Management of mental illness in medical doctors: attitudes and orientations based on the Centro Hospitalar do Porto population

Diogo da Costa Oliveira

2018
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Thesis to obtain Integrated Master’s Degree in Medicine.

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Porto, May 2018
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End the Stigma.

Change lives.
Acknowledgements

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I would also like to acknowledge Dr. Ana Silva Pinto of the Instituto de Ciências Biomédicas Abel Salazar at the University of Porto as the second reader of this thesis, and I am gratefully indebted to her very valuable suggestions on this thesis and for keeping in touch always. She was my professor in my third year when doing my psychology course at university and it was a privilege to work with her again.

Both, my advisor and second reader, consistently allowed this paper to be my own work but steered me in the right direction whenever they thought I needed it.

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On the same note, I would also like to thank Prof. Carolina Lemos, for helping me with the statistical analysis of my results. She is truly good-hearted, readily agreed to help me and patiently sat down with me reminding me of my long-gone statistic knowledge.

Finally, I must express my very profound gratitude to my parents. They continue to live in Malawi, from where I left six years ago and even though they are far away, their immeasurable support in the decisions I took and their continuous encouragement throughout my years of study and through the process of writing this thesis is boundless. Leaving Malawi was not easy, but I was fortunate enough to make incredible friends that made me feel home. This milestone would not have been possible without them.

Thank you.

Diogo da Costa Oliveira
Preface

The thesis topic was suggested by the main advisor. Initially, the plan was to investigate the epidemiology of mental illness in the Centro Hospitalar do Porto, risk factors and thoroughly analyse help-seeking barriers. However, this study was carried out in the previous year by another sixth-year student of the Instituto de Ciências Biomédicas Abel Salazar – University of Porto, developing her thesis to obtain her integrated master’s Degree in medicine. Therefore, the idea was to follow through from her study and brainstorm on how to manage these situations. The proposed algorithm should be viewed as a starting point for the development of a solid action plan to manage mental illness in this professional class and possibly extend it to all health professionals.

Initial research was challenging as there is not a large amount of published literature regarding the management of these situations and few examples to serve as models. The motivation to further investigate the topic escalated with the intensive research on help-seeking barriers and awareness of alarming percent of doctors with some sort of mental illness. This directed the authors to frame ideas to better the conditions of a professional group with an increasing amount of stress, as the pressure on an ideal national health system culminates.

Please note that although this study focuses on the development of an orientation line for the Portuguese medical class and the Centro Hospitalar do Porto, the thesis was elaborated in English language (United Kingdom) because it is the native language of the main author, Diogo da Costa Oliveira. The questionnaires distributed to the participants of the study were developed in Portuguese language (Portugal), but all efforts were made to maintain the intended or demanded function in the discussion of the results.
Resumo

**Contexto:** A doença mental é mais comum nos médicos comparativamente à população geral. Existem vários fatores de risco inerentes à profissão, bem como características individuais encontradas nesta população que explicam tal facto. O estigma em relação à procura de ajuda especializada também ocorre na profissão médica, uma vez que assumir o papel de paciente pode ter consequências profissionais, sobretudo quando a comunicação e a confiança entre os profissionais de saúde não são asseguradas.

**Objetivos:** Reunir a opinião dos responsáveis dos serviços e departamentos hospitalares do Centro Hospitalar do Porto e fazer o paralelismo com outros serviços especializados existentes e a literatura publicada para, desta forma, criar um algoritmo orientativo das atitudes a adoptar na gestão da doença mental na classe médica. Com este algoritmo pretende-se traçar uma diretriz relativa a um sistema não punitivo que apoie a auto-referenciação mas que também permita o encaminhamento, quando necessário, e que forneça ajuda e tratamento adequados; sugerindo-se, também, métodos que favoreçam a saúde mental neste grupo.

**Métodos:** Foi criado, validado e distribuído um questionário original a 49 diretores de serviços e departamentos hospitalares do Centro Hospitalar do Porto. Este questionário foi utilizado para recolher a opinião dos inquiridos sobre como deve ser gerida a doença mental na classe médica, de um ponto de vista institucional.

**Resultados:** A taxa de resposta foi de 83,7%. 58,5% dos inquiridos referiram já ter tido na sua equipa médicos com sintomas de doença psiquiátrica, mas 65,9% não tinham conhecimento de como agir nessas situações. A maioria reconheceu a importância da doença mental na aptidão profissional dos médicos e concordou com a realização de avaliações psiquiátricas regulares. 65,0% considerou benéfica a formação de um serviço especializado nacional para gerir estas situações, reiterando a importância do diretor do serviço / departamento hospitalar e do serviço de medicina ocupacional como intermediários no encaminhamento hospitalar.

**Conclusões:** O estigma associado à saúde mental e a existência de obstáculos relativos à procura de ajuda evitam que os médicos dêem conhecimento da sua condição psiquiátrica. Os fatores de risco precisam de ser melhor estudados para que possam ser definidas novas estratégias que visem reduzir a pressão sobre a classe médica. Reitera-se a importância de informar os profissionais de saúde acerca da doença mental de forma a destigmatizar o tema. É, então, sugerida a formação de uma organização externa especializada na gestão destas situações.
Abstract

**Background:** Compared to the general population, mental illness is more common among medical doctors. There are several risk factors that are linked to the profession, as well as individual features found amongst most doctors that account for this increased rate of mental illness. The stigma regarding the search for specialized help also occurs in the medical profession, where assuming the role of the patient can have professional consequences, especially when the communication and trust among health professionals is not ensured.

**Aims:** To gather the opinion of the heads of hospital services and departments of the Centro Hospitalar do Porto and in parallel with other specialized services and published literature, design an orientation line with attitudes to adopt to manage mental illness in medical doctors. The aim is not only to suggest methods to counteract the development of a mental illness but to create a guideline of a non-punitive system that supports self-referral but allows for referral, if necessary, and provides adequate aid and treatment when required.

**Methods:** An original questionnaire was created, validated and distributed to 49 head of hospital services and departments of the Centro Hospitalar do Porto. This questionnaire was used to collect the opinion of the participants on the management of mental illness in the medical class from an administrative point of view.

**Results:** The response rate was 83.7%. 58.5% of the participants had had a previous contact with members of their team with mental illness but 65.9% were uncertain of how to act in these situations. The majority recognized the importance of mental illness in the doctors' fitness to practice and agreed to regular psychiatric evaluations. 65% saw benefits in the formation of a national specialized service to manage these situations but advocated the importance of the head of hospital service/department and the occupational medicine unit as intermediates in in-hospital referrals.

**Conclusions:** The stigma associated with mental health and several other obstacles avert doctors to not disclose their condition. Risk factors need to be further studied to instill new strategies to reduce strain on doctors and the health professionals should be further educated on the matter. An algorithm is suggested to create a specialized external organisation that manages the mental illness in the medical class.

**Keywords:** mental disorders, occupational medicine, stigma, referrals, self-referral, fitness to practice.
List of abbreviations and acronyms

**ESO** – External Specialized Organisation

**GP** – General Practitioner

**GMC** – General Medical Council

**OM** – Ordem dos Médicos

**OMU** – Occupational Medicine Unit

**PHP** – Practitioner Health Program
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Introduction

Mental illness in medical doctors

Across literature, it is stated that mental illness is common among doctors and although doctors are generally physically healthier than the general population, they have higher rates of mental illness and suicide. A broad spectrum of mental illness have been identified in this professional class, more commonly including: depression, anxiety, addiction to alcohol or illicit drugs, misuse of prescription drugs, and emotional exhaustion or burnout. These may manifest as behavioural alterations and may have detrimental effects on cognitive function, affecting the doctor’s clinical performance.

With the rise of a patient-centered model and rapid technological advent, together with the increased importance of health economics; pressure on an already stressful and wasteful career has escalated. These factors have placed a greater stress on the workplace, making health and wellbeing of the entire healthcare team important factors to deliver the expected quality of care.

Risk factors that lead to poor mental health can be divided in two categories: occupational and individual factors. Occupational risk factors include the heavy working hours and the stress related to the patient. Doctors are put under harsh physiological pressure when faced with delivering bad news and are in frequent contact with illness, anxiety, suffering, and death; which have been seen to be a key predictor of depression in doctors. Other authors discuss that it is not so much the painful and challenging problems that the patients bring, but the way the work is structured and organised, at an individual and institutional level. Dysfunctional teams, characterized by problematic relationships and conflicts with colleagues; workplace bullying and lack of teamwork, likewise contribute to a difficult working environment, increasing the psychological distress. The easy access to prescription drugs and the knowledge of how the drugs works, also increase the likelihood of misuse of prescription drugs.

