BMA

Mental health & wellbeing in the medical profession

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The associated executive summary and recommendations can be found in a separate document titled 'Mental Health and Wellbeing in the Medical Profession_SUMMARY'.

Introduction & objectives

In October 2018, the British Medical Association (BMA) launched an open survey[1] to collect robust 'moment of truth' data about doctors' mental health and wellbeing.

The survey was well received by a receptive audience of medical students and doctors and a significant success, generating 4,300 responses and providing a strong quantitative base of evidence. The BMA wished to deepen their understanding of the issues identified in the online survey and commissioned DJS Research to conduct qualitative research with a cross-section of the respondents.

The overarching objective of the research was to inform the development of practical policy solutions to support wellbeing and improve mental health support available to the profession.

Specifically, the research aimed to:

1. Understand more about **the current situation** including potential causes of mental health deterioration, perceptions of mental health within the profession, the types of mental health problems that occur most frequently and the impact of these issues on the professional and personal lives of doctors.

2. Understand more about the types of **support currently available to doctors and medical students experiencing mental ill health and for promotion of wellbeing**, including awareness and perceptions of available support, accessibility and any barriers to use, as well as efficacy of support.

3. Understand more about the types of support that doctors and medical students **would like to see provided in the future** to maintain good mental health and for the promotion of wellbeing.

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[1] https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/supporting-the-mental-health-of-doctors-in-the-workforce

Methodology & sampling

Overview

Of those who took part in the online survey, 1059 expressed an interest in taking part in further, qualitative research.

These respondents were provided with a registration link for the second phase of research, of which 219 doctors responded to the link providing their name, email address and telephone number. These doctors were called by a member of the DJS recruitment team and were asked a number of confirmatory questions including their main branch of practice, age, region, ethnicity, and their mental health. A copy of the screeners can be found in the appendices.

DJS Research, in collaboration with the BMA, developed a purposive sampling strategy to ensure participation from a wide range of doctors. As this is qualitative research, the sampling strategy was not designed to be representative of the original survey or the profession, but chosen for the purposes of fulfilling the research objectives outlined above. In keeping with the principles of qualitative methods, this research has attempted to describe the range of subjects relevant to the individual and collective lived experience of participants in the study, rather than to quantify them.

We aimed to speak to an equal split of respondents who had either:

1) Been formally diagnosed with a mental health condition by another healthcare professional,

2) Had symptoms which could be associated with a mental health condition but had no formal diagnosis, and

3) Those who had no formal condition, diagnosis or symptoms.

It is important to note that responses to the survey were self-reported and confirmed during the screening process; we did not verify the status of diagnoses or symptoms.

DJS Research conducted two methods of qualitative research: 45-minute interviews by telephone and 90-minute online focus groups.

Depth interviews

- We conducted 30 telephone interviews with the below respondents (Table 1).

- DJS Research designed a topic guide in collaboration with the BMA to guide the discussions (see appendix for discussion guide).

- Interviews took place between 13th – 31st May 2019.

- Interviews were moderated by DJS Research and were audio recorded and transcribed for analysis purposes.

Table 1: overview of doctors taking part in telephone interviews

	Mental health status		
	Formal diagnosis (n=10)	Symptoms, no diagnosis (n=11)	No condition/ symptoms (n=9)
Female (n=18)	8	7	3
Male (n=12)	2	4	6
20s – 30s (n=10)	4	2	4
40s (n=7)	5	-	2
50s – 60s (n=13)	1	9	3
England (n=23)	8	9	6
Scot/Wales/NI (n=7)	2	2	3
Consultant/SAS Doctor (n=10)	4	5	1
GP Partner/Locum, Salaried or Seasonal GP (n=10)	3	4	3
Medical student (n=5)	2	/	3
Junior doctor (n=5)	1	2	2
BAME* respondents (n=10)	6	3	1

*BAME: Respondents from Black, Asian or Minority Ethnic backgrounds.

Online focus groups

- We conducted two online focus groups, one with medical students and one with junior doctors (Table 2). We chose to speak to these two groups online to generate more extensive dialogue with younger audiences (i.e. the doctors of the future) who are also familiar with interacting with their peers online. Online groups were chosen above traditional face-to-face groups as the setting provided anonymity whilst discussing sensitive topics.

- All participants had either received a formal diagnosis of a mental health condition or had symptoms which could be associated with a mental health condition but had no formal diagnosis.

- We designed a topic guide in collaboration with the BMA to steer the discussions (see appendix for discussion guide).

- The groups took place online on 29th May 2019.

- A moderator from DJS Research facilitated discussions and colleagues from the BMA observed to increase their understanding of the issues.

- Discussions were transcribed for analysis purposes.

Table 2: **overview of junior doctors and medical students taking part in online focus groups**

Medical students:

	Gender	
	Female (n=4)	Male (n=2)
20s (n=4)	3	1
30s (n=2)	1	1
England (n=4)	3	1
Scot / Wales (n=2)	1	1
Formal diagnosis (n=5)	3	2
Symptoms, no formal diagnosis (n=1)	1	-
BAME respondents	-	-

Junior doctors:

	Gender	
	Female (n=3)	Male (n=2)
20s (n=3)	1	2
30s (n=1)	1	-
40s (n=1)	1	-
England (n=4)	2	2
Scot (n=1)	1	-
Formal diagnosis (n=5)	3	2
BAME respondents (n=1)	-	1

Analysis

In line with most qualitative research, this project was exploratory in nature and aimed to increase understanding of the overarching themes identified in the quantitative research. The purpose of qualitative research and analysis is not to quantify findings, instead it is used to build a rich body of information which explores individuals' personal experiences and opinions.

We used a thematic analysis approach for this research, and identified themes iteratively to illuminate the research objectives. Themes and insights are therefore drawn from the body of qualitative evidence collected and selected primarily according to relevance (linked to research objectives) and prevalence (ideas mentioned multiple times). Anonymised quotations have been used to evidence and illustrate, while case studies provide personal examples.

Main research findings

Being a doctor: risk factors

Throughout our discussions with doctors, some relatively common themes emerged in terms of the types of factors that could potentially cause problems and in various combinations, put mental health at risk.

We attributed these themes to five areas which can impact on doctors' mental health.

Figure 1: set of five overarching risk factors

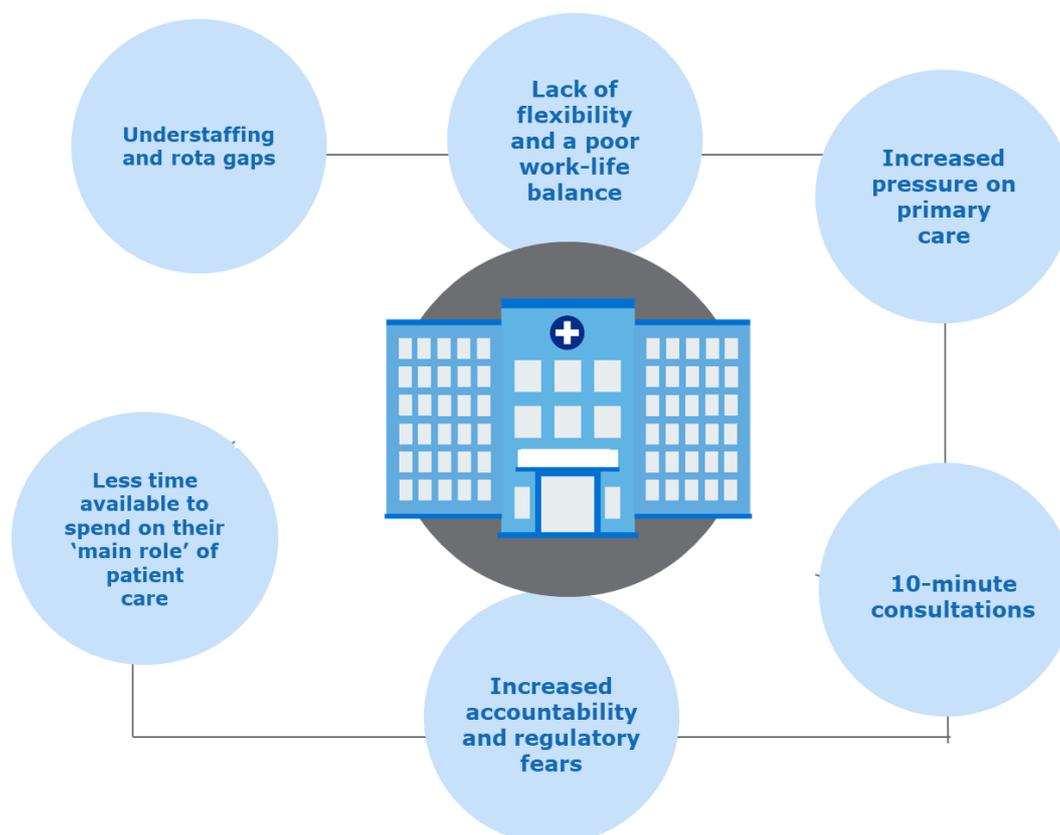|	
Systemic factors:	Issues which resulted from problems with systems and processes within primary and secondary care.
Endemic factors:	Issues which were considered necessary realities of the job and the profession.
Interpersonal factors:	Issues which resulted from doctors' relationships with their peers.
Environmental factors:	Issues which were more practical in nature, often linked to workplace environment.
Socio-cultural factors:	Wider contextual factors outside of but impacting the medical profession.

Systemic factors

Overview

Systemic challenges tended to form the backdrop for all other factors identified and were the priority area raised throughout the research by all doctors.

Doctors in the study repeatedly highlighted changes to workplace structures and workflows as being fundamentally damaging to their work, and in the context of this research, problematic for mental health.

These factors were interpreted as being imposed on doctors, including through government-led cost-cutting initiatives, either at place of work, Trust or CCG level. Discussion about these points was often tinged with nostalgia, or yearning for a time predating these changes, especially by older doctors, who often expressed regret about a continuing trend in declining resources and the impact of this on doctors and their mental health.

Key systemic factors considered to impact on doctors' mental health

Understaffing and rota gaps

Participants in this research made frequent reference to understaffing within both primary and secondary care, and felt they were spread 'very thinly' and many were experiencing a huge increase in workload. Rota gaps were a frequent occurrence mentioned among those in secondary care, due to sickness, vacant posts and reduced resourcing, which in turn increased the workloads for all those on shift. This led to doctors feeling like they were 'firefighting'

rather than doing the best job possible and sometimes led them to work increasingly long hours to complete necessary tasks. As well as physical exhaustion, this also generated feelings of frustration and guilt that they were unable to perform their job as they would like.

"The expansion that we have needed to keep up with the increase in the number of patients, we haven't seen the same increase with members of staff and so it just feels like we're being stretched thinner and thinner. Patients are getting more and more of a poor service."

- Junior Doctor, symptoms but no diagnosis

"We are running from one thing to the other all the time, firefighting."

- Consultant, symptoms but no diagnosis

For younger doctors, understaffing and rota gaps could have an even bigger impact. Junior doctors in the sample described working shifts with no registrar or consultant to support them, meaning that they were often left managing complex cases and situations without medical support that could lead to them feeling overwhelmed and insecure in their abilities.

These factors resulted in many doctors feeling anxious that they could not perform at their best, whilst also losing sleep worrying if they had missed something. It also meant that confidence in their abilities can become eroded, particularly for junior doctors.

Furthermore, when faced with mental health challenges, some doctors felt unable to request time away from work or reduced hours because they suspected that their post would not be filled and this in turn would increase pressure on colleagues.

"It's knowing that if you have time off, your colleagues have to pick up the slack and it just makes everyone else's jobs even more difficult."

- GP Partner, formal diagnosis

"I think people are just very busy. If you have to book a day off, who's going to cover your work!"

- Consultant, symptoms but no diagnosis

Lack of flexibility and a poor work-life balance

With more patients and fewer doctors this resulted in many doctors, in this study, working more hours than ever before. Many felt they had a poor work-life balance, which impacted on their personal life. Though many had requested greater flexibility or reduced hours, often at times of perceived mental health risk (exhaustion, stress), there were many examples within our sample of these requests being refused. A handful of the female doctors included in the study also mentioned that requests for more flexible hours relating to childcare were also typically dismissed, as though family life and caring for children were deemed less important than work. The reluctance to make adjustments to working hours resulted in a perceived lack of flexibility and increased frustration at perceived systemic challenges.

Junior doctors in particular felt like they always drew the short straw, often working back-to-back or night shifts. Many felt the working hours of a doctor are above and beyond other professions, as 40 hours is still deemed "part-time" within the profession.

"There is more and more research coming out which shows the negative effects on our physical and mental health of shift working and working long hours and we're still one of the very few professions where our average working week is above a forty-hour week. Most of the rest of society are working thirty-eight hours, forty hours as full time. For junior doctors, our standard working week is still between forty-six and forty-eight hours and it doesn't look like that is going to be able to change any time soon."

Junior Doctor, symptoms but no diagnosis

The lack of flexibility and long working hours resulted in all doctors feeling like they have a poor work-life balance, which can lead to some doctors feeling like they are 'failing at home and at work'. As a result, doctors can feel overwhelmed and see no alternative way out but to resign or change careers.

"I'm 55 and I would have thought I would have another 10 years of being a GP in me, but I think we are probably looking at another couple of years and that will be it."

- GP Partner, symptoms but no diagnosis

Increased pressure on primary care

Some secondary care doctors in our sample mentioned that they felt pressure to discharge patients more quickly than they would like due to bed shortages and staffing pressures. This systemic pressure to discharge left some consultants feeling unsatisfied with the care they were providing in secondary care, but this was also considered to put greater pressure on primary care services. The sense was that the push to discharge patients more quickly means greater numbers of patients treated by primary care services for post-operative and follow-up treatment and thus increased GP workloads in terms of numbers of patients, but also complexity of cases.

"Over the time since I've been at work there is more and more pressure on hospitals to turnover patients....in, seen, out. But that actually kind of happens with broadly the same number of staff. If you discharge someone every day, then in your week you're going to see an awful lot more patients than if everyone stayed for two or three days. That actually creates a lot more work. There's not the time to do that. You kind of run around firefighting a bit, rather than what I would feel is doing my job as thoroughly as I'd like to."

- Junior Doctor, symptoms but no diagnosis

Furthermore, GPs in deprived areas reporting facing increasing pressures due to insufficient funding in social and community care services – the number of psychiatric cases treated at primary care level was perceived to have increased, and again, patient complexity was thought to be growing. Both of these factors were considered to add further pressure and stress to already overstretched GPs.

10-minute consultations

Many of the doctors interviewed in primary care struggled with the 10-minute consultation window – it was mentioned by most GPs that we spoke to in this research. The consultation time was considered at stark odds with the increasing complexity of patient care in general practice. The doctors mentioned that the patient population is ageing, and these patients present with multiple diagnoses and more medicines to monitor. As previously stated, doctors referred to the fact that primary care is seeing a changing patient population, with increased proportions of post-operative patients and patients with more complex social needs.

Most primary care doctors interviewed insisted that they are unable to deliver adequate care in 10 minutes and that maintaining the current convention on consultation time introduces an unacceptable level of risk to patients. This in turn generated increased stress and anxiety about their ability to do their job, and for some could result in an increased level of risk for the doctor too.

"I've only got a 10-minute consultation and I've got a lot of information in that 10 minutes!"

- Salaried GP, symptoms but no diagnosis

"We don't see people with just a sore throat, in and out, that's easy. But we're seeing a lot more complex stuff."

