ORCA – Online Research @ Cardiff

Doctors' decisions when disclosing their mental ill health

Abstract

Background: Understanding what prevents doctors from seeking help for mental ill health has improved. However, less is known about what promotes timely disclosure and the nature of doctors' decision-making.

Aims: This study aimed to define how doctors make decisions about their own mental ill health, and what facilitates disclosure. It explored the disclosure experiences of doctors and medical students; their attitudes to their decisions, and how they evaluate potential outcomes.

Methods: Qualitative, semi-structured interviews with UK doctors and medical students with personal experience of mental ill health. Participants were recruited through relevant organisations, utilising regular communications such as newsletters, emails and social media. Data were subject to a thematic analysis.

Results: Forty-six interviews were conducted. All participants had disclosed their mental ill health to someone; not all to their workplace. Decision-making was complex, with many participants facing multiple decisions throughout their careers. Disclosures were made despite the many obstacles identified in the literature; participants described enablers to and benefits of disclosing. The importance of appropriate responses to first disclosures was highlighted.

Conclusions: Motivations to disclose mental ill health are complex and multifactorial. An obstacle for one was an enabler for another. Understanding this and the importance of the first disclosure has important implications for how best to support doctors and medical students in need.

Introduction

High rates of mental illness continue to be reported in both doctors and medical students (1, 2). Dedicated support services have grown across the UK (3). Despite this, many doctors and medical students still do not fully understand the support structures available to them (4), and an extensive range of obstacles to help-seeking has been identified (3, 5-8). This includes access to support, lack of time, and long working hours. Concerns over confidentiality remain significant (8), and stigma has consistently been found to influence doctors' illness behaviours (9). For example, in a UK study, doctors with depression who had taken time off work were more than twice as likely to cite a physical reason for their ill health (5). Shame, self-stigma, embarrassment, and fear of disciplinary action also influence illness behaviours (10).

To date there is little evidence on enablers to disclose, nor on the decision-making processes behind disclosure decisions by doctors and medical students. This study builds on a quantitative survey of UK doctors about disclosure undertaken by the authors (4). It uses qualitative methods to explore the experiences of doctors and medical students with mental ill health. It focuses on their attitudes to disclosure decisions, and how they evaluate the potential benefits and negative consequences to disclosing.

Methods

Purposive sampling was used.   Participants were UK resident doctors and medical students, with personal history of mental ill health. Qualitative, semi-structured interviews collected detailed accounts about their decision-making regarding disclosure of their own mental ill health.

Study invitations and information sheets were distributed through relevant organisations for doctors and medical students and key contacts (Table1) using their dissemination routes. Ethical approval was granted by Cardiff University Medical School Research Ethics Committee (Reference number: SMREC 13/43).

Table 1 here

Interested individuals were asked to contact the first author (SR). Those who met the inclusion criteria on a first come basis completed a consent form, and a brief questionnaire collected demographic information and mental health history. A convenient time and place of interview was agreed.

SR carried out individual semi-structured interviews between April and July 2015. Interviews lasted 20 - 50 minutes, averaging 30 minutes. The interview schedule was informed by a literature review and previous research (4). The schedule aimed to elicit participants' personal experiences of mental ill-health and disclosure. A funnelling approach was used. Participants were asked generally about their experiences of working or studying with mental ill health. Focused questions then asked specifically what factors contributed to participants' decision-making about disclosure. Scope was left to reorder questions and pose additional questions dependent on responses. Interviews were audio-recorded, transcribed, anonymised and imported into NVivo 10 for a six-stage thematic analysis as described by Braun and Clarke (11). The data analysis was primarily conducted by SR, in collaboration with the second and third authors (DC and NM).

Results

46 individuals met inclusion criteria and were interviewed (42 by telephone, 4 face-to-face) in Cardiff. Participants were aged 19 - 73 years. 35 were female and 11 male. Participant specialty/grade is shown in table 2.

Table 2 here

Data collated from the pre-interview questionnaire about participants' mental illness is presented in table 3.

Table 3 here

All participants had made a disclosure of mental ill health to someone. 42 participants stated that someone in their workplace or medical school knew about their mental ill health. A small number had not disclosed to their workplace themselves, but their workplace's knowledge of their mental ill health came about via third parties. Four participants had confided solely to friends, family, or providers of external support such as GPs/counsellors.

