DH Department of Health

Mental health and ill health in doctors

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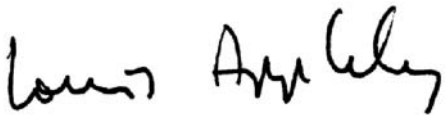
Foreword

Many doctors find it difficult to admit that their work is stressful, that they have a drink or drug problem or that they need help. There are many reasons for this: the high personal standards of the people who choose careers in medicine, a culture of always coping, fears about damaging job prospects, uncertainty about who to tell.

It was against this background that in 2000 a young psychiatrist, Daksha Emson, killed herself and her three-month-old baby, Freya. She had suffered a relapse of bipolar disorder after Freya's birth.[1] Her illness was long-standing but well controlled, allowing her to qualify as a doctor and practise medicine. The inquiry into her death and the death of her daughter highlighted inadequacies in the way that mental ill health in doctors is managed. It was her tragic story that prompted the work that is reported here.

There are many ways in which the healthcare system can improve to better manage mental ill health in doctors. There are many ways in which organisations can change policy and practice, so that the stressors on doctors are diminished. However, to make a difference, action needs to be taken both nationally and locally. I hope that all those who read this report will play their part in achieving this.



Professor Louis Appleby
National Director for Mental Health

Tribute to Daksha and Freya Emson

Daksha arrived in the UK from India speaking very little English aged 8. She became the first student from her school to enter medical school at the Royal London Hospital Medical College. After a serious suicide attempt as a first-year medical student, Daksha was diagnosed with bipolar affective disorder. Despite suffering from such a debilitating illness, and in testimony to her inner strength and self-belief, Daksha won a Medical Research Council scholarship for her BSc (Hons) in pharmacology. She won the David Reeve Prize in embryology, the Buxton Prize in combined anatomy, biochemistry and physiology, the Howard Prize in pharmacology and the Floyer Prize in history-taking.

On her elective to Cork in 1991, Daksha met and fell in love with radiographer David Emson and they were married in 1992. After completing her house officer jobs she went on to specialise in psychiatry, gaining Part I and Part II MRCPsych at her first attempt and a distinction in her MSc in mental health studies.

Although she was undoubtedly an academic, Daksha always considered herself a 'hands-on' psychiatrist. She pursued her special interest in the different aspects of psychotherapy, and trained as a psychodynamic psychotherapist and a cognitive analytical therapist.

Daksha was incredibly humble and unassuming in her academic achievements. She was strongly determined that her mental illness would not hinder her ambition to become a respected psychiatrist.

After taking the advice of her treating psychiatrist, Daksha stopped her medication, to enable her to plan safely for a family, but she experienced three miscarriages in as many months. However, we were blessed with the arrival of our much-loved beautiful baby daughter, Freya, on 4 July 2000.

Daksha was considering taking a consultant post in community and rehabilitation psychiatry in February 2001 at Oxleas NHS Trust, on a part-time basis so that she could fulfil both roles as a mother and as a clinician.

Regrettably, the day before she was to resume her medication, Daksha became psychotic and, in an act of 'protecting our daughter', she gave our daughter Freya back to God, where Daksha would find herself being reunited with Freya nearly three weeks later.

Her own mental illness enabled Daksha to become an exceptional psychiatrist, and she was most grateful for the care and treatment that she received from her carers. Daksha had the most extraordinary presence and empathy with everybody who met her. She was highly respected by her colleagues and by her patients. She was a loving and devoted mother and wife.

The independent inquiry into the care and treatment of Daksha and Freya will enable Daksha, even in death, to have a positive impact on the care and treatment of other mothers suffering with bipolar illness, and also on the care and treatment of other healthcare workers, stigmatised because of their diagnosed mental illness.

She leaves an honoured and privileged husband.

David Emson, husband

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Section 1:
Introduction

We know that many doctors are affected by mental ill health – particularly depression and alcohol or drug problems. We also know that they do not ask for treatment early, if at all. The system, as it is currently organised, may militate against their being able to do this easily. There are too many worries about confidentiality and potential impact on career and colleagues for many doctors to do what they would tell their patients to do. The combined forces of stigma, shame and secrecy make it particularly difficult for individuals, organisations and policy makers to address mental ill health in doctors.

After the publication of the Daksha Emson Inquiry Report, the National Director for Mental Health, Professor Louis Appleby, established a group that worked with key organisations[i] to consider what steps might make it less likely that doctors would become unwell and easier for them to seek help early. The group focused on doctors, but many of the problems and recommendations described in this report are also relevant to other health workers. The group limited its work to mental health and ill health; other conditions were not considered.

This report and its recommendations are the result of their findings. It is for local and national organisations to consider and determine how they can take forward the issues raised.

[i] See Appendix 1 for membership and organisations consulted.

Section 2:
Mental ill health in doctors

2.1 Risk of mental disorder

Although figures vary, research suggests that doctors have higher rates of mental disorder than the general population.[2 3 4 5] Problems with alcohol, drugs and depression are particularly common. Up to 7% of doctors will have a substance use problem during their lifetime.[6 7 8 9] Suicide rates are also increased, particularly in female doctors, anaesthetists, GPs and psychiatrists.[10] Suicide as a cause of death may be under-reported.[11] Doctors' access to prescription drugs plays a part in their risk of substance use and suicide, as well as making it easier to treat themselves rather than seeking help.

