress, but because you can't have a drink in the evening, let alone the morning. Something's wrong when operations which were a breeze become insurmountable obstacles, and you hate a job you once loved because it gets in the way. In the next month, my wife left me, taking our children, and I descended into a 24-hour drinking binge. I remember little of that time, and to this day I'm still unsure as to how I ended up – still retching, sweating and vomiting – at PHS about four months later. My recovery was not straightforward. It was another two years before I truly began to feel I had broken the back of my addiction. PHS, without a doubt, saved both my life and my career. I referred myself to the GMC on the advice from PHS and, whilst never a pleasurable experience, at least I felt honest, something unfamiliar for an addict! Six years down the line from my last drink, my life is great. Most importantly, I'm still a doctor, and that is what defines me. I'm an alcoholic – that defines me too – but because I put up my hands to PHS, it hasn't destroyed me.*

Peter, surgeon. Abridged from PHS Website



Year	% of doctors involved with the GMC or GDC
2008/09	33%
2017/18	5.1%
2008-2018	11%

Across the 10 years, 430 doctors have been involved in regulatory proceedings – from referral to the GMC/GDC through to investigation, undertakings, conditions or Fitness to Practice hearings to erasure. Younger doctors are more likely to be involved in regulatory processes than older ones; and men are more likely to be than women (69.3% vs 30.7%).

A major change over the years is the number of doctors coming to us who are involved in regulatory or formal disciplinary procedures. During the first year, 33% of all new patients had some sort of regulatory involvement. This dropped to just over 5% by year ten (2018) and averaged over the 10 years (2008-2018), 11% of all patients have been involved in regulatory processes. We hope that the drop over the years is a result of doctors are coming to PHS earlier, before their problem has begun to cause difficulties at work.

Age breakdown of those involved with the regulator	%	Number
Under 29	3	13
30-39	25	107
40-49	30	129
50-59	25	105
>60	18	76

Whilst the use of drugs and/or alcohol is a common reason why doctors coming to PHS are involved with the regulator, it is by no means only this group who find themselves for one reason or another referred to them.

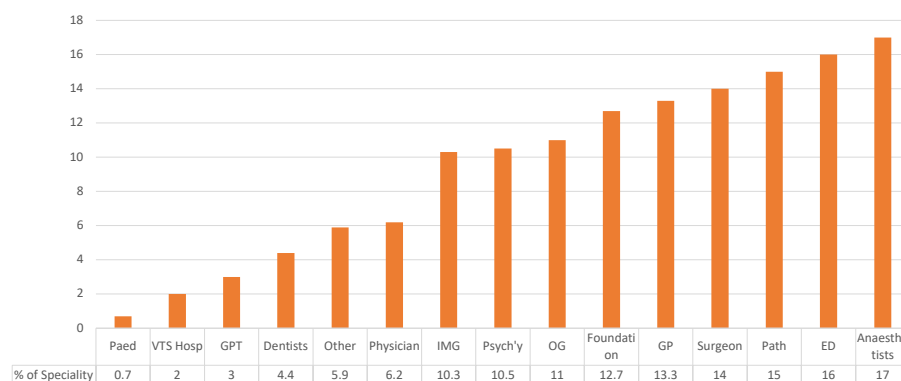
Breakdown of those involved with regulatory procedures vs mental health/addiction category.

Category	Number	%
Addiction	161	37
Mental Health		
Common	169	39
Complex	80	19
Other	20	5
Total	430	100

When compared with the number in each category, overall those presenting with addiction are most likely to be involved in regulatory processes (42.3% of all of those with addiction vs 15% complex mental illness, 7% common mental illness).

All the major specialties have had doctors involved with regulatory processes, but some specialties are over-represented. These tend to be the ones with higher rates of addiction. For example, involvement with the regulator is more likely to be a feature of anaesthetists (17%) and emergency department doctors (16%) as a percentage of those presenting to PHS. Paediatricians (<1%), those undertaking their hospital GP vocational, trainees undertaking their hospital posts (2%) and GP trainees (3%) have the lowest involvement.

### All: Regulator involvement as % of specialty presenting



As a team, we have built up a considerable understanding and expertise around the interface between disciplinary processes and ill health. We are able to help doctors along the whole disciplinary pathway from initial complaint to contact with the GMC/GDC or Performers List/Trust investigation.

We have also built good relationships with all of the major medical defence organisations and at the time of writing are developing a guide for doctors attending the GMC/GDC. We have been greatly assisted by our patient and volunteer group, and by our suspended doctors' group. These doctors provide hands-on support to others

who might find themselves involved in a referral to the GMC or GDC. Doctors who are undergoing disciplinary processes are often traumatised and stressed and the effects can be long lasting. Most are entering an unknown territory over which they have no control. This is alien to most doctors who are used to being in control. At PHS we consider any doctor with a complaint or referral for further investigation as high risk for suicide, more so if the doctor is also suspended from work. We try to minimise distress for those doctors by asking the GMC/GDC, with the patient's consent, to copy us into correspondence and as such we are able to open these letters on behalf of the doctors (who are often paralysed into not doing so through fear). We liaise directly with the GMC/GDC and/or NHSE case managers or occupational health where we are particularly concerned about a doctor.

For more information on GMC hearings, see:

<http://php.nhs.uk/resources/facing-a-disciplinary-process-or-investigation/>

The considerable drop over the years in the number of doctors involved with the regulator (in particular with the GMC) may be because doctors are now seeking help at a much earlier stage. As PHS has become more well-known and trusted, and as doctors begin to recognise that signs of stress or burnout can lead to more significant problems if left undealt with, they are seeking out help. The fact that a confidential service now exists probably gives doctors the confidence to ask for support, when in the past they may have tried to hide their problems until they became apparent through a mistake, complaint or other performance problem.

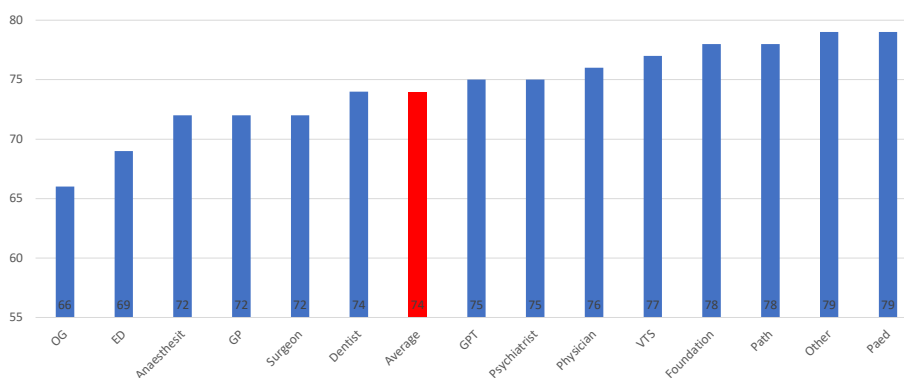
## How PHS helps doctors involved with the regulators:

- helps improve the experience of doctors with mental health problems passing through their processes.
- has low threshold for offering psychological and pharmacological treatments following a complaint.
- helps signpost access to a solicitor who offers fixed price advice.
- helps doctors access pro-bono or low cost legal services.
- helps doctors obtain financial support from the GP charity, the Cameron Fund <http://www.cameronfund.org.uk> and/or the Royal Medical Benevolent Fund.
- helps prepare doctors for hearings, including writing reports and attending the GMC hearing if possible.
- offers a place on our suspended doctors' group which meets monthly.
- offers support for at least one year post-erasure.
- helps erased doctors return to the medical register (including carrying out appraisal-style discussions and advising on developing a personal development plan).
- helps doctors prepare for a review after a period of suspension.
- supports doctors back to work after a period of suspension.
- helps doctors find supported employment after a period of suspension.
- helps doctors find employment if they cannot work in their capacity as a doctor.

## Work and Training

Work is central to doctors' identity and at PHS we try very hard to help doctors return to safe employment and/or training, or where necessary to change their speciality or even career. At presentation to PHS, around 74% of doctors are in work. Paediatricians, pathologists and foundation doctors are most likely to be at work (nearly 80% of them were at work at presentation), compared to obstetric and gynaecologists (only 66% were working), and emergency department doctors (69% were working).

All: % working in each speciality



Of those not working (around 25%), 40% are on short or long-term sick leave; 33% are on either sabbatical/maternity/paternity/retired or unknown, 20% define themselves as unemployed and 7% are suspended from work.

Of those not at work at presentation, 76% return to work within 12 months of accessing the service. This included doctors who had been unemployed for over 10 years, and doctors with severe and enduring mental illness.

There is considerable overlap between unemployment and being involved with regulatory or disciplinary processes. PHS doctors who were not at work at presentation were more likely to be under regulatory processes compared to those who were working at presentation (46.7% compared to 11.5%). Of those doctors with addiction problems who were not working at presentation (161), 67 of them (42%) were undergoing regulatory procedures; 57.5% (46/80) were in the complex mental health category and 46% (77/169) were in the common mental health group.

The reasons for the overlap between not working and involvement with the regulator are varied. These include:

- A referral to the regulator may lead to a doctor becoming depressed or worsen a pre-existing mental illness.
- Mental illness, such as depression, can lead to cognitive impairment which might lead to the doctor crossing a professional boundary or acting inappropriately with a patient or work colleague.

- Mental illness might lead to out-of-character criminal behaviour (such as shoplifting) which itself can lead to worsening of the mental illness.
- Mental illness in itself might be a criminal activity – the most obvious being drug use.
- Drug use can lead to doctors transgressing good medical practice such as stealing drugs, self-prescribing or prescribing in a patient's name for the doctor's own use.
- Mental illness in itself might be considered counter to fitness-to-practise – bipolar affective disorder or personality disorder, for example.
- The very act of trying to kill oneself might lead to criminal or professional sanctions where the means of the suicide attempt involves obtaining drugs illegally or via self-prescription.
- Certain mental illnesses (e.g. autism spectrum or personality disorder) might lead to communication difficulties which then might lead to complaints from patients, supervisors or colleagues.

PHS runs a monthly group for suspended doctors. This helps address the stigma and isolation many of these doctors feel.

Returning a doctor to work or education requires a coordinated approach involving practitioner-patient, case manager, occupational health, workplace supervisor and at times also a number of personnel from the relevant deanery or NHS England.

This takes time, but we reassure the patient that if there are no performance or health reasons why a doctor cannot return to work, then in most cases they will. For GPs this is often harder than for hospital doctors and we have begun to highlight inconsistencies between different professional groups. We are working with Royal Colleges and other stakeholders to try and redress them.

For those doctors who are suspended, erased or choose to pursue a life outside of medicine, we can assist with suggestions and signposting to alternative career advice. The skills gained through medical training and clinical practice include:

- communication skills
- empathy
- problem-solving
- coping with pressure
- professional integrity
- teamwork
- decision-making

These are highly transferable to a variety of scientific, technological, managerial, academic and financial professions. We work with organisations such as Medic Footprints ([www.medicfootprints.org](http://www.medicfootprints.org)) to help doctors consider alternatives that will ensure their skills and training can continue to benefit the public in some way.



## Research and Development

As the largest physician health service in Europe, and one which provides the widest range of treatments, we believe it is our duty to advance the knowledge about sick health professionals. Over the decade we have published a number of academic papers, been involved in PhD, masters and degree dissertations and participated in a number of research projects. PHS hosts a research consortium made up of clinicians and academics involved in original research and outcome measurement in the field of practitioner health across the UK. The consortium shares expertise and knowledge of the emerging research base as well as developing partnerships between clinicians and academics.

Current and upcoming collaborations are looking at PHS outcome data to investigate mental health and social functioning scores using validated measures to evaluate outcomes across the service. This will enable formal outcome measurement and statistical analysis by, for example, gender, specialty, diagnosis and severity.

Following the Wounded Healer conference in October 2018, PHS will guest edit a special edition of the Research and Advances in Psychiatry journal which will be published in May 2019. This edition will be dedicated to issues around physician health and wellbeing.