Vaillant et al. suggest that doctors typically exhibit traits, such as perfectionism, excessive sense of responsibility, desire to please, self-doubt, and guilt for things out of control. These can be perceived as vulnerabilities, as they lead to doctors being self-critical with obsessive-compulsive traits, which account for individual risk factors.
Medical students and young trainee doctors have shown, in some cases, to be the initial trigger of the development of poor health.¹ When students enter medical school, their mental health status is comparable to the same-age population. However, this trend declines soon after they initiate their medical degree and students present with higher rates of depression, anxiety, and burnout in comparison to the population of the same age. Moreover, a consequential percent of students have had suicide ideation.⁷ Unappropriated coping methods (e.g. emotional distancing), lack of mental health education and lack of monitoring from an early stage, may cause vulnerabilities, which at a later stage, together with occupational risk factors, may lead to a psychological distress revealed in young doctors.¹

Obstacles to help-seeking

S. K. Brooks et al. divide the obstacles to help-seeking into four different categories: lack of knowledge about where to find help; professional implications, difficulties with disclosure and psychological barriers to help-seeking.¹

As shown previously, the lack of information and poor monitoring of young doctors are the primer step obstacles to disclosure. Doctors are unaware of the poor mental health⁸ and it’s frequency amongst health professionals but also the procedure to undergo if they require assistance. Many young doctors are not registered with a general practitioner (GP) and are unsure of the role of occupational health services.¹

The lack of information extends beyond the fact that doctors do not know where to look for help, to the uncertainty of the professional implications. High levels of “presenteeism” in doctors may lead to anxiety as they worry about the patients they may disappoint in the case of temporary suspension; letting down colleges and patients, the difficulty in finding a replacement, as well as the adversity they may face when they try to get back to work.⁹,¹⁰

Personal physiological factors are also a barrier to help-seeking. Mental illness has been perceived as a “weakness”, opposing the social imposed image of the doctor, as a “healthy person”. This can bring about feelings of embarrassment and shame. The public stigma itself can induce self-stigma, resulting in low self-esteem and deficient self-efficacy.¹

Doctors continue to resist the “role reversal” and often fall back on self-diagnosis and self-medicated approaches or opt for no treatment at all. The main reason for this is the fear of confidentiality breach and anxieties associated with the disclosure, as well as denial of psychiatric symptoms. By self-medicating, the doctors try to minimize their perception of the
psychological disorder. The “role-reversal” itself, not only makes it difficult for the doctor with the mental illness (sick doctor) but also makes it extremely difficult for the doctor attempting to treat him/her.

Doctors have become increasingly accountable for their decisions and actions. Sick doctors may add a stress to the equilibrium held to keep the good functioning of a hospital team. However, doctors with mental illness, in general, only disclose their condition at a much later phase of their illness, when there has already been a significant negative impact on their work, the work of the other health professionals and on the patients. ⁵

Specialist services

The American Medical Association initially defined an impaired doctor as one with any physical, mental or behavioural disorder that interferes with the ability to engage safely in professional activities. Regulations are therefore set to guarantee good medical practice and to protect public service users from malpractice.

In several countries, a specialist service has been created, specifically for the health professional, where they can get support and treatment in an environment that is designed specifically for their needs. ¹ Although some risk factors have been identified, there is still very little knowledge and results to back up the impact of each of these risk factors, making it difficult to identify who will have a mental illness.

Situation in Portugal

Law enforcement

The Portuguese medical regulating body is called Ordem dos Médicos (OM) and it has the competence to act as a disciplinary entity for the exercise of the medical profession. ¹¹ The OM follows what is regulated under the general labour code and law number 102/2009, of September 10 of 2009 (Código do Trabalho e da Lei 102/2009, de 10 de Setembro de 2009); which also contains the promotion of occupational safety and health. The law states that it is under the general obligations of the employer to ensure that exposures risk factors do not pose a risk to the safety and health of the worker and states that there should be an adaptation on work conditions to alleviate monotonous work and repetitive work and reducing psychosocial risks. ¹²

Although there is no specific rule in the OM relatively to psychiatric illness within the medical class, when the behaviour of an employee indicates a mental disorder that jeopardizes the
normal performance of his duties, the head of the department may order him to be submitted to a medical committee. The medical committee decides whether the employee can return to work and in cases where he considers that he is unable to resume his activity, indicates the foreseeable duration of the illness. The law, however, doesn't specify the members who shall constitute the medical board: their area of specialization or even training to assume such position. ¹³

Centro Hospitalar do Porto (CHP)
Occupational Medical Unit (OMU)

As of now, there is no specific evaluation of the mental health state of the health professionals, other than the consultation / occupational health examination in which health assessment is done for the work, which results in the fitness (physical and psychic) for work. The consultation/health examination is carried out for 2/2 years for workers under 50 years and annually over 50 years.

The medical fitness card (see Appendix I) evaluates the workstation, identifies professional risk factors and the exposure related to the profession of the physician. Following an occupational consultation, the doctor is identified as: fit to practice, conditionally fit to practice, unfit to practice or temporarily unfit to practice. Recommendations may be made by the examiner related to the evaluation of risk factors, adjustments to work conditions, use of individual protection equipment, the proposal of work organisation and training of the employee.

Doctors working in the OMU have no targeted training in the psychiatric branch, limiting their analysis of mental health to the training received in medical school. The psychiatry department of the hospital, to safeguard professional secrecy and to avoid conflict of interest controversy, don't attend health professionals of the hospital. Therefore, if a sick doctor needs to be referred to a psychiatrist, he/she is sent to psychiatry consultation outside the hospital, namely, Hospital Magalhães de Lemos. Situations are dealt on a case-by-case basis with the involvement of the director of the respective service, with eventual conditional status on their medical certificate. At the time written, there was still no institutional opening for a social worker nor a psychologist, to act in the identification and prevention of stressors that the professions linked to health services are subjected to.
Centro Hospitalar do Porto – Mental Health Stigma Investigation 2016

The Master’s degree thesis, elaborated by Doctor Sara Catarino, as a student of the Instituto de Ciências Biomédicas Abel Salazar - University of Porto, oriented by Doctor Ana Sofia Pinto; explores the epidemiology and obstacles to disclosure as well as preferred paths for disclosure.

Relevant results of this thesis are summarized in Appendix II and the full-version can be viewed on the University of Porto repository.

Methods of Investigation

Objectives of the study

This study intends to audit the opinion of the hospital service and department directors regarding the procedures to be adopted when the doctors who integrate their teams are faced with a mental illness. Using the data gathered and based on the existing literature, the aim is to elaborate an algorithm of the procedures to be adopted in these situations.

Participants

The aim of this study would be best drawn upon by the hospital’s service and department directors: members of the hospital that are accustomed to decision-making and possesses in-hospital organisation skills. A total of 49 questionnaires were distributed.

Instruments

An original questionnaire was created to collect the necessary information (see Appendix III). The construction of the questionnaire was based on the Coventry University and Loughborough University guidance manual and was developed according to the literature review presented above, together with procedures that are carried out in specialist services abroad (namely the Practitioner Health Program - PHP).

The questionnaire was anonymous and consisted of sixteen questions: ten multiple response questions and six ranking questions. For these later ones, a Likert Scale grading from one to five was used. The survey was analysed by the thesis advisor and second reader and then reviewed by two head of departments before being submitted for approval.
1.1 Procedure for collecting data

The thesis project was approved in December 2017 and the study was then authorized by the Board of Directors of the CHP, having previously been analysed by the Ethics Committee and CHP investigation department (Departamento de Ensino, Formação e Investigação), having obtained a favourable opinion (see Appendix IV).

Data collection was executed between February and March 2018. Due to limited time availability of the participants in this study, most of the questionnaires were left at their secretary with the following constituents: a note presenting the main investigator and thesis advisor; an explanatory note of the study; informed consent request and the questionnaire (see Appendix IV). The participants' right to privacy and anonymity was guaranteed.

Data analysis procedures

To study the relationship between the different variables, categorical data was organized in crosstabs and when meaningful, a chi-square test was applied. A p<0.05 was considered statistically significant. The statistical analysis of the data collected was performed using the Statistical Package software for Social Sciences - version 25 (SPSS 25.0).

Results

Of the 49 questionnaires distributed, 41 were completed (response rate of 83.7%). The CHP has 13 hospital departments and 45 hospital services, and therefore this study covered only 70.7% of the total defined population. Of the 41 that completed the questionnaire, six participants were department directors and the remaining were hospital service directors. 33 of participants were from the HGSA and eight from the CMIN.

Please note that a descriptive review of the results is presented below. Full results, surveyed question-by-question, can be consulted in Appendix V.

Most of the participants (58.5%) had had previous or present contact with a member of their team with psychiatric illness or symptoms of a psychiatric illness. Of these, the majority (79.2%) had only registered one to two cases. 12.2% of the participants, opted to select
that they had no knowledge of a member with a psychiatric illness or symptoms of a psychiatric illness, rather than selecting the option no (29.3%).

58.5% of the participants claimed that maybe they would know how to act in a situation where a member of their team presented with psychiatric illness or symptoms of a psychiatric illness. However, in table I (shown below), when those that do not know how to proceed are combined with those that were unsure of how to act, we can see that the majority are uncertain of how to proceed.

**Table I Certainty of how to act in these situations where a member of their team presented with a psychiatric illness**

<table>
<thead>
<tr>
<th>Certain</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td></td>
<td>34.1</td>
</tr>
<tr>
<td>Uncertain (responses: No + Maybe)</td>
<td>27</td>
<td>65.9</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Despite this, 29.3% of the participants strongly disagree (i.e. selected value one on the Likert scale) with the benefit of a regular psychological/psychiatric consultation for all doctors. However, close enough, 24.4% strongly agree (i.e. selected value five on the Likert scale) that a consultation would be beneficial and 14.6% do not agree or disagree with the benefit of a regular consultation. However, after grouping those that don’t agree (i.e. selected value one and two on the Likert scale) and those that agree (i.e. selected value four and five on the Likert scale), more participants agreed that a regular consultation would be beneficial.