Over half of participants talked about the very first time they disclosed their mental ill health to anyone outside of their friends/family. Of these, three-fifths disclosed to their workplace or medical school (e.g. to Occupational Health, Human Resources, colleagues or senior staff, or on an application form). The remaining two-fifths first disclosed to a GP. Of those who talked about their first disclosure outside of friends/family, just under a quarter were at medical school/applying for medical school when the disclosure was made. Nearly half were doctors in training, and over a quarter were working as a consultant or GP.

5 major themes were identified, informed by the interview schedule.

Theme 1, 'first disclosure decisions'. This encompassed participants' very first experiences or decisions about disclosing.

One of the main motivations to disclose to someone outside of friends/family, was help-seeking. This included seeking treatment, diagnosis, support, or workplace adjustments (quote 1, box 1). Other motivations included a sense of responsibility, and how concealing mental ill health was not a long-term solution (quote 2, box 1).

Some disclosures were prompted by specific events or interactions.   This included colleagues commenting on a change of behaviour, having to take time off due to symptoms, or an unplanned hospital admission (quote 3, box 1).

Reasons why participants did *not* disclose within early experiences of mental ill health included a conscious decision not to disclose due to fear of repercussions, and finding it difficult to talk about when struggling with symptoms. Others did not recognise their own ill health at the time (quote 4, box 1).

Theme 2, 'further disclosure decisions', describes further decisions to disclose mental ill health to others after an initial disclosure. All participants had disclosed their mental illness to more than one person. Some participants made further disclosures in quick succession. For others, an unhelpful response to their first disclosure resulted in no further disclosures

for some time (quotes 5-6, box 1). Two participants made no further disclosures until severe symptoms led to hospitalisation. Further disclosures were made both within participants' organisations (e.g. Occupational Health, line managers), and outside (e.g. charities, specialist services).

As with early disclosure experiences, help-seeking was a key reason for further disclosures. This included seeking treatment, workplace adjustments and informal advice (quote 7, box 1). Additional reasons for further disclosures were diverse. Many related to work implications. These included concern about the impact of participants' symptoms on their ability to manage the demands of their work/studies, and the impact of their work/studies on their mental health. Some further disclosures were made for professional responsibility. This included adherence to General Medical Council (GMC) guidance and truthful completion of official documentation (quotes 8-9, box 1). Others considered how disclosing could be helpful to their employers and colleagues, i.e. by forewarning them of a potential health relapse.

Interactions with other people prompted some further disclosures. Participants described how conversations about their wellbeing that felt supportive led to a decision to actively disclose (quote 10, box 1). Other conversations felt more 'directive' and less helpful e.g. being 'told' to inform their regulator (GMC).

Participants' open attitude to mental ill health also stimulated further disclosures. This included wanting to share positive facets of their experiences (quote 11, box 1).

Some decisions were based on participants' perceptions of how understanding they felt their workplace would be about their ill health (quote 12, box 1). Others came from a desire to help others, such as supporting colleagues going through similar experiences (quote 13, box 1).

Responses to disclosures in some instances were felt to be inappropriate, unhelpful or didn't address participants' concerns (quotes 14-16, box 1). Negatively perceived responses occurred mainly within the workplace/medical school. Some participants felt the need to find someone else to disclose to, or resorted to taking sick-leave. Others continued working without support, or experienced difficult negotiations regarding working conditions. These outcomes added to participants' mental distress and left them feeling angry and let down.

Box 1 here

Theme 3: 'additional factors influencing disclosure decisions'. This theme details factors that were secondary to participants' primary reason for disclosure. Factors that influence disclosure were very individual. A primary motivation in one participant's decision may have played a minor role in another.

An 'additional factor ' that was discussed throughout was advice from others about who else to disclose to (quote 17, box 2). Advice given influenced the decision, but was not the primary motivation.

Another 'additional factor' was the potential impact on others of disclosure decisions (quotes 18-19, box 2). Many participants felt that they would be letting colleagues down if

after disclosing their mental ill health, they took time off or requested workplace adjustments. Others feared disclosure would worry other people. ==Conversely, some participants had considered the impact of non-disclosure on patients, colleagues, or family, and felt a responsibility to disclose.== Some participants felt they owed colleagues an explanation of how their illness might impact on their work.

