BENEATH THE WHITE COAT

DOCTORS, THEIR MINDS AND MENTAL HEALTH

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What Makes Medicine Such a Difficult Task Master and Doctors at Higher Risk of Mental Illness?

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While mental illness in doctors is not new, levels of unhappiness and disillusion are reaching worrying levels. It is hard for those not working in medicine to understand why doctors are so unhappy, and even though I work with mentally ill doctors, it still surprises me that they do become so unwell, and at such high rates. Of course, I know on one level that having a medical degree does not confer immunity from mental illness nor protect against experiencing traumatic life events. Yet given that doctors have a host of protective factors (rewarding career, good social networks, high status, financial stability and flexibility in their working lives) it would be expected that their rates of mental illness should be considerably lower, not as research suggests, higher than in the general population.

The reasons why doctors are so unhappy are complex: some contributing factors are associated with the job itself (especially the emotional toil of working close to suffering); others stem from the common characteristics of those who choose to become doctors; and some are due to wider, socio-political factors that relate to the changing place doctors have in society. Perhaps the best narrative I have read about doctors' causes of distress is by the American, Abigail Zuger.[1] Her article is written from a USA perspective and as such mentions stressors that might not currently be so relevant in the UK, such as managed care and the malpractice crisis. Others, such as the inability to care for patients in the way one was trained to do due to lack of time and the increasing burden of observation and scrutiny, are common across the world.

THE EMOTIONAL WORK OF MEDICINE

Perhaps the best place to start in understanding why doctors are so distressed is by looking at the job itself. A previous editor of the *BMJ*, Richard Smith, wrote an opinion piece titled *Why are doctors so unhappy*?, and concluded that doctors are overworked and under-supported.[2] Smith is right. It seems obvious, but the most important risk factor is **the job**. Medicine is a hard taskmaster, and is intellectually, physically and emotionally demanding.

It is not just the unsocial hours or long shifts that make it so (though they add to the stress). Nor is medicine difficult simply due to the vast amount of knowledge we need to remember (after all, lawyers have to learn the equivalent of several telephone directories to do their work well). What makes medicine difficult is having to deal with human suffering and all its attendant emotions.

The sociologists Harold Lief and Renée Fox *wrote that medicine is about:*

> exploring, examining, and cutting into the human body; dealing with fears, anger, sense of helplessness, and despair of patients; meeting emergency situations; accepting the limitations of medical science in dealing with chronic or incurable disease; being confronted with death itself.[3]

All of these are difficult. However, it is more than the visible manifestations of disease that we have to deal with (and one can argue it is nurses who carry much of this burden) but the hidden, emotional aspects that are perhaps even harder to deal with.

Working with people is complicated and deeply satisfying but can also be psychologically painful. Patients bring their unique histories, expectations, beliefs and desires into the consultation room. They bring their emotions – joy, sadness, shock, fear, aggression, worries and everything else wrapped up in being mortal. For those brief moments we become guests in their lives as they share with us their most intimate concerns and using all our senses, we become attuned to their needs. We must create a space, if only for a few minutes, that is entirely theirs, uncluttered by our own needs. Forty years on, I am still in awe how, within seconds of a stranger meeting me, they are willing to disclose the most personal parts of their minds and bodies, parts that are forbidden in all other human encounters, even to those nearest and closest to them.

Patients rarely come with fully formed diagnoses and rather present with undifferentiated symptoms ('pain all over', 'feeling odd', 'out of sorts'), which, detective-like, we need to gently piece together into a coherent diagnosis. They do not follow textbook descriptions of illness. I remember a patient who presented with 'watering eyes', only when he passed a certain street. It turned out to be tears of grief for a long dead friend, resurrected each time he passed by the house. Patients make personal choices that might be out of kilter with our medical training. Georgina refused all conventional treatment for her cancer and I had to watch for years as her health deteriorated and the only 'treatment' she accepted was that recommended by her herbalist. My role was to be present and ready when and if she changed her mind; she never did and died prematurely. One cannot see

patients, day in day out for years, without being profoundly affected by this experience and the struggles we witness. Even now, as I write this chapter, I see the faces of my patients and hear their words, some long deceased. I see their ghosts as I walk my dog, shop in the supermarket or walk past their old homes. Many of my patients still live in my mind.