- Salaried GP, no symptoms / condition

Case study: the strain of rising patient complexity and increased demand

Gender: female
Role: salaried GP
Mental health status: no condition/symptoms

Background:

- Works as a salaried GP and does some work for the Clinical Commissioning Group.

- Has young children (and is currently on maternity leave) so having a good work-life balance is important to her.

> "It's just not enough time with patients! And people are expecting us to sort people out in 10 minutes. So, I'm booking patients and if I know that going to take longer than 10 minutes then I will whizz through, but for me that just doesn't work… it's not safe, I don't think."

Experience:

- This GP has found work busier throughout her career.

- Increasingly struggles with the pressure of fitting patients into back-to-back ten-minute consultations, with hardly any time to reflect.

- The practice operates a 3-minute telephone triage. While the triage is effective at prioritising care, it means that all the patients who come to the practice are more complex and the GPs rarely get the previous 'respite' of an 'easier patient'.

- As a female GP, often she finds she has a lot of gynaecological bookings which take more time than other appointments; this means she frequently books double slots.

The results of systemic problems:

- Believes more doctors are opting to reduce hours because they find the pressure of seeing more complex patients within the same available time impossible to maintain.

- One of the problems caused by ten-minute consultations is the impact these can have on patients. Doctors are unable to spend the appropriate time diagnosing and she worries about the quality of care she can provide.

- She has found that her practice is having to 'ration' referrals (which they have to keep 'at referral rate average') because of considerable pressure on general practice to justify its funding.

- With limited time in the day to see patients, she finds there is even less time to spend on the growing number of admin tasks.

Increased accountability and regulatory fears

Amongst our sample, there was a perceived increased accountability placed on doctors meaning that evidence gathering and administration tasks are becoming more necessary as part of the day-to-day job - an additional source of workload and a further constraint to time available. There was a sense that doctors need to 'cover their backs', especially since media coverage of high-profile legal cases. For doctors in the study, these cases were felt to demonstrate the failure of hospitals to support their employees and to generate a culture of fear for their own professional integrity. This was even believed to lead to the practice of 'defensive medicine', where doctors avoid complex cases due to fear of litigation and prosecution.

"Because you are always rushed, you are always short, you are always supposed to be covering someone that day. Then if something goes wrong, the focus is on the individual whereas really it's a systemic problem"

- Consultant, formal diagnosis

"When I was doing my jobs before I took up my training post, I could hold the role of registrar and I could cover shifts on that. But I'd be asked to do them, and because I wasn't familiar with doing them, I'd say no, because I knew if something went wrong, I wouldn't be supported by the hospital."

- Junior Doctor, symptoms but no diagnosis

Less time on 'main role' of patient care

Due to underfunding of the NHS, all doctors in the sample mentioned the fact that there are fewer ancillary staff (e.g. secretaries, support staff etc.) which is thought to result in doctors taking on more administration-based tasks themselves. GP partners in particular were frustrated at the business-related tasks they deal with (e.g. organising a new carpet in the waiting area etc.).

"I think the best thing would be for us to have less managerial responsibility."

- GP Partner, formal diagnosis

This further increased the general workload of the doctors included in the study and meant they had less time to complete their work effectively. In turn, for some, it led to a culture of fear and a decrease in camaraderie between doctors, who were less able to help one another

out due to time constraints - these left doctors feeling isolated and lonely within their place of work.

"You never really have the relationship to each other because you are spending so little time as a team and then you move on really quickly."

- Consultant, symptoms but no diagnosis

Targets around discharge rates in secondary care, cutting costs and reducing referrals (in general practice especially) were also considered to take their toll on the wellbeing of doctors. The perceived focus on targets meant some doctors felt they were not fulfilling their aspirations around why they became doctors in the first place. Above all else, it left them feeling as though they have less time to focus on patient care. For some, this was manifesting as guilt, leaving them disappointed both in themselves and their overall role as a doctor.

"If you've got it in your head that it's the job to get the patient out in 10 minutes, and then you do that, then you feel that you've done a good job. Well, I don't think that's the job of a doctor. I think we should be treating all these people and their diseases. We should be reassuring the patient, helping them care for themselves..."

- GP Partner, formal diagnosis

The impact of systemic pressures

Ultimately, all of these systemic factors left many doctors interviewed feeling like they did not have enough time. This resulted in doctors feeling overwhelmed and anxious that they had 'missed something' critical, as well as feeling frustrated that they couldn't perform their role to the best of their abilities. When this lack of time was combined with the expansion of their roles, including the rapidly evolving pharmacological landscape, rising patient expectations and increasingly complex patients (see **endemic and sociocultural factors** for more information), it led to doctors in the study feeling anxious and stressed. In addition, the doctors also commonly mentioned increased depression / depressive-like symptoms, obsessive behaviour, post-traumatic stress reactions and burnout[2].

While poorer mental health, including diagnosed conditions, had the potential to impact on doctors' ability to perform at work, this was reported to significantly impact them personally.

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[2] *The BMA collected data on burnout in the mental health and wellbeing survey conducted in October 2018 using the Oldenburg burnout inventory. During this qualitative research participants may have used the term colloquially/we did not seek to verify.*

Doctors spoke about becoming detached and distant from family, friends and children, as well as becoming increasingly short-tempered. Many spoke about experiencing symptoms at multiple points in their career and it was almost expected that they would need to take time off at some point as a result of mental health issues.

"When I took him aside and said, "I'm struggling" he said to me, "This is not uncommon. This is something that everybody experiences to some extent.", which was reassuring. And he said, "Of all my fellow colleagues, we have all taken time out at one point or another for the same reason as you. And we've all experienced this and you'll be back and you'll be okay. You need to look after yourself"."

- Junior Doctor, formal diagnosis

A further risk was identified in terms of the impact this could have on patients. Doctors from our sample, who had a confirmed mental health diagnoses spoke about making mistakes that they would not typically make as a result of their declining mental health and the time-pressures they were under. These doctors felt as though they were missing key signs and symptoms when evaluating patients as they weren't able to give the patient their full concentration. These doctors were concerned their ability to care for patients had declined, as their aptitude to feel compassion and sympathy decreased.
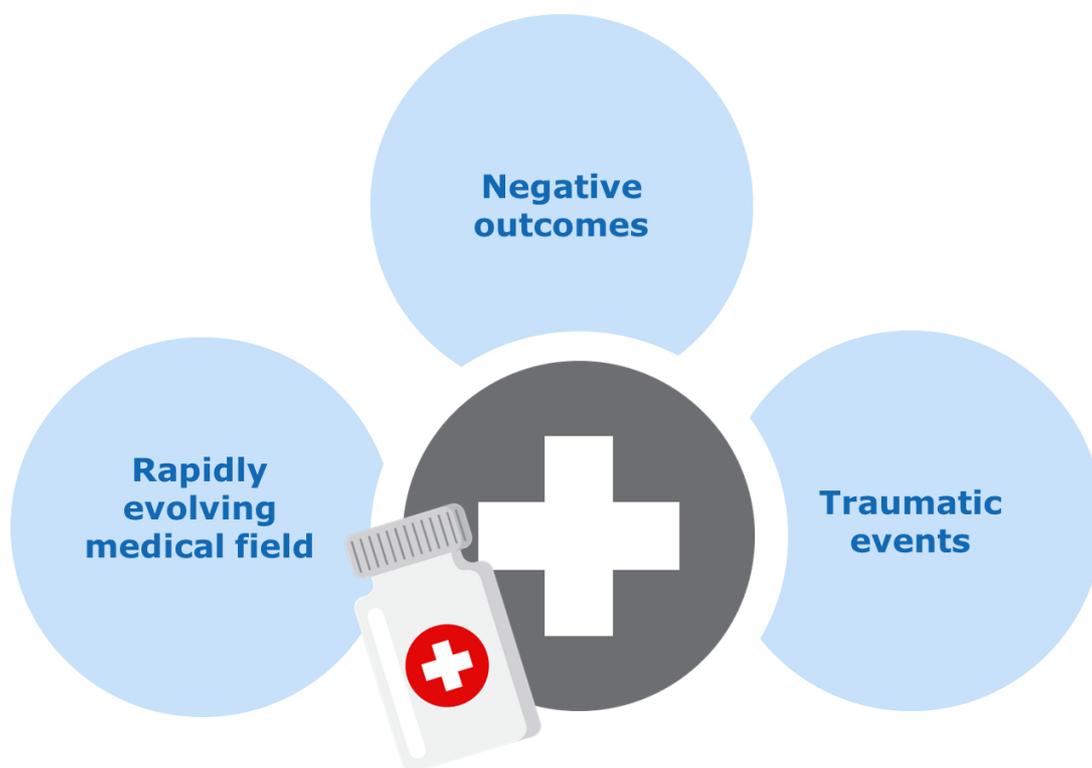
"I went from somebody who actively promoted coils to somebody who never promoted them to somebody who almost actively discouraged patients to have them and I knew I was doing it and I'd have panic attacks and all sorts of anxieties when I was physically doing them and gave up on them quite quickly."

- Salaried GP, formal diagnosis

Endemic factors

Endemic factors are those which were considered necessary realities of the job of being a doctor.

Although doctors were fully aware and prepared to encounter these factors at various points over the course of their career, when these were combined with time pressures and limited resources these factors in some cases, led to saturation, where doctors were no longer able to cope as they had previously. Based on the findings, these factors could be particularly damaging to doctors' mental health when they were experienced early on in their careers, as little support or guidance was offered and as such it impacted (and limited) future patient care.

Rapidly evolving medical field

Doctors spoke about how they are operating in a field which is advancing exponentially and becoming increasingly complex both in terms of the drugs and treatments available and the types of conditions that patients are presenting with. This meant doctors in both primary and secondary care felt they were left with more to learn, more to retain and more to actually do. This led to GPs, who were often acknowledged as the first contact point and so-called 'gatekeepers' to the NHS and have to deal with a wide range of conditions, feeling anxious that they were not fully up to date with medical advances.

"Scientific improvement in the management of patients is mushrooming so you have got to make sure you keep yourself up to date. So, there is patient pressure, scientific pressure and employment pressure."

It was also an issue for the younger doctors that we spoke to, in particular junior doctors, whose progressive medical education is expected to be rapid and extensive, but when combined with the day-to-day aspects of being a doctor and understanding medical and scientific advancement, could lead to a sense of feeling overwhelmed.

"It is just patients are more elderly, they're living longer. They are much more complex. You are coming up with drug names that you may have never have come across before."

- Junior Doctor, no symptoms / condition

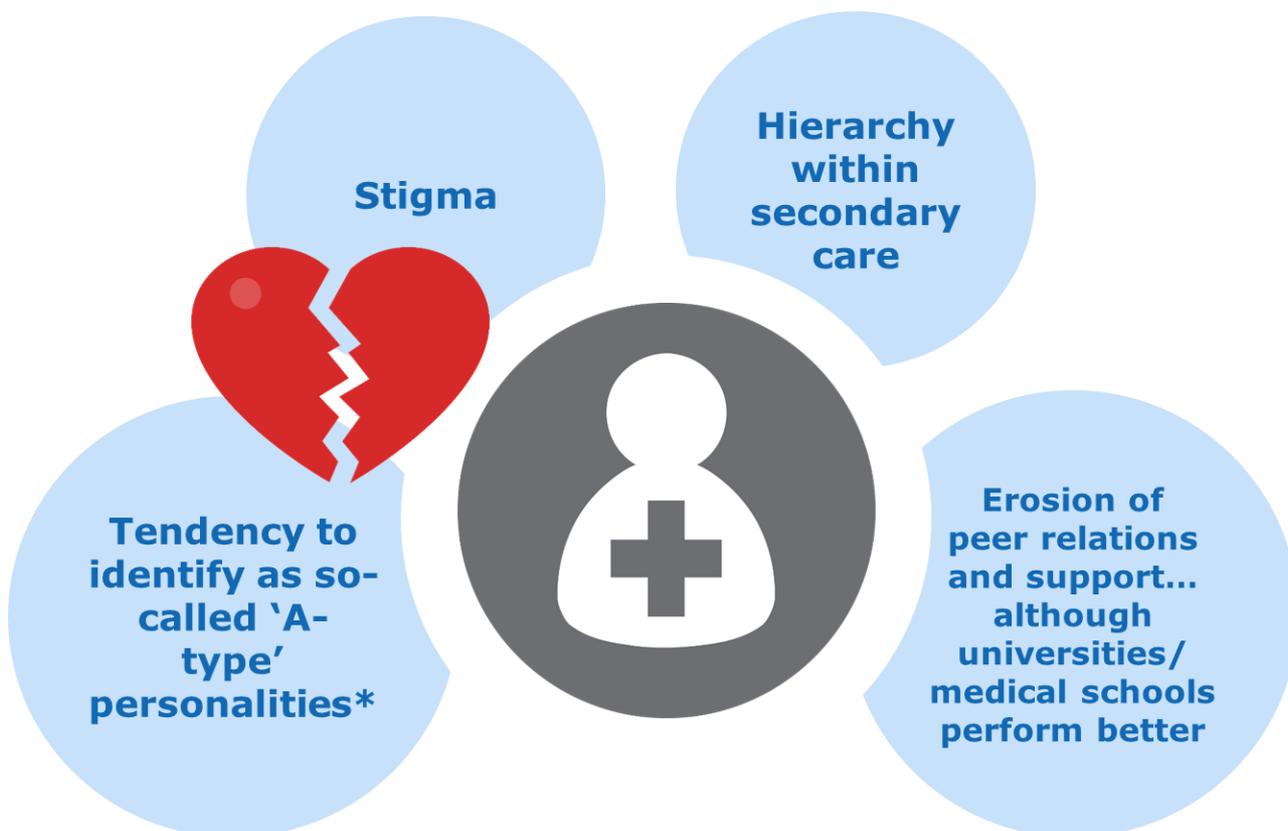## Traumatic events and unexpected outcomes

A number of doctors in our sample spoke about traumatic events, which occurred over the course of their career and led to symptoms of unresolved trauma. When traumatic events did arise or things went wrong, some doctors in the research felt there was a lack of support and no-one to talk to or off-load on. This was a particular issue for younger doctors as they had little prior experience of dealing with traumatic situations and then in turn had no-one to deconstruct with after the first time it did happen.

This could then have a knock-on effect and cause problems to manifest in much more serious ways including anxiety and even symptoms considered comparable to post-traumatic stress reactions. This sometimes led to doctors avoiding certain procedures or situations and could also limit their desire to try out new or difficult procedures. These types of events could also lead to saturation where doctors were no longer able to cope as they had previously.

Interpersonal factors

Interpersonal factors were those which resulted from doctors' relationships and interactions with their peers.

The erosion of peer support networks formed the backdrop of the doctors' experiences, as those spoken to in the research did not feel supported or connected on a personal or a professional level. As such this led to those doctors bottling up their feelings and not reaching out to each other as their mental health declined. When this combined with fears of stigma around mental health, it sometimes led to doctors suffering in silence.

Stigma

Hierarchy within secondary care

Tendency to identify as so-called 'A-type' personalities*

Erosion of peer relations and support... although universities/ medical schools perform better

* A-type is one of two contrasting personability types as identified in one school of psychology theory. Doctors in the study often used this terminology in relation to themselves or doctors generally, believing that they exhibited tendencies that correlated with that type.

Stigma

Most doctors in the research believed that although stigma around mental health is decreasing it still exists within the profession. Within the sample, a couple of older, more senior (often male) doctors were more dismissive of mental health problems within the profession. One consultant, felt that he had not worked with anyone with a mental health problem over the course of his career, and that mental health problems were not caused by the workplace.