Our research consortium includes members from a number of UK universities and departments specialising in practitioner health research, as well as representatives from provider organisations, and we also have active links with universities in Europe.

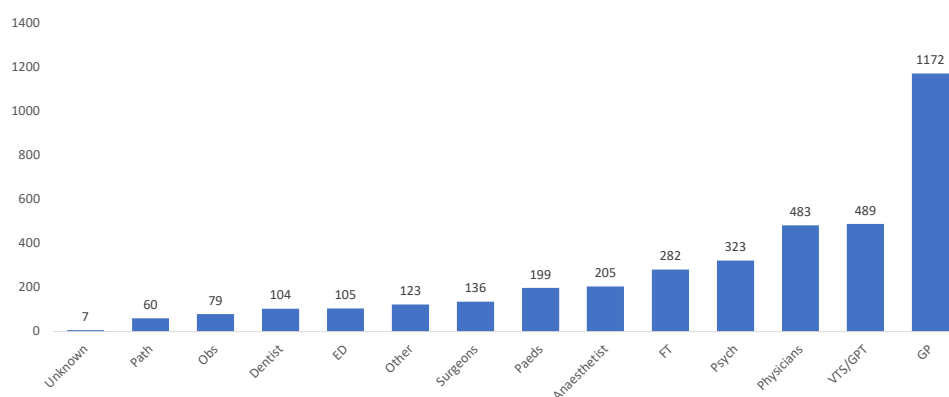
# PART FIVE: Highlights from different specialty groups

## All doctors

Doctors from a wide range of specialities have presented to PHS over the years. Some specialties have presented proportional to their numbers on the on the medical register (psychiatrists, physicians); others have over-presented (paediatricians, general practitioners) and others under-presented (surgeons, obstetricians).

This section will look at the data of some of the different specialities which have presented to PHS over the years in more detail.

All: Specialities at Presentation 2008-2018  
(3767)



## General practitioners

General practitioners (GPs) make up around half of all patients we have seen at PHS. Numbers presenting to the new GPHS service have exceeded expectations by 20%. Across the years, the average age of the GPs seen in the service has dropped from 54 years in 2008/9 to 40 years in 2017/18. At presentation, 67% of the GPs have been women, 33% men, and 75% have been working.



Most GPs (88%) present with mental illness (common and complex), with only 10% presenting with problems with addiction. The remaining two per cent fell into the 'Other' category.

#### GP Employment status

Locum 10%
Salaried GP 27%
Partner GP 31%
Hospital VTS and GP trainee 32%

We know that whilst all doctors are working very hard in difficult circumstances, GPs are probably bearing a disproportionate burden of work load against diminishing resources. GPs are the front door of the NHS. They provide first contact care to more than 1.2 million patients per day. They are always expected to adapt to the changing needs of the patient population and the mantra 'GPs are well placed to...' is repeated following any special interest patient group wanting better services. GPs are interchangeably seen as both the scapegoats and the saviours of the NHS, when all they want to be is good doctors.

Across the NHS, GPs are operating under significant workload pressures and with decreasing resources, including time and people. Workload has increased 16% over the past seven years.<sup>26</sup> The University of Manchester has been surveying the wellbeing of GPs for a number of years and the ninth national report has recently been published (2017).<sup>27, 28</sup> According to this survey, 90% of GPs felt they were drowning in their work and finding it hard to deal with its complexity in the time allocated. The survey also found that the number of GPs who say they are likely to quit direct patient care within five years rose from 35% in 2015 to 39% in 2017. There are many other reports of increasing dissatisfaction, distress, anxiety and suicidal thoughts. One study involved in-depth interviews of 47 GPs with mental illness about barriers and facilitators to their help-seeking for mental ill health and/or chronic stress.<sup>29</sup> Workload barriers included guilt-induced 'presenteeism', internalised and perceived stigma, and concerns about privacy and confidentiality. Distressed GPs often found it difficult to overcome their feelings of inertia or do not always acknowledge their own illness to themselves. GPs often reach crisis point before being spurred (or encouraged) to seek help.

## Causes of GP distress

We have begun to look at some common factors which are causing distress amongst GPs and we have grouped them in different aetiological areas. These are our own (PHS) descriptions but are easily recognisable by many of the doctors coming to seek help from us.

Approximately 25% of all GPs presenting to PHS are in each group.

<sup>26</sup> Hobbs F, Bankhead C, Mukhtar T, Stevens S, Perera-Salazar R, Holt T et al. Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14. *The Lancet*. 2016;387(10035):2323-2330.

<sup>27</sup> <http://blogs.lshtm.ac.uk/prucomm/files/2018/05/Ninth-National-GP-Worklife-Survey.pdf>

<sup>28</sup> <https://www.manchester.ac.uk/discover/news/numbers-of-gps-who-want-out-within-5-years-at-all-time-high-finds-survey/>

<sup>29</sup> Spiers J, Buszewicz M, Chew-Graham C, Gerada C, Kessler D, Leggett N et al. Barriers, facilitators, and survival strategies for GPs seeking treatment for distress: a qualitative study. *British Journal of General Practice*. 2017;67(663):e700-e708.

## Practice meltdown



### *These doctors often present with depression.*

This is usually where a practice has lost one or two partners, most likely through early retirement. One or two doctors might be away from work, perhaps through maternity leave or sick leave. Given the difficulty in recruiting doctors, this leaves the remaining doctors having to carry the workload of their absent colleagues. The practice usually has to rely on locums which adds to the burden of work as patients often book to consult with 'their usual' doctor, even having had a perfectly reasonable consultation with the locum. The workload builds up and costs begin to spiral out of control as more locums are needed to clear the backlog. The remaining doctors work harder and harder, staying later and coming in over the weekend just to stay afloat. Eventually, of course, this becomes impossible to sustain, and the GP feels guilty, hopeless and helpless. Inevitably this takes a toll on their mental health, with low mood, poor sleep and poor concentration worsening their ability to function. Unless some action is taken, including taking time out, the GP might make an error, behave inappropriately at work, drink alcohol, self-prescribe medication, or even feel so guilty as to attempt suicide.

*Continuing care after discharge has helped through tricky times and is currently, I feel, a success*

## Too Much Too Soon



### *These doctors often present with anxiety or panic disorder.*

Typically, this doctor is a newly-qualified general practitioner fresh out of vocational training who moves into doing locum work. They move, therefore, from the well protected training environment to the cut and thrust of locum work. Locums are used to cover gaps in surgeries and are often given the hardest shifts or triage clinics. They are expected to work hard and to help out with home visits, extras and administrative work. They rarely know the practice or patients. They work in isolation and can spend the whole session not meeting any other clinician. They tend to be unsupported and pass through practices with little acknowledgment of the hard work they do.

Being a locum doctor is by definition a difficult job. GPs carry risk but minimise this by reviewing the patients as often and as soon as needed. This is not possible for locums and they have to carry the risk and uncertainty of their decisions home at the end of the day. Newly qualified GPs have yet to gain the confidence to carry this risk and, ironically, they have put themselves into the riskiest place they could possibly work. These doctors typically become more and more anxious about the decisions they make. They might return to the practice (if they can) to check on the outcome of the patient. They might over-refer and over-investigate and still not reduce their anxiety. Far from enjoying their work, they begin to dread going to work, develop anticipatory anxiety and sometimes even panic attacks on their way to work.

## The Straw Which Breaks the Camel's Back



*These doctors often present with burnout or depression.*

This GP often has been just about functioning – working hard just to stand still. They may have been coming in early and leaving late, but basically completing the work that needs to be done. This doctor and usually the practice team have no room to absorb any extra work or extra stress. Typically, an additional stress (e.g. an extra home visit, or preparing for a care quality commission visit or a complaint) pushes the GP over the edge.

## From Sad to Bad



*These doctors often present with a complaint which has led to a mental illness.*

The GP might have never had any performance issues in the past. However, a depressive illness might lead to erratic or behaviour change with patients or staff, perhaps shouting at a member of staff or colleague or being rude to a patient. This may lead to a complaint which in turn worsens any underlying mental ill health.

Over the years we have had doctors who have shoplifted, thrown objects at colleagues, shouted at patients and, in some extreme cases, crossed professional boundaries, all when the doctor is depressed.

## Psychiatrists

Over the years, 334 psychiatrists have attended PHS; 154 (46%) have been men and 180 (54%) have been women. As with all specialities there was a drop in age over the years. For psychiatrists this was from 50 years (2008/09) to 39 years (2017/2018). At presentation, 75% were working.



The vast majority (89%) of the psychiatrists coming to the service have problems with mental illness (common and complex); 8% have had addiction issues and 2% have had problems with their physical health or other issues.


Psychiatrists have the highest percentage of any speciality presenting with complex mental health problems compared to the average (24% vs 13%).

Psychiatrists, as with general practitioners, have significant problems in obtaining confidential help within mainstream health services, especially so where they might live and work in the same area as the treating clinician (which is not unusual). This acts as barrier for them seeking care. At PHS we have seen psychiatrists who have been inadvertently referred by their GP to themselves or to their own team. With large mental health Trusts, it is almost impossible for a psychiatrist, who lives and works in the same geographical area to obtain care not delivered by a colleague. This will of course mean that the doctor might be reluctant to attend for care or disclose very personal information.

Psychiatrists are a particularly high-risk group, as evidenced by the high numbers with complex mental health problems. A number of reports show that psychiatrists have higher rates of mental illness than other doctors.<sup>30</sup> Long-term studies in the UK also suggest that psychiatrists as a group suffer from high levels of stress, and the

highest levels of job dissatisfaction and depression. The higher levels of depression are mirrored by high levels of suicide. There are some obvious reasons for this. Those who go into the mental health field (counsellors, psychiatrists, psychotherapists) are more likely to have a history of mental health problems themselves – many enter this area in order to understand their own difficulties or in the hope of repairing past traumas. Such close contact with distress places a significant emotional toll on psychiatrists.

Their work tends to be quite isolated and there may be threats of violence. Whilst blame seems to be inherent in the whole health system, for psychiatrists this is particularly acute as they are blamed when a patient with mental illness takes their own life or kills or harms another. Government policy means that psychiatrists have to undertake a very difficult, if not impossible, task of assigning a risk ahead of any discharge. The stigma attached to mental illness is not an abstract issue for psychiatrists. They see their own patients exposed to it on a daily basis. When mentally unwell themselves, they are also the recipients of stigma from their colleagues, and in our experience, psychiatrists are often reprimanded for not identifying their own mood disturbance before it became so severe as to cause problems at work. Psychiatrists also practice self-stigmatisation, with a deep-rooted sense of shame and guilt. As experts in mental health, they are expected not only to identify their own illness but also to 'get on and treat it'.



*Fast access to help.  
Excellent confidential  
nature of service.  
Invaluable*

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<sup>30</sup> Firth-Cozens J. Improving the health of psychiatrists. *Advances in Psychiatric Treatment*. 2007;13(3):161-168.

## Surgical specialties



Over the decade we have seen 143 surgeons at PHS. Unlike most other specialities, more men than women have presented (59% vs 41%). The average age at presentation has dropped from 53 years (2008/2009) to 38 years (2017/2018). Across the years 90% of all surgeons fell into the mental health category (68% common, 22% complex); 9% presented with addiction problems. At presentation, 72% were working.

Outside studies point to a pattern similar to the findings regarding surgeons presenting to PHS – principally high rates of burnout, anxiety and depression and low levels of addiction.<sup>31, 32</sup>

Surgeons tend to have lower rates of reported mental illness than other specialties, and this is certainly the case in PHS. Surgeons' lower rates of presentation could be due to their having protective factors for developing mental illness (e.g. better resilience to cope with occupational stress). There might be some validity in this, as those who cannot cope with the pressure and competitiveness of a surgical career may well fall along the way, leaving only the fittest to survive. Surgeons might be protected by their close working relationships with others, allowing for sharing of distress, successes and general support.

