

THE COMPETENT NOVICE

How to handle stress and look after your mental health

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Junior doctors can take action to avoid stress and depression associated with their workload. This article explains how, and gives advice on who to seek help from if the need arises

Twenty years ago Firth-Cozens reported that among doctors in their first year of graduating 50% were estimated to have emotional disturbance and 28% fulfilled criteria for depression.¹ Since then, working hours have decreased, and the way that doctors are trained and managed has changed substantially. Despite this, the proportion of doctors experiencing psychological distress has remained constant, at about 28%, compared with about 18% in the general working population.^{2,3} For junior doctors, 79% of those caught up in the recent problems of MTAS (the UK medical training application service, an online system for the selection of junior doctors) scored above the threshold for psychological distress and 21% had significant distress.⁴ Psychiatric morbidity and burnout among hospital specialists in the UK are also increasing, rising between 1994 and 2002 from 27% to 32% and from 32% to 41% respectively.⁵ The four fictitious case scenario boxes illustrate a typical experience of a junior doctor becoming increasingly stressed.

Stress

Stress is a controversial term but is broadly understood to result from an “imbalance between demands and resources” or occurring when “pressure exceeds one’s perceived ability to cope.”⁶ Although stress is not unique to medicine, commentators have suggested that the following combination of factors may contribute to stress in doctors: excessive workload⁷; dealing with patients’ suffering and one’s own mistakes or fear of them; and lack of professional support and training, particularly in the areas of communication, leadership, and management.

These factors contribute to a subjective sense of overload and inability to cope, which may then be compounded by maladaptive responses such as working long hours or drinking heavily.⁸ A longitudinal study of 1668 UK doctors found that perceived high workload and lack of support correlate with stress

and burnout reported five or six years earlier, when the doctors were preregistration house officers carrying out entirely different jobs. The study also found that doctors with greater stress and emotional exhaustion had higher neuroticism scores.⁹

Why does stress matter?

Stress matters because a proportion of doctors experiencing prolonged job stress will develop a more serious problem such as burnout (defined as emotional exhaustion, depersonalisation, and decreased sense of personal accomplishment owing to work stress), depression, an anxiety disorder, and/or drug or alcohol dependence.¹⁰ The risk may be particularly acute for women doctors, in whom psychiatric morbidity is more common than in male doctors and suicide is twice as common as in women in the general population.¹¹

Stress matters for patients too. A postal survey of 1794 UK NHS hospital consultants found that those with poor mental health were more likely to report that they gave reduced standards of care to patients by, for example, taking short cuts.¹² A third of 225 doctors in another survey reported incidents where they believed that symptoms of stress had negatively affected patient care.¹³ These findings might indicate that stressed doctors are more likely to be self critical and thus report errors. However, more objective studies suggest that reducing stress for doctors is good for patients. A case-control study found that the introduction of stress management courses to 22 hospitals was associated with a substantial reduction in the rate of malpractice claims compared with the control hospitals.¹⁴

CASE SCENARIO: PART 1

Sarah Craven is a first year foundation doctor working on a busy and understaffed medical admissions unit. She has been skipping lunch and staying after work to try to finish all the jobs from the daily ward round and is getting tired and irritable as a result. The second year foundation doctor is off sick, and the registrar often has to deal with patients elsewhere in the hospital and seems stressed and short tempered when she calls him for advice.

This series aims to help junior doctors in their daily tasks and is based on selected topics from the UK core curriculum for foundation years 1 and 2, the first two years after graduation from medical school.

CASE SCENARIO: PART 2

Sarah becomes increasingly preoccupied by her workload and has not had time to go for a run, call her parents, or see her friends. In the evenings she feels exhausted and tearful; she feels ashamed of this as she has always been someone who “gets the job done” and “doesn’t let the side down.” She drinks four to five glasses of wine each night to help her get to sleep.

How to prevent stress from affecting your mental health

Prevention of stress related illness is currently the subject of a vast amount of empirical research. A recent systematic review of the literature on interventions to prevent burnout in junior doctors concluded that few of the existing studies undertaken were of sufficient methodological quality to be included.¹⁵ However, two interventions that used meditation-type practice

did seem to improve mood disturbance in both junior doctors and medical students.^{16,17}

A postal questionnaire sent to 2456 UK doctors working in their first year showed that these doctors found that talking through their problems, either with a colleague or with someone outside medicine, was a helpful coping strategy.⁷ The responses indicated that these doctors’ workload often made it difficult for them to find the time for such discussions; formal mentoring schemes separate from appraisal and embedded in training rotations may therefore help.