"I've been aware of colleagues within ...well colleagues I don't work with directly, but others elsewhere in a range of services who have had significant mental health problems. I'm not convinced that for them, workplace pressures have been a component."

- Consultant, no symptoms / condition

Many junior doctors were worried about being perceived as weak by their superiors, as there is still the perceived link between professional competency and being able to cope emotionally and mentally. For example, many of the junior doctors we spoke to mentioned that they had experienced situations where a registrar or consultant had either explicitly mentioned or more casually implied that, if they could not cope at this stage then medicine might not be the right career for them.

"There's some concern that other people see you as weak or not able to cope. I've heard that supervisors have suggested people seek help because they're not really resilient enough or whatever, which is not helpful."

- Junior Doctor, symptoms but no diagnosis

"Because of the stigma attached to mental health, it remains an area which you scarcely dare mention. It is becoming better amongst the younger generation, people are more prepared to discuss things than they were, but certainly in my time I don't think it was the right thing to do to talk about mental health issues. People immediately think 'oh dear, the poor chap is becoming incapable' whereas that isn't necessarily so."

- Consultant, symptoms but no diagnosis

Many doctors feared that a mental health diagnosis would reflect negatively on how their peers perceived them and the junior doctors included in the study in particular feared the impact on their career progression. This was tied in with a general belief that 'doctors shouldn't get ill' and are notoriously bad at taking days off - even for physical illnesses as they don't want to 'leave colleagues in the lurch'.

"I think that there are still areas where, however much they've got a mental illness policy and all those kinds of things, that actually if you were taking time off with mental health, you probably wouldn't get short-listed for that promotion."

- Salaried GP, formal diagnosis

These factors all resulted in the perception that doctors bottle up their feelings and problems, and some only speak up when they are at crisis point. Despite this, it is interesting to note that of those that we spoke to that had suffered from poor mental health, many had had

positive experiences when they finally opened up to colleagues. In some cases, it appears that a self-perpetuating perception of 'stigma' generated a general fear around opening up about mental health and being perceived as weak.

"I think we, as a profession, tend to stigmatise ourselves more than have others do it for us."

- Consultant, no symptoms / condition

"It's almost like you have to up an act when you've got to work, you have to be there professionally. You have to be in control of yourself otherwise you can't advise a patient or look after somebody else if you can't even take care of yourself. And then, if you show that to your friends and your seniors, I think it's seen as a weakness and I suppose anything you do will be judged."

- SAS Doctor, formal diagnosis

Tendency to identify as so-called 'A-type' personalities

Many doctors in the research described themselves as "perfectionists" and "obsessive". They placed great pressure on themselves to perform to their absolute best at all times and, for some, this took a toll on their mental health. When this was paired with a system where doctors felt time-poor, they are frequently left feeling like they are disappointing their patients, colleagues and themselves by not doing the best job possible. Some felt these traits combined with their working environment contributed to them developing symptoms they described as obsessive-compulsive behaviours and increased anxiety levels.

"Doctors all have personality traits that make us more susceptible to certain conditions but I think it was directly as a result of the work-related stress that it, the OCD, became a diagnosable mental health problem."

- GP Partner, formal diagnosis

Hierarchy & bullying

A pain point amongst a number of secondary care doctors included in the study was the hierarchy which exists within the workplace. While the doctors understood that a certain level of hierarchy is needed in a hospital, some junior doctors in particular, mentioned that their seniors pay them little respect which could lead to low morale.

Also due to hierarchy, many younger doctors (junior and newly registered foundation level doctors) who were interviewed in this study felt unable to talk to their senior colleagues for fear of judgement that they just 'aren't up to the job'. There was the sense amongst

participants that those who have been in the profession for a number of years had themselves likely experienced a tough ride and that their mental health had not been prioritised, resulting in them believing it should be no different for younger or future doctors.

In some cases, doctors felt they had been "bullied" or belittled by their seniors. This left some of the doctors feeling anxious about their progression and also isolated from their peers (see case study below).

"I got bullied by a registrar and there was some belittling going on and again just lack of support. Middle grade and a couple of consultants being quite funny as well and a few specific incidents. So, after three months I came home one weekend and screamed to my parents and said 'I can't do this anymore'."

- Salaried GP, formal diagnosis

Case study: instances of bullying in the workplace

Gender: female
Role: Consultant

Mental health status: formal diagnosis

Background:

- Works as a consultant Psychiatrist in a Mental Health Crisis team, often doing home visits to patients who are acutely ill with a mental health illness and / or a suicide risk.

- Currently on sick leave due to work-related issues and has had two previous instances of this.

- Achieving a good work-life balance (and maintaining good mental health) is particularly important as she has a young family.

Experience:

- Her role is very challenging, and she finds the emotional stress of dealing with suicidal patients an additional worry.

- On top of this she has experienced continual problems with her managers, especially regarding the need to go less than full-time.

- Feels she has been subject to bullying behaviours by one particular manager.

How did she experience bullying in the workplace?

- There were some instances where bullying behaviours could have potentially harmed her patients. She was pressured to release patients despite feeling they were too ill to be discharged.

- When she was struggling, she requested to go less than full-time. This was met with hostility and 'various obstacles' including blocking requests to reduce hours by 1 day a week. This was a key moment in reaching a point of burnout.

- This also led to her feeling isolated from her team as she felt unable to discuss the bullying she was experiencing with her colleagues.

> "I could have predicted that I would burn out if I didn't reduce my hours, but instead of supporting that they [management] just blocked it. All I was asking to do at one point was reduce by one day a week, as I felt that would give me a little bit of breathing space."

Erosion of peer networks and peer support

Many doctors interviewed mentioned that they felt that the camaraderie and team spirit, which once characterised the profession, had now dissipated. Doctors reported that they were increasingly working in silos and had very little interaction with their peers; this was especially common amongst GP participants. This was thought to result in further isolation and a distancing of themselves from the profession, sometimes meaning that colleagues whose mental health is suffering could go unnoticed. There was the perception amongst a number of participants in the study, that they were so busy trying to survive each day that they did not have the time to notice, or have the emotional resilience to help, a colleague in need.

This is reinforced by the fact that the doctors within our sample who had been able to maintain good mental health tended to feel this was a result of supportive colleagues and workplaces, as well as supportive families and a well-balanced homelife (see below case study).

"In the majority of practices, you know, you don't see your colleagues from one day to the next, you know, people don't make an effort to say hello and goodbye. They don't talk to each other. So, unless you've got a really well-organised practice where everybody takes breaks together and have that coffee in the morning where people can off-load, I think you know it can be really isolating."
- Salaried GP, no symptoms / condition

Doctors who had maintained good mental health mentioned compassionate and caring supervisors who had responded well to requests for more flexibility in working patterns. Other doctors spoke about supportive managers / supervisors and colleagues who they felt they could talk to about difficult patients or stressful situations.

"I had a set of friends outside of medicine beforehand, and so my life doesn't revolve just around medicine. I think that's quite an important balancing factor – good friends and family and some hobbies outside of work."
- Junior Doctor, no symptoms / condition

Case study: support networks at home and the workplace

Gender: male
Role: Junior Doctor
Mental health status: no condition/symptoms

Background:

- This Junior Doctor is a trainee anaesthetist and is contracted to work anywhere between 42 and 48 hours a week.

- Believes he maintains good mental health as he has a strong support network, most notably his family.

> "I had an amazing surgeon that truly believed that even if we were only there for three months, she was going to make sure that we got as much out of it as possible. She gave me a lot of responsibility and a lot of supervision and that really, really helped. It brought my confidence on massively"

Experience:

- He feels lucky to work in Wales as he believes that, compared to England, the profession has more freedom to perform operations and give treatments.

- Overall, he feels there is less camaraderie in the profession and that people spend increasing amounts of time 'firefighting'. He thinks a huge cause of this is the lack of relationship between consultants and more junior members of staff.

How does he maintain good mental health?

- On one of his early rotations, he was lucky to be in a team with a surgeon who felt personally responsible for his (and the other trainees) development. This built his confidence and gave him a solid foundation for his later training rotations, where he often felt his seniors viewed him as a way to offload their administration tasks.

- Having a supportive family also makes a huge difference for this doctor. He believes they act as a stabiliser for him and allow him to recognise that his life is filled with positive influences.

> "For me, my family, and my job are a sort of stability. When you see patients from intensive care, who are so much worse off than where you are, you just need to buck up your ideas and get on with it quite frankly. I am also very good at debriefing with my wife."

Comparatively more positive attitude of medical students

Medical students' perceptions and experiences appeared comparatively more positive than other groups in this study. Many of the students involved in this research had positive experiences with regards to their mental health and broader wellbeing at medical school. Wellbeing offerings mentioned by medical students included mandatory wellbeing lectures and conferences, provision of freely available meditation classes, mandatory buddy-systems and informal 'families'. A couple of students in our sample also spoke about having access to talking therapies, such as counselling services and CBT; however, this wasn't mentioned by all students. Students also spoke about having welfare committees and disability advisory services which were available for students with mental health issues. Most medical students in our sample did feel that mental health is high on their universities' agenda.

The provision of these services was considered to help medical students manage the stress of medical school and provide transferable skills which can be used to better maintain good wellbeing and mental health in the future. After graduating to become foundation level doctors, students often believed they would enter the workforce with fewer perceptual barriers to seeking support if they should need it at a stage in their career. However, based on feedback from our sample of junior doctors (comparatively less positive), the services and support received as undergraduates had not transitioned into the workplace, where there was the feeling that services and support 'drop off a cliff'. In fact, junior doctors were one of the groups who felt least supported by their workplace (detailed in the **Systemic Factors** section).

"I've been really lucky at my university, there's an excellent counselling service which has helped a lot. They're really well-promoted. It's well-promoted from the beginning of the year, and it's always been very easy to access."

- Medical Student, formal diagnosis

Case study: support provided at university/medical school

Gender: male
Roles: medical student
Mental health status: no condition/symptoms

Background:

- This medical student is in his fourth year of medical school.

- Has no formal mental health diagnosis, but upon reflection
thinks he may have suffered symptoms during his time at university.

> "We have wellbeing sessions that are mandatory."

Experience:

- Generally feels he copes well with the pressures of medical school but believes academic assessments should be spaced more evenly throughout the year rather than all at the same time.

- In his eyes, this is one of the main sources of pressure for students and often results in those who are already struggling reaching crisis point.

- He also feels that ranking students against one another on the course can negatively impact on the mental health of students, including himself.
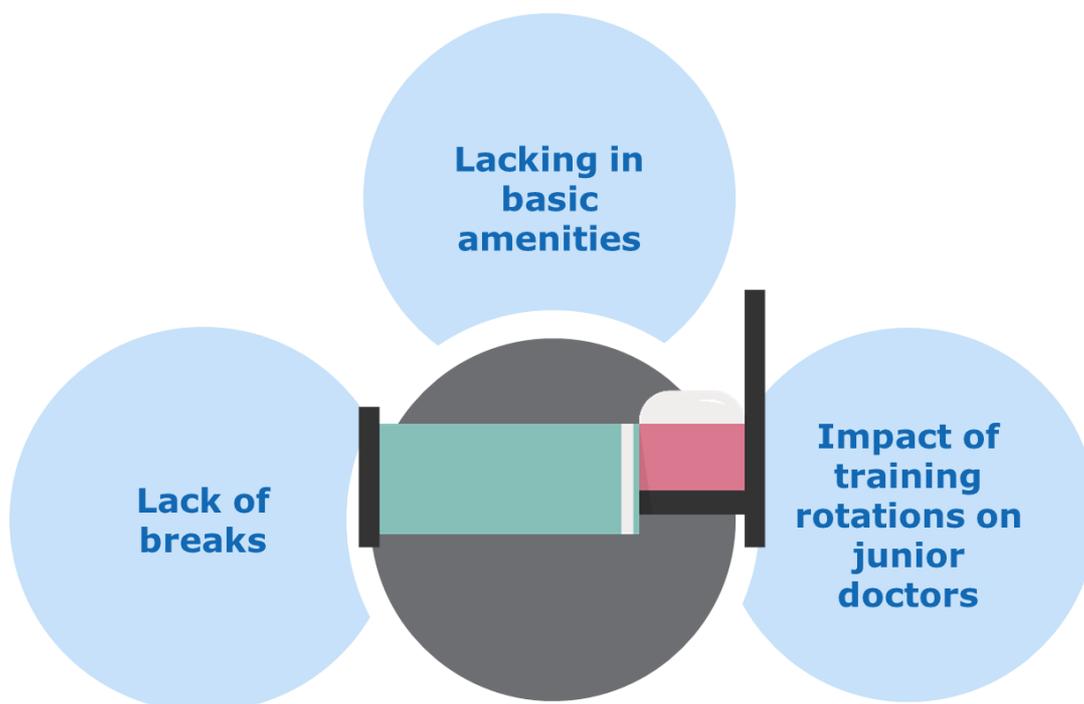
How do universities support their medical students well?

- His medical school implemented mandatory wellbeing classes within the curriculum.

- He found these useful and felt the university was generally very good at promoting good mental health and wellbeing.

- The medical school also has an easily accessible information point where counselling services can be accessed, which have a very short waiting time in comparison to equivalent NHS services.

- While he notes it is good that this is on offer, he believes that it could be more comprehensive as students are only entitled to six sessions.

Environmental factors

Environmental factors are issues which were practical in their nature and were typically linked to the workplace environment.

There was a feeling amongst the older doctors interviewed that there has been a slow retrenchment of facilities, where expected facilities and resources have been gradually taken away from doctors. Doctors interviewed believed their working conditions and environment are not what they should be and in some cases are making their jobs harder, leading to doctors feeling undervalued by their employer.

Lacking in basic amenities

Lack of breaks

Impact of training rotations on junior doctors

Lack of basic amenities

From our sample, all doctors felt that their place of work was lacking in basic amenities. This included nowhere to cook or prepare food away from patients and a lack of personal space such as lockers or break rooms. For those in secondary care, a lack of accommodation or place to rest for those on long night shifts was also a problem. The lack of these basic amenities sometimes led to doctors feeling unappreciated, undervalued and for some means that the care they can give their patients is compromised.

"I don't think there's a doctor's mess in any hospital anymore, they're just not talked about as much, people just come in [to work]. There's no accommodations for junior doctors is there?"

- Consultant, symptoms but no diagnosis

Training rotations

Junior doctors in our sample spoke about feeling they have no autonomy over their early career as they experience 6-monthly rotations, moving departments, hospitals and locations, during the Foundation Programme. This was also true for some medical students having to travel for placements, although this was less frequently mentioned.

"Med school can be very lonely in the clinical years because of moving around the country for placements."

- Junior Doctor, formal diagnosis

This uncertainty impacted both their personal life and their professional life. They may have to live away from family / friends or travel long distances to work every day on top of working long shifts. They may have no consistent peer support network and found it difficult to form relationships before moving on again.

Having to relocate every six months or so, had left many junior doctors interviewed without a professional or personal support network and as such feeling isolated and destabilised.

Lack of breaks

All doctors mentioned that lunch breaks are now no longer 'protected time' and are often filled with meetings, administration and learning. As a result of this, doctors described rarely socialising with colleagues or having any opportunity to discuss issues. Not having protected time (and space) for doctors to socialise, relax and get together was believed to lead to loneliness and isolation within the profession.