Participants spoke about their expectations of the responses they might receive when disclosing/concealing their mental ill health. Expectations regarding support centered on perceptions of the quality and availability of support. Some participants views were negative and felt that support would not be offered or be sufficient if they disclosed (quote 20, box 2). Others were more optimistic (quote 21, box 2), or recognised the importance of informing the workplace about what support would be most helpful to them.

Some participants had negative expectations about career repercussions if they disclosed (quote 22, box 2). They assumed that disclosing would necessitate time away from their work or studies and worried about the impact on their future careers. Other participants had no such concerns (quote 23, box 2).

Participants' perceptions of other peoples' attitudes to mental ill health also influenced decisions in both directions about disclosure. Some participants felt that they would be perceived as 'weak' (quotes 24-25, box 2) which hindered disclosure. For others, the assumption that people already suspected they had mental illness was an added factor in their final decision to disclose. Some were concerned about gossip and feared breaches of confidentiality.

Participants felt that some disclosure decisions were forced by their situation, with no option but to disclose - or in some cases to conceal - their mental ill health. This included the GMC obliging doctors to inform their workplace of their ill health ('undertakings') (quote 26, box 2). Others required a period of sick-leave or adjustments to remain in, or return to work. Some participants felt that they had no option but to conceal their mental ill health, to be able to continue their job or studies (quote 27, box 2).

Participants also explained how their own attitude towards and understanding of mental illness acted as an additional influencing factor. Some equated mental health to strength of character (quote 28, box 2), some paradoxically noting that they would however not judge others in this way. The general acceptability and stigma of mental illness both within and outside medicine was also mentioned as influencing participants' own attitudes (quote 29, box 2). Some wanted to disclose to help create a culture that was mental health aware. Others noted that some causes of mental ill health appeared more 'acceptable' than others.

Box 2 here

Theme 4, 'reflections on disclosure decisions' looks at participants' feelings about disclosure decisions.

Participants described various emotional responses to the actual act of disclosing (quotes 30-31, box 3). Positive feelings included finding it 'good' or 'therapeutic' to disclose. Negative or mixed feelings included embarrassment, anxiety, and fear.

Participants were prompted to reflect on their past disclosure decisions. Most participants felt that they had made the 'right decision', with only a minority of participants regretting disclosures. Some had mixed feelings.

Some participants elaborated on why they felt disclosing had been a 'good' decision (quotes 32-34, box 3). This included averting serious consequences, managing guilty feelings, and no longer having to worry about being 'found out'. Some also experienced an improved work situation due to adjustments and support being put in place.

Other participants had mixed feelings about past decisions to disclose (quotes 35-36, box 3). Negative feelings related to the impact disclosure had on their career, the lack of privacy, and mental health stigma. Positive feelings related to disclosure facilitating access to support, and the potential for worse outcomes from not disclosing.

Some participants stated they had no regrets about non-disclosure (quote 37, box 3). Others had mixed feelings, and detailed the disadvantages they saw in that decision (quote 38, box 3). This included not liking secrecy, finding work harder because of it, and not being able to access the full range of support available.

Box 3 here

In theme 5, 'approaches to disclosure', participants described how they approached disclosure decisions. This includes the level of planning, strategies for future disclosure decisions, and how selective disclosures were.

A number of decisions were made quickly and spontaneously, with little or no planning. Other decisions were considered carefully, with participants having to 'weigh it up' before acting (quote 39, box 3). For some, disclosures were purposely delayed.

On speculation about future decisions, some participants felt it was clear how they would proceed in future, who they would tell, and at what point. Others acknowledged that future disclosures would be dependent on the working environment (quote 40) or the severity of their mental ill health. Some participants mentioned how their past experiences had helped them recognise symptoms, and that this would help them to disclose at an earlier stage in future.

Participants also highlighted the selective nature of their disclosure decisions. This included the amount of information disclosed about their mental ill health, and who they disclosed it to (quotes 41-42, box 3). Ongoing disclosures appear to be decided on a case-by-case basis; very few participants were completely open.

