

Self-referrals to a doctors' mental health service over 10 years

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Background	The adverse impact on doctors' health of constant organizational change in healthcare is well established.
Aims	To investigate the change in self-referral rates to a doctors' mental health service, and associated morbidity over a decade.
Methods	All doctors attending a doctors' mental health service between 1 January 2002 and 31 December 2011 were asked to complete the Clinical Outcomes in Routine Evaluation questionnaire and Maslach burnout inventory as part of routine assessment before treatment. Univariate analysis of variance was used to test for statistically significant differences between severity scores in different years.
Results	Between 1 January 2002 and 31 December 2011, 1062 doctors attended the service; 852 (80%) completed both questionnaires and 64 (6%) completed one of them. The overall response rate was 86% (916/1062). Referrals increased >4-fold, from 44 in 2002 to 185 in 2011. Sixty-one per cent scored above the threshold for psychological distress and 59% for burnout. There were no significant changes in morbidity over time.
Conclusions	Increasing numbers of doctors sought help from the doctors' mental health support service. More than half scored above the thresholds for burnout and psychological distress and these proportions were consistent over 10 years. Doctors may be more willing to seek help than a decade ago. Further research is needed to confirm the underlying reasons for this. More resource is needed to meet the increase in demand.
Key words	Burnout; doctors' mental health; medical profession; stress.

Introduction

Researchers around the world have known for decades that physicians have high rates of depression and suicide compared with the general population [1–3]. In recent years pressure on doctors has risen in many countries, with different healthcare reforms affecting doctors' autonomy, prestige and income, resulting in higher work stress [4]. In Europe and North America there is increasing pressure on healthcare funding. The impetus to support doctors' health has therefore never been more pressing [4]. In the UK, the National Health Service (NHS) has undergone unprecedented change and re-organization in an effort to control healthcare costs.

In September 2012, the UK Royal College of Physicians (RCP) published a report, *Hospitals on the Edge? The Time for Action*, highlighting the relentless pressure on acute services [5]. Doctors must respond to increasing clinical demand, an ageing population with multiple complex needs, reduced continuity of care and inadequate out of hours care [5]. The overstretching of accident and emergency services has recently been highlighted [6]. The RCP report warned of a looming workforce crisis. Three quarters of hospital consultants reported being under more pressure than 3 years previously. The Francis report described how organizational culture is adversely affecting service delivery, professional performance and engagement [7].

Primary care has also undergone radical changes in recent years and become an increasingly stressful area of work [8,9]. General practitioners (GPs) report progressive increases in demands competing for their attention, including new commissioning arrangements, administration and documentation on which payment depends. Older GPs report striking change, while GP trainees struggle to acclimatize to workload, the multiple skills required of them and the pressure to complete patient consultations in less time. The role of GPs is increasingly complex, including managing the difficult dynamics of GP partnerships, maintaining professional and financial relationships and employing a diverse range of non-medical staff and salaried partners.

For junior doctors, the implementation of the European Working Time Directive has resulted in complicated rotas that frequently change at short notice. This makes it very difficult for them to plan their personal lives. Peer contact and support is eroded and financial pressure has increased. Changes in the job appointment system for junior doctors make it more difficult for doctor couples to be able to work in the same area. Several recent government reports on the health of healthcare professionals emphasize that when healthcare professionals become unwell, there are economic, patient care and personal consequences [10,11]. MedNet is a doctors' mental health service, funded by Health Education England, providing doctors of all grades working in London with confidential psychiatric and psychotherapeutic consultations, since 1995. This study aimed to investigate changes in self-referral rates to the service and associated morbidity over 10 years.

Methods

All doctors attending the MedNet service between 1 January 2002 and 31 December 2011 were asked to complete the Clinical Outcomes in Routine Evaluation (CORE-OM) questionnaire and Maslach burnout inventory (MBI) as part of routine assessment before treatment. Informed consent was obtained from each participant. The study was approved by the Trust's Research Ethics Committee in 2002.

The CORE-OM [12] is a 34-item self-report questionnaire that assesses subjective well-being, commonly experienced problems or symptoms, life/social functioning and risk to self and others on a five-point Likert scale ranging from 0 (not at all) to 4 (most or all of the time). We calculated a total CORE-OM and a score for all four subscales. Standardized scores determining clinical thresholds on this measure were used as provided by the distributor [12].

The MBI [13] is a 22-item self-report questionnaire that evaluates work-related distress on a seven-point Likert scale with three dimensions: emotional

exhaustion, depersonalization and personal accomplishment. We scored each dimension independently as high, moderate or low. Researchers have relied solely on the emotional exhaustion subscale of the MBI because of its strong predictive properties of burnout [14]. In-line with this we present the analysis of this subscale only. Low and moderate levels were considered below and high levels above clinical threshold.

The validity and reliability of both measures have been confirmed in previous studies [15–18]. Statistical analysis was conducted in SPSS v 21 using descriptives to examine the change in numbers of self-referrals, and univariate analysis of variance to test for differences between average severity scores on the CORE-OM and MBI in different years.