Box 1 outlines key steps that doctors can take as individuals for preventing stress, and suggestions for organisations, educators, and leaders.

How to recognise when job stress has affected your or a colleague’s mental health

The General Medical Council advises that doctors should be “alive to mental health problems, depression, and alcohol and drug dependence [in colleagues]” and should “Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk.”²⁵

It is sometimes difficult to distinguish job stress from a more serious mental health problem. Box 2 gives some “red flag” symptoms that alert you to the possibility that you or a colleague may need further support or advice. If in doubt, the priority is to seek appropriate assessment for you or help a colleague to do the same.

How to access services for yourself or a colleague

An overview of sources of help for doctors is outlined in box 3. Doctors need to be aware that most sources of help operate entirely confidentially and separately from internal bodies (such as trusts) or external agencies (such as the GMC) and that it is only necessary to breach this confidentiality in exceptional circumstances.

How to best help and support an unwell colleague is a complex matter, and little empirical evidence currently exists to guide doctors about the best way to proceed. An appropriate response will depend on the nature of your colleague’s apparent difficulty. If you think a colleague is stressed or may have depression, perhaps start by talking about your concerns gently but directly with him or her and then try to facilitate an assessment (by directing your colleague to a source of help).

If you believe that a colleague’s poor mental health may be influencing his or her ability to practise as a doctor, you will require more expert guidance about

Box 1 Preventing stress*

What can you do to keep yourself well?

- Find mentors to support you at different stages in your career.¹⁸ The London Deanery offers four sessions of mentoring for all doctors in training in the London Deanery (<http://mentoring.londondeanery.ac.uk/mentees>), and the Northern Deanery operates a similar scheme (<http://mypimd.ncl.ac.uk/PIMDDev/news/mentoring-in-the-northern-deanery/>)
- Adopt a regular self care practice as part of your routine (such as exercise¹⁹)
- Engage in reflection—acknowledge your emotions about difficult patients or challenging clinical scenarios (for example, by joining a Balint group, or similar)^{20,21}
- Familiarise yourself with basic techniques of cognitive behavioural therapy, which can help you to challenge unhelpful beliefs you may have about yourself or your work (for example, look at www.moodgym.anu.edu.au)
- Put time aside for family and friends⁷
- Influence your own happiness through re-examining and honouring your personal values—for example, setting boundaries around work or making time for religious, spiritual, and social activity†
- Specific skills such as time management may be useful if you are overwhelmed with work. Various courses are available in the UK (try googling time management courses)†

What can employers and educators do?

At medical school

- Encourage mentoring and peer support networks through medical school and beyond²²
- Provide teamwork and leadership training from medical school onwards²³
- Educate students to be aware of their own health needs and reduce the stigma associated with asking for help²⁴

For junior doctors

- Increase supervision of a new doctor for the first few weeks and at night⁷
- Do not allow junior doctors to get sleep deprived⁷
- Ensure juniors have time to discuss difficult or challenging cases, and encourage open and constructive discussion of errors^{20,21}
- Ensure that juniors have a work-life balance so they can get informal support from family and friends⁷

Throughout doctors’ careers

- Improve provision of flexible childcare†
- Preserve clinical autonomy by allowing doctors some control over the way they work and the content of their workload†

*Based on surveys and interventional studies, except where indicated otherwise.

†Authors’ suggestions.

CASE SCENARIO: PART 3

It is becoming harder for Sarah to work as she feels exhausted and finds it hard to concentrate. She begins to doubt her own ability, but keeps going to work so that she doesn’t let her team down. She stays later and later to try to clear the mounting paper work. She begins to question whether she still wants to be a doctor. One morning, she feels so demoralised and tired that she “cannot go on” and she calls in sick

CASE SCENARIO: PART 4

Sarah takes a week off work and decides that she needs to examine some of her own health needs to enable her to continue. She registers with a local general practitioner, signs up for a time management course, walks the two miles to and from work, and prepares packed lunches to ensure she does not miss out on a midday meal. She tries to be less self critical if she doesn't manage to complete all her planned daily tasks. She talks to other foundation year doctors at her hospital to pick up useful tips on how to manage her workload. Unless an emergency arises, she makes sure that she leaves work on time and hands over any urgent jobs to her on-call colleague. She makes a commitment to herself that she will see friends and family at least once a week, regardless of how busy the ward is.

the best way to proceed. Your local hospital authority may have existing procedures that can offer you support and advice; hospital trusts' guidelines vary but most would encourage you to share your concerns with a supervisor, trainer, or trusted colleague first. The medical defence organisations or the BMA's "Doctors for Doctors" service also offer anonymous advice in such situations.