"You don't get any breaks. Any break you get is the time to walk to the sandwich shop and back, and some days you don't even do that. I don't know anyone who takes a lunch break, because then you just go home an hour later…"

- Salaried GP, formal diagnosis

Case study: lack of breaks & training rotations

Gender: female
Role: SAS Doctor
Mental Health status: formal diagnosis

Background:

- This doctor was formally diagnosed with a mental health condition.

- Having struggled with the instability of continued training, she has stepped out of her specialty programme and now works in an SAS role.

> "Just getting out for a walk for half an hour would make a difference. We don't have any lunch break; we're doing emails and all the admin stuff so we just eat at our tables. We don't get out from our work at all. Something like a gym or something, anything (!), some simple things would make a huge difference."

Experience:

- While training, she was struggling with her workload and finding it was impacting her mental health.

- This was damaging her quality of life, causing detachment from her family and children, as well as leaving her generally exhausted and fatigued.

- She found that she was working overtime, becoming exhausted and did not have time to take any breaks throughout the day.

- She felt that these 'little things' would be a good first step in helping doctors who are struggling.

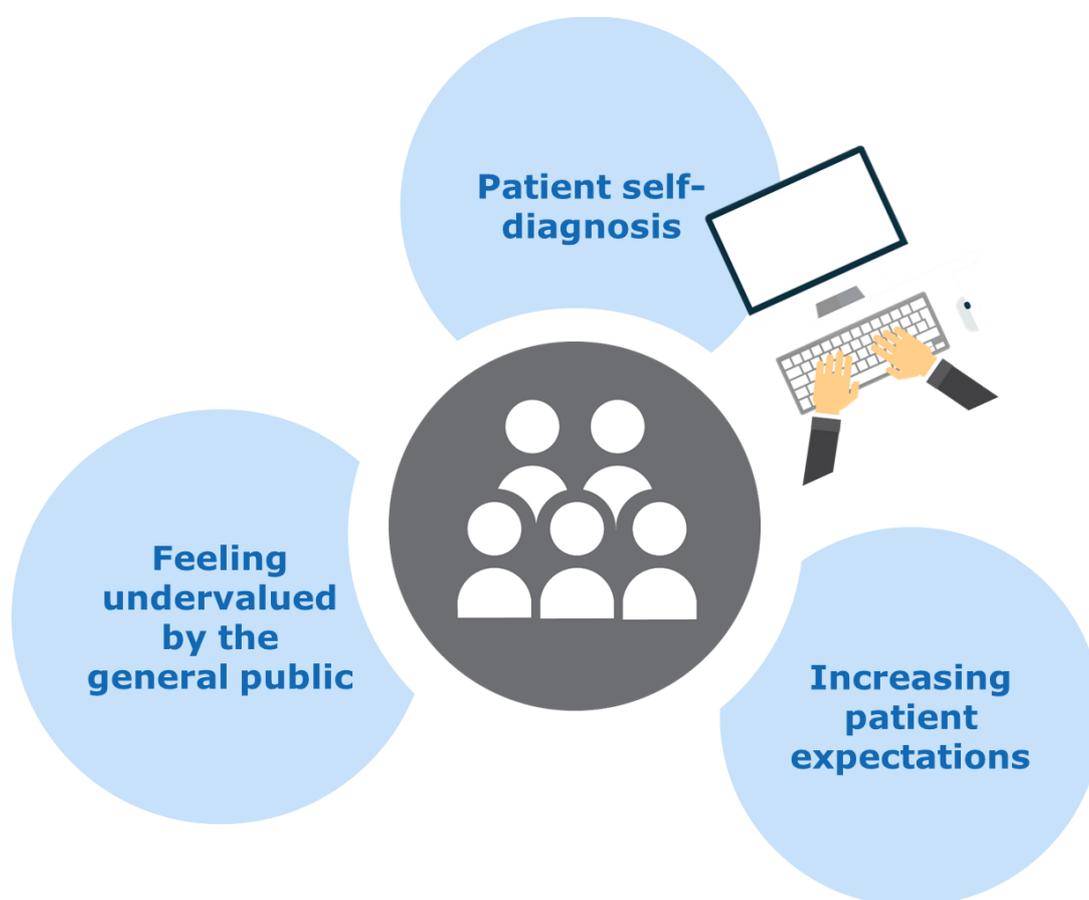**What was she able to do to help alleviate her situation?**

- Realising she was reaching crisis point, she applied to go less than full-time, but this was denied by the hospital.

- This resulted in her taking nine months leave from work.

- While she was off, she reached out to the 'community leaders' at the hospital and they did not offer any support. She also found that the consultants were particularly unsupportive and unhelpful.

- She eventually found support when she turned independently to her GP. With the support of her GP, she negotiated a phased return to work.

- She felt her only option to maintain balance, stability and flexibility to avoid her mental health declining again was to exit training and continue work as SAS doctor.

Sociocultural factors

Sociocultural factors are wider contextual factors which are outside of the control of the medical profession but they were nevertheless considered a significant stressor to doctors' wellbeing when combined with the other 4 factors and a time-pressured environment.

These factors build on the sense of loss of value, with doctors in the study feeling that their standing and reputation with the public is slowly being eroded by factors outside of their control; this can leave doctors questioning their value and the career.

Patient self-diagnosis

Many of the GPs interviewed mentioned that their patients are more informed (or potentially misinformed), partly due to the democratisation of the internet, with more patients self-diagnosing before they have even made it to their GP. Some GPs in the sample said they sometimes found themselves spending the majority of their 10-minute consultations explaining to patients why their self-diagnosis isn't correct. Doctors found this leaves them with very little time to diagnose what actually is the problem and to find the correct solution. This added to the pressures they already felt about managing patients in 10-minute windows and the anxiety that they have missed something important.

"Quite rightly, now you have to explain things to your patients and you have to give people choices. You have to explain the pros and cons of different things. But the idea that you can do that in the same amount of time as when you would just pat them on the head and say, "Just take the pink tablet, dear," it is peculiar. And although we've got a more health literate population, there's a lot of that in-between… you know? Enough health literacy to be worried, but not enough to be able to self-manage, and those people are often quite difficult to look after."

- Salaried GP, formal diagnosis

Increasing patient expectations

Internet democratisation during the last two decades was also thought to have led to increasing patient awareness of possible treatments, in particular in-trial or new treatments. This increasing awareness was believed to have led to increasing patient expectations of what is possible, what can/cannot be medicated and when a diagnostic test is appropriate, as well as demands for newer or more expensive treatment options. GPs interviewed also described the competing demands of patients wanting to be referred for a diagnostic test or to a specialist, whilst trying to manage the NHS budget effectively.

GPs described the fact that for care options that are not readily available on the NHS, it sometimes means spending limited appointment time explaining to patients that a treatment is not available, which often leads to disappointment and disgruntlement. This in turn means that the doctors have less time to discuss the treatment options that were available and which is most relevant for the patient. This left both doctors and patients feeling frustrated and disappointed.

"Patients expect us to be there all the time and get back to them straight away so there's definitely a lot of pressure in terms of patient expectation."

- Salaried GP, no symptoms / conditions

Doctors can feel undervalued by the public

A couple of doctors also spoke about high profile cases of doctors being negatively portrayed in the media and the impact that these had on how doctors are perceived by the general public. Some doctors felt that public sentiment had begun to turn on them and that they were not viewed in as such a positive light. There was a sense that doctors felt they once had a high-standing and were well-respected both by the public and their employer but this was no longer the case. This led to some doctors in the study having felt hugely undervalued, which caused them to question their role, their career choice and their impact.

"We need a sense of being appreciated by physicians, surgeons, and hospital specialists as well as by our patients for the work that we were doing."
- Consultant, no symptoms / conditions

"I think it's just generally really demotivating when you can see doctors that have gone through something difficult, which may or may not have been their fault, and then instead of the hospital seeming to wrap around them to try and support them, or see what happened and why it happened, it feels like it's just a scapegoating opportunity."
-Junior Doctor, no symptoms / conditions

Barriers to doctors accessing & seeking support

When faced with challenges resulting from any combination of the five stress factors (described above), doctors interviewed identified a number of practical and perceptual barriers, which meant that they often put off seeking support.

Practical barriers

There was some **lack of awareness** of the types of health and wellbeing services that already exist for doctors within primary care / hospitals and within Trusts more generally. Many doctors in the sample mentioned that they were unsure of where they would turn to for support, particularly locums and junior doctors (who move around frequently). There was also an issue identified amongst more senior doctors in the sample (consultants or GP partners) who felt that there is no-one more senior for them to turn to for support.

All doctors we spoke to were very **time-poor** and as such would find it difficult to find time to go to see a GP and / or seek support. When they were able to find the time, doctors and in particular GPs, had **fears over confidentiality** as they would need to visit their local GP, which could mean running into their own patients in the surgery and / or that they may know the GP on a professional level.

"I know doctors have their own GPs, and informally one can approach your colleagues, but there is a divide where your colleagues might be the partners, and are your employers as well. So, there could be a conflict of interest within the practice."

- Salaried GP, no symptoms / condition

Many junior doctors or those early in their career **did not feel that they could open up to their manager / supervisor about mental health issues**, because that person was also responsible for their professional development and progression. There was the feeling that potentially opening up to a line manger about mental health problems could be seen as a professional weakness that would impact on their future career.

"The support structure in place is one where you have an educational supervisor who is meant to be your first port of call if you're having a wellbeing difficulty. The problem is they're the one who is in control of assessing you and assessing your progression throughout your career."

- Junior Doctor, symptoms but no diagnosis

Finally, there was also the perception from a small number of doctors interviewed, that support is localised around big cities (e.g. London/Manchester etc.) and as such is **less accessible for those in rural areas**. More remotely accessible support, such as more online and telephone services, was mentioned as a potential solution to help to reduce this perception.

Case study: career progression and perceived conflict of interest

Gender: female
Role: Junior Doctor
Mental health status:
symptoms but no diagnosis

Background:

- This junior doctor is working as a trainee in paediatrics.

> "There's almost a little conflict of interest there where the person that you need to highlight your worries and your concerns to, you feel the least able to tell that person because you don't want them to give you a negative assessment or report and hold you back in your training."

Experience:

- Throughout her career she feels that hospital standards have been slipping, delivering lower standards of care to patients.

- Understaffing combined with growing numbers of patients means her workload is growing constantly.

- Primarily, she feels that there is no recognition for the strain put on NHS staff in terms of working shifts and long hours.
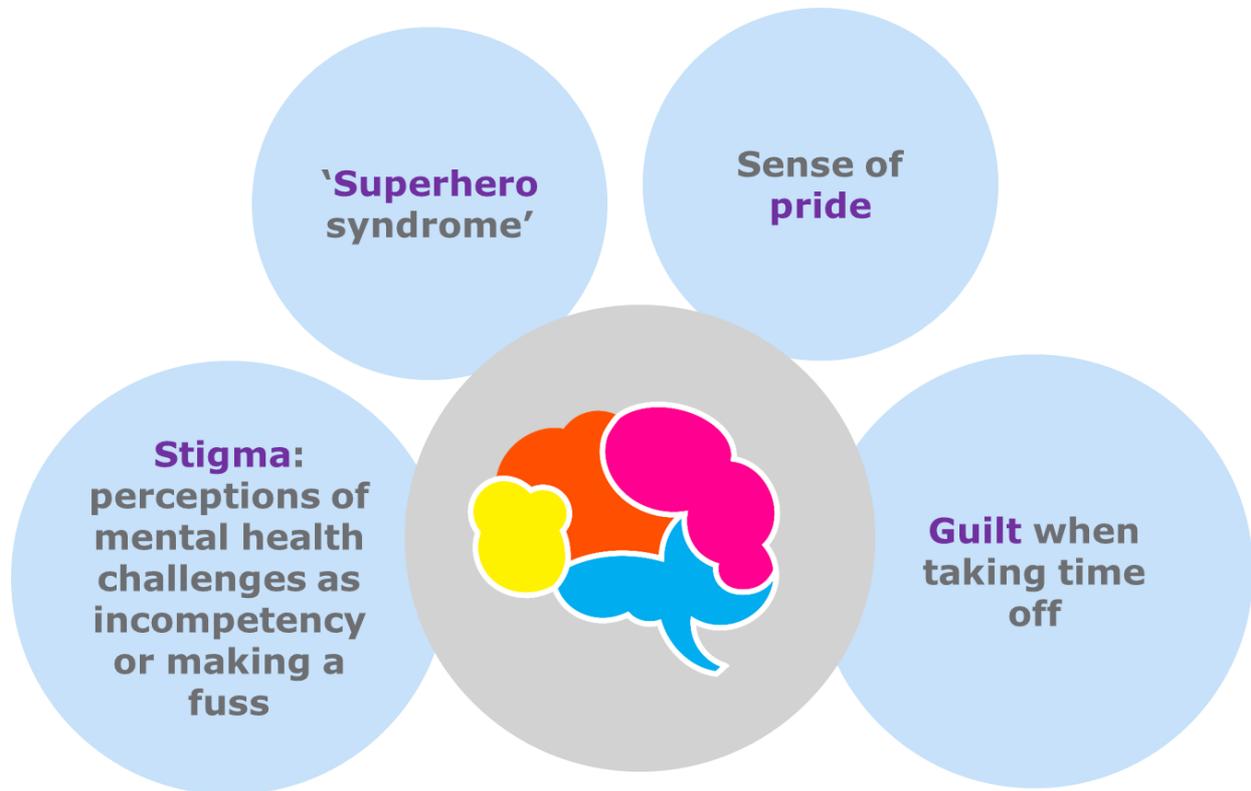
Practical barriers:

- She believes the support structures in place are currently failing doctors (and wider NHS staff).

- The first port of call for junior doctors who are struggling is often the manager who is responsible for their future career progression. This gives rise to a perceived conflict of interest.

- She feels that this in turn prevents junior members of staff seeking help or support, causing them to reach breaking point before taking action.

- She feels there needs to be a neutral middle ground which allows someone to access support, without fear of being seen as a 'difficult' employee.

> "There doesn't seem to be any middle ground, you're either identified as a person in difficulty or a person not in difficulty, it seems to be quite binary. It doesn't seem to be any grey which I think is a quite strange way of looking at it and it means that people tend to have a very, very high threshold indeed for putting their hand up and signalling that they want support."

Perceptual barriers

'Superhero syndrome'

Sense of pride

Stigma: perceptions of mental health challenges as incompetency or making a fuss

Guilt when taking time off

Some participants acknowledged they were uncomfortable at the thought of being perceived as vulnerable and conversely admitted to being prone to what some referred to colloquially as **'superhero syndrome'**. As such, accepting that they needed some additional support due to their mental health was seen, by many, as a sign of weakness not only by themselves but by their peers, thus perpetuating stigma.

"I think the doctor role is very much considered to be like you're a coper, you're expected to see lots of patients, and cope with lots of things, and be a strong person. I think that doesn't fit very closely with letting people be honest about their own concerns or fragilities."
– Junior Doctor, no symptoms / condition

"We have this expectation that we should be healing the sick and that we shouldn't get sick ourselves."
- Salaried GP, no symptoms / condition

There was also a sense of **pride** amongst many doctors in the study; they believed that the profession in general is under considerable stress, so they feared singling themselves out as not being able to 'hack it'. This is compounded by the fact that many younger doctors had received resilience training as part of their studies, so there was almost the expectation that they should 'plough on'. This resulted in some doctors not wanting to engage with any wellbeing initiatives

(such as yoga, meditation etc.) or more formal mental health services as they were fearful that attendance would single them out.