2.2 Stressors and risk factors

Medicine is a stressful profession. Stress and fatigue rates are high, especially in female and junior doctors.[12 13 14] Occupational health statistics reported by consultant psychiatrists suggest that medical practitioners, along with the armed forces, have the highest incidence of work-related mental ill health.[15]

Sources of stress may include:

- work pressure – workload, inadequacy of resources and poor support;
- nature of work – high demand and low control, in conjunction with the inherent trauma of dealing with suffering;
- poor relationships with colleagues – particularly poor team working; and
- service pressures – investigations, complaints and court cases, including inquests.[16 17 18]

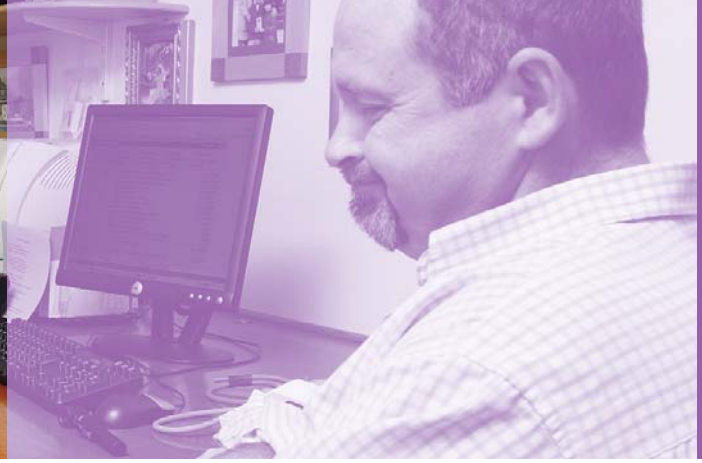
There may be additional stressors for some groups – for example, women with small children have to manage the competing tensions of work and home life. Isolation, lack of peer support and marginalisation can cause particular stress for refugee doctors, single-handed GPs, private practitioners and locums.

It is uncertain how much mental ill health in doctors results from the stresses of the job and how much from the characteristics of those who choose medicine as a career. Both are likely to play a part. Doctors are a committed and conscientious group. Personality traits such as perfectionism, self-criticism and dependency are reportedly common in medical students. In some, such traits may influence their perceptions of work, making it more stressful.[19 20]

Irrespective of the relative contributions of personality and environment, UK doctors report that stress has a negative impact on their health and well-being.[21] A fifth report that they use drugs or alcohol to help them cope. Worryingly, an increase in both mental ill health and emotional exhaustion has been reported in recent years, with suggestions that job stress has increased without any increase in satisfaction.[22] Low job satisfaction and stress increase the risk of burn-out and mental ill heath.[23 24]

2.3 Stigma and culture

The prevailing 'medical culture' – and the expectations that doctors place on themselves as a result – is likely to contribute to the problem. The caricature persists that good doctors do not make mistakes and that illness,



particularly mental ill health, is a weakness.[25 26] Taking time off work is letting colleagues and patients down. Showing vulnerability may lose the respect of others, a particular concern for those in training grades. The disclosure of mental illness, particularly alcohol or drug use, or the admission of error can be seen as inviting disciplinary action or General Medical Council (GMC) involvement, and therefore as a threat to career and livelihood. It is perhaps understandable, but clearly undesirable in terms of patient safety and personal well-being, that doctors tend to be secretive about their problems – and that colleagues collude in ignoring medical problems, including substance abuse.[27]

These difficulties are set against significant organisational and cultural change in the workplace. Doctors may feel they are expected to be infallible; at the same time there has been a shift away from medical dominance in care as multidisciplinary working has become widespread. There is greater scrutiny and criticism of professions, and a number of high-profile inquiries in recent years have been severely critical of doctors. The public is increasingly well informed and patients are more likely to challenge their doctors' views. For some, these shifts have resulted in a perceived loss of autonomy and control, but with a continuing sense that the 'buck stops with me'.

Stigma and culture are part of the reason why doctors go to work when they are unwell. Doctors average less than three days' sickness absence per year, while in the general population the figure is eight days, and for nurses it is 15. They conceal problems and do not seek formal consultations, using colleagues for informal advice instead.[28] This also reflects their concerns about confidentiality; doctors do not trust the system to keep their medical information safe.[29]

2.4 The impact on care

Doctors report that stress has an impact on their ability to provide high-quality care.[30] At its most serious this is reflected in GMC referrals. Most doctors who are referred on health grounds have one or more mental disorders; in half of all cases this is substance use. The prevalence of psychological problems is also reflected in the cases seen by the National Clinical Assessment Service (NCAS).[31] Only a minority of all cases will be seen by either of these organisations.

The impact of health problems is also seen earlier in careers – 4% of medical students are excluded for academic reasons; however, 1% is excluded for health reasons and half of these cases result from mental health problems. The same pattern continues later in life – 40% of early retirement is due to psychiatric problems.[32]

Poor performance is not an inevitable consequence of mental ill health. Three-quarters of alcoholic doctors who receive appropriate help could recover, and many stay in or return to work.[33] Even those with serious mental illness, if they are provided with appropriate help and are given support at work, can continue to practise successfully.

2.5 Summary points

There are specific features of mental ill health in doctors that have to be considered when designing and providing care for them:

- They have high rates of disorder.
- They may conceal or deny their problems, carry on working when ill and consequently ask for help late.
- They have access to prescription drugs and may bypass formal channels for help.
- Their working environment may contribute to their illness and delay recovery.