So perhaps surgeons genuinely have a lower rate of mental illness than other doctors. However, an alternative explanation is that surgeons are a hidden group within medicine, with even greater reluctance to seek help. There is some evidence for this. Different surveys show high levels of suicidal ideation (especially in older surgeons), significant levels of distress, anxiety and/or burnout.<sup>33, 34</sup> These studies suggest that surgeons presenting with mental health problems are a hidden minority within a hidden minority.

<sup>31</sup> Shanafelt T, Balch C, Dyrbye L. Special Report: suicidal ideation among American surgeons. *Archives of Surgery*. 2011;146(1):54.

<sup>32</sup> Balch C, Freischlag J, Shanafelt T. Stress and Burnout Among Surgeons. *Archives of Surgery*. 2009;144(4):371.


<sup>33</sup> Benson S, Truskett P, Findlay B. The relationship between burnout and emotional intelligence in Australian surgeons and surgical trainees. *ANZ Journal of Surgery*. 2007;77(s1):A79-A79.

<sup>34</sup> Sharma A, Sharp D, Walker L, Monson J. Stress and burnout in colorectal and vascular surgical consultants working in the UK National Health Service. *Psycho-Oncology*. 2008;17(6):570-576.

It is hardly surprising that surgeons would suffer from mental illness, given the long, unpredictable hours and high-stress work they undertake. Doctors have their own unwritten group norms, developed over generations, and for surgeons these include: coming in early; working late; working nights and weekends, sometimes even when not rostered to do so; meeting multiple deadlines; never complaining; and finally keeping emotions or personal problems away from the workspace. These group norms might make it harder for surgeons to present for care compared to other medical specialties. For example, stigma associated with mental illness might prevent surgeons from admitting that they are anything other than tough and resilient. It may be that surgeons are more at risk. Their personality traits such as commitment, self-sacrifice and perfectionism mean that they are likely to go that extra mile, do that extra shift, work harder. Even when off duty, their minds will be full of the residual stress of the day's events; they will ruminate over the difficult operation or worry about the patient in intensive care.

There are other contributing factors in the development of mental illness amongst surgeons. Patients are at their most vulnerable when they see a surgeon, whether unconscious on the operating table or lying on their hospital bed waiting for reassurances, pre or post-operative. Patients trust surgeons, totally. They relinquish all authority and power to the doctor. They become helpless. The surgeon's job requires that they constantly contain others' fears of death. This places a heavy toll on the individual doctor.

Despite these risk factors most surgeons enjoy their job and thrive. This is especially the case in an environment which fosters professional development and provides support, where the doctor is appreciated by their patients and where they feel they are achieving good work. What we must ensure though is that surgeons are able to access confidential support services when they require them.



*A containing  
and supportive  
atmosphere*



## Anaesthetists



Over the 10 years, 212 anaesthetists have presented to PHS; 51% have been female and 49% male. The average age has dropped from 49 years (2008/09) to 37 years (2017/2018). At presentation, 72% were at work. Across all speciality groups, anaesthetists and emergency doctors have the highest percentage presenting with addiction (anaesthetists and emergency doctors have similar issues).

Around 20% of all anaesthetists present with addiction compared to an average across all specialties of 10.5%. Given the higher rate of drug use amongst anaesthetists, it is perhaps not surprising that as a group they have the highest percentage of doctors involved with the regulator (17%).

The anaesthetist Ruth Mayall and other researchers have reviewed the area of substance abuse in anaesthetists, including the interaction with work and the regulator.<sup>35</sup> Whilst up to 10-14% of all doctors will become addicted to drugs and/or alcohol over their life time, the incidence in anaesthetists is greater. Including alcohol, between 0.86% and 2% of anaesthetic trainees and 1.3% of consultants are reported to be addicted; if alcohol is excluded, drug addiction occurs in 1.6% of trainees and 1% of non-training grades.<sup>36, 37, 38</sup> The risk of drug-related death is higher in anaesthetists than all other specialties, peaking in the first five years after medical school graduation.<sup>39</sup> Death is unfortunately not infrequently the first sign of addiction or the presentation of relapse. The increased risk of addiction is due to a number of factors, of which the most important is the close contact with, and ability to use, potent medicines.

<sup>35</sup> Mayall R. Substance abuse in anaesthetists. *BJA Education*. 2016;16(7):236-241.

<sup>36</sup> Booth J, Grossman D, Moore J, Lineberger C, Reynolds J, Reves J et al. Substance Abuse Among Physicians: A Survey of Academic Anesthesiology Programs. *Anesthesia & Analgesia*. 2002;95(4):1024-1030.

<sup>37</sup> Skipper G, Campbell M, DuPont R. Anesthesiologists with Substance Use Disorders: A 5-Year Outcome Study from 16 State Physician Health Programs. *Anesthesia & Analgesia*. 2009;109(3):891-896.

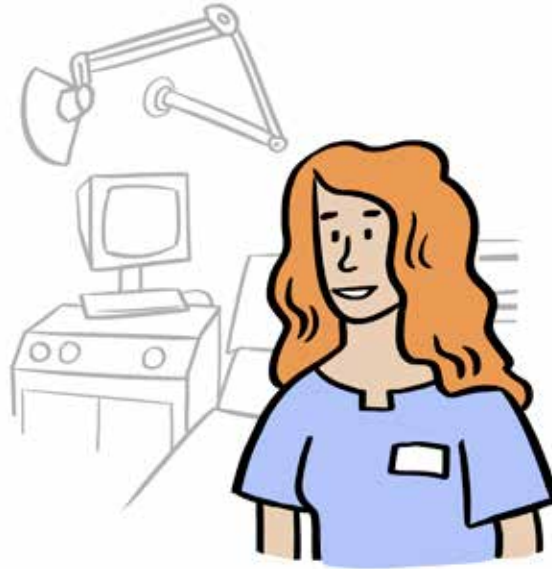
<sup>38</sup> Bryson E. Should anesthesia residents with a history of substance abuse be allowed to continue training in clinical anesthesia? The results of a survey of anesthesia residency program directors. *Journal of Clinical Anesthesia*. 2009;21(7):508-513.

<sup>39</sup> Oreskovich M, Caldeiro R. Anesthesiologists Recovering From Chemical Dependency: Can They Safely Return to the Operating Room? *Mayo Clinic Proceedings*. 2009;84(7):576-580.

### Anaesthetists: headlines

- Low users of mental health services compared to other medical practitioners
- High rates of addiction compared to other medical practitioners
- Consultant grades have high rates of alcohol compared to non-consultant grades
- Trainees have high rates of drug use compared to non-trainee grades
- Death amongst anaesthetists (either accidental or suicide) is higher compared to other medical practitioners.

## Obstetrics and Gynaecology (O&G)

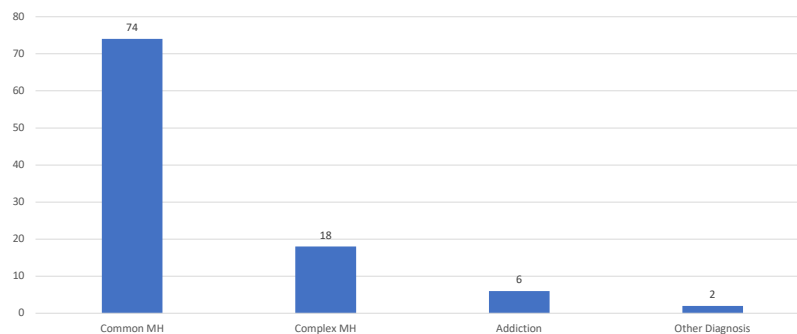


Over the ten years, 83 obstetricians and gynaecologists have presented for care. This specialty had one of the highest percentage of women presenting for care (78% female vs 22% male).

As with other specialties, the average age dropped over the years, from 64 years (2008/2009) to 32 years old (2017/2018). Nearly two thirds of all O&G doctors are under 39 years old; nearly 70% of all the group were trainees.

Almost all O & G practitioner-patients (92%) presented with mental health issues and only 6% with an addiction issue.

O&G: Mental Health Category (%)



At presentation, 33% of O&G were not at work, the highest percentage of all the groups.

Whilst the numbers of O&G doctors presenting to PHS appears to be low (around 1.7% of the total), studies suggest that there are high levels of burnout, depression and other forms of mental illness in this group.<sup>40</sup> This may be related to the 'high stakes' nature of the work and the high propensity for medicolegal issues to surface when things go wrong.

However, we believe that lower levels of presentation at PHS compared to other specialities might actually be due to inherent protective factors found within this specialty.

These might be:<sup>41</sup>

- O&G is a speciality which allows a mixture of medical (including primary care), psychological and surgical skills.
- O&G is a team activity – often practitioners work side by side with other practitioners from different specialties.
- O&G practitioners, perhaps more than any other specialty, really do change the lives of their patients and are by their side at the most significant and momentous moments of a woman's life, across all ages.
- O&G is a specialty which has in-built 'victories' – delivering healthy babies. This provides constant positive reinforcement.

## Paediatricians



Over the decade, 201 paediatricians have presented for care; this represents around five per cent of referrals to PHS. Paediatricians attending PHS are more likely to be younger (their average age drops from 53 (2009) to 34 (2018)) and female (76%). Given the young age of paediatricians, it is hardly surprising that a large percentage of them were still in training (more so than any other group) – 70% of paediatricians have been trainees. At presentation, 79% were working.

The vast majority of these doctors have mental illness and only a very small number of paediatricians have presented with addiction. Paediatricians have the lowest percentage of addiction problems of all specialties.

<sup>40</sup> Smith R. Burnout in Obstetricians and Gynecologists. *Obstetrics and Gynecology Clinics of North America*. 2017;44(2):297-310.

<sup>41</sup> Gibson H. Why Obs and Gynae? by Harry Gibson [Internet]. Royal College of Obstetricians & Gynaecologists. 2018 [cited 28 August 2018]. Available from: <https://www.rcog.org.uk/en/careers-training/considering-a-career-in-og/why-choose-og/harry-gibson>

With respect to regulator involvement, only 14 paediatricians had any regulatory involvement over the decade. This was also the lowest of all the specialty groups. Why this might be is difficult to fully understand, it may be that paediatricians have better systems in place to identify poor performance or where performance is beginning to impact on work. It might also be that those who go into paediatrics are more willing to follow rules, guidelines, and policies than other professional groups.

There might be many reasons why paediatricians are becoming more mentally unwell. For example, notable cases such as the inquiry in 2009 into the death of 'Baby P' (a young child who died following repeated assault by its parents, the signs of which were reported to have been missed by social services and doctors) and more recently, in 2018, the Dr Bawa-Garba court case (Dr Bawa-Garba was a paediatrician convicted of gross negligent manslaughter and given a suspended sentence) highlight pressures within the speciality and the negative exposure paediatricians face. PHS sees the knock-on effect of this on the numbers presenting for care. As such, the number of paediatricians presenting to PHS appears to be an over-representation compared to other specialties. Paediatrics has always been a tough but rewarding job but has become more difficult in recent years. The increasing workforce pressures and rota gaps have had a negative impact on both morale and recruitment. There is now a more insidious and growing problem having a more corrosive impact on the wellbeing of clinicians working in the specialty. Conflict within paediatrics appears to be happening more and more, as increasing number of cases are managed outside the hospital ward – in the court rooms and/or social media. The impact of this on the doctor is increasing self-doubt, fear, spiralling anxiety and depression. Charlie Gard and Alfie Evans were both babies with severe and untreatable genetic disorders whose last months of life were played out in the full glare of the public eye and decided in the High Courts. Paediatricians' professionalism was doubted by a small minority of the public, whose voices were magnified through the pervasive power of social media. This appears to have had a detrimental effect on the mood of paediatricians who felt vilified when all they were concerned about was the wellbeing of the children concerned.