"I think there's definitely a worry that people don't want to be seen as the weakest link."

- Medical Student, formal diagnosis

As well as fearing judgement, all doctors in our sample mentioned feeling **guilty** about taking time off due to staff shortages. If they did need to take any time off for any reason, they knew their colleagues would have to pick up workload. Furthermore, there was the fear that having time off for a mental health issue could potentially have a knock-on impact on a colleague's mental health, as they would be picking up extra work on their behalf, thus something of a 'vicious circle' was identified by some.

"The more people leave, the worse it is for those of us left behind and soon I'll be one of the people leaving, making it worse for who is ever left behind."
- GP Partner, symptoms but no diagnosis

"There's this very clear dichotomy that you need to be well to be a doctor, because there's simply not enough time or energy to look after you, as well as all the patients that your team has to look after."

- Medical Student, formal diagnosis

Finally, there was also the perception for some of those interviewed, that mental health problems could be treated as **incompetency**. So not only would it impact on their peer relationships and progression opportunities, but there was also a fear that it could be fed back to the General Medical Council (GMC) and result in a fitness to practice case.

"I was saying 'I can't cope with the workload, and by the way I think it's dangerous here!' and they [senior partners] told me that I must be incompetent."

- Salaried GP, formal diagnosis

Case study: perceived incompetence

Gender: female
Role: Locum
Mental health status: formal diagnosis

Background:

- This doctor is freelance, with all her clinical work being as a locum.

Experience:

- Throughout her career she has particularly struggled with adopting 10-minute consultations, which causes her great deals of stress.

> "I think that part of it is that people are setting themselves up, think a GP should be like this. So, when they part from that, they feel guilty and ashamed and strive to do better, spending longer at work and all those kinds of things. So, it's not so much I'm ashamed to have depression, it's I'm ashamed not to be able to cope."

- She feels that doctors are expected to be more focussed on hitting targets than actual patient care.

- She opted to work as a locum as she needed a more flexible working situation; however, she finds that this only increases her feeling of isolation.

Perceptual barriers:

- She believes stigma is still prevalent within the profession, backed up by her experience of senior colleagues labelling her 'incompetent' for seeking support.

- Along with this, she feels that seeking support for a mental health condition risks signalling to other doctors that you are struggling to cope and she worries about being perceived as weak.

- In the past she has been concerned about formally acknowledging her diagnosis of depression as she fears it will block her future career progression.

> "If you were taking time off with mental health, you probably wouldn't get short-listed for that promotion."

Current support

Next, we consider the support and services identified by participants as currently available to doctors.

As per the previous sections of this report, the information covered below was elicited from the study participants and is not intended to be a comprehensive and systematic summary of the types of support offered to doctors across the UK.

The following section has been structured in chronological step-wise order (see Figure 2), in line with the trajectory most often described by participants in the study, starting with proactive / preventative initiatives offered to doctors to help them maintain good mental health through to the services offered to doctors once a mental health problem has manifested.

Figure 2: timeline of events

1.	**Proactive / preventative initiatives and support**
2.	**Requests for alternative working patterns**
3.	**Seeking GP help**
4.	**Extended periods of time off work**
5.	**Formal work-based support & mental health services**

Maintaining good mental health

Holistic initiatives for wellbeing

Within our sample, preventative and proactive workplace initiatives were currently provided to most doctors, particularly those in secondary care. Most secondary care doctors that we spoke to, were aware of and able to access services intended to support broader wellbeing such as yoga, meditation, Tai Chi and walking groups etc. However, while such initiatives may be perceived to have a role to play in supporting all-round wellbeing for some people, there was some disdain for these services for two reasons:

1. Some participants did not understand why services such as these are offered when hospitals are struggling for funds and doctors are exceptionally time poor.

2. Some did not consider these initiatives to be 'real' or 'scientifically-backed' and felt they were 'tokenistic'.

Others liked the option of these services but found it frustrating that they are unable to attend as they were often offered in a central location in a hospital, which could take 20-30 minutes to get to.

"I can't even think of anything, but I know there are things offered like yoga sessions in other places. But it feels like whatever is done it's a tick box."

- Consultant & SAS Doctor, formal diagnosis

Within primary care, 'happy healthy' workplace initiatives, such as the ones outlined above, seemed to be less common amongst the sample that we spoke to. GPs spoke about being advised to take breaks and socialise more and referenced the BMA's recent fatigue and facilities charter for junior doctors; however, it did not seem as if there was the same level of wellbeing support as offered within secondary care.

"I'd say it's a really rewarding job, but you'll be working in systems that which are increasingly understaffed, overstretched. And it's really important that you look after yourself. You need to take your breaks. You need to have time away from the job."

- Junior Doctor, symptoms but no diagnosis

"I was aware that there was a Pilates thing that you could go to. The timings were always really bad, and it's on the other side of the hospital."

- Consultant, symptoms but no diagnosis

Peer interactions & support

Most doctors included in the study felt that professional camaraderie and peer-to-peer support is a necessity for maintaining good mental health as a doctor. Unfortunately, most who had been in the profession for a number of years felt this was disappearing due primarily to systemic pressures and lack of time (as highlighted above). This meant that the doctors we spoke to barely had time to speak to colleagues and often felt professionally isolated.

"There's just no communication, just even the niceties. A colleague of mine came back from maternity leave, so she'd been away for a year, and not one of the partners came in to see her or even sent a message saying welcome back, nothing."

- Salaried GP, formal diagnosis

"There are 100 consultants and there are at least 100 trainees. But I can't say that I have met them all. I have been working here for over 18 months and there are still consultants that I am meeting for the first time. I can't even tell you any of the trainees to be honest, we rotate so much…"

- Junior Doctor, no symptoms / condition

Within our sample, there was evidence of some wellbeing initiatives in some regions which seem to have had a positive impact. Balint groups and Schwartz rounds, where introduced, had generally been well-received by doctors as they allowed them to get together and learn from each other. It also provided an opportunity to socialise with peers, and overcome the feeling of isolation often reported. Another GP mentioned that her practice had implemented protected lunch breaks and had increased the 10-minute consultation time to 12 minutes; this GP believed these changes had improved her working life significantly.

"We have focussed on workload in terms of access. How we can improve services to patients, and take the load off doctors. Our appointments are now 12 minutes. The pressure is taken off in a way."

- Salaried GP, no symptoms / condition

"When I was on my psych placement there was a Balint group - it was really useful for juniors to talk about difficult cases or situations where they second guessed themselves. It was a safe space to admit worries and I always left feeling like "oh, it's not just me then?!"."

- Junior Doctor, formal diagnosis

A handful of more senior doctors however, mentioned that they found that Balint groups were increasing their workload, as more junior staff were sometimes using them to gain help from senior doctors. A couple of senior doctors interviewed mentioned they would like to have Balint groups specifically for consultants or GP partners, believing that this would be more appropriate and more useful.

Requests for flexibility

The doctors in our sample who had a formal mental health diagnosis had frequently initiated steps to seek support with a request for more flexibility. These doctors became aware that their mental health was deteriorating and had proactively requested reduced hours or to part-time working as a way to alleviate symptoms. These requests had often been refused, which had left doctors feeling that their attempts to help themselves and avoid burnout were futile. The perceived lack of flexibility in the workplace led doctors to feel like the NHS would rather risk losing doctors rather than make accommodations for mental wellbeing. Some junior doctors interviewed also experienced a similar level of inflexibility on their 6-monthly rotations, for instance a junior doctor who was diagnosed with depression applied for a transfer to a hospital which was closer to her home (so she had her support network close by) but it was refused.

"I had to move hospitals because the previous one that it was very stressful working in that unit, and they point blank refused making me part-time."

- SAS Doctor, formal diagnosis

"It took 9 months to sort out, by which time I had full blown depression, and whilst I can take time off my paid job, it has an impact on how I am able to parent my children, and how much I am able to do with them."

- Consultant, formal diagnosis

This perceived lack of willingness to accommodate requests for time and flexibility left some doctors feeling helpless, which when they were faced with a challenging combination of risk factors mentioned earlier (lack of time, high caseloads, a lack of senior support etc.) could gradually lead to a build-up of anxiety-like symptoms, stress and depressive-like symptoms. However, as a result of the practical and perceptual barriers outlined earlier (barriers subchapter), many doctors still put off seeking support. During this time, a couple of doctors in the sample spoke about using alcohol, drugs and self-medicating to help them cope.

"At that time, I self-sought anti-depressants from a patient that was stockpiling them and had died. His daughter gave them to me."

- Salaried GP, formal diagnosis

During this window of time before breaking point, doctors mentioned that a traumatic event, unexpected outcome (as outlined in Endemic Factors sub-chapter) or an experience of workplace bullying may then have pushed them over the edge, and they reached burnout. At this point of greater severity, doctors' felt that their barriers to seeking support would break down and they would eventually seek help from their GP, including medication and also to be signed off from work.

The doctors in our sample with a formal mental health diagnosis typically took time off work - from a couple of weeks to a number of months; during this time, a proportion had re-evaluated their careers. Where it was an option, a number of those interviewed had decided to move to less than full-time working. For others where this was not an option, a small number of participants opted for a more fundamental change in career path which allowed for a more flexible work-life balance. This included individual examples of doctors choosing to work as locums or as a SAS doctor as these were perceived as offering greater flexibility, for others it involved a move from secondary care to primary care (see case study on next page). For medical students and junior doctors, it often meant recalibrating aspirations and career plans entirely, to enter roles where career prospects and progression were considered more limited, but work - life balance more acceptable. For more experienced / older doctors, many spoke about plans to retire early. As such the deterioration of doctors' mental health was considered to lead to an avoidable loss of talent from the workplace.

Others spoke about resigning from their current position as they felt there was no other option, as going back to their previous job would just lead to a further decline in their mental health. Other participants in similar situations felt as though they had little choice but to return to work knowing that it may lead to a second or third mental health issue.

"I think there is a lack of flexibility [in the NHS] that can make things really difficult. If I'd been allowed to transfer back home then I wouldn't have needed to take 18 months off."
- SAS Doctor, formal diagnosis

"I don't do traditional General Practice anymore and, to be fair, when I left four years ago, I just couldn't go back."

- Salaried GP, formal diagnosis

Case study: time off work & career changes

Gender: female
Role: salaried GP
Mental health status: formal diagnosis

Background:

- This doctor has a formal diagnosis of depression.

- She has worked in secondary care and also in general practice.

- She now works as an out-of-hours GP and an ambulance clinical supervisor.

Experience:

- As a younger doctor she felt the pressures of understaffing and, despite being newly qualified, the requirement to take on more senior roles. This was particularly true when hospitals did not have sufficient 'middle-grade' staff.

> "I was thought of as somebody who knew what they were doing but, for me, that was me serene on top with my feet paddling underneath. I would go back to my room and comfort eat and not speak to family when I got home because I spent most of my time slightly shocked and traumatised by everything. I remember vividly going to my consultant once saying you are going to have to see the patients with me because I am having nightmares."

- Throughout her career, this pressure contributed to the decline in her mental health.

- She also had positive experiences in some hospitals. In one instance, she was placed on a very 'nurturing' A&E ward and had a strong support network.

- However, after having such a positive experience, transferring back onto a ward without this in place (and even instances of bullying and belittlement) meant her mental health declined even further, leading to a referral to occupational health.

- Intense workloads combined with negative experiences with other staff (including bullying) were the tipping point for this doctor.

What action did this doctor eventually take?

- Took 3 months sick leave as she reached crisis point and felt unable to work, both for her own and her patients' safety.

- After taking time off, she took more drastic action, leaving secondary care all together and entering general practice as a salaried GP as she felt this would offer greater control over her workload.

Once a mental health problem has manifested

Formal work-based support

Within our sample, doctors who had not had any experiences of mental health problems, were unaware of the more formal support options available to them if they were to struggle in the future. They were unaware of modified working arrangements sometimes available in parts of the NHS such as therapeutic return, phased returns, WRAPs (wellness and recovery action plans), rapid access schemes and workplace adjustments. A couple were aware these services existed but did not realise they were relevant / available for mental health problems and assumed they were only available for physical health problems or those with a disability. There was more awareness of BMA representatives, the BMA's wellbeing services helpline and associated charities, but there was very little proactive use of these services as doctors tended to dismiss their symptoms until a crisis point was reached.

> *"I've never heard of any of those things that you just said, and I know that there are a lot of barriers to less than full time working."*
>
> *- Junior Doctor, symptoms but no diagnosis*

Within our sample of doctors with a mental health diagnosis, of those who had accessed formal support (such as phased returns, reduced hours, workplace adjustments etc.) they had typically done so under the advice of their GP or occupational health. Generally, these doctors found this type of formal support to be beneficial but also too short-lived. For example, a GP was able to operate shorter surgeries and no on-call activities for between 2-4 weeks during the return to work period but then he felt that normal working hours resumed almost 'as if nothing had happened'. As such, this had meant in some cases, doctors experienced a second or third mental health problem as it was perceived that nothing had significantly changed.

Other doctors, particularly GP Partners, mentioned that they did not have access to formal services (such as phased returns to work, workplace adjustments etc) at all, as they themselves were responsible for providing these services in their workplace and there was no-one more senior to take this responsibility when they themselves are ill.

> *"In some ways, it's sort of harder when you first go back. I did think during that time of whether I actually wanted to go back or not but due to the other pressures on the partnership, it was a difficult decision to make at that time. I decided to try back and I did shorter surgeries for the first few weeks when I went back."*
>
> *- GP Partner, formal diagnosis*

The negative experiences outlined above were typically amplified for the locums and junior doctors within our sample, who did not have a consistent work base or team. These doctors

usually did not know who they would turn to if they needed support, and how or where they would access support.

Medical services

Our sample of doctors had rarely been offered psychological support such as counselling, psychotherapy and CBT etc.). Many spoke about funding private services themselves, which they found to be effective in the short-term, but not maintainable long-term due to cost. Of the minority who were offered counselling, psychotherapy or CBT services by their place of work, there was the feeling that the quality was inadequate. For example, one doctor spoke about attending a counselling session ran by a new graduate who did not understand the complexities of her role as a consultant.

"I'm sorry, they looked about 12. They've got zero life experience. Just lack gravitas and authority in my view to even know what on earth I'm going on about."

- Consultant, symptoms but no diagnosis

"I think it would have been really helpful to have had some CBT available through a recognised scheme because actually I just had to find someone privately."

- GP Partner, formal diagnosis

Based on this research, most doctors in secondary care returning to work following absence for mental health reasons received an occupational health visit to ensure any workplace adjustments were made. However, many found their experiences with occupational health to be disappointing. Doctors spoke about a lack of communication from occupational health teams, including unanswered emails and ineffective telephone reviews which would have been better conducted face-to-face. There was also a disparity between primary and secondary care occupational health provision. Based on the sample we spoke to; occupational health support wasn't offered as readily to those who work in primary care vs. secondary care. Those in primary care were more likely to see their only option as to resign and then apply for a part-time or locum role.

Supporting doctors in the future

Next, we consider the support and services which participant doctors would like to see in place in the future. The following section has been structured based on the group of five risk factors which were outlined earlier as potential drivers for the deterioration of doctors' mental health.

Systemic changes and improvements

All doctors participating in the research highlighted widespread systemic improvements to the NHS as being the most significant way to prevent the deterioration of doctors' mental wellbeing in the future. Although many of the suggestions made were believed to be impossible within the current environment and NHS budget (e.g. hiring of more support staff to complete administration and safeguarding tasks, hiring of more locums to cover gaps in rotas etc.) doctors interviewed did feel that creating more time and allowing for more flexibility should be possible in the shorter term.