Selective disclosures often took the form of telling some people but not others, revealing only basic health information (e.g. not revealing full extent of symptoms), or disclosing in some working environments but not others (e.g. different specialties, hospitals etc.). Some participants disclosed during specific episodes of mental ill health but concealed others (e.g. one participant disclosed depression after a bereavement, but kept other instances of low mood with no obvious cause private).

Many participants described how they tailored their disclosures, dependent on their motivefor disclosing, and on their judgement of the possible risks and benefits. For

example, 'being open' with management as a safeguard, yet not telling peers because of not wanting to be 'under surveillance'. An 'unofficial' disclosure was implied by participants who had disclosed to someone at work or medical school where conversations were not officially documented and did not result in processes being enacted by the workplace. Some of these disclosures were intentionally 'off the record' by the participant (e.g. a disclosure to just one trusted colleague).

Discussion

The principal finding was that disclosures were made despit*e* obstacles identified. This study highlighted the very complex and individual nature of disclosure and how the first disclosure an individual makes can be life-changing. If poorly managed the individual may not disclose again for some time, delaying support and treatment.

This study was the first to explore in depth doctors' and medical students' decision-making regarding disclosure of their mental ill health. It identified enablers, and key factors that influence decision-making. . It cannot be assumed that just identifying obstacles means that we understand enablers.

Our study found that among those disclosing their mental ill health outside of friends and family for the first time, the majority disclosed to the workplace or medical school. This differs from previous research that found that doctors expressed a preference to first disclose outside of friends and family to their GP (12), and two studies of psychiatrists that showed low levels of preference to disclose to colleagues (13, 14). These studies examined who doctors would hypothetically disclose to. In reality, disclosures to the workplace or

medical school are often made - albeit for many reluctantly - because it is the only way to manage both work and ill health and access workplace adjustments. This disparity between what individuals think they might do and what they actually do when disclosing mental ill health was found in a previous study (4).

Fear of discrimination and stigma have consistently been cited as obstacles to accessing help (5, 6, 8, 9, 12). However, in this study an individual's motivations to disclose often outweighed their perceived obstacles. Of importance from this study is recognising that decisions made were personal. What was an obstacle for some, e.g. the impact of disclosing on other people, was an enabler for others.

We also found that 'further disclosures' as described in the results were often prompted by others. This is similar to other studies that have shown that doctors often access support services after being prompted or referred by others (15). This emphasises the importance of doctors and medical students receiving a positive response to initial attempts at help-seeking.

The multiple routes of recruitment used across the UK was a strength of the study, as was the number of interviews across career grades. However, bias is inherent in any study of this kind; the data collected must be reviewed with caution. The study only recruited participants who had disclosed to someone and so the opinions of those who have never disclosed is missing. Self-selection and recall bias are of most concern. Recruitment focussed on hospital versus primary care and some specialties may not be represented The

number of medical students taking part was low. The study was time limited; running the study over a longer period could have boosted student recruitment.

This study provides evidence for clinicians and policymakers in how they may improve and promote disclosure and wellbeing within their own organisations. Support and organisational culture requires a cultural shift. Core values that expressly value and respect staff and students, show appreciation for their contributions and be compassionate need strengthening. Policies and processes must mirror these core values. Consistent messages must be provided for doctors and medical students wishing to disclose, and staff trained in the boundaries of confidentiality and pathways to support. In addition support structures must be varied, transparent, confidential and easily accessible. One route does not suit all and this must be addressed by both Universities and employing organisations. At present our research suggests that this is not the case. Organisations must clearly demonstrate and 'practice' improved processes and policies rather than just state - that they care.

Key points:

What is already known about this subject

- Many obstacles to help-seeking have been identified, including lack of access to support, lack of time, long working hours and concerns about confidentiality.

- To date there is little evidence on enablers to disclose, nor on the decision-making processes behind disclosure decisions by doctors and medical students.

What this study adds

- Motivations to disclose mental ill health are complex and multifactorial.

- Enablers to disclosure include help-seeking, compassionate environments and professionalism concerns.

- Disclosures were made *despite* the many obstacles identified in the literature.

What impact this may have on practice or policy

- Poorly managed conversations inhibit further disclosure and put individuals at risk. This identifies a training for those managing doctors to ensure vulnerable individuals are signposted to appropriate support in OH and elsewhere.

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Table 1.