In addition, other factors which might be leading to increasing mental health problems amongst paediatricians are that paediatric wards are no longer filled with patients who bounce back to health within 24 hours; instead, many beds are occupied by longer-stay patients who have acute and chronic illnesses. Paediatricians have to deal with chronic complex illness in children, as well as tired and stressed parents. The fragmented health, education and social care systems often fail to serve these children well, through a combination of: inadequate resources; difficulty managing complexity and uncertainty; and a mismatch between expectations and what is deliverable. As a result, the parents of these children are often angry, distressed, exhausted and resentful. Paediatricians may take the brunt of this anger and disappointment and have an almost impossible task of appearing emotionally neutral in areas of incredibly highly expressed emotions.

Neonatologists and intensive care specialists form a significant subgroup of the paediatricians attending PHS. This should not be surprising, since these doctors

are perhaps the most exposed to the changes seen in children's medicine over the last decade.<sup>42</sup> They carry the hope of parents, desperately wanting their children to survive. They become the lightning rod for a hospital's fear of death, the container of hope against all odds, and the focus of distress when medicine fails. It is hardly surprising therefore that many paediatricians are feeling beleaguered, de-professionalised and confused as to their role.

## Dentists



*I began working in general dental practice in 1998. In 2002 I attempted suicide. I quit my practice and it would be three years before I found my way back into part-time clinical work. I spent several years attempting to self-manage my depression, but I continued to get regular and deep episodes. Finally, in 2015, my depression interfered significantly with my work and my manager told me I needed to see a GP. The GP I saw was very supportive. As well as prescribing medication, he recommended PHS. One of the team patiently listened to me, discussed options PHS could offer as help and ultimately organised for me to see a therapist for CBT as well as seeing me regularly himself. I remember the huge sense of relief that there were others supporting me. Independently, I began using online guided mindfulness sessions. I am aware of how depression can suddenly take me by surprise, but the last 12 months have been some of the psychologically calmest of my adult life.*

**A dentist with depression. Adapted from PHP website.**

We have found it hard to reach dentists and have had only 108 dental practitioners presenting for care. The percentage at the start of PHS (2008/9) was around 11% and now, after ten years averages at around just 3%. Their average age in 2008 was 61 years, while in 2018 it has fallen to 42 years. At presentation, 75% of the dental practitioners were working.

<sup>42</sup> Fields A, Cuerdon T, Brasseux C, Getson P, Thompson A, Orlowski J et al. Physician burnout in pediatric critical care medicine. *Critical Care Medicine*. 1995;23(8):1425-1429.

Dentists have higher rates of substance misuse than most specialties, often related to their easy access to drugs. They are also more likely to suffer from stress-related problems than the general population. As with the medical profession, dentists have a higher suicide rate than the general population (twice the rate). Emotional illnesses (anxiety, depression) are the third most frequent health problems suffered by dentists, while they are the tenth most frequent in the general population.

The reasons why dentists have such high rates of mental illness are thought to be due to: (adapted from *Stress in Dentistry: It Could Kill You!*)<sup>43</sup>

- a. **Confinement:** the average dentist spends most of their working life confined to a small, sometimes windowless room. Their work is intricate and meticulous and is performed in a small, restricted oral space. The procedures are physically, and mentally taxing and back troubles and fatigue are common as a result.
- b. **Isolation:** most dentists practice alone. Consequently, they do not have the opportunity to share and solve problems with their colleagues the way other professional groups do through peer support.
- c. **Competition:** dentists tend to be competitive with one another.
- d. **Perfectionism:** as with doctors, perfectionism is instilled in dental school. However, dentistry is an imperfect science and even the most perfect restoration will ultimately be rendered imperfect by time and patient neglect, despite the efforts of the dentist.
- e. **Economic pressure:** due to high costs of training and establishing a practice. Another result of the economic pressure of practice is that dentists often feel that they literally cannot afford to be sick or take holidays. When a dentist is absent from the office, the income totally stops, but the high overhead expenses continue to grow relentlessly.
- f. **Time pressures:** that is, never having enough time to carry out the work required and always seeming to be running late.
- g. **Compromising treatment due to financial constraints:** a dentist spends their training learning perfection and 'ideal' treatment for his or her future patients. Yet the realities of private practice or the NHS are that many patients, due to financial restraints, do not have 'ideal' treatment plans. The result is that the dentist is continually forced to compromise treatment and is frustrated in not being able to reach his or her ideal treatment goals.

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<sup>43</sup> Lang R. *Stress In Dentistry - It Could Kill You!* - Oral Health Group [Internet]. Oral Health Group. 2007. Available from: <https://www.oralhealthgroup.com/features/stress-in-dentistry-it-could-kill-you/>

- h. Personality: as with medical doctors, the personality traits that characterise a good dentist are also traits that predispose to depression in mid-life, drug and alcohol abuse and the attendant risk of suicide. Among such traits are:
- compulsive attention to details;
  - extreme conscientiousness;
  - careful control of emotions;
  - unrealistic expectations of self and others (i.e. employees and patients);
  - a marked dependence on individual performance and prestige.
- i. Patient anxiety: the psychological stress of working with apprehensive and fearful patients can be very difficult. There is evidence that dentists experience patterns of physiological stress responses (increased heart rate, high blood pressure, sweating, etc.) that parallel the patient's responses when performing dental procedures that evoke patient fear and anxiety. This in turn can lead to an early heart attack for the dentist.
- j. Lack of exercise.

## Trainees and the Trainee Doctors and Dentists Support Service

As can be seen from our data, we have a high percentage of doctors who are in training. To try and prevent mental illness amongst trainees we have been specifically commissioned to provide wellbeing and prevention services to trainees in London and the South East area. The Trainee Doctors and Dentist Service (TDDSS) is not a treatment service per se, and rather a service which is able to signpost trainees to the most appropriate services. It can offer up to four sessions of individual face-to-face support and signposting to a range of support services including online CBT, mindfulness and the other groups offered by PHS.

Over the first 14 months of this service, 297 junior doctors and a much smaller number of dentists have self-referred, of whom 61 doctors were unwell enough to be on sick leave and five were suspended or unemployed. The majority of self-referrals were for anxiety, low mood and stress-related problems, often related to workplace stress and difficult working conditions such as understaffing, difficult rotas, long working hours and lack of senior support. Approximately half of these doctors when fully assessed were found to be mentally unwell to the extent of needing medication and/or behaviour treatment for conditions including depression and addictions. These doctors were signposted to the PHS main service or to their own GP and local services. Others reflected the wide variety of distress found across the service including relationship difficulties, adjustment problems and employment issues.



*Very thorough;  
excellent  
support; superb  
management*

## International medical graduates (IMGs)

This report has already touched on the issue of international medical graduates when we discussed risk-rating issues. In our experience IMGs have additional needs compared to other doctors who have presented to our service.

*Dr Aziz, aged 45, presented to PHS. He had been suspended by the GMC for several months. Originally from Egypt, he had lived in England for seven years, leaving a post as a surgeon during a period of civil unrest. He described himself as a high flyer, having passed near the top of his year and secured good jobs. To come to England, he had left his family – two small sons and his wife. He hoped that they would be able to follow him once he was settled. They never did.*

*After passing his Professional and Linguistic Assessments Board (PLAB) exams he got an unpaid clinical fellow post. He struggled financially but borrowed from his relatives. He eventually joined a locum agency and started working in a number of posts, mainly in accident and emergency, but also in junior posts in different surgical specialties. In a 12-week period he recalled working in 17 different hospitals across England and Wales. When not provided with accommodation, he would book a bed and breakfast but mostly he slept where he could in the hospital he was working in.*

*Though he didn't notice at the time, in retrospect he became increasingly tired and found that the more he moved around, the more tired and demoralised he became. After 18 months of working in this way, he secured a six-month locum post (the longest continuous employment since arriving the UK). Even before starting, he found it difficult to sleep, even when off duty. He noticed his appetite decrease and he lost weight. Halfway through a night shift he was challenged by a nurse about his management of an elderly patient. He disagreed, saying that what he was suggesting in terms of management was correct. The nurse shouted at him, telling him he was patronising. He felt tearful but walked away.*

*Over the next few weeks Dr Aziz lost interest in most things. When not working he would just stay in his bedsit and cry. He often wished he were dead. He began to think that people at work were talking about him and he noticed them staring. This was especially the case with the nurses. One day when waiting for a patient to return from X-ray he told a nurse to stop blaming him for things that were nothing to do with him. He shouted and told the nurse that she was spying on him and trying to wreck his life. The next day he was called in to see the Clinical Director who informed him that they were concerned about his behaviour and referring him to the GMC. Dr Aziz didn't quite know what this meant but realised that he was in trouble. He had not given any forwarding address when he started this locum post and therefore missed all the correspondence from the GMC. When he eventually returned to his bedsit in London he opened a letter from the GMC to say that as he had not been communicating with them he was suspended and would*

**From a London-based team of three in 2008, over the last decade we have grown to a network of over 300 clinicians, special advisors, clinical leads, therapists and operational staff.**



*be informed of the date for the Fitness to Practise Hearing. That night Dr Aziz tried to kill himself by taking an overdose of aspirin and alcohol. He failed in this endeavour and instead rang one of the numbers provided by the GMC in their correspondence. This was how he made contact with PHS.*

As with Dr Aziz, doctors who have undertaken medical training overseas are at particular risk. International medical graduates (IMGs) represent a mosaic of different races, cultures and ethnicity and discussing them under one heading might overly simplify their issues. Nevertheless, collectively they do have a set of unique problems which are illustrated in the case of Dr Aziz, a composite patient.

This case scenario illustrates the multiple difficulties faced by our overseas colleagues. They are often isolated and less integrated with their peers, both on a professional or personal level. They have additional problems of having to work as locums in multiple specialty areas and roles without a support structure. Not all locum agencies offer the same level of support, including appraisal or a responsible officer (necessary for revalidation), and as such these doctors might have to pay for an appraisal or have a complex route (involving an examination) to revalidation.

IMGs have additional burdens. These doctors may come from cultures where mental illness is such a stigma as not to be recognised and instead 'disguised' or sublimated into a physical health (somatic) disorder. There may be cultural barriers to taking antidepressants and receiving other treatments for psychological disorders. Some may fear that if they admit to having a mental illness that their license to practice will be removed and at worst they might face deportation, along with their families.

PHS is seeing increasing numbers of IMGs presenting to the service, up from 5% in 2014 to 10% in 2017. IMG doctors attending PHS are more likely than non-IMG doctors to be involved in regulatory or disciplinary processes, usually following a performance issue at work. For many involved in regulatory processes, it appears that the 'performance issue' or complaint which led to a referral was in fact preceded by a clear history of undiagnosed (or unrecognised) mental health problems, such as depression or anxiety, which contributed to problems in the workplace. IMGs attending PHS are more likely to have a diagnosis of depression or anxiety and less likely to have problems associated with addiction than non-IMG patients.

Current support for IMGs is patchy and often ad hoc across the country, usually only available at the outset of their registration. As new IMGs are less likely to become employed through training programmes or gain longer-term placements, they are not usually eligible for or cannot access existing support services or programmes run by hospital Trusts or Royal Colleges. All of this contributes to their sense of isolation and to the risk of mental illness.

# PART SIX:

## outcomes of care at PHS

Over the ten years we have used different measures to determine the level of distress our patients present with and whether they improve after treatment.

Overall, all instruments used have shown that patients presenting to PHS:

- Have high levels of psychological distress;
- Have significant impairment in work and social functioning;
- Significantly improve following treatment at PHS.

Overall, the results show significant reductions in levels of depression and anxiety and improvements in wellbeing across the range of measures.

### Patient wellbeing questionnaires

At the start of the service we introduced a number of simple self-report questionnaires.

These include: Psychlops,<sup>44</sup> Warwick-Edinburgh Mental Wellbeing scale,<sup>45</sup> Perceived Stress scale,<sup>46</sup> PHQ-9<sup>47</sup> and GAD-7.<sup>48</sup>

### Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM)

(to measure the severity of distress). This is a general measure of distress measured on four sub-scales – wellbeing, psychological problems (such as anxiety and depression), functioning (both general and social) and risk (both to the self and others).

Higher scores indicate higher levels of distress. Patients are considered to be a clinical case if they score an average of 1.19 per question (men) or 1.29 per question (women).