**Figure 1 Benefit of a regular psychological / psychiatric consultation (Qualitative analysis)**
Most participants agreed that mental health of doctors was very important (68.3%) when evaluating the fitness-to-practice of the doctors. Remarkably, no participants rated mental illness as not important (value one on the Likert scale).

43.9% thought that an external specialized special should be responsible for dealing with these situations (where a doctor on their team develops a mental illness/symptoms of a psychiatric illness). Close enough, 34.1% thought that the OMU should oversee these same situations. Three participants selected the option others: one did not suggest an alternative, another recommended the Ordem dos Médicos and finally, the last appealed that it depended on the diagnosis and the severity of the incapacity of the individual.

Question seven and eight obtained similar results. 75.6% of participants thought they should be responsible to receive a complaint from a patient and in the same way, 70.7% would prefer to be themselves to receive an alert that came from another health professional that questions the mental health and inappropriate behaviour of a doctor from their team.

If the director of the hospital service/department understands that the complaint or alert may be feasible of a possible psychiatric alteration of the doctor, then 41.5% assume that the OMU should be the next intermediate to be informed. 29.3% think the hospital board should be responsible and 26.8% would prefer to transmit the message to an external specialized service. However, these results were shown to not be statistically significant as $p>0.05$. One participant selected others and suggested that it would depend on the problem – occupational medicine vs. psychiatry consultation.

41.5% of participants selected that the evaluation of the mental health of the hospital should be done by a psychiatry service external to the hospital service, followed by the psychiatry service of the hospital with 31.7%. When grouped as internal and external (to the hospital) evaluations, an internal evaluation was more selected with 55.3%.

Question twelve showed that the in the opinion of the participants, the evaluation of a doctor’s fitness-to-practice should be carried out by, in order of preference, the external specialized organisation council together with the hospital (21.8%); the OMU of the hospital (15.4); director of the respective service (15.4); the doctor’s own psychiatrist (12.8); the psychiatry service of the hospital (11.5), followed by the hospital administrative board and the referred doctor, with fewer candidates choosing these later two.
TABLE II PREFERENCE TO BODIES TO BE INVOLVED IN THE EVALUATION OF FITNESS-TO-PRACTICE OFREFERRED DOCTORS

<table>
<thead>
<tr>
<th></th>
<th>Responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent (%)</td>
</tr>
<tr>
<td>The doctor being evaluated</td>
<td>4</td>
<td>5,1</td>
</tr>
<tr>
<td>Director of the respective service</td>
<td>12</td>
<td>15,4</td>
</tr>
<tr>
<td>Psychiatry service of the hospital</td>
<td>9</td>
<td>11,5</td>
</tr>
<tr>
<td>The doctors’ own psychiatrist</td>
<td>10</td>
<td>12,8</td>
</tr>
<tr>
<td>OMU of the hospital</td>
<td>12</td>
<td>15,4</td>
</tr>
<tr>
<td>Hospital Administrative Board</td>
<td>6</td>
<td>7,7</td>
</tr>
<tr>
<td>External Specialized organisation council</td>
<td>8</td>
<td>10,3</td>
</tr>
<tr>
<td>External Specialized organisation council together with the hospital</td>
<td>17</td>
<td>21,8</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>100,0</td>
</tr>
</tbody>
</table>

When questioned on what should be done when a doctor is referred for an evaluation of his mental health condition, 41.5% of the hospital service/department directors believe the doctor under evaluation should be suspended on a temporary term (*certificado de incapacidade temporária para o trabalho*, commonly know as “Baixa médica”). Few believe that they should continue to practice activities that do not pose a high risk to patients without supervision (19.5%), contrary to the 36.6% that consider that the doctor should continue to practice under supervision.

When categorized between agree or do not agree, 65.0% agree that a national external specialized organisation should be founded to manage these cases. Even when analysed with the uncategorized data, 51.1% selected the number five on the rating scale and in concert with the categorized group analysis.
Although more participants (34.1%) strongly disagree with the compulsory declaration of mental illness of a doctor, the results are closely distributed, as 29.3% strongly agree. When grouped, only 2 participants make a difference between the greater preference for compulsory declaration than against.

73.2% believe that doctors should have the possibility of access to specific and confidential means for psychiatric treatment of these situations.

Cross-Tabulation of several variables

60.9% of the participants that agreed with the creation of an external specialized organisation, had already had previous or present contact with a doctor in their medical team with psychiatric symptoms. However, in those that disagreed with the formation of an external specialized organisation, more had also had contact with a similar situation.

Table III (shown below), confirms consistency between the participant choices (i.e. those that agree with the creation of an external specialized organisation, think that these situations should be managed by an external specialized organisation).
Similarly, those that opted for an external evaluation of the mental health, agreed with the creation of an external specialized organisation.

### Discussion

The perception and importance of mental health have become increasingly understood and highlighted in the results of this study. Disclosure, on the other hand, continues to be an impasse. There is a vast amount of published literature analysing the various aspects of mental illness in doctors. However, few of these matched our aims for this study: solutions of how to manage mental illness in doctors. Our study was based on an original questionnaire with no studies to carry out direct comparisons. Nonetheless, we tried to compare our results with conclusions extrapolated from other studies.

The sample chosen had an internal population with strict time availability. Even so, a good response rate was expected as the population was frequently motivated, and the questionnaire was straight-forward: requiring less than ten minutes to read the explanatory note and complete the questionnaire. The sample chosen was sufficient for the results we required, although a larger sample size could allow for greater distinction between the different options in each question.

We analysed the results we obtained, in parallel with those previously collected by Dr. Sara Catarino that applied her study in the same hospital. This allowed for a more embracing approach, as the orientation line was drawn upon the opinion of the general population of doctors, with the results of the study carried out by Dr. Sara Catarino and a more institutional approach with our study.
The well-being of the medical team is becoming increasingly important and this has been proved by a growth in the incidence of impaired health professionals. 4 Our results showed that more than half of the participants had had contact with at least one member of their medical team with psychiatric symptoms or illness. Each of these had registered at least one or two cases. According to the results of the study of Dr. Sara Catarino, 12.3% of the doctors of the CHP had had past or recent history of mental illness. Of these and of these, a worrisome number (30%) did not seek help. We believe this value might be overestimated, as those that had had a previous experience of mental illness, or knew of someone that had had that experience, were more likely to respond to the questionnaire.

Nevertheless, considering that our results also showed that 65.9% of the CHP hospital service and departmental directors were uncertain of how to act in a situation where a member of their team presented with psychiatric illness, together with the risk factors for mental illness in this profession and the obstacles to seeking help, the urge for the problem to be addressed becomes more evident.

Some authors have identified important areas to address such as: managing unrealistic expectation of doctors (both personal and from the general population) and reducing barriers to help-seeking.15 We have identified three main approaches that we believe can be helpful to target: pre-graduate education; monitoring and reducing risk factors for mental illness; and an orientating algorithm for self-referral and referral of a doctor, if required.

Pre-graduate Selection and Mental Health education

In our opinion, medical schools should be one of the targets to manage this problem, as strategies applied at an early stage of medical training, not only increase awareness and destigmatisation but also highlights pathways for seeking help. 4 Firstly, medical student selection needs to be reviewed and secondly, early education on mental health needs more emphasis.

In Portugal, entry into medical school is regulated by the national education ministry. Student selection is only based on the average of the final year evaluation and specific entrance examination of science-based subjects. There are no interview phases. All candidates are required to have a medical declaration completed by a registered doctor (see Appendix VI) to advocate that he/she is absent of psychic, sensory or motor deficiency that could interfere with the functional capacity and of interpersonal communication, to the
point of hampering with their learning ability. With respect to mental health, this form has only a reduced fill field, regarding behavioural changes and interpersonal communications.

Roberts and Porter, emphasize that certain personality traits in medical students/doctors, such as obsessionality, lack of pleasure seeking, feeling of indispensability - may predispose to affective disorder in middle life. They defended that medical student selection should be more stringent and urged for greater use of psychometric testing and personality assessment. School examination results are the main discriminator between students applying for medical schools and although these may seem to be a good predictor of good preclinical examination results, they are a poor predictor of subsequent clinical performance. 

In some countries, medical schools try to filter students who have personal characteristics that could impact negatively on their ability to interact with others and so disrupt their ability to cope with the stress of medical teaching. However, there aren’t enough long-term studies to prove a clear relationship between personality characteristics and performance in healthcare. Therefore, attending to the multiplicity of personality traits and the lack of straight-forward correlations, the generalized use of these parameters can be prejudicial as it is the inferred value of these evaluations is uncertain. For this reason, caution needs to be taken in their use as a complementary tool in medical school interviews. To overcome these problems, some medical school have adopted for *multiple-mini interviews* allowing candidates to demonstrate key skills and can eliminate the problems associated with potential biases and errors associated with unstructured, dubious interviews and tests. Maladaptive coping behaviour begins at an early stage in the doctor’s medical career. 