How to get well

All doctors should be registered with a general practitioner, who should be your first point of contact if you have any concerns about your health. Depending on the problem, various interventions are available. For depression, antidepressants and talking treatments based on cognitive behavioural therapy have the best evidence base currently.²⁷ Other types of talking treatment, such as interpersonal or psychodynamic psychotherapy, are also effective.^{28,29} For more information about these treatment options see the Royal College of Psychiatrists' website (www.rcpsych.ac.uk/mentalhealthinfo/treatments.aspx), and for an accredited UK therapist in your area you can search on www.bacp.co.uk (for psychodynamic or interpersonal therapists) or www.cbregisteruk.com (for cognitive behavioural therapists).

Box 2 "Red flag" symptoms for depression*

If you or a colleague have experienced some of these symptoms every day or nearly every day in the past three to four weeks, it is time for assessment.

- Having little interest or pleasure in doing things
- Feeling down, depressed, or hopeless
- Feeling tired or having little energy
- Having trouble falling or staying asleep, or sleeping too much
- Having a poor appetite or overeating
- Feeling bad about yourself—that you are a failure or have let yourself, your patients, or your family down
- Having trouble concentrating on things, such as reading the newspaper or watching television
- Moving or speaking so slowly that other people could have noticed, or being so fidgety or restless that you have been moving around a lot more than usual
- Having thoughts that you would be better off dead or of hurting yourself in some way

*Based on the Patient Health Questionnaire-9 (PHQ-9)³⁶

General practitioners can often recommend local therapists, and the new initiative Increased Access to Psychological Therapies will mean that cognitive behavioural therapy will become more widely available in primary care in England in the coming years. Other approaches that may be useful for depression include mindfulness,¹⁹ and exercise.³⁰

How the system can help

High quality services providing confidential counselling, coaching, psychotherapy, and treatment for alcohol and drug problems need to be visible and promptly available to doctors throughout their training.²³ Additionally, doctors should be able to access consultations, and admission if necessary, outside their area of work. The establishment of the new Practitioner Health

Box 3 Sources of help for doctors

A comprehensive list of all general and specialist services for doctors in the UK, both regional and national, can be found on the BMA's website (www.bma.org.uk/ap.nsf/Content/d4dmaingeneral/). Key sources are listed below.

- *BMA Counselling Service*—24 hour telephone line staffed by accredited counsellors from the British Association of Counselling and Psychotherapy (tel: 08459 200169)
- *BMA Doctors for Doctors Service*—Part of the BMA Counselling Service that enables doctors in distress or difficulty to speak in confidence to another doctor. The service is available to all doctors, is confidential, and is not linked to any other external or internal agencies (tel: 020 7383 6739; email: info.dfd@bma.org.uk). Telephone and face to face appointments are available.
- *MedNet*—Provides doctors and dentists working in the area covered by the London Deanery with practical advice about their career, emotional support, and access to brief or longer term psychotherapy. The service operates on a confidential basis (tel: 020 8938 2411; website: www.posts.londondeanery.ac.uk/specialty-training/mednet).
- *Practitioner Health Programme*—Newly launched, general practitioner led initiative offering free and confidential health care to any medical or dental practitioner living or working in the London area who has a mental health or addiction problem, or a physical health concern that may be affecting their work (www.php.nhs.uk)
- *Doctors' Support Network*—Self help group for doctors with mental health concerns (www.dsn.org.uk)
- *Royal Medical Benevolent Fund*—Provides financial help for sick doctors (tel: 020 8540 9194; email: seniorcaseworker@rmbf.org; website: www.rmbf.org)
- *Sick Doctors' Trust*—A proactive, self help organisation for addicted physicians (24 hour helpline: 0870 444 5163; website: www.sick-doctors-trust.co.uk)

Help and advice is also available from general practitioners, medical defence organisations, occupational health departments, colleges, and postgraduate deaneries.