Section 3:
Current services

Despite their proximity to health services, doctors often do not receive timely or appropriate mental health care. We do not have good national data on the services that doctors use, although anecdotally many use the independent sector. We do know that many, particularly junior doctors, are not registered with a local GP – job mobility may make this difficult. Of those who are registered, many would not choose to consult their GP when ill.[34 35] Instead, doctors often prefer to have informal discussions with colleagues about their health – 'corridor consultations' – rather than using conventional referral routes.

Many doctors treat themselves – self-diagnosis, self-referral and self-prescribing are common – and many also treat their families.[36 37] They may do this for a variety of reasons, including convenience. However, if mental ill health is the problem, it is likely that stigma and the perceived risk of acknowledging that they are ill may also play a part. Impaired judgement resulting from their illness may be a factor in some cases.

Doctors do not make the easiest of patients. There can be considerable tensions in being a doctor to other doctors – for example, in enquiring about private matters, in keeping records, and in responding to their knowledge and treatment requests. It may be harder to provide the same standard of care as non-medical patients would receive. In general, it is likely that age and experience, together with a particular interest in treating doctors, will make doctor-to-doctor consultations more effective.

3.1 Occupational health services

Occupational health services are intended to advise employers on fitness to work, before and during employment, and on adjustments that will help an employee stay in or return to work. They also advise employees on resuming work, on rehabilitation and on early retirement.[38] Since occupational health services do not provide treatment services, their role in relation to work and health is often not well understood. Linking those who should use or could work with occupational health services, as well as GPs and other clinicians, is often hampered by poor communication. The provision of occupational health services in the NHS varies widely. Many such services have no regular medical input and many occupational health staff have little training in mental health and well-being issues or in the care of those with mental illness. Perceived lack of expertise may therefore be one reason that doctors do not tend to use occupational health services. Just as importantly, they may be seen as too closely associated with the employer and less likely to maintain confidentiality and anonymity.

3.2 Specialist care

Referrals for doctors who need specialist mental health or addiction care are usually made on a case-by-case basis. Referrers may rely on university departments or willing individuals known to them. Sometimes they are entirely ad hoc, referrals being seen by whoever is available on the day. Historically, some organisations have had reciprocal agreements for the care of senior staff and some areas have had arrangements for out-of-area treatment.

Many areas have no specific arrangements for doctors.

3.3 Specific support services for doctors

There are also specific support services for doctors (see Appendix 2), although provision is patchy. There has been a recent increase in the availability of telephone helplines, but there are few face-to-face services. The British Medical Association (BMA) provides an advice line open to all – Doctors for Doctors – but its counselling service is available only to members. Some medical colleges and deaneries provide services for their members or constituents.

It can be difficult to find out about these services. Few medical college websites list them, information distributed by the GMC does not cover them and a general internet search misses many. They are not always listed in relevant NHS documents.

3.4 Summary points

- Doctors often use informal pathways for mental health advice and treatment.
- Few areas have agreed formal pathways for specialist mental health care for doctors.
- There are few specialist services for doctors with mental ill health.

Section 4:
What is needed?

The pathways to care for sick doctors are largely ad hoc, dependent on informal arrangements. At their worst they have been described as 'deficient and discriminatory'.[39] This section describes the changes that are needed under two broad headings:

> accessible and appropriate services; and

> promoting mental health and well-being in doctors.

4.1 Accessible and appropriate services

If doctors are to receive appropriate mental health care, they, their colleagues, their employers, commissioners of services and key national organisations must have a shared view of what is needed. This should cover:

> access to information;

> designated care pathways and services;

> the role of occupational health services; and

> the need for confidentiality and privacy.

4.1.1 Access to information

Information about services should be widely available. Once a doctor becomes ill, they may not know how to look for help. The information needs to be easy to find – difficult to miss, in fact, so that the doctor knows about it before they need to use it. Potential referrers and employers need the same information.

Professional and training organisations are in a good position to highlight sources of help as they are already in regular contact with their members through websites, newsletters and other correspondence. The Department of Health will be considering further how best to signpost doctors to health services, including mental health care.[40]

RECOMMENDATIONS: ACCESS TO INFORMATION

NATIONAL ACTIONS

Recommendation for:

Medical Royal Colleges* and all medical schools in England

- Royal Colleges and medical schools should consider publicising information about sources of help on their websites, in newsletters and through other appropriate media channels.

Recommendation for:

GMC

- The GMC should consider publicising information about sources of help, for example with doctors' registration documents, on its website, in newsletters and through other appropriate media channels.

Recommendation for:

Department of Health

- The Department of Health will disseminate relevant information to key stakeholders, including commissioners, providers, medical schools and colleges, to enable a comprehensive list of services for doctors to be publicised.

*Royal College of Physicians of London, Royal College of Surgeons of England, Royal College of Obstetricians and Gynaecologists, Royal College of General Practitioners, Royal College of Pathologists, Royal College of Psychiatrists, Royal College of Anaesthetists, Royal College of Ophthalmologists, and Royal College of Paediatrics and Child Health.

Recommendation for:

NHS Direct

- NHS Direct should consider holding information to signpost doctors to available services and telephone numbers for doctor-specific services.

LOCAL ACTION

Recommendation for:

NHS trust occupational health departments

- Occupational health departments should consider holding an updated list of local and national services for doctors, which should be made available during induction and at initial occupational health assessments.

4.1.2 Designated care pathways and services

Doctors with mental ill health need access to services that recognise their particular needs. The following principles should govern provision of mental health care for doctors.