Initiatives to reduce this problem at this phase include: improving access to mental health care, educating students about mental health problems, and reducing the stigma related to seeking mental health treatment. Some medical schools have implemented several approaches, for example, the University of Hawaii School of Medicine developed a program for third-year students, that included counselling services with greater anonymity in referral, provide education on risk factors and educative communication with students about depression. Other universities, such as the University of California, provide *grand rounds* and other educational sessions on burnout, depression, and suicide. Studies also show that increased knowledge was associated with an approximation and greater understanding of mental illness. 

Other universities have taken a bigger step and followed through with curricular changes. These include several strategies like changing from numerical or letter-grade hierarchical
systems to pass/fail grading which has shown to reduce perceived stress and improve overall well-being and group cohesion. Teaching methods also have an impact on student well-being: problem-based learning seems to have less perceived stress than traditional teaching methods. 19

Higher mental health correlates with medical student professionalism and a better personal experience. 20 We believe that changes need to be enforced in Portuguese medical schools to help not only identify and help students who develop mental disorders or psychological symptoms, but also to invoke better mental health well-being within the students from an early phase.

Mental health monitoring and risk factor control

Published literature tends to focus on schemes to increase the efficiency of doctors’ in a more economical and time-based approach. 21 Few interventions are done taking into consideration the effect it may have on the well-being of the doctors – usually unfavourable, increasing their vulnerability for mental ill-health. 4 There is an urge for monitoring and providing support to doctors from an early phase in the career, guaranteeing clear steps they need to take to seek help and also educate doctors on the higher prevalence of mental illness in the profession relative to the general population. 1 Although risk factors have been identified for mental health problems in doctors, it is difficult to anticipate those that will effectively suffer from a mental health illness. 1 Some authors suggest that the focus should be on early identification and treatment of problems, rather than depending on unreliable predictors. 22

In our opinion, the OMU should have a greater role with the recruitment of a labour psychologist, to manage occupational risk factors, with further studies need to be carried out in the CHP, to investigate the impact on the organisational schemes being applied: working hours, team functionality and identification of services with a greater need for follow up or mental health state.

A greater importance should be given to the psychiatric evaluation, taking into consideration that 68,3% of the participants of our study agreed that mental health is an important factor in the doctor’s fitness-to-practice. Regular occupational medicine consultations could be introduced and perhaps an optional questionnaire could be sent to the doctor for self-evaluation of mental health state before each OMU consultation. The doctor could then decide if he/she wishes to discuss the questionnaire results or not.
As with medical students, we also believe that doctors need to be more informed about mental health in health professionals. By being more informed about the frequency of mental health in health professionals, we believe the matter will become less stigmatising.

Specific situations guidance

The NHS Practitioner Health Program (PHP), is a specialized service, established in 2008, to deal with the mental health of doctors and dentists in London but has expanded to cover all GPs and GP trainees in England. The service provides care to these, maintaining confidentiality with staff using the same confidential electronic record. There are daily multidisciplinary team meetings and a patient can make appointments with the clinician of their choice. In 10 years, over 3000 doctors had presented to the PHP (this is approximately ten percent of all London doctors). An organisational chart of the PHP can be viewed in Appendix VII.

The study of Dr. Sara Catarino evidenced that if members of the medical class were to develop a mental illness they would prefer to be treated by the private health services and the main determinant that would weigh on their decision of where to seek help was confidentiality, followed by the quality of health service and stigma. Our interpretation of these results is that doctors working in the public sector, where this study was applied, would prefer to seek help exterior to the hospital to safeguard themselves from the possibility of breached confidentiality (either between health professionals or via the electronic registration software). This is understandable as studies in the published literature show that the most frequent (54.6%) observed breaches, were related to the consultation and/or disclosure of clinical and/or personal data to medical personnel not involved in the patient's clinical care, as well as people external to the hospital. Our questionnaire was concordant with this wish, as most of the service/department directors (43.9%) agreed that an external specialized organisation (ESO) should be responsible in the management of these situations.

According to the published literature, many doctors don’t make use of the already available means to access healthcare and continue to self-treat themselves with medication, exercise, relaxation, despite guidance going against this channel. 65.9% of the participants in our study strongly agree that doctors should have the knowledge or the possibility of access to specific and confidential means for psychiatric treatment of these situations. This is imperative because we believe that more crucial than designing an in-
hospital orientation line, is the self-referral of doctors that acknowledge that they need help, instead of just ‘keep going’ on. Nevertheless, an in-hospital orientation line is also required because several doctors with psychiatric symptoms unconsciously or deliberately neglect these and above all, patient safety must be assured. 15

The facts highlighted above, and the existence of help-seeking barriers already highlighted, favoured the formation of an ESO in Portugal, similar to the PHPs: an independent national organisation, with a trained team to manage situations related to mental health problems in all health professionals. It is important to create a system that does not have a punitive character with immediate sanctions against their medical registration and to pinpoint that the ESO manages the whole spectrum of psychological alterations or psychiatric illnesses and not only severe cases. To assure confidentiality, the ESO’s working staff team should be independent of the hospitals and made up of psychiatrists, mental health nurses, therapists and legal advisors that would be trained to manage this professional group – understanding both their role as a health professional and a patient. It is important to involve the referred doctor in his/her own treatment plan and provide support to avoid embarrassment; feeling of being undermined as a doctor and/or reluctance to be treated by a peer. 1

The ESO being proposed should have different access routes: either by self-referral or referred by the sick doctor’s GP or OMU. Self-referral should be the preferred route and for this reason, a direct route to the ESO without intermediates was created to encourage this pathway and allows for greater confidentiality as it involves fewer bodies in the process.

In situations that doctors don’t disclose or aren’t aware of their problem, they can be referred by others. In the UK, doctors that are referred to the GMC or PHPs, usually involve doctors who have been sent on sick leave or have been suspended following up from a crisis. 24 Referrals to the GMC can only be done via the primary care and so occupational health services cannot directly refer a doctor. This often makes a referral more difficult and may retard the beginning of the treatment. 24 For this reason, in our model, we believe that the impaired doctor’s GP and the OMU should be able to independently refer a doctor to the ESO. Meanwhile, we agree with the participants in this study that accusations from patients or alerts that may come from other health professionals, should first pass through the respective hospital service director, so that he/she may act as an initial filter, to discard inappropriate or unsustainable accusations.
Before referrals from the service/department directors reach the ESO, results for question number nine in our questionnaire suggest another intermediate step before a referral to the ESO, namely, the OMU. 41.5% agreed that this hospital service should be the first contact when the service director thinks there is a significant level of wariness and request for referral of a member of their medical team. It would then become the responsibility of the OMU to evaluate the referred doctor and decide whether he should be referred to ESO.

GPs or OMU should foremost encourage the doctor to self-refer to the ESO but if there is sufficient evidence granted, with reluctance to self-disclose, imposing a risk to patient safety; they should be able to refer the doctor straight to the ESO.

The ESO must guarantee to evaluate the doctor, in the shortest time possible and decide if he/she should be placed under temporary leave from the hospital (baixa médica). Almost half of the participants of our study (41.5%) believe referred doctors should be put under temporary suspension after referral to the ESO. Close enough, 36.6% consider that these doctors should continue to practice but under supervision. In our opinion, we can foresee some complications with this latter option: dispute in clinical decisions, conflicts of power as the referred doctor may feel undermined and an even more stressful environment, as the referred doctor may feel under constant assessment. In our opinion, unless a threat is imposed to the safety of others, all decisions should be discussed with the referred doctor before involving the other bodies, therefore, empowering the referred doctor. We don't agree with the immediate temporary suspension, as this may discourage self-referral but the use of it must also not be totally discouraged, as the safety of others must be assured first.

The ESO’s main function is to ensure adequate support and must also guarantee and facilitate immediate access to treatment. As shown in the study of Dr. Sara Catarino, and in published literature, doctors should receive treatment elsewhere from the hospital of origin, yet preferably in their residential area. In-patient treatment should be provided by the ESO to avoid potentially embarrassing encounters between sick health professionals and their own patients, similar to what happens in the PHP in the UK because impaired health professionals are treated by ad hoc arrangements between neighbouring Primary Care Trusts. Otherwise, if not feasible, the ESO should provide and discuss with the referred doctor places where he can have access to local health services and prompt access to confidential treatment if the locally available services are unable to meet their needs.
Farther in the ESO process, if there was an initial need to place the doctor under temporary suspension and/or need for in-patient treatment when the ESO together with the referred doctor believe he/she is prepared to return to work, we believe that the referred doctor should undergo a fitness-to-practice evaluation. Fitness-to-practice evaluations may be a multifactor process because firstly, diagnosis in psychiatry, by itself, is not clear-cut and success of treatment is dependent on several factors, for example, the relationship between the doctor and the patient, as well as the patient's personal circumstances and the acceptability of their own treatment. According to the results obtained in our study, the members that should be involved in this evaluation are the ESO, OMU, and the department director. It is important to analyse if the doctor is fit-to-practice independently or not and if there are any limitations that need to be accounted for. Some of these limitations have been highlighted, such as the need for psychotherapy, cognitive behavioural therapy, medication as well as psychiatric care; flexible working practices and biopsychosocial strategies.