Results

Between 1 January 2002 and 31 December 2011, 1062 doctors attended the service, 80% (852) completed both questionnaires and 6% (64) completed one of them. The overall response rate was 86% (916/1062). Thirty-nine per cent (360) of the doctors were male. The age range was 22–68, mean 35 years. Fifty-four per cent (496) were Caucasian; 20% (187) were Asian, the largest minority ethnic group. Figures 1 and 2 show the distribution of career grades and specialties of participants. Figure 3 shows that there was a >4-fold increase in annual self-referrals from 44 in 2002 to 185 in 2011. Mean MBI and CORE-OM scores for each year are shown in Tables 1 and 2, respectively. On the MBI, 59% of doctors scored above clinical cut-off for emotional exhaustion (≥ 27). On the CORE-OM, 61% of doctors scored above clinical cut-off for psychological distress (1.19 for males, 1.29 for females). We found no statistically significant difference in CORE-OM or MBI scores between years.

Discussion

Despite an over 4-fold increase in self-referrals to our service between 2002 and 2011, we found no significant change in morbidity over time. However, more than half of doctors consistently scored above the threshold for burnout and psychological distress in each of the 10 years studied. Strengths of our study include the large data set collected over 10 years, using validated questionnaires and a high response rate. Weaknesses include possible response bias from the self-report measures and the absence of formal, systematic, qualitative data to explore the underlying reasons for the increase in referral rate and the high rates of burnout and distress.

In a recent survey by the RCP, nearly 80% of the respondents agreed that being a physician now is harder than it has ever been [19]. Asked about underlying causes of the problems revealed by the survey, responders

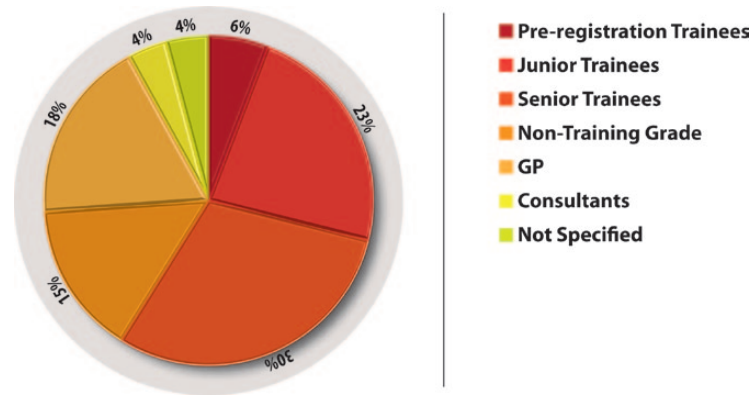


Figure 1. Distribution of presenting doctors' career grades.

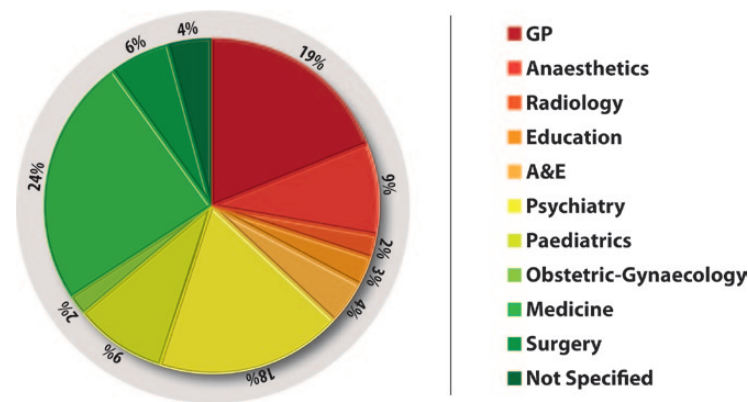


Figure 2. Distribution of presenting doctors' specialities.

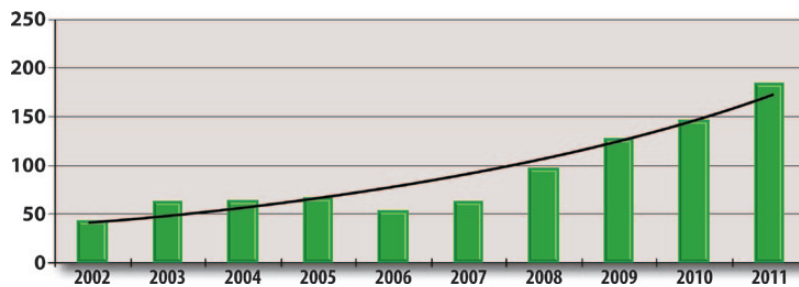


Figure 3. Annual increase of self-referrals.