FIGURE 1: PRINCIPLES FOR CLINICAL CARE OF DOCTORS

- **Doctors who are ill should be treated first and foremost as patients, not colleagues.** Doctors' expert knowledge may not extend to their own condition. They may not be able to make objective judgements about treatment, illness severity and impact, risk or ability to work.
- **Rules on confidentiality should be strictly observed.** Doctors who are ill may need explicit reassurance about this (see also the section on confidentiality, page 10).
- **Additional safeguards to ensure privacy of care should be in place.** These should cover, for example, the location and timing of appointments, correspondence and case notes, and the passing on of messages by telephone or email.
- **Doctors should be registered with a local GP.** For GPs, this should be someone outside their own practice.
- **Doctors treating other doctors should have appropriate expertise and seniority.** They should have an interest and therefore experience in treating doctors. They should not have close professional or social contacts with those whom they treat.
- **Out-of-area care should be arranged unless local care is specifically requested.** This is particularly true if inpatient care is required.
- **Doctors should receive the same care and risk management as other patients.** For example, if treatment under the Care Programme Approach or the Mental Health Act 1983 is justified on clinical grounds, the treating doctor should not be influenced to make a different decision on care by the fact that the patient is also a doctor.

Specialist care

No one model for service provision has been demonstrated to be better than others. However, ad hoc arrangements cannot provide the speed of access and specialist expertise that may be needed. Local agreements should be in place that describe pathways of care for doctors. These should cover:

> mental health assessment and treatment;

> access to psychological therapies;

> inpatient care; and

> treatment of addictions.

Agreements need to include the identification of senior clinicians who will see doctor patients. One option is for reciprocal arrangements to be established between neighbouring organisations. The senior specialists providing such a service would be able to develop a network of experts, increasing the availability of appropriate care, with the potential to learn from each other's experience. The time needed to develop their special interest should be reflected in job plans.

To support local service development, the Department of Health will be considering further the provision of addiction and mental health care for health professionals.[41]

RECOMMENDATION: DESIGNATED CARE PATHWAYS AND SERVICES

LOCAL ACTION

Recommendation for:

Mental health trusts, health service commissioners and deaneries

- Local protocols that describe care pathways and funding arrangements for doctors should be developed. These should reflect the principles in Figure 1 on page 8 and should be supported by the identification of named senior clinicians to see doctor patients.

4.1.3 The role of occupational health services

Occupational health services have a key role to play, working alongside primary care and specialist mental health and addiction services. Current proposals for larger, regional occupational health services are likely to increase their scope, improve their access to expertise, and strengthen their links to primary care. The health at work strategy – *Health, Work and Well-being: Caring for our future* – makes a commitment to improve training for occupational health professionals in the management of common mental health problems.

RECOMMENDATIONS: THE ROLE OF OCCUPATIONAL HEALTH SERVICES

NATIONAL ACTION

Recommendation for:

Faculty of Occupational Medicine

- Occupational health practitioners should have sufficient training in order to understand and recognise common mental health problems, the environmental and organisational factors that may contribute to their development, their potential impact on work and how to access help and advice for their management.

LOCAL ACTIONS

Recommendations for:

NHS trusts and their occupational health departments

- Occupational health departments should clarify their local role and responsibility for doctors with mental ill health, in agreement with local mental health service providers, primary care and commissioners.
- Occupational health departments should be funded to ensure that appropriate services are available for doctors with mental ill health.
- Occupational health departments should have in-house mental health expertise.
- Occupational health departments should develop formal links with local mental health service providers for:
  - > staff development, for example shared training/shadowing opportunities; and
  - > occupational health consultation/liaison services for assessment and management advice for individual cases.
- Occupational health departments should have clear policies for supporting doctors and other workers with mental ill health on return to work. These should follow the same principles as for other diagnoses, such as reduced working hours and reduced/no on-call activities.

Recommendation for:

Occupational health departments and deaneries

- Links between deaneries and local occupational health departments should be made to help ensure appropriate support and job structure for vulnerable students and trainees.

4.1.4 The need for confidentiality and privacy

Confidentiality is a fundamental principle of healthcare. It is not, however, absolute, and good clinical care can sometimes be more difficult if it is. In treating doctors, clarity about both the importance and the limits of confidentiality, and agreement on how the rules of confidentiality will operate, are essential for all parties.

Doctors as patients are likely to be particularly concerned about confidentiality and this may make them reluctant to seek help or accept

treatment. They may fear that acknowledging the need for help will damage their career prospects or lead to scrutiny of their fitness to practise. These fears might be heightened by the features of their illness, such as low mood or suspicion. The location of a service – for example based in a local trust – or its organisational links – for example to a deanery – may increase fears. In these situations, services need to provide reassurance about their independence.

Local agreements can reassure doctors that information about them will be kept appropriately confidential. It is more likely that doctors will agree to disclosure if there is a clear explanation of why it is important and how the information will be treated. Agreements will also guide the treating doctor about how and in what circumstances information should be passed on.

In terms of the need for privacy, doctors may need to be assured that, during treatment or clinic attendance, they will not come into contact with their own patients or work colleagues and that their medical information will not be seen by colleagues.

Transfer of information

As medical students and junior doctors move through the system, it is important that health information moves with them. This is more likely to occur if there is local agreement between medical schools, deaneries and clinical tutors, making it clear how this should be done and who has, and who does not have, access to such information. For example, it may be appropriate for a clinical tutor to know about a doctor's health problems, but not necessary for this to be included in personnel files. Students could be asked to include information about mental health issues in transfer of information forms.

RECOMMENDATIONS: THE NEED FOR CONFIDENTIALITY AND PRIVACY

LOCAL ACTIONS

Recommendations for:

Deaneries, medical schools, local mental health and primary care service providers, and NHS occupational health services

- Local agreements should be drawn up concerning confidentiality.
- Assessment or treatment services should make explicit their independence and their rules on confidentiality.