We ideally prefer that the ESO work as an independent organisation. However, only in exceptional circumstances where the fitness-to-practice and patient safety is compromised, the ESO should inform the national medical regulating board – Ordem dos Médicos. This should be done with the full knowledge of the referred doctor, as this end line option could have implications for their medical registration.

Participants were divided when questioned whether mental illness should be of a compulsory declaration. Although most participants strongly disagree with the concept, many can't disagree or agree or strongly agree. This is comprehensible as this question leads to an ambiguous ethical discussion. The bioethical principle of autonomy is governed by three conditions: decisions must be taken intentionally, with understanding and without influences that determine the action of the patient. The barriers for help-seeking explored previously, apply intimidating influences in decision making for self-referral, which is, an act of autonomy. For this reason, in this proposed guideline, we take into consideration this principle by trying to include the referred doctor in all decisions made in each step: the need for temporary suspension, treatment decisions and return to work procedure. The respect for this autonomy may be jeopardized when impaired doctors refuse to look for help or don't perceive the problem. In these cases, the principle of beneficence refers to the moral obligation of the other health professionals to act for the benefit of others in an impartial manner, promoting the interests of all patients. That is, the referral of another doctor to the ESO becomes crucial to protect a third person (i.e. the patients of the referred doctor). The principle of non-maleficence can be challenged as the referral of a doctor can be a distressful period: fear of breached confidentiality, temporary suspension or implications of
medical licence. Although the intention of creating the ESO is to hurdle this belief and be viewed as *lifesaving* for doctors with mental illness to receive appropriate treatment.

The compulsory declaration is ethically challenging because of the United Nations Article 27 of the UN Convention on the Rights of Persons with Disabilities (CRPD). The law does not allow for discrimination of people with mental illness. Compulsory declaration counteracts this law, as it may increase stigmatising factors or even hinder contract renewal of the referred doctor. The matter is too complex to be generalized, due to the broad spectrum of psychiatry diagnosis but also the effect limitations that each of these has on a patient are different. Some persons with mental illness can work equally as well as other persons if regularly monitored and under medication (if required), whereas others can't and may put the hospital patients under risk. This is a case-by-case situation and therefore we do not agree with a compulsory declaration. If the principle of beneficence is questioned, in the light of the hospital patient, then these severe cases should be reported to the *Ordem dos Médicos* that should be responsible for the ethical discussion of each individual.

**Strengths and weaknesses of this study**

It was not the purpose of the study to obtain a population characterization as the selected population was strictly chosen to obtain an administrative view to manage situations of poor mental health within doctors, however, although the sample size allowed us the obtain the necessary results, a larger sample size could allow for greater distinction between the several options within each question. Collecting information from the chosen sample was also shown to be difficult, due to the reduced availability of the participants. Questionnaire surveys are used to obtain important information about attitudes, however, are limited when trying to understand subjects with such depth and complexity. Individual meetings with each participant would have been beneficial to explain the project and all terms and concepts being proposed. Despite space for improvement, a good response rate was obtained, and the questionnaire results helped us support the model we are proposing.

There were no previous studies like the one we carried out and therefore we had very few bases to create our questionnaire. We tried to draw up our questionnaire based on published literature and specialized services that already exist (PHP, GMC and the Barcelona Integral Care program for Sick Doctors).
By including results of the study of Dr. Sara Catarino to draw up our algorithm, we are accepting the errors that may have occurred in her study and using these results to influence the final aim of this study, increasing the margin of error.

Unanswered questions and future research

Further investigations need to be done with a larger sample size so that we can understand the main barriers to seek help and attempt to identify those at greater risk to develop poor mental health. Strategies and in-departmental organisations need to be analysed and re-thought in favour of promoting well-being among health professionals. Studies also need to be carried out to understand the impact that previous education on mental health in doctors and that anti-stigma campaigns have on doctors, as well as analyse how progress in the general population can be applied to doctors. The impact of mentally impaired doctors has not been thoroughly reported, and therefore there are few cases to rely on.

The proposed model requires a lot of bodies to be put into practice and government action. However, it would be interesting to evaluate the prevalence of mental illness or psychiatric symptoms in other hospitals in Portugal and try to evaluate if the tendencies mirror those seen in the CHP. If so, this would encourage the formation of a national-level ESO. Studies should also be extended to all health professionals.

Conclusion

The medical class has been shown to be at higher risk for mental illness. Due to the stigma associated with mental health and several other obstacles, such as confidentiality and role-reversal, doctors continue to not disclose their condition and continue to practice until a later stage of their illness.

Our results allowed us to construct an algorithm of attitudes to adopt to manage medical doctors with mental illness. The formation of an external specialized organisation is suggested, as a safe-place for doctors to seek help in a confidential manner and in this way receive adequate treatment. The algorithm proposed should act as a template to be discussed at a national level, with the regulating bodies: Administração Central do Sistema de Saúde (ACSS) and Ordem dos Médicos to establish a guideline, to be later be approved.

Our aim was to define strategies to manage mental health of medical doctors to guarantee patient safety and to ensure quality in the health service provided.
# APPENDIX I – CHP Medical Fitness Card

## FICHA DE APTIDÃO PARA O TRABALHO

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<tr>
<th>Entidade Empregadora/Empresa</th>
<th>NIPC/NIF:</th>
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</thead>
<tbody>
<tr>
<td>Designação Social:</td>
<td>CAE principal:</td>
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<tr>
<td>Estabelecimento:</td>
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</tr>
<tr>
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</tr>
<tr>
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<td>Localidade:</td>
</tr>
<tr>
<td>Telefone:</td>
<td>E-mail:</td>
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### Serviço de Saúde do Trabalho

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<tr>
<th>Modalidade de Organização do Serviço de saúde do Trabalho</th>
<th>Interno</th>
<th>Externo</th>
<th>Serviços comuns</th>
<th>Outro</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Designação da empresa se serviço externo de saúde do trabalho</th>
<th>NIPC/NIF:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processo de autorização (PA) da DGS nº:</td>
<td></td>
</tr>
</tbody>
</table>

### Trabalhador

- **Nome:**
- **SEXO:**
- **Data de Nascimento:**
- **Idade:**
- **Nacionalidade:**
- **Categoria Profissional:**
- **Data de admissão na empresa:**
- **Posto de trabalho (principal):**
- **Atividade/Função:**
- **Data de admissão na atividade / Função:**

### Posto de Trabalho

- Analise do risco: **Sim** / **Não**
- Identificação do risco: **Sim** / **Não**
- Avaliação da exposição: **Sim** / **Não**

### Exame de Saúde e Resultado de Aptidão

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<th>Data do Exame</th>
<th>Resultado de Aptidão para a Função Proposta ou Atual</th>
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<td>In apto Definitivamente</td>
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<td><strong>A pedido do Trabalhador</strong></td>
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<td><strong>A pedido do Serviço</strong></td>
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<tr>
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### Recomendações

- Sem recomendações
- Com recomendações, designadamente as abaixo assinaladas com "X":

- Avaliação de fatores de risco no posto de trabalho
- Correção de condições de trabalho
- Uso de equipamento de proteção individual
- Proposta de organização de trabalho
- Formação e/ou informação do trabalhador
- Outras

### Médico do Trabalho

- **Nº Cédula Profissional**
- **Identificação** (Vinheta ou assinatura digital)

### Responsável Serviço SST/Recursos Humanos

- **Nome do responsável**
- **Assinatura**

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21
APPENDIX II – Study of mental illness in the CHP’s medical class

Doença Mental na Classe Médica do Centro Hospitalar do Porto - INFLUÊNCIA DO STIGMA NA PROCURA DE CUIDADOS (July 2017)

Author: Dr. Sara de Castro Catarino

Advisor: Dr. Ana Sofia da Silva Pinto (Psychiatric assistant of the service of psychiatry and mental health service of the Centro Hospitalar do Porto).

***

460 surveys were distributed to doctors of the central hospital of Porto: Centro Hospitalar do Porto - CHP, with a response rate of 55%. First, on the epidemiologic conclusions that can be drawn from this population is that there is small, yet notable prevalence of doctors with a past or recent history of mental illness or psychiatric symptoms (12,3%). Most of these doctors were women. Of the doctors that suffered from a mental illness or psychiatric symptoms, 29% did not pursue medical help. When questioned on their awareness of a higher prevalence of mental ill health amongst doctors, only 26,5% of the participants seemed to be acquainted – mostly doctors within a younger age range.

More than half of the participants (62,5%), confirmed that they have experienced or witnessed stigmatizing attitudes towards mental illness from other colleagues. Most of these situations occurred in a personal context, followed by a clinical context and less frequently in both contexts.

Paths of disclosure of mental ill health were also investigated. If the same participants were to develop a mental illness, initially most of them would call upon a psychiatrist (65,1%), followed by, in descending order: family and friends, work colleagues, family’s doctor, others or no-one. The majority were concerned about the professional consequences, followed by professional integrity, or finally with least worry, the stigma associated.