<sup>44</sup> Psychlops [Internet]. Psychlops.org.uk. 2018. Available from: <http://www.psychlops.org.uk/>

<sup>45</sup> Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) [Internet]. Warwick.ac.uk. 2015. Available from: <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/>

<sup>46</sup> Cohen S, Kamarck T, Mermelstein R. A Global Measure of Perceived Stress. *Journal of Health and Social Behavior*. 1983;24(4):385.

<sup>47</sup> Kroenke K, Spitzer R, Williams J. The PHQ-9. *Journal of General Internal Medicine*. 2001;16(9):606-613.

<sup>48</sup> Spitzer R, Kroenke K, Williams J, Löwe B. A Brief Measure for Assessing Generalized Anxiety Disorder. *Archives of Internal Medicine*. 2006;166(10):1092.

**Work and social adjustment scale** (to assess ability to participate in everyday life). This is a measure of impairment in everyday functioning. Patients respond to five questions about different aspects of impairment (such as ability to work and ability to maintain relationships) by selecting a number between 0 and 8, with higher scores indicating a higher level of impairment.

**Global improvement and satisfaction self-rating scale.** This is used at follow up.

**Work questionnaire.** In order to monitor the working status of practitioner-patients, participants were asked to complete a short questionnaire created by the researchers, asking about: their current working status; their reason for not working or date of return to work (if applicable); and whether they have had any GMC or GDC involvement.

The full set of questionnaires were used to evaluate at PHS. The first 200 patients were the subject of a PhD study<sup>49</sup> and patients were asked to complete them at registration, and again at 8-week and 26-week follow-ups. At presentation, PHS patients scored higher than the non-clinical group on every sub-scale, indicating higher levels of distress than the general population.

Over all, patients showed less distress and less impairment of work and social functioning over time. At the 26-week follow-up, scores were significantly improved on every sub-scale of the CORE-OM as well as the work and social adjustment scale.

As a result of discussions with our PHS research network we introduced (from December 2017) a new baseline set of five validated mental health questionnaires:

- PSYCHLOPS
- Warwick–Edinburgh Mental Well-being Scale (WEMWBS)
- Perceived Stress Scale (PSS)
- Patient Health Questionnaire-9 (PHQ9)
- Generalised Anxiety Disorder-7 (GAD7)

All practitioner-patients are asked to complete these questionnaires at registration and to fill them in again six months later.

### **PSYCHLOPS ('Psychological Outcome Profiles')**

With the onset of the new GPH service, PHS begun to use (we believe for the first time with this patient group) the 'Psychological Outcome Profiles questionnaire, PSYCHLOPS.

By way of background, PSYCHLOPS is a recently developed, individualised, patient-generated, psychometric instrument which can be used as an outcome measure.

PSYCHLOPS is designed to measure change following a therapeutic intervention. It seeks to ask from the patient's perspective about psychological distress and is

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<sup>49</sup> Brooks S, Gerada C, Chalder T. Doctors and dentists with mental ill health and addictions: Outcomes of treatment from the Practitioner Health Programme. *Journal of Mental Health*. 2013;22(3):237-245.

intended to capture items of greatest personal significance rather than imposing an external frame of reference to interpret psychological distress.

- PSYCHLOPS promotes a patient-centred definition of therapy outcome. It is patient-generated and can be self-completed.
- PSYCHLOPS has questions on problems, function and wellbeing.
- Patients are asked to describe their main problem (or problems) and how this affects them (function). Responses to all free text questions are scored.
- PSYCHLOPS may be used as a means of setting a focus for therapy from the outset.
- PSYCHLOPS is not intended as a diagnostic instrument; it is a highly sensitive measure of change during the course of psychotherapeutic interventions.
- PSYCHLOPS captures data before, during and after a course of therapy. Change can be measured throughout the process of therapy, whether or not therapy is completed.

The most distinctive feature of PSYCHLOPS is its high sensitivity to change. Sensitivity to change is quantified using the 'Effect Size'. Effect Size values greater than 0.8 are generally considered large in health service research.<sup>50</sup>

**The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)** was developed to allow the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.

WEMWBS is a 14-item scale with five response categories, summed to provide a single score ranging from 14-70. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing. Mean scores for the general population are generally around 51 in the UK.

People with a WEMWBS score of  $\leq 40$  could be at high risk of major depression and should be advised to seek help. Those with scores between 41 and 45 should be considered in high risk of psychological distress and increased risk of depression.

**The Perceived Stress Scale** was developed to measure the degree to which situations in one's life are perceived as stressful. The PSS was developed in 1983 and has become one of the most widely used psychological instruments for measuring nonspecific perceived stress.

**Patient Health Questionnaire-9 (PHQ-9)** and **Generalized Anxiety Disorder Assessment-7 (GAD-7)** are the national standard measures routinely used by GPs, therapists and psychiatrists as screening tools. PHQ-9 (is a measurement for depression and the GAD-7 is a measurement for generalised anxiety disorder.

The Effect Size for all instruments is  $>0.80$ .

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<sup>50</sup> Kazis L, Anderson J, Meenan R. Effect Sizes for Interpreting Changes in Health Status. Medical Care. 1989;27(Supplement):S178-S189.

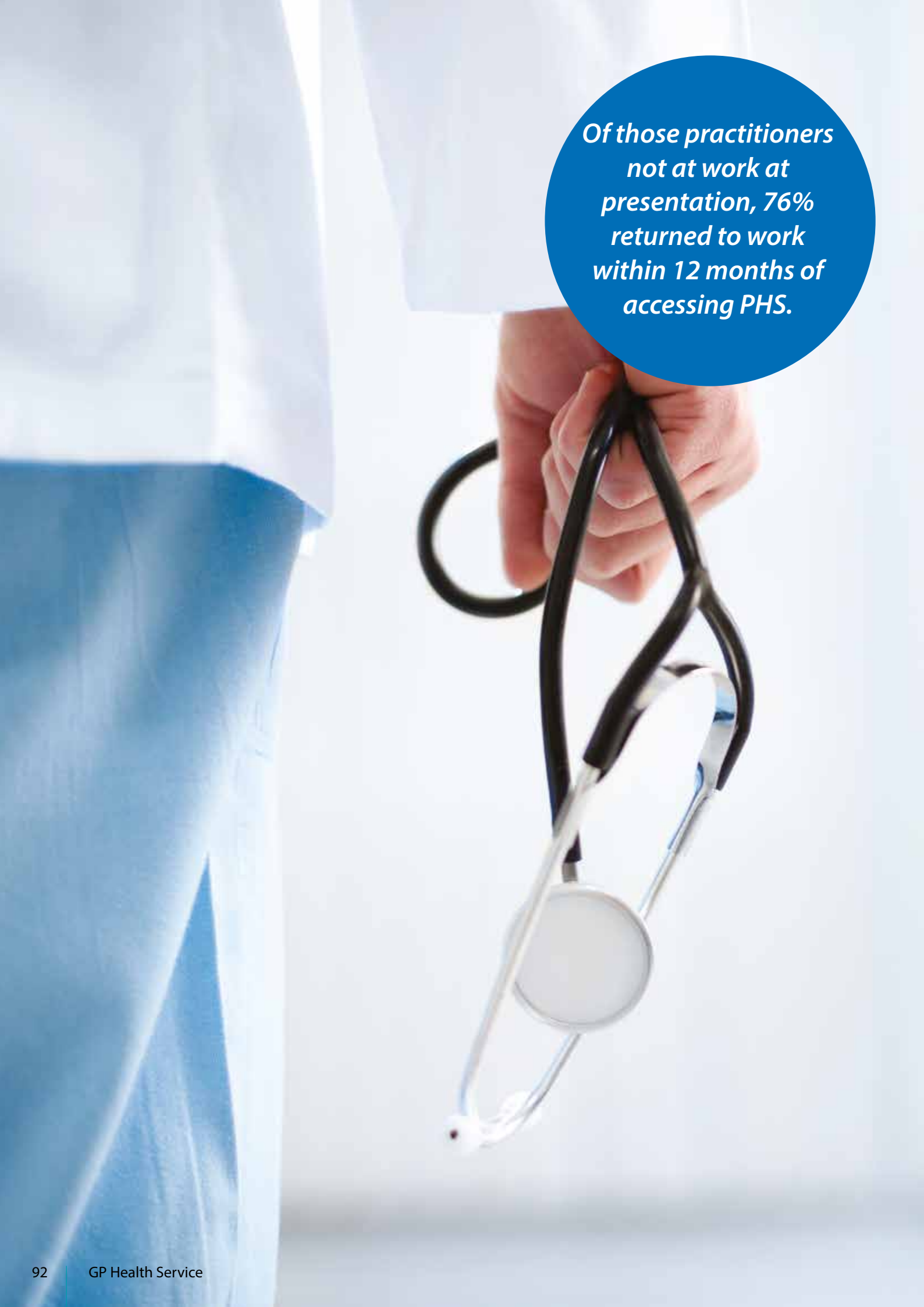
## Outcome from patients using PHS based on five psychometric instruments

The baseline scores and changes in scores during the six months for those patients who completed questionnaires from December 2017 to June 2018 are summarised below.

Instrument	Effect Size	95% confidence intervals
WEMWBS	1.34	0.82, 1.87
PSS	1.71	1.07, 2.35
PHQ9	1.16	0.68, 1.64
GAD7	1.40	0.82, 1.97
PSYCHLOPS	2.37	0.82, 3.13

Based on these findings, all five psychometric instruments demonstrated significant improvement following treatment with PHS, and the patient-generated instrument (PSYCHLOPS) showed a much larger Effect Size (improvement scores) than the other standardised instruments.

*The admin team is wonderful – helpful, professional, pleasant on the phone. They get things moving*



*Of those practitioners  
not at work at  
presentation, 76%  
returned to work  
within 12 months of  
accessing PHS.*

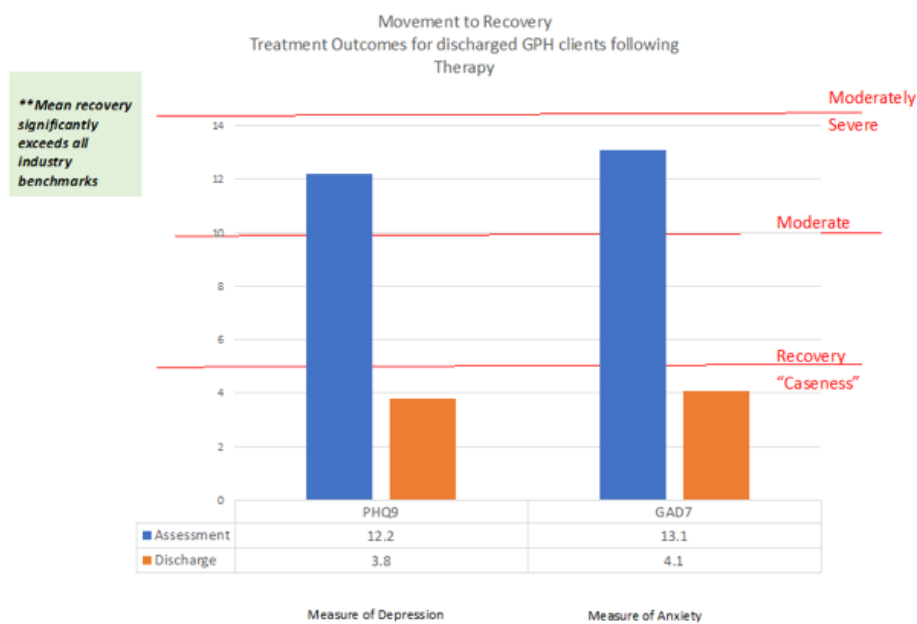
## Outcomes for patients receiving CBT therapy via Efficacy

Cognitive behavioural therapy (CBT) is the most common treatment provided for patients at PHS. Over the years, more than 1,200 patients have had this treatment, many delivered by our main provider, Efficacy.