KEY POINTS

Stress is common among junior doctors
 A proportion of stressed doctors will develop mental health problems
 Factors that contribute to stress can be identified and modified
 Many confidential and free sources of help are available for doctors

Programme pilot in London is an innovative service model that is likely to appeal to doctors as patients (box 3).

What are the challenges?**Stigma**

There is still a lot of stigma related to seeking help for stress related illness. This is partly because doctors fear lack of confidentiality or think that seeking help may result in challenges to their “fitness to practise” but also because of the wider culture of medicine in which “an image of invincibility is encouraged and vulnerability is denied.”³¹ A culture shift is needed, starting at medical school.

Barriers to care

Doctors do not make good patients. Typically they do not follow their own health care advice, they self diagnose and self medicate, and they present late after “corridor consultations.” Once unwell, doctors are often reluctant to consult a general practitioner (even if registered) or to take time off work.³² The General Medical Council is clear that doctors should not treat themselves and should avoid treating those with whom they have a close personal relationship, and it recommends that all doctors should register with a general practitioner who is not part of their family to ensure they receive independent and objective care.²⁵ Another barrier is that many doctors do not know where to seek help; box 3 lists key sources of help.

Workload

Doctors often feel that they “don’t have time to be a patient” or that they are somehow “letting the side down” by taking time off to consult or be treated. Such attitudes are unhelpful and perpetuate poor health in doctors; for example, one study has shown that when doctors finally allow themselves to take time off for ill health, they tend to be off work for longer periods because they consult so late.³³

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10-MINUTE CONSULTATION

Request for slimming tablets

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A 43 year old hairdresser who has recently moved into the area after a divorce asks you for slimming pills. Medical records from her previous GP shows that she rarely consults doctors.

What issues you should cover

Optimal management of obesity combines diet, exercise, lifestyle advice, and, where necessary, pharmacotherapy and surgery. Current drugs used in weight management are not the “slimming pills” used many years ago. However, they are all expensive and should be used rationally within structured management programmes. Shared care between the GP and a practice nurse trained in weight management may make the management of obesity in primary care more feasible.

Explore the request in a non-judgmental way

Whether the patient looks overweight or not, find out why she is requesting the pills. Often patients will present because of an impending social or personal event (a wedding or holiday). What exactly does she know about slimming tablets? Where did the information come from? What does she expect from them? Has she ever taken them in the past and, if so, who prescribed them? Has she taken any recently?

Take a history

Take a detailed history of her weight and weight gain. Assess her current dietary habits and activity levels. How is her weight affecting her life? Check for comorbidity: is she known to have diabetes, heart disease, hyperlipidaemia, or other obesity related conditions? Are there any markers of these conditions if they are not diagnosed? Explore associated psychological problems such as depression or bulimia: which came first

and which should be treated first? Take a menstrual history and a family history (looking especially for polycystic ovary syndrome, diabetes, and thyroid disease).

Ask her about current and past attempts to lose weight. Does she attend slimming clubs, programmes, or clinics or take any other variety of slimming products such as those from health food shops or private doctors?

Assess her stage of change and motivation

Is she ready to adopt lifestyle modifications? Or is she looking for a “magic pill”? What does she understand in terms of the dietary and physical activity changes needed to initiate and maintain weight loss. What support does she have?

What you should do

- Listen and be empathic. A therapeutic alliance will be important whatever is decided.
- Measure her body mass index (BMI) and waist circumference and compare these with defined values (table). Use this information to guide management but tailor plans to fit her needs.
- Code for obesity in the medical records and document her BMI and waist circumference.
- Measure her blood pressure unless this has been measured recently and arrange for fasting blood tests for glucose concentration and lipid profile and, if indicated clinically, thyroid function tests. Further physical examination or investigations later will depend on the clinical picture. Review her current treatments. Is she taking drugs that promote weight gain?