If treated as out-patients, most of the participants would opt for formal medical advice, with preference by private health services in their local residential area. Otherwise, they would seek informal medical advice, or in very few, consider self-medication option or even for no treatment. If treated as in-patients, even though the majority would opt for private health services, a not very far proportion of participants would like to be treated in the public health services in their local residence area, rather than outside their residence area. Confidentiality is the factor that would most weight on their decision, followed by quality of health service and relatively few choosing stigmas as a factor to be weighed when choosing a treatment site. Both these tendencies, for in and out-patients, were mirrored in the patients with a previous mental illness.
APPENDIX III - Questionnaire

NOTA EXPLICATIVA

TESE: Doença mental na classe médica do Centro Hospitalar do Porto || Abordagem & orientação para os serviços hospitalares

De acordo com alguns estudos, a classe médica apresenta uma elevada taxa de doença mental e de morte por suicídio em comparação com a população geral. Existem vários fatores de risco, previamente estudados, que se encontram ligados à profissão, como o facto de ser exigente e por acarretar grande responsabilidade para os profissionais. O stigma no que respeita à procura de ajuda especializada também se verifica na classe médica, uma vez que assumir o papel de doente pode originar dificuldades a nível in-hospitalar, quando a comunicação e confiança entre profissionais de saúde não é assegurada.

Na sequência da Tese de Mestrado realizada no ano lectivo anterior por uma outra estudante do Instituto de Ciências Biomédicas Abel Salazar, da Universidade do Porto (ICBAS – UP), Drª Sara Castro Catarino, intitulada por “Doença Mental na Classe Médica do Centro Hospitalar do Porto - INFLUÊNCIA DO STIGMA NA PROCURA DE CUIDADOS”, orientada pela Drª Ana Sofia Pinto, este trabalho pretende averiguar qual a opinião dos diretores de serviço e diretores de departamento relativamente aos procedimentos a adotar pelos médicos que integram as suas equipes, quando se deparam com uma doença mental. De acordo com as informações que viram a ser recolhidas e com base na bibliografia existente, pretende-se elaborar uma Norma de Orientação Interna que indique quais os procedimentos a adotar nestas situações, de forma a facilitar o pedido de ajuda por parte dos profissionais afectados pela doença e garantir um encaminhamento correto, livre de stigma, por parte dos seus superiores.

Em alguns países existem serviços especializados ou protocolos específicos para gerir situações destas, enquanto que em Portugal, não existe nenhuma lei e/ou orientação específica para estas situações, sendo apenas referenciada nos termos do Código do Trabalho e da Lei 102/2009. No Reino Unido, o General Medical Council (GMC) é uma organização a nível nacional, que estabelece padrões profissionais, regula a educação médica básica e estabelece normas de aptidão para os médicos exercem. Um médico registado pode ser encaminhado para o GMC se houver dúvidas quanto à sua aptidão para exercer e passam por um processo de avaliação da sua aptidão para exercer. O GMC tem poder para emitir conselhos ou avisos aos médicos, aceitar compromissos, ou encaminhá-los a um...
painel de aptidão clínica, que tem um funcionamento que se assemelha a um processo tributário. O conselho responsável por este processo pode emitir avisos, impor condições sobre a prática de um médico, suspender ou até cancelar o registo médico. O seu papel é garantir a segurança dos doentes, e não punir ou tentar compensar pacientes após problemas.

**OBJETIVO DO TRABALHO:**

Em paralelo com o sistema utilizado no Reino Unido e noutros países, pretende-se usar a informação recolhida, através de um inquérito aos Directores de Serviço e de Departamento do Centro Hospitalar do Porto, bem como a informação mais atual disponível na PubMed, para elaborar uma Norma de Orientação para situações nas quais médicos se apresentem com doenças do foro psiquiátrico, tendo em conta fatores como a sua aptidão (fitness to practice), trabalho em equipa e confiança transmitida. Esta Norma de Orientação visa tornar o processo de procura de ajuda mais fácil, sendo que evitará o stigma por parte dos demais profissionais de saúde e, ao haver uma orientação para dar seguimento ao processo de tratamento, tornará a resolução do problema mais ágil e linear.
DOENÇA MENTAL NA CLASSE MÉDICA DO CENTRO HOSPITALAR DO PORTO || ABORDAGEM E ORIENTAÇÕES PARA OS SERVIÇOS HOSPITALARES

QUESTIONÁRIO PARA DIRETORES DE SERVIÇO E DEPARTAMENTOS DO CHP

Saúde Mental: um estado de bem-estar no qual o indivíduo percebe o seu próprio potencial, é capaz de lidar com o stress normal da vida, trabalhar de forma produtiva e frutífera e de dar um contributo para a sua comunidade. [OMS, 2005].

IMPORTANTE: Deve ler primeiro a Nota Explicativa, de forma a compreender os objetivos e importância deste estudo.

Tempo estimado: 5-10 minutos.

Na sua opinião:

PARTE 1

1. Enquanto diretor de serviço/departamento, alguma vez já esteve/está numa situação em que um membro da sua equipe médica tivesse uma doença do foro psiquiátrico ou sintomas de uma doença psiquiátrica (selecionar uma única opção)?
   a. Sim
   b. Não
   c. Não tive conhecimento

2. Se respondeu SIM à questão anterior, quantos casos teve (selecionar uma única opção)?
   a. 1-2 casos
   b. 3-5 casos
   c. 6-10 casos
   d. Mais de 10 casos

3. Caso tivesse uma situação em que um membro da sua equipa médica desenvolvesse uma doença do foro psiquiátrico ou sintomas de uma doença psiquiátrica, saberia como deveria proceder (selecionar uma única opção)?
   a. Sim
   b. Não
   c. Talvez

4. Seria benéfico para os médicos, realizaram uma consulta psicológica/ psiquiátrica regularmente?
   Não concordo  1  2  3  4  5  Concordo
5. Qual deve ser a importância da saúde mental do médico(a), como fator na avaliação da aptidão do médico?

Não é importante 1 2 3 4 5 Muito Importante

PARTE 2

6. Quem deve estar encarregue de lidar com estes casos (em que um médico(a) da sua equipa desenvolve uma doença mental/sintomas de uma doença psiquiátrica) será (selecionar uma única opção):
   a. Próprio(a) médico(a) sobre avaliação
   b. Serviço de Saúde Ocupacional
   c. Serviço de Psiquiatria
   d. Direção do Hospital
   e. Organização Externa Especializada
   f. Outro: _______________________________________.

7. Uma reclamação proveniente de um doente, que questiona a saúde mental e comportamento inadequado de um médico(a) do seu serviço/departamento, deve, primeiramente, ser encaminhada para (selecionar uma única opção):
   a. Diretor(a) de serviço
   b. Serviço de Saúde Ocupacional
   c. Direção do Hospital
   d. Organização Externa Especializada
   e. Outro: _______________________________________.

8. Uma reclamação proveniente de outro profissional de saúde, que questiona a saúde mental e comportamento inadequado de um médico(a) do seu serviço/departamento, deve, primeiramente, ser encaminhada para (selecionar uma única opção):
   a. Diretor(a) de serviço
   b. Serviço de Saúde Ocupacional
   c. Direção do Hospital
   d. Organização Externa Especializada
   e. Outro: _______________________________________.

9. Caso se confirme que possa existir um problema, este problema deve ser comunicado em primeira instância a (selecionar uma única opção):
   a. Serviço de Saúde Ocupacional
   b. Direção do Hospital
   c. Organização Externa Especializada
   d. Outro: _______________________________________.

10. Um(a) médico(a) que desenvolve uma doença mental/sintomas de uma doença psiquiátrica, deve ser alvo de uma avaliação, de forma a garantir a segurança do doente?

Não concordo 1 2 3 4 5 Concordo

11. A avaliação do estado de saúde mental do(a) médico(a) em questão deve ser preconizada por (selecionar uma única opção):
   a. Serviço de Saúde Ocupacional do próprio Hospital
   b. Serviço de Psiquiatria do próprio Hospital
   c. Serviço de Psiquiatria externo ao Hospital
   d. Outro: _______________________________________.
12. A avaliação da aptidão do médico para continuar a exercer tendo um diagnóstico de uma doença psiquiátrica, deve ser decidida por (selezione até 3):
   a. Próprio(a) médico(a) sobre avaliação
   b. Diretor(a) do respetivo serviço
   c. Serviço de Psiquiatria do Hospital
   d. Psiquiatra do(a) próprio(a) médico(a) (caso exista)
   e. Serviço de Saúde Ocupacional do Hospital
   f. Direção do Hospital
   g. Conselho da Organização Externa Especializada
   h. Conselho da Organização Externa Especializada juntamente com o hospital
   i. Outro: ___________________________________________.

13. Durante uma investigação para avaliar a aptidão de um(a) médico(a), o(a) mesmo(a) pode (selecionar uma única opção):
   a. Continuar a exercer normalmente
   b. Continuar a exercer sem supervisão, certas funções que não impliquem um risco elevado para os doentes
   c. Continuar a exercer com supervisão
   d. Ser impedido de exercer temporariamente (baixa médica)

14. Concorda na formação de uma entidade/organização externa nacional que se encarregue de tratar destes casos:

   Não concordo  1    2    3    4    5    Concordo

PARTE 3

15. Deveria ser de declaração obrigatória presença de doença psiquiátrica, pelo médico que fez o diagnóstico?

   Não concordo  1    2    3    4    5    Concordo

16. Os médicos deveriam ter conhecimento/possibilidade de aceder a meios específicos e confidenciais para tratamento psiquiátrico destas situações?