4.2 Promoting mental health and well-being in doctors

In addressing mental ill health in doctors, it is equally important to consider what positive steps can be taken to promote mental health and well-being and prevent illness and relapse. Doctors, their colleagues, their managers and their employers have a shared responsibility in this area.

Our Health, Our Care, Our Say, the public health White Paper, emphasised the role of the NHS as a model employer, building on the Improving Working Lives standard and highlighting the importance of:

> tackling stigma and discrimination;

> healthy working practices; and

> reducing workplace stressors.[42 43]

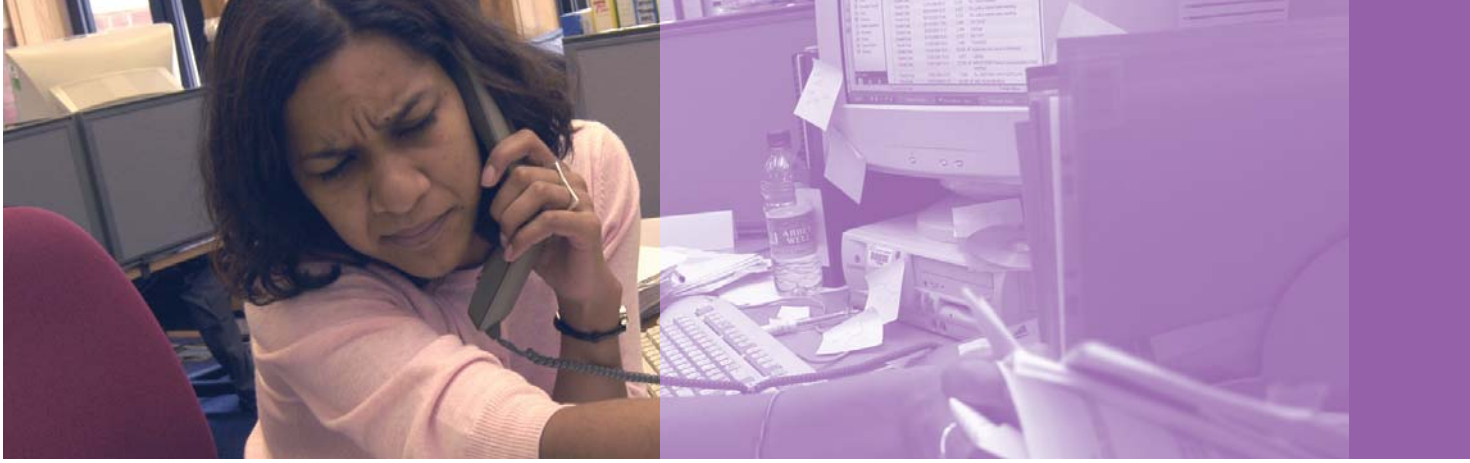
4.2.1 Tackling stigma and discrimination

The stigma that surrounds mental ill health remains a major barrier to seeking help – this is as true in health services as elsewhere. Ways in which employers can address stigma and discrimination are set out in the recent *Action on Stigma* initiative from Shift – the Government's mental health campaign against stigma and discrimination.[44] The five principles of *Action on Stigma* are listed below – they correspond closely to the Disability Equality Duty with which all public sector employers must now comply. These are the building blocks for employers – NHS organisations in particular – aiming to take practical steps to eliminate discrimination on the grounds of mental ill health.

FIGURE 2: *ACTION ON STIGMA* – PROMOTING MENTAL HEALTH, ENDING DISCRIMINATION AT WORK – THE PRINCIPLES

1. Employers can demonstrate that employees are helped to look after their mental health by making them aware of the steps they can take to preserve and maintain their own and others' mental well-being.
2. Employers promote a culture of respect and dignity for everyone, ensuring that staff are trained to recognise and be sensitive to mental distress or disability in others, whether they are workplace colleagues or customers.
3. Employers encourage awareness of mental health issues, so that employees are aware of the danger signs and understand the importance of seeking help early.
4. Employers can demonstrate that no one is refused employment on the grounds of mental illness or disability.
5. Employers make reasonable adjustments to the work environment for people with mental health problems so that they can continue working.

Medical schools can also take action. Direct contact with people with mental health problems can reduce pejorative views of mental illness. Medical schools and trainers can provide this by using mental health service users as teachers and trainers. Integration of the psychological aspects of illness with other parts of the undergraduate curriculum, as many medical courses now provide, is likely to strengthen the message that mental and physical aspects of ill health have many clinical and scientific similarities – discrimination thrives on the idea of 'difference'.



RECOMMENDATIONS: TACKLING STIGMA AND DISCRIMINATION

LOCAL ACTIONS

Recommendation for:

NHS trusts

- Healthcare organisations should be encouraged to adopt the principles of *Action on Stigma* as outlined in Figure 2 on page 12.

Recommendations for:

Medical schools and Medical Royal Colleges

- Education and training organisations should encourage the use of mental health service users in training.
- Education and training organisations should encourage the integration of psychological aspects of disease aetiology and management in training programmes.

4.2.2 Healthy working practices

There are many ways in which organisations can promote good working practices and, as a result, enhance the physical and mental health and well-being of medical staff. Managers can ensure that staff have access to good food on call, protected meal times, sufficient sleep after being on call, and opportunities to address overwork through supervision and appraisal. Staff appraisals should routinely include enquiries about health – this is a chance to make clear the importance to work performance of looking after one's general health and well-being. Medical schools, trainers and employers have an important part to play – through induction, supervision, support and appraisal.

