Debate & Analysis

Healing doctors through groups:

creating time to reflect together

Since 2008 the NHS Practitioner Health Programme (PHP) has offered a confidential service to doctors with mental health problems (www.php.nhs.uk). To date, over 2000 doctor-patients have been seen: three-quarters suffering from depression, anxiety, and a form of post-traumatic stress disorder; and one-quarter with problems with alcohol and/or drug dependence. As well as individual therapy, the service has treated doctors using doctor-only groups, helping to engage this hard-to-reach population in a psychotherapeutic process and to take on the patient role.

DOCTORS AND MENTAL ILLNESS

International evidence suggests that doctors are at a higher risk than the general population for depression and up to three times the rate of death through suicide, yet are reluctant to seek help.[1] There are many reasons for this.[2] Explained briefly, working and living in the same area poses practical problems in obtaining confidential help. Frequent changes of address due to training rotations make it hard to register with a doctor or, once in treatment, have continuity of care. Psychological defences, such as depersonalisation and denial of feelings, are necessary to work in close proximity to death, despair, and disease[3] but if left unchecked can lead to burnout or depression.[4] Personality traits, such as perfectionism, obsessiveness, and denigration of vulnerability, common in good doctors, if exaggerated can cause problems.[5] A compulsive triad of doubt, guilt, and an exaggerated sense of responsibility is a common finding among doctors.[6] When doctors *do* approach services, staff and patients can treat them differently, adding to the isolation already felt by a doctor experiencing mental illness. There are other reasons linked to how doctors are trained that prevent them from seeking timely help, and through the creation of a 'medical self'.[7]

During training, students learn, play, work, live, and love together; they learn a unique scientific vocabulary and 'new' senses, such as the medical gaze. Symbolically their medical self is reinforced, through dress (the white coat, albeit worn less and less), and especially through the acquisition of a new name: 'doctor'. The doctor embodies 'certainty', 'authority', 'objectiveness', and an exclusive habitus set within an imagined community of doctors. The process is reinforced through the dynamic interaction and relationship with colleagues, and juxtaposed against the 'other' — namely patients. This calls to mind the psychiatrist Thomas Main[8] describing the defensive interplay of projections between care-givers and patients, and the 'phantastic' collusion that occurs between the two:

'The helpful unconsciously require others to be helpless while the helpless will require others to be helpful. Staff and patients are thus inevitably to some extent creatures of each other.'

DOCTORS BECOMING PATIENTS

Becoming a patient is a challenge to the medical self as the persona of a 'doctor' is always in stark contrast to not being a patient.[9] In our experience at PHP, doctors experiencing mental illness become more entrenched in their medical self and work harder, not less, the phenomenon called 'presenteeism'. Literally and metaphorically, it is hard for doctors to remove their white coat and replace it with the patient gown.

In the consulting room, for example, practitioner-patients try to regain control by 'talking shop' or underplaying their symptoms, obscuring their suffering behind a 'mask' of invincibility. A consultant breast surgeon who had just been diagnosed, in her own hospital, as having breast cancer tried hard to be a normal patient and to stop being a doctor, but failed in her endeavour, as this quote illustrates:[10]

'I self treated a lot during chemotherapy and got told off for not calling nurses for advice. Why didn't I? Partly embarrassment of admitting that I might not know what to do, partly because I don't like bothering people for something I should be able to fix myself.'

The need to fix oneself and the shame of getting it wrong is a common theme among the doctors attending PHP — especially when the illness needing fixing is related to mental health.[11]

GROUP WORK

The psychiatrist SH Foulkes was a German-born Jewish *émigré* who came to the UK in the early 1930s. His greatest contribution was the development of Group Analysis, moving therapy from the couch to the circle, treating soldiers with trauma returning from the Second World War. Although Foulkes and others following him ran groups for NHS patients with 'neurotic' conditions (for example, depression, marital problems, specific phobias), long-term (over 16 weeks) group therapy is now largely relegated to the management of patients with personality disorders, moving from long-stay therapeutic communities to out-patient psychotherapy departments; short-term therapy for specific groups (for example, those with eating disorders, the bereaved, and survivors of abuse); and ward-based groups for psychiatric in-patients or drug rehabilitation units. Longer-term group analysis is largely confined to the private sector.

DOCTOR-ONLY GROUP SPACES

Doctor-only spaces are now rapidly disappearing, be they for training or treatment purposes. Medical training, now with its multi-professional focus, non-medically-led hierarchies, and loss of 'medical spaces' such as the doctors' dining room or doctors' mess, no longer permits such close identification with each other. Doctors are encouraged to share decision-making with patients and be less authoritarian though just as authoritative. Doctor-only treatment groups are unusual and usually very specific, for example, support groups such as the British Doctors

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and Dentists Group (the AA equivalent for medical and dental practitioners). Balint groups, introduced to improve the GP–patient consultation, increasingly occur only within psychiatry training. The group analyst Gerhard Wilke introduced time-limited 'Beyond Balint' groups for doctors experiencing trauma.[12] There are a number of doctor groups for doctors with boundary violations, addiction, or regulatory issues.