   Não concordo  1    2    3    4    5    Concordo
APPENDIX IV – Authorisation by the CHP Hospital Board

Exmo. Sr. Diogo Oliveira
Aluno do ICBAS

ASSUNTO: Trabalho Académico - MIM - "Doença mental na classe médica do Centro Hospitalar do Porto || Abordagem & orientação para os serviços hospitalares " – N/ REF. nº 2018.031(028-DEFI/028-CES)

O Conselho de Administração do CHP autoriza a realização do estudo acima mencionado, a realizar em todos os Serviços Clínicos desta Instituição e tendo como Investigador Principal Diogo Oliveira, aluno do ICBAS.

O estudo foi previamente analisado pela Comissão de Ética para a Saúde, pelo Gabinete Coordenador de Investigação, pela Direção do Departamento de Ensino, Formação e Investigação do CHP e pelo Presidente do Conselho de Administração, tendo obtido parecer favorável.

Cumprimentos,

* Em todas as eventuais comunicações posteriores sobre este estudo é indispensável indicar a nossa ref. nº.
APRECIAÇÃO E PARECER PARA A REALIZAÇÃO DE TRABALHO ACADÊMICO - MIM

Título: “Doença mental na classe médica do Centro Hospitalar do Porto || Abordagem & orientação para os serviços hospitalares”

Ref. nº: 2018.031(028-DEFI/028-CES)

Investigador: Diogo Oliveira
Aluno do ICBAS

DIREÇÃO DE ENFERMAGEM:

☑ NÃO SE APLICA

☐ PARECER FAVORÁVEL

☐ PARECER NÃO FAVORÁVEL

Data:

________________________

PRESIDENTE DO CONSELHO DE ADMINISTRAÇÃO:

☐ PARECER FAVORÁVEL

☐ PARECER NÃO FAVORÁVEL

Data: 7 MAR 2018

Dr. PAULO BARBOSA
Presidente do Conselho de Administração do CHP

Em conformidade. Pode ser autorizado

Prof.ª Doutora Luísa Lobato
Diretora do DEFI

Luísa Lobato
Diretora do DEFI
APRECIAÇÃO E VOTAÇÃO DO PARECER

<table>
<thead>
<tr>
<th>Deliberação</th>
<th>Data: 20.2.2018</th>
<th>Órgão: Reunião Plenária</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocolo/Versão: TA-MIM</td>
<td>Promotor: o próprio</td>
<td>Investigador: Diogo Oliveira Aluno ICBAS</td>
</tr>
</tbody>
</table>

A Comissão de Ética para a Saúde – CES do CHP, ao abrigo do disposto no Decreto-Lei n.º 97/95, de 10 de Maio, em reunião realizada nesta data, apreciou a fundamentação do relator sobre o pedido de parecer para a realização do TA-MIM acima referenciado:

Ouvido o Relator, o processo foi votado pelos Membros da CES presentes:

Presidente: Dr.ª Luisa Bernardo
Vice-Presidente: Dr.ª Paulina Aguilar

Dr.ª Fernanda Manuela, Prof.ª Doutora Carla Teixeira, Prof.ª Doutora Maria Manuel Araújo Jorge, Dr. Gonçalo Senhorães Senra.

Resultado da votação:

**PARECER FAVORÁVEL**

A deliberação foi aprovada por unanimidade.

Pelo que se submete à consideração superior.

[Assinatura]

Data: 20.2.2018

A Presidente da CES

Dr.ª Luisa Bernardo

Assessor do Presidente do Conselho de Administração

7 MAR 2018
APPENDIX V - Results

Note: For the Likert Scale used in questions number four, five, ten, fourteen and fifteen, please consider these end-point values:

- Value of one (1) = strongly disagree
- Value of five (5) = strongly agree

For the grouped results of the Likert Scale:

- Values below three ($v < 3$) = Disagree
- Value three ($v = 3$) = Neither agree nor disagree
- Value above three ($v > 3$) = Agree

Question 1: As a service / department director, have you ever been in a situation where a member of your medical team has or has had a psychiatric illness or symptoms of a psychiatric illness?

Table IV Previous or present contact with a doctor with psychiatric illness or symptoms of a psychiatric illness

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>12</td>
<td>29,3</td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>58,5</td>
</tr>
<tr>
<td>Not that I had known</td>
<td>5</td>
<td>12,2</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100,0</td>
</tr>
</tbody>
</table>

Question 2: If you answered yes to the previous question, how many cases?

Table V Number of doctors with previous or present psychiatric illness or symptoms of a psychiatric illness

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 cases</td>
<td>19</td>
<td>79,2</td>
</tr>
<tr>
<td>3-5 cases</td>
<td>5</td>
<td>20,8</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100,0</td>
</tr>
</tbody>
</table>

Question 3: If you had a situation in which a member of your medical team developed a psychiatric illness or symptoms of a psychiatric illness, would you know how to proceed?

Table VI Knowledge on how to act in a situation where a member of their team presented with psychiatric illness or symptoms of a psychiatric illness

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>3</td>
<td>7,3</td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>34,1</td>
</tr>
<tr>
<td>Maybe</td>
<td>24</td>
<td>58,5</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100,0</td>
</tr>
</tbody>
</table>
**Question 4:** Would it be beneficial for the doctors to have regular psychological / psychiatric consultations?

**Table VII: Benefit of a regular psychological / psychiatric consultation**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29.3</td>
</tr>
<tr>
<td>2</td>
<td>9.8</td>
</tr>
<tr>
<td>3</td>
<td>14.6</td>
</tr>
<tr>
<td>4</td>
<td>22.0</td>
</tr>
<tr>
<td>5</td>
<td>24.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**Table VIII: Benefit of a regular psychological/psychiatric consultation (qualitative analysis - grouped)**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t Agree</td>
<td>39.0</td>
</tr>
<tr>
<td>Don’t Agree nor Disagree</td>
<td>14.6</td>
</tr>
<tr>
<td>Agree</td>
<td>46.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**Question 5:** What should be the importance of the doctor’s mental health as a factor in assessing his/her fitness-to-practice?

**Table IX: Importance of mental health in the fitness-to-practice of a doctor**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>3</td>
<td>12.2</td>
</tr>
<tr>
<td>4</td>
<td>17.1</td>
</tr>
<tr>
<td>5</td>
<td>68.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**Figure 3: Importance of Mental Health in the fitness-to-practice of a doctor**
**Question 6:** Who should deal with these cases (in which a doctor of your team develops a mental illness / symptoms of a psychiatric illness)?

**TABLE X** Entity that should be oversee situations where a doctor develops mental illness/psychiatric symptoms

<table>
<thead>
<tr>
<th>Entity that should oversee situations</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others</td>
<td>3</td>
<td>7,3</td>
</tr>
<tr>
<td>OMU</td>
<td>14</td>
<td>34,1</td>
</tr>
<tr>
<td>Psychiatry service</td>
<td>6</td>
<td>14,6</td>
</tr>
<tr>
<td>External Specialized Service</td>
<td>18</td>
<td>43,9</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100,0</td>
</tr>
</tbody>
</table>

**Question 7:** A complaint from a patient that questions the mental health and inappropriate behavior of a doctor of your medical team should first be directed to:

**TABLE XI** First contact when a complaint comes from a patient

<table>
<thead>
<tr>
<th>First contact when a complaint comes from a patient</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Service Director</td>
<td>31</td>
<td>75,6</td>
</tr>
<tr>
<td>OMU</td>
<td>7</td>
<td>17,1</td>
</tr>
<tr>
<td>Hospital Administrative Board</td>
<td>1</td>
<td>2,4</td>
</tr>
<tr>
<td>External specialized Service</td>
<td>2</td>
<td>4,9</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100,0</td>
</tr>
</tbody>
</table>

**Question 8:** A complaint from another health professional, that questions the mental health and inappropriate behavior of a doctor of your medical team should first contact:

**TABLE XII** First contact when a complaint comes from another health professional

<table>
<thead>
<tr>
<th>First contact when a complaint comes from another health professional</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Service Director</td>
<td>29</td>
<td>70,7</td>
</tr>
<tr>
<td>OMU</td>
<td>6</td>
<td>14,6</td>
</tr>
<tr>
<td>Hospital Administrative Board</td>
<td>2</td>
<td>4,9</td>
</tr>
<tr>
<td>External specialized Service</td>
<td>4</td>
<td>9,8</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100,0</td>
</tr>
</tbody>
</table>
**Question 9:** If it is confirmed that a problem may exist, this problem should first be reported to:

**TABLE XIII Opinions to Whom the Hospital Service/Department Directors Should Communicate the Problem**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>OMU</td>
<td>17</td>
<td>41.5</td>
</tr>
<tr>
<td>Hospital Administrative Board</td>
<td>12</td>
<td>29.3</td>
</tr>
<tr>
<td>External Specialized Service</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

- Test Statistics: \( \chi^2 \) (2) = 1.55; p=0.461

**Question 10:** Should a doctor that develops a mental illness or symptoms of a psychiatric illness be evaluated, to ensure patient safety?

The big majority of participants (95%) agree that doctors that develop psychiatric symptoms, should undergo a medical evaluation, to guarantee the safety of the patient.