Organisations and key contacts through which the study was advertised
Organisations
British Medical Association (BMA) Wales
Royal College of General Practitioners Wales
United Kingdom Association for Physician Health
Health for Health Professionals Wales
Postgraduate School of Medicine in Wales (Wales Deanery)
Doctors' Support Network
A support service for medical students in Wales based in the School of Medicine, Cardiff University
Key contacts
Doctors that had expressed an interest in previous research on disclosure undertaken by the research group.
Social media contacts with large numbers of physician/medical student followers.

Table 2: Specialty/grade of participants

Specialty/grade	N
Medical student	4
Doctor in training	20
Consultant	5
General Practitioner	15
Specialty and Associate Specialty (SAS)	2

Table 3: Mental health history

Type of mental illness experienced	N
Long-term condition with recurrent episodes	32
Fully recovered from isolated episode	9
Presently unwell with mental illness	5
When mental illness first experienced	**N**
Before medical school	12
At medical school	20
As a trainee	10
As a consultant/locum/SAS	4
Impact of mental ill health on studies/work	**N**
Significantly impacted, had to take time off	27
Partially impacted, was able to stay studying/working	19

Box 1. Participant Quotations

Theme 1: First disclosure decisions

Quote 1

"When I was a house officer, within six weeks of starting the job, I had a really um almost life-threatening um depressive episode, precipitated by just by being thrown in at the deep end, not having a team, not having support, and I went to Human Resources every single day saying that I couldn't cope and I needed somebody to help." (GP)

Quote 2

"I applied to med school ten years ago… there was obviously like the Occupational Health bit on the application form… you just think 'well actually, if I don't say anything and it comes out at a later date, I will be in a worse situation then'." (Trainee)

Quote 3

"They (workplace) got a phone call to say I wouldn't be in at work because I'd been admitted to a psychiatric unit (laughs), there wasn't really any getting away from it!" (GP)

Quote 4

"I think in the earlier years I didn't really realise that I was depressed, I just thought I wasn't coping, you know, and I was a bit useless." (GP)

Theme 2: Further disclosure decisions

Quote 5

"I didn't really get anywhere at all, I just remember them (GP) printing off some like leaflets on depression and that was about it, so I never went back." (Trainee)

Quote 6

"I had in mind to get help um and talk to one of my consultants who used to be a supervisor, and he basically said 'don't go and see your GP, because if you go and you have a record of mental illness you will never have a career as a doctor'… It was obviously totally off-putting which made me really hesitant in whether I go and get help or not." (Consultant)

Quote 7

"Early in the course of my higher training I felt that things were starting to… get too much for me and I needed the time off work… I had to sort of meet with my clinical supervisor to explain why and… got agreed a period of time off work." (SAS)

Quote 8

"I've always been up front with Occupational Health, because you have to be." (Trainee)

Quote 9

"The guidance as far as I understand it from the GMC is that if you have any disorder which might compromise your judgement then you should tell an appropriate colleague, so that's what I did." (Consultant)

Quote 10

"My friends were like asking me what was wrong and stuff at the time, so it was because they'd been like 'You seem different', that's why I went to my GP as well." (Medical student)

Quote 11

"I kind of came to the conclusion that this is how things are, and you know I no longer to make a big secret of it. I was quite proud of the fact that I'd sort of um, recovered and got back to work and you know, I wanted to tell people about it I suppose really" (GP)

Quote 12

"I was basically moved from the hospital job to being a registrar in a GP practice. After a few weeks there I did actually tell the manager and I told my clinical supervisor who was a

GP, just mainly because they were nicer, more understanding people and I felt comfortable to tell them." (GP)

Quote 13

"I do talk to like my peers… if you say to them "This is what happened to me" I think… it's helpful for them." (Trainee 8)

Quote 14

"I was aware that my mood was slipping again and I went to my consultant and explained what had happened when I was a house officer and the response was 'Well we all get a bit sad sometimes, dear'." (GP)

Quote 15

"I'd said that I could keep going in the daytime but I couldn't… handle doing on call and um they sort of said 'Well we're not prepared to do that' and I kind of went 'Well sod you, I'm going off sick then'." (GP)

Quote 16

"Everything kind of went out of control very quickly… it was just a mess, they didn't really know what to do with me, and even when I got better they said it might be a professionalism issue, a fitness to practice issue, which is nonsense." (Student)