Classification of weight by body mass index (BMI), waist circumference, and associated disease risk* (adapted from data from the US National Institutes of Health)

	BMI	Risk of disease (relative to normal weight and waist circumference)	
		Waist circumference <102 cm (men) or <88 cm (women)	Waist circumference ≥102 cm (men) or ≥88 cm (women)
Underweight	<18.5	Not increased	Not increased
Normal	18.5-24.9	Not increased	Increased
Overweight	25-29.9	Increased	High
Obesity (class I)	30-34.9	High	Very high
Obesity (class II)	35-39.9	Very high	Extremely high
Extreme obesity (class III)	≥40	Extremely high	Extremely high

Most of the relevant information in relation to risk can be derived from measurement of waist alone.

*Risk of type 2 diabetes, hypertension, or cardiovascular disease.

FURTHER READING

National Institute for Health and Clinical Excellence. *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children*. NICE clinical guideline 43 (December 2006). www.nice.org.uk

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- Discuss the options open to her, depending on the clinical picture, and enable her to make an informed decision. Explain that behavioural modification (lifestyle changes, including diet and physical activity) is essential, whether with or without slimming tablets. Offer referral to an evidence based community weight loss programme, if one is available locally, or to a dietician or the practice nurse if your practice runs its own weight management programme. Commercial slimming clubs can also help, as can exercise referral schemes. Some commercial organisations offer online support for people who do not wish to attend groups.
- Be positive and offer support and follow-up. Agree a realistic target (such as 5-10% reduction in weight, at a weekly maximum of 0.5-1 kg).
- Sibutramine (a noradrenaline (norepinephrine) and serotonin reuptake inhibitor) and orlistat (an

intestinal lipase inhibitor) have been available on prescription in the United Kingdom for some time (see NICE guideline). They should not be used in combination. Explain the possible benefits, safety issues, contraindications and side effects, which differ for each drug (see *British National Formulary* 56, September 2008).

Together with diet and lifestyle changes they can contribute to weight loss, and even modest weight loss (5-10 kg) improves all major risk factors. However, weight loss over three months of managed care that involves diet, exercise, and behavioural modification should be monitored before any decision is made about drug treatment in obese individuals. Only those who fail to achieve a realistic reduction in weight should be considered.

- Emphasise the need for weight loss (big changes, mainly in diet, for 3-6 months) and weight maintenance (small changes, for life, in diet and physical activity).

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TARTS at the dinner table

At the end of a busy clinic, I was immediately interested on picking up the notes of a 20 year old with bilateral testicular swelling for several months. His only other symptoms were increasing thirst and genital pigmentation over the previous six months. Clinical examination was highly suggestive of bilateral testicular malignancies, and initial ultrasonography seemed to confirm the clinical findings. Further investigations were needed, but I warned the patient of my worry that, on the face of it, he might need orchidectomies. Clearly, such news was devastating. However, in the back of my mind something did not seem to be quite right: for a start, synchronous testicular tumour presentation is very rare. What seemed to me at the time to be another red herring was his antenatal diagnosis of congenital adrenal hyperplasia. Feeling slightly uneasy about the whole scenario, I promised to discuss his case with my colleagues the next day and then to telephone him.

At the dinner table that evening, I was mulling over the case with my paediatrician wife. To her the diagnosis was immediately clear, and I was charged with stereotypical "surgical ignorance" for not knowing the well recognised association between congenital adrenal hyperplasia and testis adrenal rest tumours (TARTs). Later that evening, I telephoned the patient to explain that all was not what I had suggested. He readily admitted to taking his steroids only intermittently over recent months. Subsequent investigations revealed azoospermia, normal testis

tumour markers, and grossly enlarged adrenals in keeping with congenital adrenal hyperplasia. He is now being managed medically.

Literature reviews suggest that TARTs can be found in about 25% of men with congenital adrenal hyperplasia. They may represent aberrant adrenal tissue, and there is strong histological resemblance to adrenal tissue. Recommended treatment consists of increasing glucocorticoids to suppress secretion of adrenocorticotrophic hormone. There are reports of inappropriate orchidectomies. Failure of TARTs to regress may be an indication for testis sparing surgery, but only rarely has this resulted in improvement in semen parameters. The natural course is uncertain.

My main memory of this case is the distress I caused the patient and his family when telling them of the potential for bilateral orchidectomies. To my wife, it shows the difficulties of ensuring that children with chronic disorders continue to adhere to treatment after moving from the often sheltered world of the paediatric clinic to the harsher reality of adult services. The answer, as always, was in the history.

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