We have found that doctors respond well to CBT, enabling them to return to the workplace with a new set of tools to support them in daily practice.

At referral for CBT, patients are assessed using two wellbeing questionnaires – the Patient Health Questionnaire-9 (PHQ-9) and Generalised Anxiety Disorder (GAD-7). These questionnaires are then repeated at fixed intervals to identify progress towards recovery. Our results are impressive; 90% of discharged patients achieve recovery and fall below clinical ‘caseness’ which we measure by a score of five or below on PHQ9 or GAD7.

PHS patients’ wellbeing scores are reduced by 8.4 points using PHQ-9 and 9 points using GAD-7 and across both questionnaires are almost one point below ‘caseness’, a score of five or below at discharge. The NHS benchmarks are set at a score of 10 or below on PHQ-9 and eight or below on GAD-7, meaning PHS patients achieve higher rates of recovery before discharge.



# PART SEVEN: our experience of caring for doctors

Our headlines are just part of the story of the patients who have come to PHS. Behind these statistics and behind the basic demographic data is our personal story of the service and what we have learnt from caring for thousands of doctors.

First and foremost, what we have learnt is that doctors will present for care if you provide them with a confidential and accessible service such as PHS. The old saying, if you build it they will come, is absolutely true. What our patients tell us they value most is being treated as a patient, and whilst being respected as a doctor (with knowledge, skills and experience) they do not have to be in control of their care. We see patients visibly relax as they see that they do not have to be in charge, that we, their clinicians are the expert in their care. For doctors who are so used to being in control, this is so important. We have already mentioned the very high attendance rate – over the years we have had tiny numbers of doctors who have not attended for their first appointment without letting us know first. So unusual is it for a doctor not to attend, that we regard it as a very important indication that they are unwell and try our hardest to re-engage, understand why they did not attend and reassure them about their fears. We have been struck how common it is for doctors to arrive early for their first appointment. Of course, this is a mixture of anxiety about what lies ahead and worries about not being able to find the venue where the assessment is being held. But sometimes doctors arrive one or even two hours ahead. Fortunately, at our main London site there is a very good coffee shop close by.

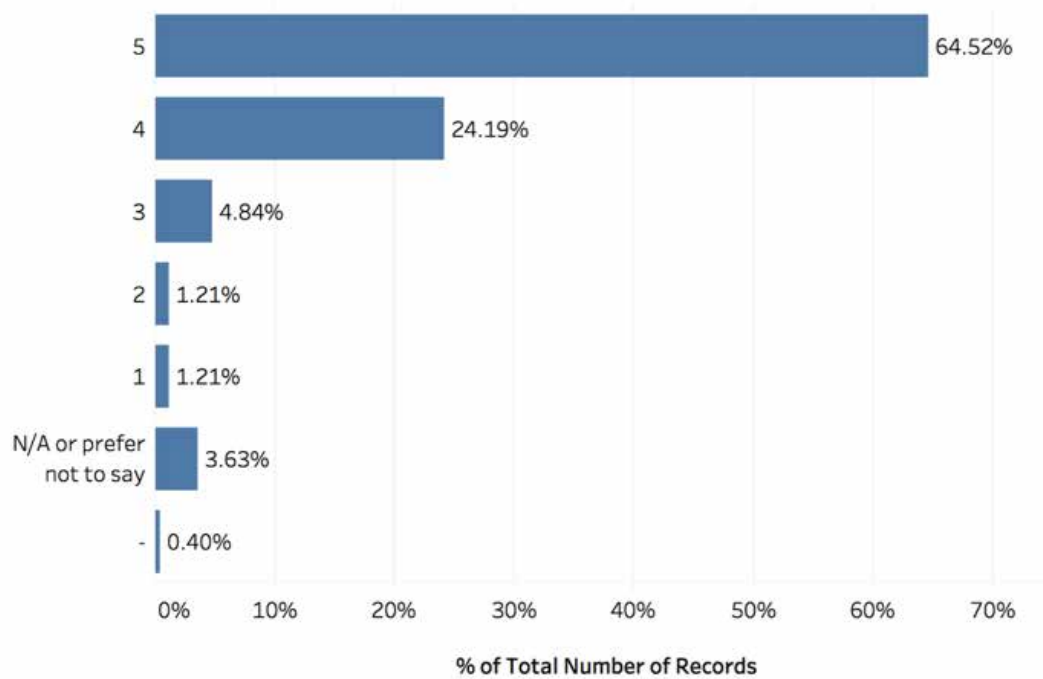
We have learned that doctors tend to minimise their problems and feel shame and embarrassment in needing to ask for help. Hopefully this has diminished over the years as so many doctors have come to see us at PHS that we are known, through word of mouth, to be a safe, confidential, and accessible space to seek help. We ask our patients how they heard of us and are pleased that they may have been told about us by colleagues, friends, family and even their own treating doctors, all of whom might have been patients of ours. This brings us to the issue of confidentiality and boundaries. A service run by doctors for doctors is bound to come up against issues relating to boundaries and we have learnt how important it is to acknowledge boundary issues right from the outset. It is inevitable that patients who attend, if not personally or professionally known to PHS clinicians at the start, might be so after



contact with us. We have seen many doctors from different specialties and levels of seniority.

We are pleased that when asked (in the Friends and Family Test) that our patients really do recommend and trust that we are a confidential service.

To what extent do you believe the NHS GP Health Service is a confidential service (where 1 is not very confidential and 5 is very confidential)?



Over the years we have had doctors in our service who have gone on to have a professional relationship with one or more of the PHS clinicians. We therefore can and often do meet our practitioner-patients in spaces outside PHS – at work, at training events, committee meetings and even at social events. This occurs more frequently as the numbers of patients going through PHS increases, we have now had more than 5,000 practitioner-patient contacts. We tell all new practitioner-patients that the chances are that we will meet them ‘in the real world’ and that we at PHS will always maintain confidentiality and never disclose that the doctor is our patient. Quite often, the doctor does the disclosing, but this is their choice. We reassure doctors that, if we meet them outside PHS, that we will also always respect the professional relationship.

Though the literature tells us that doctors have high rates of suicidal thoughts, we are still surprised how common they are – many doctors even go so far as planning their own death. Maybe suicidal thoughts are a defence mechanism against the pain and suffering that the doctor is exposed to in their work.

We have been struck that doctors seem to have an extremely high tolerance for mental distress and continue to work and appear to function despite very high scores on established and standardised scores for depression/anxiety/burnout. This is of course linked to doctors’ training and in particular the hidden curriculum – doctors are taught to give more to others than to receive themselves, to be altruistic, and to deny their own needs. We have seen doctors



who, even despite being extremely unwell (low mood, weight loss, severe insomnia, feelings of worthlessness and so on) continue to work (and seemingly effectively).

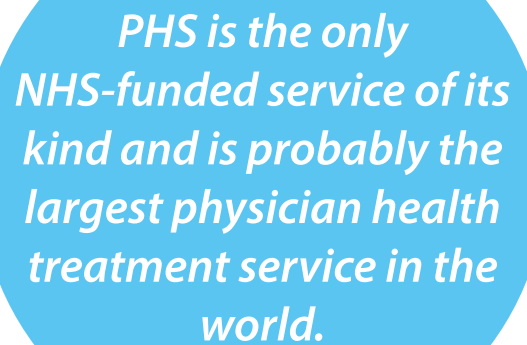
Linked to this is that doctors continue to give consistent and high-quality care to their patients despite their own psychological impairment. Their work is typically characterised by overworking and over-checking within a system of unrealistic demands. In many cases, these unsustainable behaviours culminate in the tipping point into common mental health problems. Doctors have high, unrelenting standards placed upon themselves in the form of perfectionistic beliefs and behaviours and it is these standards that have propelled academic success, but at times just cannot be maintained due to the excessive demands placed on them. Consequently, beliefs are generated around not being good enough, a sense of constantly missing something. These drive self-critical thoughts which lower mood and increase anxiety.

Treating doctors does, however, present challenges. Doctors tend to treat their therapy as they probably treat examinations – ‘I have to be the best’, ‘I must get on with this’. But treatment can also be frustrating – they feel ‘I should know this’, or question ‘how did I not know this?’. It is important that we, as their treating doctors and therapists, are always mindful not to make assumptions around the doctors pre-existing knowledge, skills or experience and rather treat them as any other patient. For example, we explain what cognitive behaviour therapy is. Even if our patient is a consultant psychiatrist, we explain how to take antidepressants, what to expect in the early days and what the side effects are. We talk about depression, what it is and how it is treated. We explain in simple terms why it is important to take time off work, even for a short time so that they can have time to recover. All of this is important.

Paradoxically, given that we are treating highly proficient health professionals who sometimes might know more about a subject than the treating clinician, we still are mindful of not sharing decisions with them – not until they are beginning to get better that is. We have learnt that it is important that when seeing sick doctors that the treating clinician takes control of the consultation.

Once in treatment, doctors get better.

We have also learnt how even those doctors who are in desperate straits when they come to see us do get better, with many returning to almost full function, including returning to work. Doctors have many good prognostic factors which of course contribute to this. They are intelligent and tend to have good social networks (even if these are made up exclusively by doctors). They tend to be more financially secure than non-medics and therefore able to withstand periods without any income (though we have over the years been amazed as to how financially compromised sick



*PHS is the only  
NHS-funded service of its  
kind and is probably the  
largest physician health  
treatment service in the  
world.*

doctors can become, especially if unable to work). Doctors on the whole want to return to work and for many, work is central to their lives. The thought of returning to work can be a massive incentive to get better.

Sadly, we have also learnt how cruel doctors can be to each other. The psychiatrist Max Henderson and colleagues, in their qualitative analysis of mentally ill doctors, highlight how many sick doctors report a negative response from their colleagues.<sup>51</sup> Their illness is described as a failure, and because of it they are shamed and made to feel guilty or uncomfortable. The doctors in the study had all been off work due to mental illness and they described that being away from work left them isolated and sad. Many experienced negative reactions from their family and some deliberately concealed their problems. Doctors described a lack of support from colleagues and feared a negative response when returning to work. Self stigmatisation was central to the participants' accounts; several described themselves as failures and appeared to have internalised the negative views of others. The conclusion of the study was that self-stigmatising views, which possibly emerge from the belief that 'doctors are invincible', represent a major obstacle to doctors returning to work. From medical school onwards, cultural change is necessary to allow doctors to recognise their vulnerabilities, so they can more easily generate strategies to manage if they become unwell. Doctors attending our service tell us how alienated they feel from their peers and that having a mental illness is perceived as a fall from grace. Being a mentally unwell doctor can be very isolating, especially if the doctor is also excluded from work.

## Caring for ourselves

*If one doctor doctors another doctor, does the doctor who doctors the doctor doctor the doctor the way the doctor he is doctoring doctors? Or does he doctor the doctor the way the doctor who doctors doctors?*

### Anonymous

Treating doctors is an enormous privilege, but it can also be emotionally draining. At PHS we practice what we preach. We have regular team meetings which act not only to share information, but as support for each other. We meet once a week at our London multidisciplinary meeting (MDT) and across the country we have dial-in MDTs (which will be replaced as we grow by face-to-face ones). We talk about patients who concern us, and about those who have died or been erased from the register. We have a monthly Balint group led by two very experienced Balint facilitators. Our Balint group allows us to discuss how specific patients (we usually discuss two in detail) make us feel, the classic doctor-patient relationship. We explore transference and countertransference issues and invariably this helps us get over any difficulties we might be experiencing with our patients.

We encourage and fund clinicians to have clinical supervision, either on a one-to-one basis or in groups. Supervision allows a space to talk about difficult cases and also to explore issues in greater depth. As medical director of PHS, I have supervision with an experienced psychologist.

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<sup>51</sup> Henderson M, Brooks S, del Busso L, Chalder T, Harvey S, Hotopf M et al. Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study: Table 1. *BMJ Open*. 2012;2(5):e001776.

We understand that the responsibility of treating doctors can take its own toll and all our team (clinical and operational) have access to confidential treatment and support when needed.