For example, it was suggested that changes such as increasing the 10-minute appointment slot could give doctors more time to spend on their 'main role' of patient care. One GP doctor spoke about this policy being implemented in their workplace and the positive impact it had on staff morale (see below case study).

Allowing greater flexibility in working hours and patterns was also considered an achievable priority by many. Indeed, doctors suggested that allowing shorter / flexible hours would be beneficial in the longer term, enabling more doctors to continue working in their role rather than resigning or retiring early due to mental health challenges.

"I would recommend helping doctors to strike the right balance between work and non-work life by allowing them to work part-time. Family support and, crucially, working within a well-functioning department…all of whom work closely together and who respond when the pressures rise and back each other up."

- Consultant, no symptoms / condition

Case study: best practice in the workplace

Gender: male
Role: salaried GP
Mental health status: no condition/symptoms

Background:

- This GP had recently retired as a GP Partner but had come back as a salaried GP, working 3 days a week.

> "The formal coffee break [in my practice] is designed so that we don't feel isolated. In general practice, it can be very isolating. It is you and a patient in a room and that is it. And you make the decisions. You don't have a team around you."

Experience:

- He is nostalgic about the old days, feeling that now there are increasing amounts of paperwork and the increase in patient demand was making the job much more 'intense'.

- The role of a GP Partner in his eyes has become much more difficult as it involves more business skill, meaning Partners are able to spend less time on patient care and more time running the practice.

How does his practice support their employees?

- His practice is a great example of how workplaces could adopt policies to promote good mental health and wellbeing.

- They have agreed on 12-minute appointment slots for patients.

- They have administration staff training to ensure that patients are processed efficiently and effectively to ensure all staff time is allocated in a smart way. This has led to many feeling they have a reduced workload. They have also implemented "formal coffee breaks" to combat feelings of isolation within the practice.

- Another policy they have implemented, is a weekly lunchtime education session, where GPs are provided with the opportunity to get together.

- He really values having a supportive team within the practice and feels that makes a huge difference to doctors' mental wellbeing.

It was also suggested that there is an opportunity for the NHS and the BMA to help to raise awareness of the mental health services and support that already exist within most Trusts. Doctors interviewed were relatively unaware and uninformed about the processes and support available. As such there is considered to be some work to be done to raise awareness of these more formal services (such as rapid access schemes and counselling etc.) as well as encouraging employers and line managers to be more proactive and flexible in their management of staff. Better signposting to support services via staff inductions, on local intranets and printed leaflets in staff break areas were all considered useful ways to help to raise awareness, with a particular focus on those groups where awareness is lowest, such as locums, salaried doctors and GP Partners.

"You need to always know there is a contact that you can have for services… not just your own GP. I mean you are meant to see your own GP obviously which is a good way, but I am sure services have become more open and accessible now, it wasn't the case 10 years ago."

- GP Salaried / Locum, symptoms but no diagnosis

"I got to breaking point, and I realised that I needed to talk to people and reach out and tell people that I was struggling… it was very much a crisis point thing, rather than something that I'd been signposted to."

- Medical Student, formal diagnosis

As many doctors in the sample were still cautious about discussing mental illness, it was considered important to ensure that some services are available confidentially as well, including offering more online and telephone support.

Support when facing endemic challenges

There was a consensus amongst the study sample that there is little support available to doctors after traumatic events or events with unexpected outcomes. Participant doctors requested more peer support groups to help them deconstruct in a professional environment, learn from events and also to prevent the tendency to blame themselves which can compound feelings of guilt and isolation.

"If we've been through a significant event or a patient has died or something awful has happened you have to stick your hand up and say I want to have a debrief or I want to have a professional support unit."

- Junior Doctor, symptoms but no diagnosis

Junior doctor participants also requested more opportunities for peer support. This could include informal weekly catchups for all junior doctors in each hospital to create a peer support network. Some of the junior doctors and medical students spoken to would also like to be paired with a named doctor when on rotations so that they always have someone to turn when they have questions or concerns.

"I think having a named doctor would be good. You get that a bit more later on in medical school, having a doctor you're meant to be paired with, but I think it'd be quite nice to have that from the start. Or perhaps just be paired with another medical student from an older year or something."

- Medical Student, no symptoms / condition

Promoting camaraderie

Doctors in the study mentioned that they would like to see stigma around mental health reduced further as there is still little openness about the numbers who struggle with mental health issues in the profession. Doctors in the middle of their careers were often likely to mention that they would like to see better coverage of mental health problems within university lectures as creating a more open attitude to mental health at the start of a doctor's career may help to reduce the rates of burnout later down the line and also overcome some of the perceptual barriers doctors experience (**Perceptual barriers subsection**). It is worth noting that the students and junior doctors interviewed as part of this process often did highlight content on their courses relating to these issues and the research findings from students especially offered encouragement here, as they tended to have greater awareness of services and support.

"I think it is different at university because they are more aware of students' mental health, and there's clubs and societies which are not necessarily for your wellbeing, but they can help you. There's a lot more going on and you do have the more pastoral support and there's student counselling and all of that."

- Junior Doctor, symptoms but no diagnosis

To encourage more discussion about mental health in the workplace, it was considered important by the majority of doctors interviewed to normalise the topic in the workplace too. This could be through coverage of mental health topics as a standard part of inductions, frequent workshops dedicated to mental health in the workplace, and regular reviews of individuals' mental health with a dedicated mental health champion.

The provision of more peer-to-peer support groups was considered by most in the study to be highly beneficial for doctors at all levels. In addition to increasing socialising opportunities, the doctors mentioned the roll-out of more frequent Balint groups and Schwartz rounds to allow for sharing of professional problems and difficult issues with specific patients. Consultants, GP partners and other senior doctors also requested to see Schwartz rounds / Balint groups or another group forum reserved specifically for senior staff so could offer each other guidance and ensure that the widest range of doctors could take part in this type of reflection.

"There's a Schwartz round every month or two. I find it helpful when it's one of my juniors who's presenting, because I think it's helpful to know a little bit more about people, to have context."

- Consultant, symptoms but no diagnosis

"A comprehensive support system is the solution because a lot of this is just about people not being nice or understanding or maybe being stressed themselves. And everyone is just stretched."

- Junior Doctor, symptoms but no diagnosis

"Equally, I worked in a very small hospital before this, where everyone was pretty much thrown in together and there was a lot of camaraderie, and it was a lot nicer as a result."

- Junior Doctor, no symptoms / conditions

Doctors included in the study approved of the idea of also having time set aside for informal catch-ups with colleagues, as well as monthly meetups which focus on celebrating successes, socialising and raising moral within teams.

In addition to increasing peer support, a number of doctors participating in this research raised the notion of mental health 'buddies' or mentors who they could turn to in times of need. The doctors clarified that they would prefer these individuals to be independent to their specific work, i.e. not their line manager or a colleague, as they want to be able to share experiences freely without fearing that it will impact on their career progression or on their relationships and reputation with peers. Given some doctors' concerns around the quality of support offered at present, it was suggested by some that ideally these would be qualified and trained professionals who understand the complexities of being a doctor and the stress they are under.

"I think it would be great to have an independent person in the local area that you could maybe to talk. Obviously, we have an annual appraisal with a local appraiser, but I've never really felt that I can openly discuss mental health issues in an appraisal. The appraisal has always felt like more of a burden, more of an addition to the workload rather than

somewhere where you can go for support, so I think it would need to be external, not connected with appraisals, almost like a buddy system that you could tap into if and when you needed it….You could have a psychologist to fulfil that role, so somebody with almost a special interest in working with doctors who you could see for a chat and for CBT."

- GP Partner, formal diagnosis

"I think everyone needs a mentor. I think the GMC says everyone should have a mentor. I think it gives you some perspective, it gives you someone that you can talk to. And yeah, there's nothing bad about having a mentor. They're different from your clinical supervisor and your educational supervisor and they're not obsessed about your e-portfolio."

- Junior Doctor, symptoms but no diagnosis

Environmental improvements

In addition to changes to systems, processes and attitudes, doctors interviewed as part of this study repeatedly pointed to practical improvements that could be made to their working environments that they believed would reduce professional isolation and raise moral. Doctors in the research wanted more protected time, such as lunchtimes and 10-minute breaks to allow them time to speak to colleagues, practically speaking this was thought to require less top-down scheduling of meetings and learning over lunch times.

To facilitate this further, doctors in this study requested dedicated spaces at work for socialising including:

- Creation of doctors' mess rooms,
- Kitchens and canteens which are separate from patients and are open and available at all hours.

Doctors interviewed also wanted to see the creation of spaces which promote a healthier mindset:

- Bedrooms or spaces to sleep in secondary care for those working long shifts or night shifts,
- Gyms or gardens so that doctors can exercise or get outdoors for sensory experiences, to help promote physical and mental wellness.

Other practical changes to the working environment were also identified and would be welcomed:

- The provision of showers,
- Dedicated hospital parking spaces which are close to the hospital department they are working in (especially for those who work night shifts).

"Somebody else had said to me this morning they'd like to be able to go for a walk, at lunchtime. They'd like somewhere to just be able to go for a walk outside, which I thought was another really interesting idea. A picnic table, somewhere that's covered so it's useful in all weather, but it's still outside. And scented flowers or a fountain so you can hear water. …. Sport on site."

- Consultant, symptoms but no diagnosis

"And I think that we need the little things. Like if we had a staff coffee room, if we had a staff kitchen, if we had a protected area, if we had an area in the canteen that was separate so that we're not mixing with the public. Those things are really, really important."

- Junior Doctor, formal diagnosis

The importance of choice

It is important to note that the above suggestions and recommendations were provided by participants with the aim of offering doctors as many options and choices as possible. Mental health was repeatedly positioned by doctors taking part in this study, as a very personal journey to which there is no 'one-size' fits all solution. The offer of a suite of facilities and services which doctors can choose from was considered the most beneficial scenario.

Responding to sociocultural change:

These were macro social factors which by definition meant they were considered beyond the control of those working within the medical profession (e.g. press coverage of high profile cases, eroding respect for the profession) and as such the doctors that we spoke to found it difficult to articulate recommendations and guidance for how to respond to these factors. However, it was felt that there was a role here for the BMA, and other relevant organisations, to represent and defend the profession. There may also be a role that Government can play in terms of quality and honesty of discourse with the public about health resourcing, budgets and possibilities, whilst also encouraging the public to engage more with their own health. It is also possible that if improvements can be made in the other four areas then doctors will ultimately feel more supported so wider sociocultural factors will have less of an impact on their mental health.

Conclusions

1. **Social, scientific, medical, political and regulatory factors were all considered to be contributing to an evolution and expansion of the doctor's role by participants. Doctors in the study believed they have more to consider and more to do than before, though often with less direct focus on patient care and with reducing resources and support.**

   - An ageing, changing population was highlighted, meaning that patient complexity is increasing, particularly the management of co-morbidities.

   - Changes in access to information are thought to have raised patient expectations and led to an increase in so-called "self-diagnosis", requiring additional management.

   - Advances in the medical and pharmacological fields are believed to have provided a greater range of surgical, medical and medicinal routes about which to learn and consider for each patient.

   - Changes to funding and resourcing in acute care, community and social care, were seen to have increased and changed the volume and type of patient cared for in primary care – post-operative, social and elderly care.

   - Increased focus on accountability and standards were described as having forced an increase in evidence-gathering processes and accountability.

2. **Despite the increased, evolving scope of work, doctors interviewed believed the profession has arguably less capacity than ever before. Systemic changes and contextual challenges were often cited as resulting in less resource for facilities and practices, and less available time for individuals.**

   - Reduction in dedicated ancillary staff such as secretaries and administrators.

   - Reduction in nursing allocations and ratios in secondary care.

   - Retirement and resignation of senior staff in secondary care.

   - Sickness and absence worsening existing rota gaps.

   - Introduction of additional triage calls and the pressure of providing more complex care within the 10-minute consultation in primary care.

   - Reduced funding.

3. **The contradiction between the increase in responsibility and scope, and decrease in capacity and empowerment was identified by participants as the most significant difficulty facing the profession. This was said to impact doctors in a number of ways, principally a critical lack of time, increased pressure and expectations, which can increase the risk to wellbeing and potentially mental health.**

- Insufficient time leading to what some doctors perceived to be a reduction in the quality of patient care and an introduction of an unacceptable level of risk, which could generate anxiety amongst the profession.

- In some cases, doctors report being forced to work harder and longer to compensate and "plug the gaps", sometimes leading to symptoms of exhaustion and burnout.

- Limited availability was said to mean that opportunities for doctors to interact with each other through meetings, handovers or even social events are vastly reduced. A lack of collaboration and ensuing sense of professional isolation was highlighted as a growing trend in all care environments, but especially common in General Practice and for locums.

- Increased pressures on individuals was considered by some in the study to generate greater tendency towards self-preservation, and a workforce that might be generally less supportive of each other.

- For some doctors interviewed, the increased pressures on themselves and the profession, had resulted in a deterioration of their mental health.

4. **Though all doctors participating in the study identified similar trends and factors impacting the profession, many were able to maintain good mental health. These doctors often attributed this to arrangements to protect time and resource, flexibility, an open attitude and awareness of mental health risks and supportive relationships with peers and family. Organised offerings intended to promote healthy, happy workplaces and broader wellbeing (e.g. yoga) were comparatively less significant though could be symbolic.**

- Doctors working in environments where protected time has been applied, e.g. protected lunch breaks, protected meeting times were better able to manage workload.

- Where specific meeting or socialising slots were preserved, doctors were able to generate relationships with peers, which in turn led to a more supportive, more collaborative environment.

- Universities were said to work more proactively than employers to promote positive attitudes towards mental health amongst medical students and junior doctors.

- There was limited awareness and limited uptake amongst the sample of "softer" proactive offers such as yoga or mindfulness, which were considered difficult to access and could be perceived as tick-box exercises to the detriment of solving fundamental issues.

- Considered more useful, were mechanisms for bringing peers together, such as Balint groups or Schwartz rounds. Again, the perceived value being in colleagues working collaboratively to support each other.

5. **Doctors interviewed explained that those who were facing a deterioration in their mental health tended to first seek increased flexibility to working hours to generate more time and restore balance. Where this was denied, doctors facing mental health challenges often took extended periods of sickness and absence, and in some cases ultimately resigned, retired or retrained.**

   - Doctors interviewed who had symptoms of or had been formally diagnosed with a mental health condition, often retrospectively believed that being able to work reduced hours or being less time-poor could have reduced the negative impact of work on their mental health.

   - As an alternative to adjusted working hours, doctors tended to seek periods of leave from a GP. A number of doctors in the sample believed that greater flexibility and a working pattern of reduced intensity might have avoided a longer period of absence from work.

   - Periods of leave and return to work transitions had often been overseen by occupational health services in acute care, however, GPs and locums were less likely to have had access to these services.

   - Where no lasting adjustments or improvements had been made, there was considered to be a growing trend of doctors changing careers or roles. The locum role and the SAS role in particular had been used by a number of the sample as a means to achieve a better work / life balance, specifically as they were considered as ways to control workloads, though for other doctors working in such roles, this may not be the case.

6. **There was evidence of the existence of and use of formal support and treatment to support doctors with symptoms or diagnoses of mental health conditions, however, these were considered insufficient in scale and quality. Doctors working in primary care were less likely to be aware of how to access this kind of support.**

   - There was some use of counselling and talking therapies though it was also common for doctors to seek and fund this kind of support privately, particularly those working in primary care, who were generally less aware of how to access these services.