RECOMMENDATIONS: HEALTHY WORKING PRACTICES

LOCAL ACTIONS

Recommendations for:

Medical schools, local NHS employers and deaneries

- Apply the five *Action on Stigma* principles as outlined in Figure 2 on page 12.
- Employment, education and induction material should include reminders about the importance of GP registration, looking after one's own health, understanding stressors at work, understanding ways of coping, the role of occupational health services, and where to seek help.
- Improving Working Lives – particularly flexible working, healthy environments and the distribution of materials to qualifying medical students and new consultants – should continue to be promoted.
- Appraisals should aim to include discussions about health, including GP registration; they must therefore be conducted by individuals of appropriate seniority who have a clear understanding of the boundaries of the role with respect to health information and confidentiality.

4.2.3 Reducing stressors in the workplace

Employers have a legal duty to assess and address the risk of stress-related ill health resulting from work activities.[ii] In 2005, the Health and Safety Executive (HSE) published management standards for workplace stressors, a six-step approach to risk assessment for work-related stress covering demands, control, support, relationships, roles and change (see below and Appendix 3).[45 46]

FIGURE 3: The Health and Safety Executive STRESS MANAGEMENT STANDARDS

1. Demands

- Employees indicate that they are able to cope with the demands of their job.
- Systems are in place locally to respond to any individual concerns.

2. Control

- Employees indicate that they are able to have a say about the way they do their work.
- Systems are in place locally to respond to any individual concerns.

3. Support

- Employees indicate that they receive adequate information and support from their colleagues and superiors.
- Systems are in place locally to respond to any individual concerns.

4. Relationships

- Employees indicate that they are not subjected to unacceptable behaviours, for example bullying at work.
- Systems are in place locally to respond to any individual concerns.

5. Roles

- Employees indicate that they understand their role and responsibilities.
- Systems are in place locally to respond to any individual concerns.

6. Change

- Employees indicate that the organisation engages them frequently when undergoing an organisational change.
- Systems are in place locally to respond to any individual concerns.

[ii] Employers have duties:
> under the Management of Health and Safety at Work Regulations 1999 to assess the risk of stress-related ill health arising from work activities; and
> under the Health and Safety at Work etc Act 1974 to take measures to control that risk.

It is likely that in the future these will be more actively enforced, together with the requirements of the Disability Equality Duty.

Sources of job stress include excessive working hours, poor relationships with colleagues and managers, lack of opportunity to delegate work and isolation. However, the 2005 survey on behalf of NHS Employers suggests that only 27% of organisations surveyed had carried out any risk assessments related to stress. When asked about stress prevention initiatives, most cited counselling and nearly half cited job redesign/restructuring and stress management training, ie they focused on the individual rather than the organisation.[47]

There is also a key role for both national and local organisations to ensure that support is available for doctors at times of severe stress – such as during inquiries, investigations, and legal and disciplinary procedures. Recognising the stressful nature of these events, particularly contact with organisations such as the GMC, the NHS Litigation Authority (NHS LA) and the National Clinical Assessment Service (NCAS), and taking action to address it may help reduce the perception that 'the system' is punitive.

Employers should ensure that there is prompt resolution to stressful situations, that any investigations are fair, just and transparent, and that a range of support is offered to staff.[48] Support systems such as buddying and mentoring should be in place. Organisations should monitor indicators of workplace stress, such as hours worked above European directives and sickness/absenteeism.

RECOMMENDATIONS: REDUCING STRESSORS IN THE WORKPLACE

NATIONAL ACTION

Recommendation for:

GMC, NHS LA and NCAS

- National bodies should consider how to help doctors access appropriate advice and support when referred to them.

LOCAL ACTIONS

Recommendations for:

Local NHS trusts

- Action should be considered to generate a culture of fairness, openness and accountability, especially with respect to the management of investigations and complaints.
- Local peer support should be provided for all medical personnel, for example buddying schemes for new consultants and trainees, learning sets, mentoring systems and career guidance.
- There should be appropriate, independent support provided for doctors subject to stressful processes such as investigations, court cases or referral to the NCAS or GMC.

4.2.4 Supporting staff with mental ill health

A number of existing publications set out how NHS organisations should support staff who develop mental health problems or who are returning to work after a period of absence. Guidance is given in *Mental health and employment in the NHS*.[49] The Disability Equality Duty describes a trust's legal responsibilities, and these are backed by the measures in the Government's *Action on Stigma* initiative.

RECOMMENDATIONS: SUPPORTING STAFF WITH MENTAL ILL HEALTH

LOCAL ACTIONS

Recommendations for:

Local NHS employers

- Review guidance in *Mental health and employment in the NHS*.
- Request local implementation of the Disability Discrimination Act 2005.
- Develop drug and alcohol at work policies that include specific reference to the identification and management of medical staff.

4.2.5 Looking after one's own health

In addition to actions taken by employers and other organisations, medical staff have a professional responsibility to look after their own health and mental health – this is an essential part of being a competent and effective doctor. From medical school onwards, doctors need to be enabled to understand the nature of the stress that a career in medicine can bring, and the possible impact on their health, their relationships and their work. They need to acquire skills that help deal with stressors without resorting to counterproductive ways of coping, such as excessive alcohol. They also need to believe that it is safe to admit to problems or mistakes and to seek help, at the earliest opportunity, when facing difficulties.