We have away days and team-building events. We have an annual residential learning event involving all our team across England, and in 2018 had a two-day conference.

We adopt a no-blame culture.

## When treatment doesn't work

Not all patients who come to PHS have had positive outcomes, and sometimes treatment fails. Doctors relapse into drug or alcohol use despite our best intentions. We have had patients die from the effects of their drug or alcohol use. A small number of our doctors have been erased from the medical register, losing their livelihood and career. For us at PHS, it feels a terrible loss and a failure of our care. But for the doctor it can mark a catastrophic decline in their mental health as they face an uncertain future. We continue to offer care to these doctors, helping them get back on their feet. Our patient and volunteer group are creating a 'what next?' document, walking the doctor through the shock of erasure to the other side. We have a small number of doctors who have received custodial sentences from crimes committed.

Sadly, we have had patients who have taken their own lives. We know from the literature that doctors have high rates of suicide compared to the general population. Throughout time and across the world, doctors have always had higher rates of suicide compared with the general population and with other professional groups. Female doctors in particular have higher rates, 2.5-4.0 times the rate of suicide compared to an age-matched group. The reasons for suicide among doctors, as in the general population, are often related to untreated or undertreated depression, bipolar affective disorder, or substance misuse.<sup>52</sup>

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<sup>52</sup>Gerada C, Doctors, suicide and mental illness BJSych Bulletin (2018) 1-4, doi:10.1192/bjb.2018.11



*Freya would have been 18 years old this year and like many 18-year olds, in the throes of A levels, probably worrying about whether she would be getting the grades for her chosen university. She would be destined to enter the health system – primed no doubt by her mother, who was a talented psychiatrist or myself, her father, a radiologist. But all of this is inference. On 9th October 2000 Daksha stabbed Freya, then three months old, before stabbing herself, covering both of them in accelerant and setting it alight. Freya died of smoke inhalation; Daksha survived for a further three weeks in a burns unit, but died without regaining consciousness. The incident took place during a psychotic episode that was a consequence of her bipolar affective disorder, triggered by her post-natal condition and aggravated by psychosocial stresses. I still live*

*in the same house, redecorated several times to clear it from the smell of fire. A large photo has pride of place in the front room. The colour photo of 'my girls' was taken on Sunday 8th October, the day before the tragic incident. Daksha's pain and torment is hidden from view, the smile acting as a mask to her suffering. By now she had already planned their deaths and had already bought the accelerant. Masking pain is typical of doctors. They learn early on in their training to hold the line, to appear stoical, to turn up for work come what may and to never admit to their vulnerabilities. Daksha had a long history of mental illness, and the inquiry highlighted the stigma that doctor-patients experience when becoming mentally unwell. On a personal level they fear that if they disclose mental illness they will be subjected to sanctions by their employer or regulator, or worse still lose their job. They fear loss of confidentiality and that their personal details will be disclosed outside the safe space of the consulting room. Daksha was forever frightened of being 'found out' and of being exposed as someone needing help. Practitioner Health Service, as a response to the tragic deaths of my wife and daughter and other such tragedies, will enable their silent screams to be finally heard. The continued development and success of PHS will be their everlasting legacy of remembrance.*

**David Emson (husband and father)**

Among living PHS patients, the GMC is involved in around 10% of cases, compared with 52% (11 out of 21) of patients who have died and 56% (nine out of 16) of the patients who have died from accidents, suicide, or overdoses. Although correlation does not mean causation, being under regulatory or disciplinary processes nevertheless increases the risk of mental illness among doctors and a complaint or referral to the GMC must be considered a red-flag risk factor for both depression and suicide. It is important to remember that the vast majority of doctors do not kill themselves. Most doctors thrive in their working environment. But each death is a tragedy which sends repercussions through the system and holds the risk of creating a contagion.

We have set up (we believe) the first group for those who have lost a doctor-relative through suicide or sudden accidental death. What members of this bereavement group have done is made real what research has told us – that suicide is more common amongst doctors (especially women) than in other professional groups; that doctors suffer from personal, professional and institutional stigma when trying to seek help for mental health problems; and that complaints are a significant contributing factor in doctors' suicides. For many of the deceased, it was the receipt of a complaint (even a trivial one) that had led to rumination, shame and depression. Often unsupported, young and older doctors alike had to face the impact of a complaint alone. Uncertain how long it would take to be resolved (or whether it ever would be), they suffered over it and exaggerated the likelihood that they might lose

their careers and livelihoods. Instead, they lost their lives. A podcast has been made of relatives speaking about the death of doctors:

<https://videos.rsm.ac.uk/video/rsm-health-matters-podcast-episode-6-searching-for-truth-suicide-and-accidental-death-in-doctors>

To commemorate doctors and medical students who have died through suicide (not just patients of ours), we have started to collect their names and have created a memory album held at PHS. We are also the first supporting organisation in UK for National Physician Suicide Awareness Day, which occurs annually on the third Monday of September.



When our patients die (as over the years some have), we take time out to talk about them, to understand as a team whether we could have done better, but most importantly to mourn them as people we cared for and valued.

### **And finally**

For ten years PHS has cared for doctors and dentists. For ten years we have seen suffering and pain but in the same time we have seen the remarkable recoveries our patients make. Our service has become a trusted space where mentally ill doctors can find the help they need from expert clinicians, a trusted space where everything they share remains confidential (unless they pose a very serious risk to themselves or others). Our experienced team appreciate how reluctant doctors are to take off their metaphorical white coat and put on the patient's gown. Despite the many challenges doctors face, once they come to us we have an impressive track record of getting doctors into treatment and safely returning them back to work or training.

*Excellent care,  
flexible to working  
timetable, supportive  
and understanding*

# PART EIGHT:

## What others have said about PHS

### What our patients tell us

*Almost 90% of our patients report that we have helped them get better. 80% of those not at work report that we are having a positive impact on their ability to return.*

#### From our Friends and Family Test

Over the years the service has received excellent feedback from practitioner-patients and others. It is a joy to work in a service which is held in such esteem by those who use it, and this is thanks to the staff we have – from the operational and administrative staff who take the first nervous calls from our patients, to our clinicians who go above and beyond to help, and our therapists across England who deliver excellent care.

*Patients speak of PHS as feeling like a bespoke service.*

#### From our Friends and Family Test

As part of the requirements of the service we have to survey all of our practitioner-patients annually including using the Friends and Family Test. This is widely used across the NHS and asks the simple question, 'how likely are you to recommend our services to friends and family?'. The feedback we have received has been overwhelmingly positive. Both PHP and GPHS services scored extremely highly in this question (extremely likely/likely to recommend). Our patients have also told us that they feel better after treatment with us. For example, the majority of practitioner-patients when questioned tell us that they feel better and that they are satisfied with the treatment they have received from PHS. Independent evaluation also shows high satisfaction rates and improvements in health, return to work and well-being areas.

*93% of our patients are extremely likely or likely to recommend PHS to their friends or family.*

#### From our Friends and Family Test

In addition, the questionnaires demonstrated that patients feel the support they



get is having a positive impact on them, their work or training and on their personal wellbeing.

These results are hugely positive and demonstrate a real sense from practitioner-patients that the treatment and support they receive is making a difference to their personal and professional lives. Scores did not differ between gender, specialty, age or by area of the country. This suggests we are delivering equitable and consistent care across all our clinicians and locations. Patients also reported high levels of satisfaction with the ways in which they could access services, and with the times, locations and methods by which care was offered.

Questions from Friends and Family Test	PHP	GPH
To what extent do you believe the service is having an impact on your...		
...ability to work or train	85%	78%
...intention to keep working as a doctor for the foreseeable future	76%	66%
...personal wellbeing	88%	88%
...family life	81%	84%

Tick box questionnaires are one thing, but what we are so proud and humbled by are



the number of patient responses to the surveys where they tell us in their own words what PHS had done for them and how the help they received has changed their lives. On numerous occasions patients talked about being on the brink of disaster, leaving the profession or even contemplating suicide and how individual PHS clinicians and administrators have shown empathy, compassion and kindness and helped them to turn things around.

***When asked, 78% of patients report the service to be 'excellent'***

**From our Friends and Family Test**

## Patient stories in their own words

Our patients appreciate what we can offer them – a safe, confidential space to be cared for in a compassionate and skilled way. They also value being able to visit the service without the fear of encountering people they know.

Doctors attending PHS are often at the end of their professional tether and many are wanting to leave medicine altogether. It is therefore pleasing that so many who have attended our service report that we have had a very positive or positive impact on their ability to work or train and keep working for the foreseeable future. Our patients are often keen to share their own stories and journeys to help others who may be facing similar situations.

We have had hundreds of comments during the last decade, almost all overwhelmingly positive. We have scattered some throughout this report.

*I am a 46-year-old medical practitioner. I had been unable to get any meaningful ongoing therapy for an addiction to opiate medication which I had been tackling in a haphazard fashion for many years. The service provided has been invaluable, and has enabled me to re-structure my life, become established in recovery from my addiction, and continue to treat patients safely. For many reasons, 'normal' mental health and addiction provision within the NHS is hardly ever appropriate for health practitioners as patients. Private treatment, particularly for addictive illness, is also fraught with difficulty. The [service] fills a gap in the care of health professionals which has been until now unfilled, with often desperate and tragic consequences. I am sure that the outstanding level of therapeutic care which PHS provides could and should be offered to health practitioners throughout the country. Without their services I cannot say for certain that I would not have survived my illness, but I would certainly still be very unwell.*

A doctor

*I would like to express how wonderful the service has been for me as a patient, a dentist dependent on tranquillisers. I was lucky enough to be referred to the medical centre and even luckier that I found a therapist, a specialist nurse, who is very successfully helping me overcome my addiction on a weekly basis by counselling and monitoring my progress. With the help of the specialist nurse, I am progressively reducing the dosage of diazepam that I am reliant upon. Nothing is rushed or coerced in this reduction, yet the combined therapy is one of a gradual, gentle persuasion to reduce dosage when I feel I am able to. The specialist nurse instils confidence both in myself and in her as she does not restrict herself to treatment only at the service but can be called upon in between visits*

*for advice, help and support as I have had to do many times. As well as treating me, she has managed to find time to make mandatory written reports about my progress when called upon by other professional bodies and people. The service is also associated with a regular group meeting of doctors and dentists to discuss their problems, addictions, treatments and recovery which I attend. This programme epitomises how addictions should be treated in the 21st century and more funds should be made available for such a modern centre. I am very, very fortunate to be included in the PHS programme.*

A dentist

*I would like to take this opportunity to say how extremely helpful the PHS programme has been. It is extremely useful to be able to access confidential help when you are a doctor. It can be a daunting task trying to access help through the usual NHS system – you often worry who will see your referral letter, who will be seeing you and how quickly you can get help. It was great to be able to be assessed and have therapy provided so quickly. I feel this has greatly improved my overall wellbeing which I have no doubt has had a positive impact on my work, treating my patients. I feel it is important to continue this service for future doctors in need of help. The fact that it is independent of other organisations is extremely helpful.*

A GP

*Five years ago, I was advised to refer myself to PHS by my occupational health department. I had been admitted to hospital and had been given a detox programme following a long history of escalating alcohol use. I had come to the conclusion that I was an alcoholic, but I needed the advice of PHS to help me to continue the rest of my life without relapse. PHS provided specialist advice to my occupational health service and supported my return to work. They also supported me through a fitness to practice investigation and the subsequent period of conditional registration. PHS also suggested that I should attend meetings of the British Doctors and Dentists Group and continue to go to Alcoholics Anonymous. I have remained sober since then and am still working full-time. I continue to attend BDDG meetings to help doctors through what is a very stressful period. The role of PHS is essential to those newcomers starting the path to recovery as I once did. Congratulations on your 10 years of treating ill doctors as patients and helping them navigate the additional problems associated with their work.*

A consultant anaesthetist

## What do our other stakeholders tell us?

PHS has been the subject of a number of independent reviews, studies and assessments.