It is not only the patient's emotions that enter the consulting room. Our emotions are there as well. Patients often stir up powerful feelings in us, which, in the main, have to be understood rather than responded to. These feelings, not always generated directly from the patients, but indirectly, are brought to life through the encounter with the patient, due to a doctor's past painful experiences. For example, a doctor who lost their mother at an early age might overidentify with someone who has recently been bereaved following a death of a parent, or with a female patient who stirs up memories of their mother. This is commonly referred to in the psychoanalytic literature as transference and countertransference. Both can occur with any doctor–patient interaction, though more frequently where there are intense and close therapeutic relationships, such as during psychotherapy. Without safe spaces to think about why a patient makes one feel or act in a certain way, these emotions can 'stick' to the doctor who is left to carry them unsupported.

Patients also create powerful negative emotions in us, not because they 'remind' us of past experiences, but just because they can be dislikeable, difficult or rude. They may be drunk, violent, demanding or engage in activities that we as doctors have deemed unacceptable. We may feel guilty if we harbour these negative feelings and are loath to admit to them, except in the safety of staff support groups or individual supervision.

There are very few jobs that require individuals to be constantly attuned to the needs of others, yet, at the end of the day, literally and metaphorically leave them behind in the consulting room or hospital ward. Irrespective of how we feel or how tough a time we've had, or the traumas we have endured or sorrows waiting for us in our personal life, in the consulting room we must always be engaged with our patient, attentive to their needs, objective and professional. The day my mother died I had to finish a busy clinic. It was too late to delegate the session to someone else (though I imagine this says more about my failure in accepting vulnerability than management's response if I had cancelled). Despite my grief, I had to focus on my patients, I had to make them my first concern. This is what I understand to be the 'emotional labour' of our work, a term first used by the American sociologist Arlie Hochschild.[4] It is about managing or supressing our personal feelings so that they do not interfere with the act of caring or giving to others. It is the emotional labour that accompanies the work of doctors that places them at particular risk of mental illness. The trope of the smiling waitress asking, 'have you had a nice day?' when she is having a terrible one is similar to the doctor maintaining their composure when confronted with patients or situations that make them recoil in fear or revulsion. On a surface level, emotional labour means that the professional controls or changes their emotional reaction so that the observer (in this case the patient) is not able to recognise what he/she really feels. The mismatch between what one expresses and what one feels can lead to cognitive dissonance – and if the gap is too large, it can cause guilt, anxiety, depression and burnout.[5]

Understanding how one modulates emotional interactions with patients, how to manage the dissonance between acting and reality, is hard, and especially so when one does not have time to stop and reflect with peers or teams.

Our job is essentially about managing human expectations and dealing with the suffering our patients bring. Patients try unconsciously to 'offload' their fears by 'giving them' (in the psychoanalytic term, projecting) onto doctors. These projections find fertile ground and, given doctors' desire to care, easily become accepted by the medical profession. Patients see doctors at their most vulnerable moments. They come wanting to be given hope and for us to contain their fear of death. Some even want us to prevent it happening at all, even when impossible. I see this fantasy of doctors and healthcare expected to have magical powers in my working life. For example, when terminally ill patients reach the end of their life, their relatives call 999 at the last moment, demanding their loved one is taken from their bed to hospital in the hope that medicine can give them 'one last chance', only for them to die a few hours later on an A&E trolley. In the case of Charlie Gard, a baby with a severe, rare and untreatable genetic disorder, his parents took the hospital to High Court, demanding they should be allowed to take the child abroad to receive experimental interventions only ever tested on mice. Even the Pope and Donald Trump got involved, buying into the delusional belief that death, even in those with life ending diseases, can be put off for ever. Of course, death cannot be prevented and even though not spoken about, it is the shadow of all healthcare, and while services are generally geared to saving and prolonging life, the spectre of death is never far away.[6] There is a reason why most hospitals have morgues onsite. I believe it is this mismatch between the expectations of medicine and its reality that fuels the development of burnout in doctors, and our hopelessness in the face of suffering that leads to depression. Denial of death is widespread.