Education and training organisations, including the GMC, have a role to play in ensuring that doctors are equipped to understand and deal with the stressors of a medical career and the potential impact on their health.

RECOMMENDATIONS: LOOKING AFTER ONE'S OWN HEALTH

NATIONAL ACTIONS

Recommendation for:

GMC

- The GMC should consider how to raise awareness of the stressors of medical careers and how they can affect doctors' physical and mental health.

Recommendation for:

GMC, Medical Royal Colleges and medical schools

- Undergraduate and postgraduate training needs to include an understanding of the inevitable stressors that medical careers entail and their impact on health and work. Training and education also need to address the development of skills to manage these stressors, for example conflict resolution, managing difficult situations, team working, dealing with complaints and court skills.

4.2.6 Summary points

> Doctors with mental ill health have specific needs that should be addressed through having explicit arrangements for mental health care agreed locally.

> These arrangements should be underpinned by the principles described in Figure 1 on page 8.

> Occupational health services should help doctors access appropriate mental health expertise.

> Training, education and employing organisations should work towards introducing policies and practices to create environments that promote mental health and well-being in the workforce, with particular reference to the needs of doctors.

> Doctors should fully understand the importance of maintaining their own health, to understand the stressors inherent in a medical career and how to manage them.

Appendix 1:

Group membership and organisations consulted

Group membership

Professor Louis Appleby (Chair)	National Director for Mental Health, Department of Health
Dr Antony Garelick	MedNet
Professor John Gunn	Royal College of Psychiatrists
Dr Rob Hale	Tavistock and Portman NHS Trust – member of the Daksha Emson inquiry team
Dr Kit Harling	NHS Plus
Dr Anna Higgitt	Consultant Psychiatrist and Senior Policy Adviser, Department of Health
Dr Chris Manning	primhe – Primary Care Mental Health and Education
Dr Lizzie Miller	Doctors' Support Network
Dr Sian Rees	Senior Policy Adviser, Department of Health
Mr Julian Topping	NHS Employers
Dr Sian Williams	Consultant in Occupational Health, Royal Free Hospital

Organisations consulted

Academy of Medical Royal Colleges

Conference of Postgraduate Medical Deans (COPMeD)

General Medical Council

Medical Schools Council

National Clinical Assessment Service

NHS Confederation

NHS Litigation Authority

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Royal College of Psychiatrists

Appendix 2:

Organisations providing support services for doctors

National services	Provider	Contact details	Description of service
BMA Counselling	British Medical Association	Tel: 08459 200 169	Provides 24/7 telephone counselling by qualified counsellors.
British Doctors' and Dentists' Group		Tel: 0870 444 5163 Website: www.medicouncilalcol.demon.co.uk	A network of support groups of recovering medical and dental drug and alcohol users. Students are also welcomed. Access is through the Sick Doctors' Trust or the Medical Council on Alcohol.
British International Doctors Association		Tel: 0161 456 7828 Email: oda@doctors.org.uk	Where cultural or linguistic problems may be a contributing factor, doctors can access the health counselling panel.
Doctors for Doctors	British Medical Association	Tel: 020 7383 6739 Website: www.bma.org.uk/doctorsfordoctors	The unit deals with a wide range of problems, including doctors subject to bullying and harassment, as well as supporting doctors who have been suspended or are going through a complaints procedure. Doctors contacting the unit are from a wide spectrum of specialties and grades, including medical students.
Doctors' SupportLine		Tel: 0870 765 0001 Website: www.doctorssupportline.org Email: deirdre@doctorssupport.org	A helpline offering peer support to doctors and medical students who want to talk through personal problems. All calls are answered by trained volunteer doctors. Completely anonymous and confidential. Open 36 hours a week.
Doctors' Support Network	Independent registered charity	Helpline tel: 0870 765 0001 Admin tel: 0870 321 0642 Website: www.dsn.org.uk Email: secretary@dsn.org.uk	Self-help group for doctors with any form of mental health concern. Also seeks to reduce the isolation and stigma associated with mental ill health. Provides an email support forum, local support meetings and newsletter and runs the Doctors' SupportLine, a confidential and anonymous peer support telephone line.

National services	Provider	Contact details	Description of service
RCOG Mentoring Scheme	Royal College of Obstetricians and Gynaecologists	Tel: 020 7772 6369 Website: www.rcog.org.uk Email: cdhillon@rcog.org.uk	Provides mentoring support for its members and fellows in difficulties. Guidelines are available on the College's website.
Sick Doctors Trust		Tel: 0870 444 5163 Website: www.sick-doctors-trust.co.uk	A 24-hour helpline manned entirely by doctors. Independent charity, established 11 years ago. Completely confidential service providing advice, support and advocacy to doctors who believe they may have a problem with alcohol and/or drugs. Calls are welcomed from families, colleagues, employing organisations and others.
Support4Doctors	Royal Medical Benevolent Fund	Tel: 020 8540 9194 Website: www.support4doctors.org; www.rmbf.org Email: enquiries@rmbf.org	Charity which can provide financial help for sick doctors who are unable to work. Also signposts a range of other organisations that can help.
Surgeon-to-Surgeon Helpline	Royal College of Surgeons of England	Tel: 0800 107 1916	Provides personal and professional advice and signposting.
The Psychiatrists' Support Service	Royal College of Psychiatrists	Tel: 020 7245 0412 Email: psychiatristssupportservice@rcpsych.ac.uk Write to: Psychiatrists' Support Service Manager The Royal College of Psychiatrists 17 Belgrave Square London SW1X 8PG	The Psychiatrists' Support Service is a confidential support and advice telephone service for member psychiatrists who, for example, find themselves in difficulty over issues such as bullying and harassment, career pathway, GMC involvement, health issues, inquiries, serious clinical incidents.