**TABLE XIV Evaluation of the Need for a Medical Evaluation of the Doctor, if Patient Safety is Questioned**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>5</td>
<td>38</td>
<td>95.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Question 11: The evaluation of the mental health status of the doctor in question should be carried out by:

**TABLE XV Body that Should Evaluations Mental Health Status of the Doctor**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>OMU</td>
<td>17</td>
<td>41.5</td>
</tr>
<tr>
<td>Psychiatry Service of the hospital</td>
<td>12</td>
<td>29.3</td>
</tr>
<tr>
<td>External Specialized Service</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
TABLE XVI Body that should evaluations mental health status of the doctor (qualitative analysis - grouped)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal (OMU + Psychiatry service of the hospital)</td>
<td>21</td>
<td>55,3</td>
</tr>
<tr>
<td>External to the hospital</td>
<td>17</td>
<td>44,7</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>100,0</td>
</tr>
</tbody>
</table>

- Test Statistics: $\chi^2 (2) = 1.55; p=0.516$

Question 12: The assessment of the doctor’s ability to continue to practice after having a diagnosis of a mental illness, should be executed by:

![Figure 4 Preference to bodies to be involved in evaluation of fitness-to-practice of referred doctors](image)

Question 13: During an investigation to evaluate a doctor's mental health state, the doctor’s fate should be:

TABLE XVII Fate of the doctor while he/she is being evaluated

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others</td>
<td>1</td>
<td>2,4</td>
</tr>
<tr>
<td>Without supervision</td>
<td>8</td>
<td>19,5</td>
</tr>
<tr>
<td>With supervision</td>
<td>15</td>
<td>36,6</td>
</tr>
<tr>
<td>Temporary suspension</td>
<td>17</td>
<td>41,5</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100,0</td>
</tr>
</tbody>
</table>
Question 14: Concordance in the formation of a national external body / organization to deal with these cases:

**Table XVIII Concordance with the formation of an external specialized organisation**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2.4</td>
</tr>
<tr>
<td>1</td>
<td>19.5</td>
</tr>
<tr>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>3</td>
<td>12.2</td>
</tr>
<tr>
<td>4</td>
<td>12.2</td>
</tr>
<tr>
<td>5</td>
<td>51.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Grouped results:

**Table XIX Concordance with the formation of an external specialized organisation (Qualitative analysis - grouped)**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not Agree</td>
<td>22.5</td>
</tr>
<tr>
<td>Don't Agree nor Disagree</td>
<td>12.5</td>
</tr>
<tr>
<td><strong>Agree</strong></td>
<td><strong>65.0</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Question 15: Should the presence of mental illness be reported by the doctor who made the diagnosis?

**Table XX Concordance with compulsory declaration of mental illness**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>34.1</td>
</tr>
<tr>
<td>2</td>
<td>7.3</td>
</tr>
<tr>
<td>3</td>
<td>22.0</td>
</tr>
<tr>
<td>4</td>
<td>7.3</td>
</tr>
<tr>
<td>5</td>
<td>29.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**Table XXI Concordance with compulsory declaration of mental illness (Qualitative analysis - grouped)**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not Agree</td>
<td>41.5</td>
</tr>
<tr>
<td>Don't Agree nor Disagree</td>
<td>22.0</td>
</tr>
<tr>
<td><strong>Agree</strong></td>
<td><strong>36.6</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

- Test Statistics: $\chi^2 (2) = 1.55; p=0.281$
**Question 16**: Should doctors have the knowledge / possibility of access to specific and confidential means for psychiatric treatment?

**Table XXII Concordance with the availability of means where doctors can receive confidential psychiatric treatment**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14,6</td>
</tr>
<tr>
<td>2</td>
<td>2,4</td>
</tr>
<tr>
<td>3</td>
<td>9,8</td>
</tr>
<tr>
<td>4</td>
<td>7,3</td>
</tr>
<tr>
<td>5</td>
<td>65,9</td>
</tr>
<tr>
<td>Total</td>
<td>100,0</td>
</tr>
</tbody>
</table>

**Table XXIII Concordance with the availability of means where doctors can receive confidential psychiatric treatment (qualitative analysis - grouped)**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not Agree</td>
<td>7</td>
<td>17,1</td>
</tr>
<tr>
<td>Don’t Agree nor Disagree</td>
<td>4</td>
<td>9,8</td>
</tr>
<tr>
<td>Agree</td>
<td>30</td>
<td>73,2</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100,0</td>
</tr>
</tbody>
</table>
Cross-tabulation of several variables:

**Question 1 vs. Question 14 (grouped):**

**TABLE XXIV Analysis to see whether previous contact with mental illness influenced opinion for the formation of an external specialized organisation**

<table>
<thead>
<tr>
<th>Contact with a doctor with mental illness</th>
<th>Agree with the creation of an external specialized organisation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>Don’t Agree nor Disagree</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

**Question 11 (grouped) vs. Question 14 (grouped):**

**TABLE XXV Verifying the concordance than an external body must regulate mental illness within medical doctors**

<table>
<thead>
<tr>
<th>Evaluation of mental health</th>
<th>Agree with the creation of an external specialized organisation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>Don’t Agree nor Disagree</td>
</tr>
<tr>
<td>Internal</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>External</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>
APPENDIX VI – Health declaration for medical students

<table>
<thead>
<tr>
<th>QUESTIONÁRIO INDIVIDUAL DE SAÚDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SISTEMA MUSCULO-ESQUELÉTICO - Ausência de deficiência motora permanente, congénita, ou adquirida, com repercussão na aprendizagem</td>
</tr>
<tr>
<td>2. VISÃO – Ausência de deficiência visual permanente bilateral – cegueira e baixa visão</td>
</tr>
<tr>
<td>Acuidade visual</td>
</tr>
<tr>
<td>Sem correção</td>
</tr>
<tr>
<td>Com correção</td>
</tr>
<tr>
<td>Senso cromático (ausência de daltonismo)</td>
</tr>
<tr>
<td>3. AUDIÇÃO – ausência de deficiência auditiva bilateral de grau severo ou profundo</td>
</tr>
<tr>
<td>Perda auditiva</td>
</tr>
<tr>
<td>Sem correção</td>
</tr>
<tr>
<td>Com correção</td>
</tr>
<tr>
<td>4. OLFATO</td>
</tr>
<tr>
<td>5. SENSIBILIDADE (TÁCTIL, TÉRMICA E ÁLGICA)</td>
</tr>
<tr>
<td>6. SISTEMA NEURO-MUSCULAR</td>
</tr>
<tr>
<td>Coordenação</td>
</tr>
<tr>
<td>Movimentos involuntários</td>
</tr>
<tr>
<td>Alteração da linguagem e da fala</td>
</tr>
<tr>
<td>Défice motor</td>
</tr>
<tr>
<td>Atrofia muscular</td>
</tr>
<tr>
<td>7. COMPORTAMENTO</td>
</tr>
<tr>
<td>Alterações de comportamento</td>
</tr>
<tr>
<td>8. COMUNICAÇÃO INTERPESSOAL</td>
</tr>
<tr>
<td>Atenção</td>
</tr>
<tr>
<td>Coerência do discurso</td>
</tr>
<tr>
<td>Outros</td>
</tr>
<tr>
<td>9. MEDICAÇÃO HABITUAL</td>
</tr>
<tr>
<td>10. OBSERVAÇÕES:</td>
</tr>
</tbody>
</table>

CONCLUSÕES:  
APTO | | (a inscrever em declaração médica autónoma)  
NÃO APTO | | O MÉDICO

Emitido em __________________ | | | | | | | | | | ____________________________________________
N.º de Inscrição na Ordem dos Médicos ____________

Figure 6 Health declaration for students applying for medicine course in Portugal

Extracted from: Direção-Geral do Ensino Superior (http://www.dges.mec.pt/)
APPENDIX VII – PHP Organisational Chart

**Figure 7** Practitioner Health Program Organisational Chart

Orientation Line Proposal

MANAGEMENT OF MENTAL ILLNESS IN MEDICAL DOCTORS: ATTITUDES AND ORIENTATIONS BASED ON THE CENTRO HOSPITALAR DO PORTO POPULATION

Medical Schools

- Mental health education; Support systems for students in distress; Curriculum changes to mellerorate student well-being; Review medical student selection.

Monitoring and Risk Factor Control

- Doctor exhibiting psychiatric symptoms or disturbed behaviour
  - Referred by the doctor's GP
  - Patient Make a Complaint
  - Health Professional: Refer a doctor

External Specialized Organisation (ESO)

- Independent organization, with a specialized team to manage and aid doctors with psychiatric symptoms or mental illness. Provides a multidisciplinary team and maximum confidentiality with a separate electronic record to the national electronic record system. Provides treatment for referred doctors as in- and out-patients.

- If temporary suspension is required: ESO must communicate with Occupational Medicine Service of the hospital and define a date for re-evaluation.

Fitness-to-practice evaluation

- External Specialized Organisation
- Occupational Medicine Service
- Department Director

- Review if doctor has specific limitations and deliberate if conditionally fit to practice (e.g. regular follow-up, working hours, limited functions) or fit-to-practice without limitations.

Severe cases

Ordem dos Médicos

Medical Licence reviewed
Bibliography