The psychoanalyst Isabel Menzies-Lyth, who conducted studies on student nurses in the 1950s talked about how society defends itself from problems it finds too difficult to deal with by locating, and then disavowing, associated anxieties into institutions such as hospitals, nursing homes and prisons.[7] Once split off from normal consciousness, the left-over anxiety is acted out through either idealising or denigrating those who have taken the unpalatable tasks away. It is no surprise to me therefore, that my speciality, general practice is increasingly portrayed as both the scapegoat and the saviour of the NHS, as health leaders locate their fear of the very survival of the health service onto us. This might also explain why paediatricians, until now the darlings of the health system, are increasingly the recipients of verbal abuse, litigation and complaints. As medicine is keeping alive children with chronic and complex diseases, parents project onto paediatricians their emotions of having an unwell child and paediatricians accept and have to deal with these painful projections. Holding these emotions for others is psychologically difficult, yet largely unspoken about. So is confronting the shadow side of our work, day in, day out, learning to cope with the knowledge that we will always fail our patients and that failure is a quintessential part of medicine. These are hard lessons to learn, needing support, supervision and spaces to explore our feelings, which are sadly lacking in modern healthcare systems.

SOCIO-POLITICAL FACTORS

I was brought up to believe that medicine is an art underpinned by science. Sound clinical judgements are the result of personal relationships as well as scientific knowledge and textbooks can never prepare us for the uniqueness of every patient we encounter. Learning to strike the right balance between the science and art of medical practice isn't easy, and failure to do so creates anxiety.

Across the world, we are facing something of a crisis in healthcare, with doctors made to focus on the disease rather than on the patient, on the science rather than the caring. This was something that Francis Peabody, professor at Harvard, identified as early as in 1927:

> The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine – or to put it more bluntly, they are too 'scientific' and do not know how to take care of patients.[8]

Nearly a century later the art of caring is under even more pressure, as medicine becomes a numbers game of measurement, monitoring and productivity. Doctors now have less opportunity to practise their craft, uncluttered by the market or external forces such as inspection or monitoring. These act to negate the individuality of the patient and the creativity of the doctor. Writing about general practitioners, the geriatrician Steve Illife talks of the dissonance created as the role of medicine changes from:

> a craft concerned with the uniqueness of each encounter with an ill person to a mass manufacturing industry preoccupied with the throughput of the sick.[9]

Iona Heath, a former President of the Royal College of General Practitioners reminisced that when she embarked on her career in 1974, to be a public servant meant doing something good. With the shift towards a market economy and through a painful and demoralising process, this pursuit of a career in medicine has changed to something 'somehow despicable'.[10] What these individuals are articulating, which I am not completely in agreement with, is the loss of their professional ideal, of the doctor having a unique and personal relationship with their patient. It is becoming harder to deliver personalised care, but I think it is the struggle to do so, at all odds, that is making doctors unhappy. Doctors are as altruistic, caring and committed as in Iliffe's and Heath's day, just that today these doctors need to work harder to achieve their desired aims.

The practise of medicine is also becoming increasingly difficult as many of the protective factors within organisations, which would have acted as a counter to work-related mental distress, have been lost. Harold Ellis, a surgeon who qualified in 1948 (and who taught me as a medical student) recalls his time working as a positive experience. Despite never being off-call, he has fond memories: 'we all knew each other… the firm was a happy band of brothers'.[11] When one reads first person accounts written by doctors of his generation, they talk about their

teams (firms) and how well supported they felt. This was my experience too. These interactions between colleagues were invaluable, offering not just access to education but support and a sense of belonging. My hospital had a doctors' mess and even a doctors' dining room where we could eat our meals and share our stories without the fear of being overheard by patients. I felt I belonged not just to my firm, but to the hospital. Today, there is a general lack of connection between individuals, and between individuals and institutions.

How doctors have been treated has also changed over the decades. Ellis woke each morning with breakfast delivered to his room by a porter; his shoes had been polished overnight; other doctors were given free accommodation, all meals, laundry and a maid service in the doctors' mess.[11] Now doctors barely even have a hook to hang their coats on, let alone hot meals and a room to rest. Poorly designed rotas, staffing gaps and increasing shift work – with the consequent loss of continuity of care – also negate a sense of belonging to, and being cared for by their employer, leading to feeling more like itinerant workers than resident doctors. Training has now become atomised and rather than coming together doctors are at risk of becoming singletons, only capable of defending their own psychological skin.