   - Those who had used counselling or therapy services tended to find the period of support too short. Similarly, phased return to work schemes, which may be active for a month, were considered insufficient.

The associated recommendations can be found in a separate document titled 'Mental Health and Wellbeing in the Medical Profession_SUMMARY'.

Appendices: telephone depth interviews screener

**5757 | British Medical Association | Mental Health Research
Individual telephone interviews | 30-45 minutes**

I declare that this interview was carried out according to instructions, within the MRS Code of Conduct and that the respondent was not previously known to me. I have carefully checked the questionnaire and am aware that it is subject to quality control procedures

Name of recruiter:………………………………Signature…………………………………………..

Date:………………………………….

INTRODUCTION

Hello, my name is _____ and I work for an independent market research agency, DJS Research. In October last year, you took part in an online survey conducted by the British Medical Association (BMA) which aimed to understand more about doctors' mental health and wellbeing, and you kindly recently confirmed your interest in taking part in an in-depth telephone interview on the subject; we are calling to arrange your participation.

Today we will just confirm a few details with you and arrange the best time for one of our Researchers to call and conduct the interview.

Telephone interviews will last between 30-45 minutes and will be conducted at a time that is most suitable for you between Wednesday 8th May and Friday 31st May. To thank you for taking part we will donate £40 to the Royal Medical Benevolent Fund on your behalf.

The BMA will use the findings from this research to help create an environment that truly supports students and doctors.

Market research such as this is not associated with commercial activities. We are interested only in your honest views and opinions on the subject, and everything you say today and during the interview will remain confidential; the BMA only receives the results of the research in a summary format. Let me reassure you that the names of participants will not be passed on to the BMA, your employer or institution, or any other third parties.

(If respondents have any concerns please provide them with a freephone number to ring The Market Research Society - 0500 396 999 and/or provide a link to our GDPR personal information privacy statement on our website http://www.djsresearch.co.uk/content/page/terms)

Q1   Would you be interested in taking part in our research?

Yes .... ☐   CONTINUE
No .... ☐   **CLOSE**

CLASSIFICATION QUESTIONS

I would just like to confirm your answers to a couple of questions before we book in an interview date and time, this is to ensure that we speak to a range of doctors in different situations.

S1. I have your main branch of practice listed as <INSERT FROM Q4 DATA CAPTURE> is that correct? CODE BELOW

Medical student	☐ 1	**N=5**
Junior Doctor	☐ 2	**N=5**
Medical academic or Public Health Doctor	☐ 3	**N=3-4**
Consultant	☐ 4	**N=3-4**
SAS doctor	☐ 5	**N=3-4**
GP partner	☐ 6	**N=5**
GP Salaried, Locum GP or Sessional GP	☐ 7	**N=5**

S2. Do you describe your gender as... CODE BELOW

Male	☐ 1	**CHECK QUOTAS BY SPECIALITY**
Female	☐ 2	**CHECK QUOTAS BY SPECIALITY**
I prefer to describe my gender in another way	☐ 3	

S3. Which of the following age brackets do you fall into? CODE BELOW

18-29	☐ 1	**MIN n=5**

30-39	☐ 2	MIN n=5
40-49	☐ 3	MIN n=5
50-59	☐ 4	MIN n=5
60+	☐ 5	MIN n=5

S4. I have it noted down that you're based in <INSERT FROM Q6 DATA CAPTURE> is that correct? CODE BELOW

England	☐ 1	MIN n=24
Northern Island	☐ 2	MIN n=1
Scotland	☐ 3	MIN n=1
Wales	☐ 4	MIN n=1

S5. I have your ethnic group listed as <INSERT FROM Q5 DATA CAPTURE> is that correct? CODE BELOW

White	☐ 1	MIN n=22
Mixed / multiple ethnic group	☐ 2	
Asian/Asian British	☐ 3	MIN n=5,
Black / African / Caribbean / Black British	☐ 4	CHECK QUOTAS BY SPECIALITY
Chinese	☐ 5	
Arab	☐ 6	
Other ethnic group	☐ 7	

S6. At the time of the BMA's 'Doctors' Mental Health and Wellbeing' survey you answered to say that you <INSERT FROM DATA CAPTURE> is that still correct? CODE BELOW

Have been formally diagnosed with a mental health condition	☐ 1	Q15 = YES CHECK QUOTAS BY SPECIALITY – CODE AS DIAGNOSED.
Have previously suffered / currently suffer from symptoms such as burnout, stress, anxiety, depression or emotional distress	☐ 2	Q15 = NO AND Q16 OR Q17 = YES

that have affected your work, study or training		CHECK QUOTAS BY SPECIALITY – CODE AS SYMPTOMS WITH NO DIAGNOSIS
Do not have a formally diagnosed mental health condition and you do not suffer from symptoms such as burnout, stress, anxiety, depression or emotional distress that have affected your work, study or training	☐ 3	Q15 AND Q16 AND Q17 = NO CHECK QUOTAS BY SPECIALITY – CODE AS NO HISTORY OR SYMPTOMS

S7. ASK TO S6_1/2 ONLY (WITH FORMAL DIAGNOSIS OR SUFFERS SYMPTOMS)

Have you received help or support from your employer or medical school in relation to your mental health?

Yes	☐ 1	MIN n=6, CHECK QUOTAS BY SPECIALITY
No	☐ 2	MIN n=20

AGREEMENT TO AUDIO RECORDING

S8. The telephone conversation will be AUDIO recorded for analysis purposes, this audio will not be passed on to the BMA or any third party apart from for transcription purposes in some instances. We may use quotes from the conversation (which will have been anonymised and therefore cannot be attributed to you) to illustrate some of the research findings. Are you happy to take part in the research on this basis?

Yes	☐ 1	CONTINUE
No	☐ 2	CLOSE

S9. We will be conducting telephone interviews between Wednesday 8th May and Friday 31st May. Interviews will last between 30-45 minutes. What is the best date and time for you? RECORD DATE AND TIME. PLEASE SEND MODERATOR AND THE RESPONDENT A CALENDAR INVITE

- •Please ensure each respondent is provided with a confirmation email (with date, time and reminder of the number provided that the Moderator will call on)

Online groups screener

5757 | British Medical Association | Mental Health Research
Individual telephone interviews | 30-45 minutes

I declare that this interview was carried out according to instructions, within the MRS Code of Conduct and that the respondent was not previously known to me. I have carefully checked the questionnaire and am aware that it is subject to quality control procedures

Name of recruiter:……………………………   Signature………………………………………...

Date:……………………………….

INTRODUCTION

Hello, my name is _____ and I work for an independent market research agency, DJS Research. In October last year, you took part in an online survey conducted by the British Medical Association (BMA) which aimed to understand more about doctors' mental health and wellbeing, and you kindly recently confirmed your interest in taking part in an online focus group on the subject; we are calling to arrange your participation. Today we will just confirm a few details with you.

We will be conducting online groups on Wednesday 29th May with medical professionals at the same grade as you. The online group will last 90 minutes. As a thank you for taking part we will donate £40 to the Royal Medical Benevolent Fund on your behalf.

The BMA will use the findings from this research to help create an environment that truly supports students and doctors.

Market research such as this is not associated with commercial activities. We are interested only in your honest views and opinions on the subject, and everything you say today and during the interview will remain confidential; the BMA only receives the results of the research in a summary format. Let me reassure you that the names of participants will not be passed on to the BMA, your employer or institution, or any other third parties.

 (If respondents have any concerns please provide them with a freephone number to ring The Market Research Society - 0500 396 999 and/or provide a link to our GDPR personal

Respondents	Date	Time
Group 1: Medical students	29th May 2019	5:30pm – 7:00pm
Group 2: Junior doctors	29th May 2019	7:30pm – 9pm

Q1   Would you be interested in taking part in our research? The online focus group will take the form of a web chat, where you'll be asked questions and you will need to provide written answers.

Yes .... ☐   CONTINUE
No .... ☐   **CLOSE**

Q2. To take part in the online group, you will need to have access to a laptop or desktop computer (as it is not possible to access the group via a phone or tablet). Do you have access to a laptop / desktop computer?

Yes .... ☐   CONTINUE
No .... ☐   **CLOSE**

CLASSIFICATION QUESTIONS

I would just like to confirm your answers to a couple of questions before we confirm the details for the online group.

S1. I have your main branch of practice listed as <INSERT FROM Q4 DATA CAPTURE> is that correct? CODE BELOW

Medical student	☐ 1	**N=7-8, GROUP 1**
Junior Doctor	☐ 2	**N=7-8, GROUP 2**

S2. Do you describe your gender as... CODE BELOW

Male	☐ 1	**N=3-4, GROUP 1**
		N=3-4, GROUP 2
Female	☐ 2	**N=3-4, GROUP 1**

		N=3-4, GROUP 2
I prefer to describe my gender in another way	☐ 3	

S3. Which of the following age brackets do you fall into? CODE BELOW

18-29	☐ 1	**N=7-8, GROUP 1**
30-39	☐ 2	**N=6-7, GROUP 2**
40-49	☐ 3	
50-59	☐ 4	**N=0, GROUP 1** **MIN N=1, GROUP 2**
60+	☐ 5	

S4. I have it noted down that you're based in <INSERT FROM Q6 DATA CAPTURE> is that correct? CODE BELOW

England	☐ 1	**N=6-7, GROUP 1** **N=6-7, GROUP 2**
Northern Island	☐ 2	
Scotland	☐ 3	**MIN N=1, GROUP 1** **MIN N=1, GROUP 2**
Wales	☐ 4	

S5. I have your ethnic group listed as <INSERT FROM Q5 DATA CAPTURE> is that correct? CODE BELOW

White	☐ 1	**MIN N=5, GROUP 1** **MIN N=5, GROUP 2**
Mixed / multiple ethnic group	☐ 2	
Asian/Asian British	☐ 3	
Black / African / Caribbean / Black British	☐ 4	**MIN N=1, GROUP 1** **MIN N=1, GROUP 2**
Chinese	☐ 5	
Arab	☐ 6	
Other ethnic group	☐ 7	

S6. At the time of the BMA's 'Doctors' Mental Health and Wellbeing' survey you answered to say that you <INSERT FROM DATA CAPTURE> is that still correct? CODE BELOW

Have been formally diagnosed with a mental health condition	☐ 1	**Q15 = YES** **MIN N=1-2, GROUP 1** **MIN N=1-2, GROUP 2**
Have previously suffered / currently suffer from symptoms such as burnout, stress, anxiety, depression or emotional distress that have affected your work, study or training	☐ 2	**Q15 = NO AND Q16 OR Q17 = YES** **MIN N=1-2, GROUP 1** **MIN N=1-2, GROUP 2**
Do not have a formally diagnosed mental health condition and you do not suffer from symptoms such as burnout, stress, anxiety, depression or emotional distress that have affected your work, study or training	☐ 3	**Q15 AND Q16 AND Q17 = NO** **MIN N=1-2, GROUP 1** **MIN N=1-2, GROUP 2**

S7. ASK TO S6_1/2 ONLY (WITH FORMAL DIAGNOSIS OR SUFFERS SYMPTOMS)

Have you received help or support from your employer or medical school in relation to your mental health?

Yes	☐ 1	**MIN N=2, GROUP 1** **MIN N=2, GROUP 2**
No	☐ 2	**MIN N=5, GROUP 1** **MIN N=5, GROUP 2**

AGREEMENT TO CLIENT VIEWING

S8. The session you are being invited is text based (i.e. no video or audio element) and may be observed online by one or more clients from BMA. <u>Let me reassure you, you will be able to take part anonymously by creating an avatar and using any name of your choosing during the session</u>. Are you happy to take part in the research on this basis?

Yes ....☐ CONTINUE

No... ☐ THANK & CLOSE

S9. We may use some quotes from the session to illustrate some of the research findings. These quotes will be anonymised and not attributed to you. Are you happy to take part in the research on this basis?

Yes ....□ CONTINUE

No.. □ THANK & CLOSE

S10. As part of the research we will ask you to share responses with DJS Research via an online platform, Visions Live. You can view their privacy statement at https://www.visionslive.com/privacy-policy/. Are you happy to take part in the research on this basis?

Yes ....□ CONTINUE

No.. □ THANK & CLOSE

S11. READ OUT The online discussion will take place on <u>Wednesday 29th May 2019.</u> We will send you a link to enter the online forum on the day of the group. You will receive a link from djsresearch@visionslive.com. Please check you spam or junk mail if you have not received the email. We will also send you the time of the focus group, plus a telephone number of the Project Manager/email address should you have any queries or need the link resent. The group will start promptly at <u><INSERT TIME RELEVANT TO GROUP></u><u>. Please log in 15 minutes before the groups starts</u>. The moderator of the group will also join the online group before the start time in case you have any last-minute questions.

> - **Please ensure each respondent is provided with a confirmation email (with date, time and link)**
> - **Please attach flyer about sources of support & send with confirmation email**
> - **Please fill in Excel profile grid in full with full details for each question**

Telephone interviews discussion guide

British Medical Association

Mental Health Research

Individual telephone interviews

Discussion Guide (30-45 mins)

Qualitative research objectives (moderator refresh):

The British Medical Association (BMA) is looking to deepen its understanding of doctors' mental health and wellbeing. The BMA will use the findings from this research to help create an environment that truly supports students and doctors, through strategic and tactical measures.

Stimulus required:

- Audio recorder

(I) Introduction		2-3 mins
Brief explanation of the purpose of the research	*Moderator to explain the nature of the research;* • I work for a company called DJS Research, we are an independent market research consultancy and today we are working on behalf of the British Medical Association (BMA). • The BMA is looking to understand more about doctors' mental health and wellbeing. The BMA will use the findings from this research to help create an environment that truly supports students and doctors. *Moderator to reassure respondents about confidentiality / GDPR compliance* • Feedback will be summarised into a report along with feedback from other participants. We won't pass on names/specific details of who we have spoken to the BMA or attribute any quotations we use. • There are no right and wrong answers; we are just interested in your views, opinions and ideas. • Our discussion is being audio recorded for analysis and transcription purposes. We may use some anonymised quotes in our report to illustrate the research findings, but these will not be attributed to you personally. • <u>You have the right to withdraw from the research at any time. Crucially, you do not have to discuss anything that you do not feel comfortable sharing. When we organised this interview, we shared with you a list of charities and organisations you can speak to confidentially about any mental health issues. We can share these details with you again if needed.</u>	

Introductions	***<Moderator to invite respondent(s) to introduce themselves>;***
	• Could you briefly introduce yourself and tell me a little bit about your current job, for example,
	   o What kind of medicine do you practice / what kind of doctor are you?
	   o ***<If relevant>:*** What specialty do you practice in?
	   o How many years have you been practising?
	   o Do you have any additional roles or responsibilities?
	   o ***<Students>:*** What stage of your studies are you at?	

	o *<Junior doctors>:* What stage of training are you at?

(II) Mental health – the profession and the individual	15-20 mins

Day to day work experiences	*Ok so let's move on to discussing your day-to-day...* • What does a typical day look like for you? Is every day similar, or do you do certain clinics / jobs / tasks on certain days?
Pressure on the profession	• How has your job evolved or changed over time? What is changing for the profession at the moment? *<Students>:* How do you expect your work in medicine to change over coming years? • What advice would you give a young person going into medicine today? Why do you say that? • *<If not mentioned above>:* Do you feel that being a doctor today is challenging? Why is that? • There has been an increased focus on the issues of mental health and wellbeing amongst doctors recently, why do you think that is? • What would you say are the biggest stresses or strains on doctors / medical students at the moment? o What are the main pressure points for you personally? • What impact are these pressures / strains having on the mental health and wellbeing of doctors and medical students? How do you feel about that?