DOCTORS' TREATMENT GROUPS AND BELONGING

PHP has been using groups to help doctors. These groups range from groups for doctors who have been suspended; to doctors who are addicted; to mixed-specialty groups run on group analytic lines; to large groups; to Balint-like groups (where the doctor brings an organisational rather than patient issue into the circle); and to time-limited and problem-specific groups. The size of the groups ranges from six to 60; from one-off to groups now running for years; from specialty-specific (for example, GPs) to mixed. Over the years, hundreds of doctors have been involved in groups run by PHP — but not exclusively for PHP patients (Table 1).

An overwhelming theme permeating doctors' groups is the reassurance of knowing that they are not alone; the therapy group provides a mirror to gain relief via the experience of others. The psychoanalyst Rouchy talks of 'belonging-groups' and the fundamental human need to be part of a group.[13] The group of primary belonging for many doctors is their work (medicine), which encapsulates their sense of self. Once this has been destroyed (and for some doctors this can be total), groups of secondary belonging, a therapy group, become crucial for mental health survival. In our experience, doctor-only groups enable doctors to become patients in a safe environment where they can drop their masks of empathy. For professional carers making such an attachment to a group validates their caring identity, which paradoxically allows them to let it go, seek care for themselves, and go on to join heterogeneous (mixed) groups or further therapy after time-limited doctor-only groups end. A doctors' group provides a secure base allowing them to separate from their medical self and embrace patienthood — to grow psychologically through the experience. The vulnerability some feared of a group setting is counteracted by the realisation that 'we're all in the same boat' and the subsequent sense of safety. Once engaged in treatment (individual and group therapy), doctors have excellent outcomes.[14]

Table 1. Examples of groups in which doctors can engage

Treatment group modality	Brief description
Large group	Half-day, one-off events for variety of medical audiences, including trainers, trainees, educators, psychiatrists, GPs, hospital doctors, health service managers
NHS listening events	Half-day, one-off events for NHS staff aimed at understanding current discontent
Reflective practice	GPs, whole-day events including small and large groups
Beyond Balint groups	Aimed at GPs, monthly — 90 minutes
Balint groups	Monthly for practitioners working at PHP
Suspended doctors group	Monthly for doctors and/or dentists unable to work. Provides solace, support, and a space to adapt to change in working life, open access
Addicted doctors group	Monthly, open access
Men-only groups	Weekly for 8 weeks
Analytic groups	Consultants/GPs only. Trainees/'junior doctors' only. Women only. Weekly (30 weeks) and open-ended (>30 weeks)
Specific time-limited groups	Mindfulness Dealing with exam stress
Doctors-in-training	Weekly, open access. Offers a space for trainees to gain support from peers, normalise their distress, and share experiences

PROBLEMS WITH DOCTOR-ONLY GROUPS

Clearly, doctor-only treatment groups might perpetuate the perceived elitism of professionals. Although this (arguably) might be the case for training groups, for doctors needing treatment (for mental health and/or addiction problems) the evidence suggests that homogenous groups are more beneficial for restoring them to health, due to the process of the group function and not due to pandering to professional arrogance. Foulkes ran soldier-only groups, one imagines not just for practical reasons (they were in-patients at Northfields), but also from his belief that they had special needs, requiring their own group to address. The same logic applies to doctors, who have unique problems and a unique set of deeply constructed barriers to getting effective treatment. Mixing junior- (training grade) and senior-level doctors has been difficult, probably much to do with the power relationships endemic in medicine.

CONCLUSION

Group analysts are comfortable with and encourage the idea of different and paradoxical selves, such as therapist and patient, and this is the substance of the work of therapy groups. This idea is however unfamiliar in other circles, such as among doctors, who have tended to cling to a unitary self as clinician and healer. Group therapy can help health professionals renegotiate their professional identity in favour of what Wilke terms a 'group matrix model of medicine' as interdependent figures in a matrix of complex relationships.

It is important that, as health professionals, we engage as patients,

participants, and as providers in group work. Part of any strategy to improve retention of doctors must involve creating spaces for doctors to reflect together, support each other, and share techniques for remaining mentally healthy. Facilitated groups are perhaps the best and most cost-effective route for achieving these aims.

RESOURCES

The Balint Society: Balint groups provide a space to think about encounters with patients. www.balint.co.uk

The Institute of Group Analysis: provides access to therapists and groups across the UK. http://www.groupanalysis.org

British Doctors and Dentists Group: provides mutual support for doctors and dentists (including students) who are recovering, or wish to recover from, addiction/dependency on alcohol or other drugs. Groups are run across the UK. http://www.bddg.org/

Doctors' Support Group: for medical professionals facing suspension, exclusion, investigation, or allegations of professional misconduct. www.doctorssupportgroup.com

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