Box 2. Participant Quotations

Theme 3: Additional factors influencing disclosure decisions

Quote 17

"I remember mentioning it in student support as well, 'cause I wasn't sure who exactly to tell and I did ask them at the time, did I need to disclose it, was it a thing I had to? And they said as long as I didn't think it was affecting your [sic] work." (Medical student)

Quote 18

"I've not been reluctant to seek help for my psychiatric problems because I think I have a responsibility not only to me but to other people to make sure I'm getting the proper help." (GP)

Quote 19

"I wouldn't want to worry my current practice partners… I'm one of the older partners there and I wouldn't want them to think that I'm falling to bits or you know, or that they have to worry about me." (GP)

Quote 20

"It's thinking about what I could gain from telling them, or what help I could get… at the moment I don't feel like they could maybe help me much." (Medical student)

Quote 21

"I've come across very supportive, understanding people and been able to be quite open." (GP)

Quote 22

"I was really scared that it might finish off my career." (Consultant)

Quote 23

"I suppose at the time I learnt that having certain things on your medical record bears no impact on what the GMC knows about you and your fitness to practice." (Trainee)

Quote 24

"People would be overly critical if something went wrong, it would be 'Ah that's because he's got depression' or a mental health problem, rather than simply because, you know, you made a mistake and everybody does that." (GP)

Quote 25

"It can be a really aggressive place to work in hospital and I think if you show any weakness then you can get bitten to bits by everybody else!" (Trainee)

Quote 26

"Every time I'd go to a different rotation I'd have to give the consultant my undertakings, so the very first thing I have to say is 'Hello, I'm your new foundation doctor, um and by the way I've got undertakings'." (Trainee)

Quote 27

"When I was at my lowest, I couldn't see any other way that meant I couldn't hide it." (Trainee)

Quote 28

"Well nobody really wants to admit they might have a health issue. And certainly not a mental health issue… It would be really, perceived weakness." (Consultant)

Quote 29

"I think everyone needs to understand that people with mental health problems can do any job they want as long as they're well and kept well…. I feel it would be hypocritical aspiring to those ideals whilst at the same time hiding my diagnosis." (GP)

Box 3. Participant Quotations

Theme 4: Reflections on disclosure decisions

Quote 30

"It was good to formally address that and say you know, I am now going to do something about this and for her (practice manager) to put on record that I'd decided I was going to seek some counselling… I didn't feel threatened at all which was really nice to know." (GP)

Quote 31

"It was very embarrassing being a professional and being in a situation where I was basically saying 'I need help, but I can't tell you what'." (GP)

Quote 32

"I felt more reassured, um, both in terms of knowing that I'm adhering to the GMC guidance but also in terms of knowing that there's someone at work who understands that aspect of me, that I could talk to if I ever felt that there were difficulties in the future." (Consultant)

Quote 33

"I think just them (workplace) having an awareness of what was going on made me feel a bit more secure and there was some safeguarding in my work." (Trainee)

Quote 34

"I'm working full-time, I've got a lot of responsibilities, I've got a young family at home, I've got a lot of need and motivation to be well so I acted really quickly and I'm really glad that I did." (GP)

Quote 35

"I think I needed to take sick leave but I wish I had broken my leg or something." (Trainee)

Quote 36

"I would rather they didn't know about me and you know, my personal life and the things I struggle with but… if they don't know about it, it just kind of probably makes things worse." (Trainee)

Quote 37

"I'm glad I did keep it private because it's sort of my information, it's my health, it's my life." (GP)

Quote 38

"It was all about sort of muttering in corners and you know, being very secretive, and I didn't really want to be like that." (GP)

Theme 5: Approaches to disclosure

Quote 39

"I had to think about what I was going to do about telling people and who, and how, and in what sort of detail." (Trainee)

Quote 40

"I think it would depend on that specific workplace, to be honest, um, it's difficult because even at the moment I wish I could tell someone." (Trainee)

Quote 41

"I even tell some of my patients, but I pick who I tell. I tell some of my colleagues, but again I pick who I tell, and there are certain colleagues I would go out of my way to hide it from, even now." (GP)

Quote 42

"Nobody knows the full extent of everything that has gone on." (Trainee)