After the first year of operation, our commissioners, the National Clinical Assessment Service (NCAS), commissioned an independent evaluation of satisfaction with and impact of PHS. This involved contacting patients and stakeholders to find out about perceived or received strengths and weaknesses of the service.

The strengths of the service were identified as:

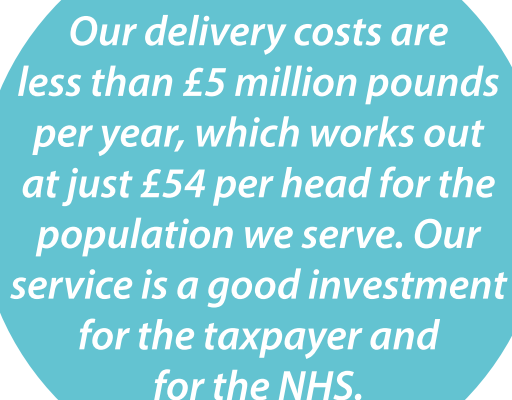
- Filling a gap in the current service provision
- High quality staff
- Independence
- Respected service
- Quick response to problems
- Flexibility of appointments
- Range of services available
- Feeling of a 'bespoke' service

PHS featured as a chapter in Dame Sally Davies, the Chief Medical Officers' annual report (2013 on mental health),<sup>50</sup> highlighting the importance of treating health professionals and the impact and outcomes that the service was demonstrating in the first five years. The piece also noted the economic benefit of supporting health professionals back to work.

There were several reasons identified for the high rating of the service, although the key reason emerging across audiences was that PHS is viewed as a holistic service which fills a previously unmet need.

Overall, the key positive features of the service were found to be:

- that it is run by specialists in treating doctors and dentists with addiction, mental health and physical health issues;
- that it provides a clear process to recovery – a focus on main goals which facilitates practitioner recovery and re-entry into (or continuation with) work and includes all mental health issues;
- that it treats the whole person rather than the presenting issue; and
- that it is transparent about confidentiality – mapping out parameters and consulting with the practitioner-patient at every stage.



*Our delivery costs are less than £5 million pounds per year, which works out at just £54 per head for the population we serve. Our service is a good investment for the taxpayer and for the NHS.*

<sup>50</sup> Davies S. Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence. [Internet]. London: Department of Health; 2014. Available from: <https://mrc.ukri.org/documents/pdf/chief-medical-officer-annual-report-2013>

Ahead of publishing this report, we asked some leaders for their views of the service.

*The team behind developing and implementing the GP Health Service should feel justly proud of their achievements in bringing support to GPs suffering with mental health problems including stress and burnout across England. With the pressures on GP colleagues greater than ever before, this service provides a vital lifeline for many GPs who have been able to access a responsive specialist service that really understands the challenges they face.*

David Geddes, Director of Primary Care Commissioning, NHS England

*GPs are often under an immense amount of pressure and it is imperative that their well-being is also looked after/maintained and that appropriate support is provided. The GP Health Service is a service provision that GPs and other health professionals can access if they have concerns regarding their own mental health. The service was launched amidst a changing and challenging climate in the NHS, which has especially led to recruitment and retention issues in Primary Care. It has definitely demonstrated that it has been a much needed and timely initiative, and it has had an exceptionally positive impact on the mental health outcomes of GPs, including GP trainees, who have confidently accessed the service. The service is offered by committed, compassionate and skilled professionals in a confidential manner and feedback from patients who have accessed it say it is outstanding, both in satisfaction levels and its impact on retention. In my opinion, this outstanding service needs to be acknowledged nationally and needs to be institutionalised, for the sustained mental and psychological support for GPs who make the foundations of our valued NHS.*

Safi Afghan, Consultant Psychiatrist



*A fantastic,  
professional  
service*

*I am delighted to be providing a supportive statement about the Practitioner Health Programme in London and NHS GP Health Service across England. These complimentary services provide unique help and support to struggling doctors at a time when our NHS is under unprecedented pressure. As head of the Royal College of General Practitioners I am acutely aware of the stress GPs are under and I was so pleased when the GP Health Service was launched to provide support to all GPs and trainees in England. The feedback from their surveys is outstandingly good and fully vindicates the trust that was placed in this team to deliver a confidential, consistent service that is supplementary to NHS services for GPs. That over 1,100 doctors have registered with them is a testimony to the reputation they have built for being 'just what is needed'. On a personal level I have been told by several separate GPs/trainees of their own personal positive experience of the service – the following are direct quotes from them to me: 'I was so relieved to be treated as an intelligent person, as someone who understands the condition but is still afflicted by it... they were spot on'; another explained, 'After giving up on NHS IAPT and therapists as being far too basic for what I needed, it was wonderful not to feel patronised by a kid with a month of training in counselling – but speaking to someone with the time and insight to appreciate where I was coming from.'; and finally, 'the biggest compliment I can give them is that I have in turn recommended the service highly to two other struggling colleagues – they have given me back my life, my confidence and my career – I want others who are on the brink to benefit in the same way and will do all I can to help them.' Finally, I truly hope that the benefits that are being seen in England for struggling doctors are replicated right across the UK as there are so many others who could benefit.*

Helen J Stokes-Lampard, Chair, Royal College of General Practitioners

*The Practitioner Health Service provides a vital service for doctors affected by health issues, enabling practitioners to confidentially access the mainstream services they need. Since its inception PHS has taken a keen interest in the GMC's vulnerable doctors' programme, providing expertise and advice on behalf of unwell doctors and giving valuable feedback on our improvement programme which informs our approach.*

Anna Rowland, General Medical Council

## Awards

We are proud that PHS has been shortlisted and won a number of external awards.

In 2014 we won the national Positive Practice award which is aimed at identifying and sharing examples of how good mental health care can be delivered.

In 2017 our booking app was recognised in an international industry award category and won the Outsystems Innovation award at a ceremony in Lisbon, Portugal. The app allows practitioner-patients to choose, where and when they want to be seen, who by, and allows them to manage their own appointments.

In 2013 and 2018 we were shortlisted for the BMJ Mental Health Team of the Year and won this category in 2018. The judges described being impressed by the significant impact PHS is having on this disenfranchised and deprived patient group (doctors). They noted the service is strongly data-driven and hugely innovative and that we are a world leader in this area and share our approach internationally. In particular, they highlighted the phenomenal partnership across different sectors, and what the team have achieved in a relatively short time period and with remarkably little resources.

Also, in 2018 we were awarded special commendation for Specialist Service of the year in the Health Service Journal Value awards. This award seeks to recognise and reward outstanding efficiency and examples of demonstrable outcomes.



# PART NINE:

## Summing up

When PHS first opened its doors to practitioner-patients in 2008, there were many doctors and dentists with mental health and addiction issues who were unable to access the NHS through fear of stigmatisation or having to receive their treatment from colleagues. The aim of PHS was to treat these patients and return them to a safe working environment, thereby reducing the financial pressures on the NHS for cost of sick leave and locum cover. We believe we have achieved these aims.

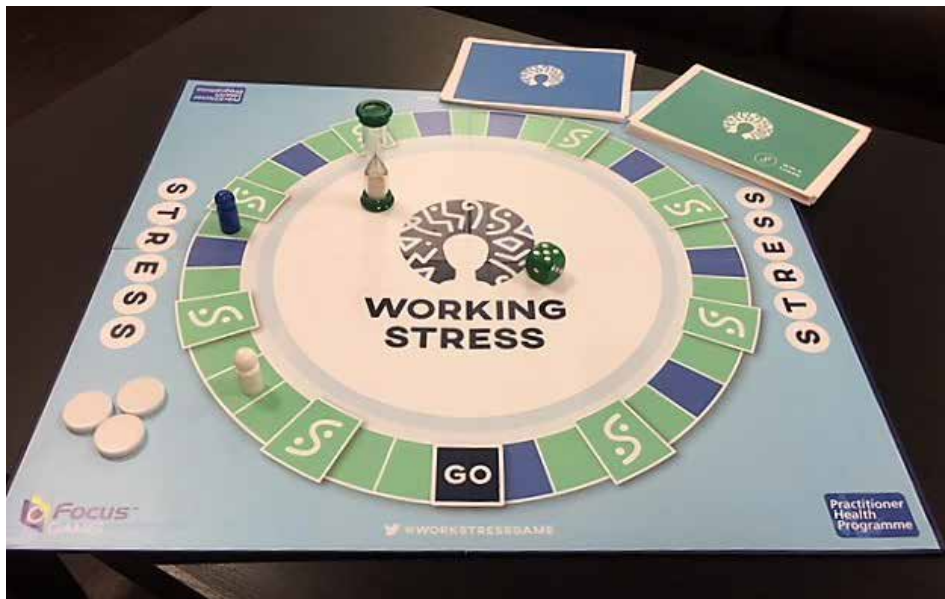
We are proud that we take a joined-up approach to the care of our patients. Whilst our network of clinicians works from different locations, we are a unified, specialist service that operates across the whole of England, from Cumbria to Cornwall.

Over the years, PHS has:

- created an integrated rather than traditional split primary-secondary care service;
- proven the financial case for investing in mentally ill doctors;
- led the way in creating care pathways for addicted doctors;
- led the way in creating care pathways for doctors with bipolar affective disorder;
- developed a competency framework (HHP) for health practitioners wanting to treat mentally ill health practitioners;
- developed training placements for GPs, psychiatrists and therapists wanting to work in field of practitioner health;
- developed a network of therapy groups for doctors;
- piloted and evaluated art therapy for doctors;
- developed the European Provider Network;
- developed a group for those bereaved following suicide or sudden accidental death of a doctor;
- developed a UK-wide research network;
- been the first to use Psychlops (standardised, patient-reported outcome measure) with mentally ill doctors;
- created a board-game to be used to help practices/practitioners work together to understand causes of and solutions to reducing work related stress;
- created the first patient and volunteer user network (all have lived experience of involvement with regulatory processes);
- contributed to national policy and to changes in regulatory approaches to sick doctors;



- contributed to media pieces, podcasts and publications related to physician health;
- held the first international conference on the wounded healer;
- written extensively on the area of practitioner health.



### Working Stress Board Game

<https://shop.focusgames.com/ProductDetails.asp?ProductCode=WSBG718>

Our delivery costs are less than £5 million pounds per year, which works out at just £54 per head for the population we serve. Our service is therefore a very good investment for the taxpayer and the NHS as a whole. Over the past ten years we have returned more than 1,000 doctors back to the workplace. If it costs around £230,000 pounds to train a doctor, we have saved the NHS somewhere in the region of £230 million pounds.

At a time when there is a critical shortage of doctors and funding, we believe our service is playing a vital role in supporting healthcare in England. It also makes sense to the wellbeing of our patients. A recent survey of our European physician health counterparts shows that, compared to them, we see more patients, the outcomes for the patients we treat are better, and we offer a wider range of treatments.

We've come a long way in ten years. Our service has grown from a standing start and a three-person team in London to an integrated network of over three hundred skilled professionals delivering a high standard of care across England.

However, we are deeply aware of the distress of the many doctors who are not eligible to access our services.

Importantly, over the ten years we believe that PHS has helped shift the national conversation regarding the wellbeing of the workforce, and doctors in particular. All NHS Trusts now have responsibilities related to staff wellbeing and we are now closer than ever to all doctors in England being able to access confidential care and treatment through a specialist service.

Our aim for the next ten years is for PHS to be expanded so that all doctors in the UK can have access to our help. We look forward to caring for doctors for the next decade and beyond.

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*In terms of how PHS helped me personally, it was invaluable. In terms of its benefit for the NHS, it kept me at work at a time when I suspect I may have ended up needing to take time off, costing the taxpayer money.*

*I just feel we need more of it – more locations and more capacity to see more doctors as what they do is essential. It is the first time in 23 years of being a doctor in this country that I feel important and cared for. Before PHS, it was lonely and scary out there.*

*Really worthwhile programme. Enables clinicians to continue to work with more insight and empathy, to have a better life/work balance.*