highlighted shortages of clinical staff, the implementation of the European Working Time Directive and New Deal, the impact of efficiency savings and insufficient NHS funding [19]. One explanation for the increase in self-referral rates to our service is reduced stigma and more willingness of doctors to seek support. However, if these were the only reasons, we would have expected reduced scores and doctors presenting earlier. Another factor could be increased awareness of our service. Doctors attending our service have been shown to have improved outcomes in CORE-OM and MBI scores and to value the service highly [20,21]. The service may

therefore have been promoted by word of mouth. The new Professional Support Unit of the former London Deanery also promoted it in 2011/12. There have been recent national developments to support doctors' health through training of educational supervisors and appraisers [10,11]. However, the increase in self-referral rates to our service preceded these initiatives. Our experience from delivering this service is that medicine has become an increasingly stressful profession, and that more doctors struggle to cope with the pressures. Doctors describe fragmentation of medical experience in hospital and primary care settings, increasing responsibility, minimal

Table 1. MBI-Emotional Exhaustion subscale mean scores, 95% confidence intervals and percentage of participants scoring above clinical threshold of ≥ 27

Year of referral	<i>n</i>	Mean score (95% confidence intervals)	Patients above clinical threshold, <i>n</i> (%)
2002	43	30.90 (26.9–34.9)	28 (65)
2003	61	31.33 (28.4–34.3)	39 (64)
2004	63	28.48 (25.3–31.6)	38 (60)
2005	65	29.68 (26.7–32.7)	39 (60)
2006	52	23.96 (20.1–27.8)	22 (42)
2007	60	29.27 (25.9–32.7)	40 (67)
2008	94	30.89 (28.3–33.5)	59 (63)
2009	118	28.40 (26.2–30.6)	66 (56)
2010	137	29.36 (27.3–31.4)	88 (64)
2011	175	28.10 (26.3–29.9)	96 (55)
Total	868	28.99 (28.2–29.8)	515 (59)

Table 2. CORE-OM total score means, 95% confidence intervals and percentage of participants scoring above clinical cut-off of 1.19 for males and 1.29 for females

Year of referral	<i>n</i>	Mean score (95% confidence intervals)	Patients above clinical threshold, <i>n</i> (%)
2002	38	1.30 (1.07–1.52)	19 (50)
2003	64	1.53 (1.36–1.69)	45 (70)
2004	64	1.40 (1.24–1.56)	36 (56)
2005	66	1.35 (1.19–1.50)	39 (59)
2006	53	1.38 (1.16–1.59)	30 (56)
2007	63	1.53 (1.37–1.69)	39 (62)
2008	95	1.58 (1.45–1.70)	64 (67)
2009	123	1.50 (1.39–1.61)	77 (62)
2010	142	1.49 (1.38–1.60)	87 (61)
2011	183	1.44 (1.34–1.53)	108 (59)
Total	891	1.46 (1.42–1.51)	544 (61)

control of their working environment and increasing challenges to their status and knowledge. This accords with Karasek's model of work-related stress being associated with high work demands and low control and support [22]. We were therefore surprised not to find significant increases in morbidity scores on the questionnaires. One explanation could be that a significant proportion of doctors were scoring above the thresholds for burnout and psychological distress at the start of the data collection period. It may be that doctors were reluctant to disclose the full extent of their distress because of concerns about the implications for their career. However, this would have been the case as much in 2002 as in 2011. Qualitative data collected from doctors seeking support would help to explore this further.

We suggest that the following measures might help to mitigate the observed high rates of distress and burnout in doctors:

1. Educating medical students about the complexity and challenges of medicine, emphasizing the normality of feelings of vulnerability and stress, the acceptability of acknowledging difficulty as the first step in managing it and that seeking support is adaptive rather than a sign of weakness. In July 2013, the General Medical Council published *Supporting Medical Students With Mental Health Conditions* for medical schools and medical students [23].
2. Case-based discussion groups for junior doctors led by senior clinicians, to allow disturbing clinical, professional and organizational situations to be discussed openly, facilitating peer support and reflective practice. Another initiative in a similar vein is a Schwartz Center Round that allows NHS staff to get together once a month to reflect on the stresses and dilemmas that they have faced. Schwartz Center Rounds were first developed by the Schwarz Center for Compassionate Healthcare in Boston, USA and have now been introduced by several NHS Trusts in the UK [24].
3. Further establishment and development of services such as MedNet for doctors, where doctors can seek expert, confidential psychological and psychiatric treatment as required. The value of such services is recognized and the increase in demand will need to be met by increased supply of suitable support services [25,26].

Key points

- A 4-fold increase in self-referrals, predominantly presenting with psychological distress and burnout, to a service for doctors was recorded over 10 years.
- It is postulated that medicine has become more stressful and more doctors struggle to cope with the pressures.
- Initiatives in medical education, support in clinical settings and increased resources to address the mental health needs of doctors should be considered.

Acknowledgements

We would like to thank the clients of MedNet for their participation in the study, Mrs Chrystalla Loizou for her very valuable and efficient assistance in terms of data collection for this paper and Dr Matthias Von der Tann for his thorough and substantial manuscript revision.

Conflicts of interest

Three of the authors work in the MedNet Service.

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