The unconscious hierarchy between patients and doctors is rapidly disappearing as patients are living longer with chronic illnesses, and doctors' exclusive access to medical knowledge is being eroded with the proliferation of 'Dr Google' and online communities. In *The Changing Face of Medicine* (2017), the British Medical Association (BMA) with contributors from across the world focused on factors impacting on physician well-being and morale, and how the traditional role of doctors and their status in society is changing and contributing to the profession's mental health crisis.[12] The themes were all familiar: the inability to deliver continuity of care; the harmful effects of bringing the market to healthcare; the changing nature of professionalism; and the intensity of workload. Another major cause of distress in the NHS, but also across many other health systems, is endless reorganisations.

It is not just doctors who are unhappy today. Many other professions, including law and teaching, have become constrained by corporate structures, resulting in loss of autonomy, status and respect. In 1982 the sociologist Paul Starr wrote that, for most of the 20th century, medicine was 'the heroic exception that sustained the waning tradition of independent professionalism… But the exception may now be brought into line with the governing rule'.[13] His ground-breaking book talks about the growth of medical authority (surpassing that of religious authority), brought about in part by the increasing body of knowledge held by doctors. Authority signifies the possession of special status and power, which doctors have largely been the recipients of until the more recent technological revolution, where knowledge is now more equally shared.

INDIVIDUAL FACTORS

Aside from socio-political factors and the realities of the profession, doctors, as individuals carry our own risk of mental illness.[14] The process for deciding which

individuals enter medical school is highly selective. We have to meet difficult entrance requirements, involving excellent examination results and challenging interviews. Aspiring applicants need to show determination, intelligence, ability to work hard under pressure; they must be good communicators and demonstrate a desire to care. The University Clinical Aptitude Test (UCAT) is an admissions test used by many medical schools in the UK to assess students' suitability to study medicine. It assesses potential students against attributes such as verbal, quantitative and abstract reasoning, decision making and situational judgment. Nowadays, unlike when I gained a place at medical school, prospective doctors must also have flawless school reports. Those who get over these hurdles are likely to share a set of attributes that are deemed to foster the makings of a good doctor. These include being patient, unselfish, responsible and highly ethical. When stressed, and in the face of demands, individuals must not show weakness or indecision and must put others first. These formidable attributes can become exaggerated, leading to doctors becoming less tolerant of errors in themselves or their colleagues, striving for perfection and never feeling 'good enough'. The academic Jenny Firth-Cozens in her research on doctors suggests that the difficult and emotionally demanding job of a doctor leads to them being overly self-critical when stressed.[15] Some practitioners can have maladaptive coping strategies – emotional distancing, for example, rather than actively dealing with stressors – which may add to psychological distress.[16] Other common psychological vulnerabilities include an excessive sense of responsibility, desire to please everyone, guilt for things outside of one's own control, self-doubt and obsessive–compulsive traits.[17]

Perfectionism is one of the most pervasive personality traits found in doctors. Perfectionists strive for flawlessness and set extremely high standards for themselves and others, which can lead to individuals becoming increasingly self-critical.[18,19] As the practise of medicine becomes less tolerant of mistakes, having perfectionists on the team is seen as positive and desirable and as such the wish for 'the perfect doctor' is a collective collusion between the doctor, the patient and the health system. This collusion is evidenced by the current 'zero suicide' initiatives, the quest for endlessly improving quality and the elimination of so-called 'never events' (which are, as they say, events that are deemed to be such catastrophic errors that they must never happen, such as amputating the wrong limb during an operation). Across the industralised world, young people now face tougher social and economic conditions than their parents and the increasing pressure to achieve is pervasive throughout their lives.[20] Today's students are under constant scrutiny, and they know it. Every attachment is graded, and these grades contribute to final scores, influencing the young doctor's ability to obtain training posts, research grants and other positions. Striving for perfection has become the new norm.[21]

Behaviour that encourages perfectionism (increased engagement, working longer hours and being more motivated) is negatively counterbalanced by the increased risk of burnout, depression and anxiety, which have serious consequences beyond just the workplace. Far from producing better outcomes, research has shown that perfectionism leads to more detrimental work and non-work outcomes, as well as higher levels of mental illness.[22]

Charlotte, an accomplished 27-year-old medical trainee, was always the best at school, not just academically, but also in sports and music. When things got tough, which they did when her younger brother died suddenly, she focused on her schoolwork to avoid thinking about her loss. She sailed through medical school, winning prizes. She was critical of her colleagues for not working as hard as she did. Once in training she found herself becoming increasingly anxious and fearful of making errors. She was always checking her work, even coming in on her days off to make sure her clinical decisions had not caused any harm to her patients. One day, while on call, a patient died unexpectedly. She blamed herself, even though her colleagues and the case review exonerated her. After this her fear of getting things wrong intensified. She arrived at work two hours early for each shift. She split up with her partner as she felt she had to remain focused on her work. Unable to bear things any longer, Charlotte took an overdose of tablets and was found by her flatmate.