Local services	Provider	Contact details	Description of service
Clinical Performance Support Unit	East Midlands Healthcare Workforce Deanery	Tel: 0115 846 7641 Website: www.eastmidlands deanery.nhs.uk	Provides a service for doctors and dentists who find themselves in difficulty, offering career guidance and one-to-one support.
House Concern	Northumberland, Tyne and Wear NHS Trust	Tel: 0191 230 0043 Fax: 0191 227 5142 Email: greta.nushet@ntw.nhs.uk; margaret.rangecroft@ntw.nhs.uk; pat.black@ntw.nhs.uk	A service specifically for doctors and other health professionals working in the Northern Deanery. It provides a clinical service to all doctors and an educational service to all healthcare professionals.
Medic Support	Oxford	Tel: 01865 223 924 or 01865 556 648 Website: www.oxforddeanery cdu.org.uk/health/help_for_ trainees/medic_support.html Email: June.Dent@obmh.nhs.uk or Philip.Roys@obmh.nhs.uk	A confidential service offering a rapid response and a choice of therapeutic treatments for personal and work-related difficulties.
MedNet	London and KSS Deanery	Tel: 020 8938 2411	Provides doctors and dentists with practical advice about their career, emotional and clinical support should they need it, and, if appropriate, access to brief or longer-term psychotherapy. It operates on the basis of strict confidentiality.

Appendix 3:

The Health and Safety Executive (HSE) stress management standards

Note on the management standards

The descriptions in each of the standards shown as 'What should be happening/states to be achieved' define a desirable set of conditions to work towards.

You can use the data from the HSE indicator and analysis tools to define the gap between where you are now and where you want to get to. The analysis tools will provide a set of data on your performance in each of the six standard areas. Also provided are representative data on current performance in the UK workforce. You will probably find that you are good on some things and less good on others. Together with any existing data you may have (for example, on sickness absence or staff turnover), this information can be used in focus group discussions with employees to determine what is happening locally and what should be done to close the gap.

The six standard areas

Demands

(Includes issues like workload, work patterns and the work environment.)

The standard is that:

> Employees indicate that they are able to cope with the demands of their job; and

> Systems are in place locally to respond to any individual concerns.

What should be happening/states to be achieved:

> The organisation provides employees with adequate and achievable demands in relation to the agreed hours of work.

> People's skills and abilities are matched to the job demands.

> Jobs are designed to be within the capabilities of employees.

> Employees' concerns about their work environment are addressed.

Control

(How much say the person has in the way they do their work.)

The standard is that:

> Employees indicate that they are able to have a say about the way they do their work; and

> Systems are in place locally to respond to any individual concerns.

What should be happening/states to be achieved:

> Where possible, employees have control over their pace of work.

> Employees are encouraged to use their skills and initiative to do their work.

> Where possible, employees are encouraged to develop new skills to help them undertake new and challenging pieces of work.

> The organisation encourages employees to develop their skills.

> Employees have a say over when breaks can be taken.

> Employees are consulted over their work patterns.

Support

(Includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.)

The standard is that:

- Employees indicate that they receive adequate information and support from their colleagues and superiors; and
- Systems are in place locally to respond to any individual concerns.

What should be happening/states to be achieved:

- The organisation has policies and procedures to adequately support employees.
- Systems are in place to enable and encourage managers to support their staff.
- Systems are in place to enable and encourage employees to support their colleagues.
- Employees know what support is available and how and when to access it.
- Employees know how to access the required resources to do their job.
- Employees receive regular and constructive feedback.

Relationships

(Includes promoting positive working to avoid conflict and dealing with unacceptable behaviour.)

The standard is that:

- Employees indicate that they are not subjected to unacceptable behaviours, for example bullying at work; and
- Systems are in place locally to respond to any individual concerns.

What should be happening/states to be achieved:

- The organisation promotes positive behaviours at work to avoid conflict and ensure fairness.
- Employees share information relevant to their work.
- The organisation has agreed policies and procedures to prevent or resolve unacceptable behaviour.
- Systems are in place to enable and encourage managers to deal with unacceptable behaviour.
- Systems are in place to enable and encourage employees to report unacceptable behaviour.

Roles

(Whether people understand their role within the organisation and whether the organisation ensures that people do not have conflicting roles.)

The standard is that:

- Employees indicate that they understand their role and responsibilities; and
- Systems are in place locally to respond to any individual concerns.

What should be happening/states to be achieved:

- The organisation ensures that, as far as possible, the different requirements it places upon employees are compatible.
- The organisation provides information to enable employees to understand their role and responsibilities.

- The organisation ensures that, as far as possible, the requirements it places upon employees are clear.
- Systems are in place to enable employees to raise concerns about any uncertainties or conflicts they have in their role and responsibilities.

Change

(How organisational change (large or small) is managed and communicated in the organisation.)

The standard is that:

- Employees indicate that the organisation engages them frequently when undergoing an organisational change; and
- Systems are in place locally to respond to any individual concerns.

What should be happening/states to be achieved:

- The organisation provides employees with timely information to enable them to understand the reasons for proposed changes.
- The organisation ensures adequate employee consultation on changes and provides opportunities for employees to influence proposals.
- Employees are aware of the probable impact of any changes to their jobs. If necessary, employees are given training to support any changes in their jobs.
- Employees are aware of timetables for changes.
- Employees have access to relevant support during changes.

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