Experiences of mental health and wellbeing	*<For those who have a mental health diagnosis>:*
	
	• At the time of the BMA's mental health survey you answered to say that you *<have been formally diagnosed with a mental health condition>.* Would you be happy to tell me a little bit more about that? What kind of symptoms have you experienced or do you experience?
	
	• What do you think initially caused your mental health to decline? How did you feel at the time? Have you previously experienced similar symptoms or feelings at another point in your life?
	
	• How or by whom were you diagnosed with your condition?
	
	• How have your symptoms impacted your working life? What impact did it have on your personal life?
	
	• Have you taken time off from work due to your mental health condition? How long? Has that proved helpful to you?
	
	    o Did you have any fears or concerns about returning to work? How did you find returning to work? Were there any return-to-work adaptations?
	    o What support was made available to you? How accessible was this support? Did you have any concerns around seeking / accepting this support?
	
	• How have your colleagues / your superiors / your employer responded to your situation and your needs? Would you have preferred different reactions and responses? Why?
	
	• Are there any ways that your work / study experience could have been improved or made different that might have avoided the situation?
	
	• Do you feel that doctors are at a greater risk of experiencing mental health issues compared to other professions? Why is that?
	
	<For those who suffer from symptoms>:
	
	• At the time of the BMA's mental health survey you answered to say that you *<you have previously suffered or currently suffer from symptoms such as burnout, stress, anxiety, depression or emotional distress that have affected your work, study or training>.* Would

Experiences of mental health and wellbeing (contd.)	you be happy to tell me a little bit more about that? What kind of symptoms have you or do you experience?
	• How have your symptoms impacted your working life? What impact did it have on your personal life?
	• Have you taken time off from work due to your mental health condition? How long? Has that proved helpful to you?
	o Did you have any fears or concerns about returning to work? How did you find returning to work? Were there any return-to-work adaptations?
	o What support was made available to you? How accessible was this support? Did you have any concerns around seeking / accepting this support?
	• What do you think initially caused your mental health to decline? How did you feel at the time? Have you previously experienced similar symptoms or feelings at another point in your life?
	• Are there any ways that your work / study experience could have been improved or made different that might have avoided the situation?
	• How have your colleagues / your superiors / your employer responded to your situation and your needs?
	• Do you feel that doctors are at a greater risk of experiencing mental health issues compared to other professions? Why is that?
	<For those who have not had personal experiences>
	• At the time of the BMA's mental health survey you indicated that you have not personally been affected by issues relating to your own mental health and wellbeing during your career / studies in medicine. How or why do you think you are able to maintain good mental health and wellbeing?
	• Do you feel that doctors are at a greater risk of experiencing mental health issues compared to others? Why is that?
	• Do you know of colleagues / friends in the profession who have had any experiences of mental health and wellbeing challenges of this nature?
	• How did you become aware of your colleague's / friend's situation? How did you respond when you became aware?
	• What do you think caused their mental health and wellbeing to decline?
	• Are there any ways that the work / study experience could have been improved or made different that might have avoided the situation?

(III) Mental health provisions in the workplace	**15-20 mins**
Seeking support	*Moving on now to think more broadly again about doctors, the profession and seeking support…*
	• Firstly, how would you (<or did you>) go about finding out more about different support types needed to for you, a colleague or fellow doctor?
	• How likely would you be to access support for your mental health or wellbeing if you needed it (<again>) in the future? Why is that?
	• Ask any respondents who express concerns around at seeking / accepting support:
	• You mentioned that you had concerns around seeking / accepting support, do you still hold those views now? Why?
	• Thinking more broadly, do you feel that doctors are good at seeking support for mental health and wellbeing? Why might that be?

	• <Probe at random only if nothing mentioned spontaneously>: Lack of awareness of support, concerns over confidentiality, stigma – fear of judgement, fitness to practice, lack of faith in support available, students – lack of learning opportunities, duty of care… • Overall how supportive is the profession of promoting good mental health and wellbeing? Why is that? Are there particular groups who are more supportive or less supportive? Why? • Would you say that there is a stigma around mental health within the profession? Where does this stem from? How can it be overcome in your opinion?
Promotion of healthy workplace	*Ok so next I'd like to move on to discuss mental health support and provision in your workplace / university specifically.* • What kind of steps or measures are in place to promote good mental health and wellbeing in your workplace / place of study? For example, this could be things like drop-in sessions, wellbeing days, mentors, yoga, meditation, etc. • Do you feel this is a priority for your employer / line-manager /workplace / university / institution? • Have you personally had any experiences of using these? o *If yes*, which ones? How easy was it to access or make use of these? Were they useful? What worked and what didn't within each service? What could be improved? o *If no*, why have you not used any of these services? Have any of your colleagues used any of these services? Did they find them useful? In your opinion, how could they be improved? • What (other) types of proactive steps and measures could be put in place to promote good mental health and wellbeing for you and your colleagues in your workplace / place of study? • Where would you expect these initiatives to come from or be provided by? What would be most useful in your opinion?
Peer reactions and support	*Next, moving on to think in more detail about how doctors might support each other…* • Did you, or have you ever, sought any help, advice or support from peers or colleagues about your mental health and wellbeing? Why? How useful did you find it? o *If yes*, how did your peers and colleagues respond to your needs? o *If no,* has a colleague ever approached you with regards their mental health and wellbeing? How did you respond? • Are there any specific peer-to-peer support systems in place that you have access to for support with mental health and wellbeing? Have you used them? How useful is this? Why? • Ideally what types of peer support systems would you like to see in the workplace for doctors? How would this work?
Services and processes in the workplace	*And, what about more formal services and processes which currently exist in the workplace to support doctors...* • What formal processes and services are available in your workplace or at your place of study to help those in need of support? ***<Probe if not covered>****: Are you aware of the following…* o Counselling services o Rapid access schemes? o Wellness and recovery action plans (WRAP)? o Therapeutic return, phased returns and return to work plans? o Return to work interviews? o Reasonable adjustments? Reduced working hours etc.? o Provision of other resources such as dedicated helplines or telephone support, voluntary sector support, financial support etc? o Are there any other services or support offered? • Have you personally had any experiences of using any of these services? ***Especially those who have taken leave from work>***

	○ *If yes*, which ones? How readily available or accessible did you find each? How long did it take you to receive *XXX* <e.g. counselling>? Was it useful? What worked and what didn't with each service or stage of the process? What could be improved specifically? ○ *If no,* have any of your colleagues used any of these services? Do you consider the processes and systems in place to be sufficient? In your opinion, how could they be improved? - Are there other steps and processes of this nature that you feel should be available to you and your colleagues to manage mental health conditions and symptoms? Why? - Where would you expect these initiatives to come from or be provided by? What would be most useful in your opinion?	

(V) Final summary	2 mins
Summary/ round up	- Finally, what 2-3 key messages or actions would like us to convey to the BMA on this subject? - Is there anything else you would like to add to the topics that we have covered today? - Thank you very much for time, it has been exceptionally useful and helpful.

Online groups discussion guide

5757 British Medical Association

Mental Health Research

Online Groups Discussion Guide (1.5 hours)

Research objectives:

The British Medical Association (BMA) is looking to deepen its understanding of doctors' mental health and wellbeing. The BMA will use the findings from this research to help create an environment that truly supports students and doctors, through strategic and tactical measures.

(I) Introduction	10 mins
Brief explanation of the purpose of the research	Good evening everyone, my name is <Claire / Charlotte / Emma> and I work for a company called DJS Research (an independent market research company). I am going to be moderating today's online focus group. We are working on behalf of the British Medical Association (BMA). The BMA is looking to understand more about doctors' mental health and wellbeing to lobby for more effective support and changes to workplace culture. The BMA will use the findings from this research to help create an environment that truly supports students and doctors. <DISPLAY BELOW ON WHITEBOARD WHEN ENTER GROUP> Feedback from today will be summarised into a report along with feedback from other doctors. The report will be published on the BMA's website later

	this summer. We may use some anonymised quotes in our report to illustrate the research findings, but these will not be attributed to you personally. • We have some people from the BMA observing the session today to aid their understanding of some of the key issues. They will just be reading your comments as we go, they won't be asking you any questions directly. They can only see the name you are using tonight and do not know anything further about you. • There are no right and wrong answers; we are just interested in your views, opinions and ideas. • <u>You have the right to withdraw from the research at any time. Importantly, you do not have to discuss anything that you do not feel comfortable sharing with the group.</u> • <u>When we organised this interview, we shared with you a list of charities and organisations you can speak to confidentially about any mental health issues. We can share these details with you again if needed.</u>
Instructions	• There are no 'rules' as such when participating in an online focus group, but if I could ask you to contribute each time I ask a question, even if it is just a short response, that's fine. Also feel free to respond to points other people make too, if you could just make it clear whose point you are referring to. • I'm not sure if anyone has taken part in an online group before … so I just wanted to show you some of the tools that you can use during the session • At the top of the screen you have a white board – I will use this space to show you different pieces of information and you can also use it to respond a little more creatively! • Shall we have a quick practice?! • On the right hand side of the white board you'll notice some icons – a text box so you can write directly into the whiteboard space, a pen so you can draw, a tick and cross so you can 'vote' or say if you like or don't like something … there are a couple of others but those are the main ones we will use • Feel free to have a little practice using the tools before we get started! • You can also use the little smiley face icon beside the chat box to bring up a selection of different emotion icons – they may be useful to add expression to your points when typing in the chat box. • Finally, please don't worry about spelling and punctuation.
Introductions	We have <insert number> Junior Doctors / Medical Students participating in the online focus group today. To start could you each briefly introduce yourself in the chat box, including your first name and what stage of your training / studies you are at? <Wait for all respondents to introduce themselves> That's great – thank you!

(II) Mental health and the profession	25 mins

Pressure on the profession	Firstly, I'd like to have a general discussion about mental health and the profession. • There has been an increased focus on the issue of mental health and wellbeing amongst doctors recently, why do you think that is? • What do think about the risks to mental health and wellbeing for doctors compared to other professions? • What would you say are the biggest stresses or strains on doctors and medical students at the moment?

	• What impact are these pressures / strains having on the mental health and wellbeing of doctors and medical students? How do you feel about that?

Seeking support	Next, let's move onto seeking support.
	
	• Generally, how good are doctors at seeking support for mental health and wellbeing? Why?
	• *If not covered probe on:*
	    o Do you feel that a lack of awareness of support is a problem?
	    o Are there any concerns over confidentiality, suspicion and fitness to practice? Please explain.
	    o Is stigma / fear of judgement a problem? Where does this stem from and how can it be overcome?
	• Overall how supportive is the profession of promoting good mental health and wellbeing? Why is that?
	• Has anyone personally sought support for their mental health and wellbeing? If so, what was it? Was the support useful?
	• How likely would you be to access support for your mental health or wellbeing if you needed it in the future? Why is that?

(III) Mental health provisions in the workplace	45 mins

Peer reactions and support	Next, I'd like to cover how doctors might support one another.
	
	• Using the quick poll function (selecting yes or no), has anyone here sought help, advice or support from peers or colleagues about their mental health and wellbeing?
	For those who have:
	    o How did your peers and colleagues respond to your needs?
	For those who have not:
	    o Has a colleague ever approached you with regards to their mental health and wellbeing? How did you respond?
	• Are there any specific peer-to-peer support systems in place that you have access to for support with mental health and wellbeing? For example, mentoring or pastoral support?
	    o Have you used them?
	    o How useful are they? Why?
	• Ideally what types of peer support systems would you like to see in the workplace for doctors? How would this work?
	• Were there any support systems that you had access to in medical school which you would like to see provided in your place of work (e.g. pastoral support)?

Promotion of healthy workplace	Okay, so next I'd like to move on to discuss mental health support and provision in your workplace / place of study. • Do you feel that providing a happy healthy place of work / learning is a priority for your employer / your university? Why? • What kind of steps or measures are in place to promote your wellbeing and make your place of work / study happy and healthy? For example, this could be things

	like drop-in sessions, rest areas, kitchens, socials, catch-ups, mentors, yoga, meditation, etc.
	• Have you personally had any experiences of using these?
	For those who have:
	o Which ones?
	o How easy was it to access or make use of these? Were they useful? Why?
	o What could be improved?
	For those who have not:
	o Why have you not used any of these services?
	• Using the whiteboard function (to the right), could you tell me what types of proactive steps and measures you would like to see in place to promote wellbeing and create a happy and healthy place of work / place of learning?
	• And where would you expect these initiatives to come from or be provided by?
Services and processes in the workplace	Lets' move on now to more formal services and processes which currently exist in the workplace to support doctors...
	• What formal processes and services are available in your workplace or at your place of study to help those in need of support?
	Probe on the following:
	• Using the quick poll function, could you let me know which of the following services that you are aware of…?
	o Counselling services?
	o Rapid access schemes?
	<SHOW BELOW TO JUNIOR DOCTORS ONLY>
	o Wellness and recovery action plans (WRAP)?
	o Therapeutic return, phased returns and return to work plans?
	o Return to work interviews?
	o Reasonable adjustments? Reduced working hours etc.?
	o Provision of other resources such as dedicated helplines or telephone support, voluntary sector support, financial support etc?
	• Has anyone personally had any experiences of using any of these services?
	• *If yes:*
	o Which ones did or do you access?
	o How readily available or accessible did you find each?
	o How long did it take you to receive support?
	o What could be improved specifically?
	• Do you consider the processes and systems in place to be sufficient? In your opinion, how could they be improved?
	• Is there anything else that you feel should be available to you and your colleagues to manage mental health conditions and symptoms?
	• Where would you expect these initiatives to come from / who should provide them?

(IV) Final Thoughts	**10 mins**

Summary/ round up	For the last few minutes, I would like you to reflect on all of the ideas we have talked about, and come up with 2-3 key messages or actions that you would like us to convey to the BMA on this subject?
	
	The BMA is in the early stages of developing a wellbeing charter for doctors and medical students in the UK to set out what level of support it expects to see in places of work and learning – do you think this would be helpful? Is there anything else the BMA should do?
	
	<Allow all respondents to answer>
	
	Any other thoughts or comments?
	
	Thank you very much for your time this evening – it has been exceptionally useful and helpful. I hope you've found it useful too.
	
	On the whiteboard are a list of charities and organisations who you can speak to confidentially about your mental health issues.
	
	<ADD BELOW LIST TO WHITEBOARD>
	
	• Anxiety UK: https://www.anxietyuk.org.uk/
	  03444 775 774
	• Beat: https://www.beateatingdisorders.org.uk/
	  0808 801 0677
	• Bipolar UK: https://www.bipolaruk.org/
	  0333 323 4008
	• DocHealth: https://www.dochealth.org.uk/
	  020 7383 6533
	• Doctor's Support Network: https://www.dsn.org.uk/
	• GP Health Service: https://gphealth.nhs.uk/
	  0300 0303 300
	• Mental Health Foundation: https://www.mentalhealth.org.uk/
	• MIND: https://www.mind.org.uk/
	  0300 123 3393
	• NHS Practitioner Health Programme: https://php.nhs.uk/
	• SANE: http://www.sane.org.uk/
	  0300 304 7000

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