We have hundreds of Charlottes in my service. She, as with other doctors, have internalised the need to be 'perfect'. This need was primed even before starting medical school and then reinforced during training, modelled by other doctors she encounters and by the culture of medical practice in which she works, where individuals who make errors are punished. At medical school, studying hard predictably translates into achievements, but there is no guarantee that this will achieve similar outcomes once qualified. Perfection, which doctors demand of themselves, is impossible in the real world of medical care, and can be harmful.[22]

In *The House of God*, the satirical description of a young doctor's journey through his internship in an American hospital, Samuel Shen describes an interaction between a more senior doctor (called Fat Man) and a junior intern. Fat Man gives the junior important lessons on how to cope with no sleep and endless patient admissions during the night:

> Key concept, said the Fat Man, to think that you're doing a shitty job. If you resign yourself to doing a shitty job, you go ahead and get the job done, and since we're all in the ninety-ninth percentile of interns, at one of the best internships in the world, what you do turns out to be a terrific job, a superlative job.[23]

Fat Man is teaching the intern an important coping mechanism, that is *not* to strive for perfection and accept that good enough is good. Maybe this is a lesson we all need reminding of. Understanding the limits of our capabilities is perhaps one of the most important antidotes to dealing with a lifetime in medicine.

The decision to study medicine, as with all choices, is influenced by conscious and unconscious motivations. Consciously, the most obvious reason might be the individual is good at science, and wants an interesting career helping others. It may be parental pressure that pushes someone into applying for medical school in the hope of fulfilling their own failed ambitions. Problems arise of course when the child finds themselves in the wrong career. Unconscious components are

important as well, especially as they might predict why some individuals are more at risk of developing mental illness. While the unconscious motivations are often speculative, there is some evidence to suggest that a desire to make reparation for traumatic childhood experiences is an important factor.[24–26] This might have been at the root of my desire to become a doctor. I chose medicine due to my admiration for my father, a GP. Fostering a love of medicine and all that went with it meant I had a 'legitimate' reason to spend more time with him, important as he left the family home when I was still very young. Through my interest in medicine I could visit him in his surgery, go on home visits with him and spend time with him talking about being a doctor. My attachment to him – and, I am sure, his to me – grew, and I felt 'special'. It is no surprise therefore that I became a doctor and then went on to be a GP.

A medical career might give individuals the information and skills to resolve previous conflicts and to give to others the care and attention they would have wished for themselves. These are not bad motives for wanting to study medicine, though there is evidence that these students might be more likely to present with mental health problems when particular clinical experiences resonate with their earlier conflicts.[27] The unconscious desire to heal a loved one and the guilt associated with failing to do so can become channelled into a relentless drive to care more, be more altruistic and work harder. These are the actions of the wounded healer. If unchecked this will not lead to reparation or healing; instead, it risks repeating the failure to cure the incurable, which further feeds the associated emotional drive to apply oneself to an impossible task. This does not mean that these individuals should not become doctors. I have flourished in my career and I hope I have been a good (enough) doctor to my patients. Having experience of personal trauma might predispose individuals to a real gift and capacity for empathy and caring, especially if their childhood conflicts have been acknowledged and the vulnerability held in awareness.[28] This is partially supported by the work of Firth-Cozens.[29] She found that those students who were more depressed both as students and as junior doctors tended to be more empathetic, more self-critical and then their peers, all of which would appear to be desirable attributes for a doctor to possess.

CONCLUSION

I have discussed in this chapter how the emotional work of medicine together with what the individual brings (especially perfectionism) and wider socio-political factors make doctors at risk of mental illness, and increasingly so. Addressing these factors is not easy, as some of them have been hard wired into doctors and society for millennia. Given the difficulties discussed, it is important to remember that most doctors thrive in their work. Working with people and having a career in which one can make such a difference to others is itself rewarding and self-fulfilling. The joy, personal satisfaction and sense of achievement at the end of a day's work, replenishes one's psychological batteries and makes it possible to face another day, refreshed and with enthusiasm.

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