“Investigation of Junior Doctors’ Contact with an Occupational Health Department and their Transitional Year”

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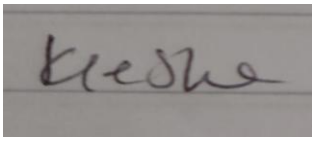
Signed K Leslie 

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Finally, I thank my late grandfather and the F1s in this study to whom I am truly grateful.

List of Abbreviations

OH	Occupational Health
MH	Mental health
PH	Physical health
MHW	Mental health and well-being
HWB	Health and well-being
GMC	General Medical Council
TOI	Transfer of Information form
HEE	Health Education England
AT	Attachment theory
CFT	Compassion focussed therapy
TR	Therapeutic relationship
FU	Follow up
STS	Secondary traumatic stress
CS	Compassion
SW	(South-West)
GP	General Practitioner
TA	Thematic Analysis
IPA	Interpretative phenomenological analysis

Abstract

Background and aim; This thesis examines the mental health (MH) trajectory of Foundation Year junior doctors (F1s) in their first year of clinical training and the role of Occupational Health (OH).

There is limited research in this field. A literature review identified that OH is often poorly utilised (Cohen et al, 2016), and no literature examined the role that OH might be able to offer for this year group has not been examined. There is a poor understanding of how best to emotionally support doctors in general, specifically F1s, to sustain their mental well-being, reduce their suicide risk and address any factors that might be associated with these phenomena (Brooks et al, 2011).

Methodology: Thematic Analysis (TA) was the qualitative method used for this research and semi-structured questionnaires. A sample of ten F1s who had self-declared as experiencing or having had health conditions (both MH and with a physical health (PH) condition impacting on MH) were interviewed twice: once at the beginning (T1) and once at the end of their first year (T2). Interview questions explored experiences of the transition year, OH and of screening as an intervention.

Personal reflexivity is an important part of the methodology, and is discussed alongside the findings of a literature review and the analysis of participant interviews.

Analysis: The analysis identified themes across the T1 and T2 interviews. The following themes formed the basis of the T1 interviews:

1. Health seeking behaviour and OH
2. Internal world of doctors
3. External world of doctors -the transition and changes experienced by doctors.

4. Professional guidance, policy and politics.

Key themes from the second (T2) interviews were screening and follow up interviews was found to be valuable .The interviews were found to offer an opportunity for individual reflexivity which the doctors found beneficial and supportive.

Main Results: Those with long standing MH or PH conditions came to accept that it was “part of themselves” and something they needed to manage during this transitional period. One of the most notable findings was the importance of having an approachable and consistent individual who was the point of contact for the F1 who would follow them up if they did not attend or missed a session. F1’s contact with OH, they still reported a tendency to feel that they were wasting someone’s time if their mood was low. The findings of this study suggest that OH has a key role to engage with F1s early in the induction process with regards to screening and to recognise warning signs as well as to make contact at times of risk. The research shows that when screening and follow up is offered to F1s by OH for those with a previously known, or current, mental and physical ill health condition it is valued as a worthwhile intervention

Discussion: This study additionally explored the findings relating to OH specifically through the lens of psychoanalysis. A hypothetical working model was developed, using the work of Steiner (1993) and Jaeggi (2014) in particular, to understand what is happening to F1s as they progressed through the year. This offers a novel contribution to existing literature.

Limitations: This was a time limited study with a small, self-selected sample size. This study could be repeated across a larger population.

Conclusion: This research makes a novel contribution to understanding the challenges in delivering good OH clinical support to F1s in a system where stigma concerning MH issues, still operates. This study indicates that OH has a key opportunity to support F1s early in their clinical year to promote and enhance their health and well-being during the

transitional period to Foundation Year Two (F2). Screening as intervention offered this group of F1s the opportunity to build an ongoing relationship with OH to facilitate their continuing well-being in a multitude of ways. These include recognising the importance of the “secure base” OH provides, and allowing for ease of access to a key contact in OH and the opportunity to build a relationship with this contact who might recognise signs of declining well-being and “reach out” if an F1 fails to attend appointments. Other important findings for OH were that these F1s gained insight and acceptance of MH conditions and increasingly drew on the potential of OH to provide a ‘reflexive space’ to support them as they transitioned to F2 and to facilitate work adjustments if necessary. These findings can be used by OH, to support the health and well-being of F1 who have a high prevalence of MH with associated risk factors (Brooks et al, 2011)

Recommendations for future research: further use of clinical diagnostic tools (e.g PHQ9 & GAD7) to monitor HWB of F1 during the screening FU process.

Keywords: Occupational Health, mental and physical health, support, transition, Foundation Year 1 doctors, junior doctors.

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Chapter 1: INTRODUCTION

1.1 Background

This thesis primarily aimed to understand the MH trajectory of F1s in their first year and the role of OH; disclosure of a MH or PH condition was not the focus. Clinical practice within OH instigated my desire to investigate the possible role that it had in improving the health and well-being (HWB) of F1s, irrespective of current mental or PH status. It is impossible for OH to have a role if F1s are not granted access, or do not know about the role of OH. The only way currently for OH to access F1s is via screening those who are unwell. It continues to be a challenge to access individuals who have never disclosed to anyone, have not necessarily accessed OH support before and may appear to be well. Gaining the input of those who have never attended OH before would therefore be a valuable step in future work. This thesis focuses on MH disclosures and OH experiences of workplaces and medical school, but some participants also spoke more generally of disclosures outside of the workplace or medical school, such as to MH professionals or friends and family, especially when at a particularly “low ebb when they had felt too low to ask for help or lacked insight. The thesis asked participants about resilience in terms of HWB. Core topics were covered via face-to-face interviews.

1.2 Significance of the Problem

I am registered as an Integrative Psychotherapist and work in the OH Team based in an Acute Hospital in the South-West of England (SW). This thesis arose from my work in clinical practice where I am head of a psychological service for National Health Service (NHS) staff. This service is provided under the framework of a countywide OH function. Approximately 1000 staff are assessed annually and then triaged for treatment with myself, one of the counselling team, and/or another OH colleague. Service users may

also be accessing other services, and/or require onward referral to appropriate services such as a general practitioner (GP) or MH teams.

Not all staff who are unwell present to OH. This is particularly true of doctors who fear confidentiality breaches or who have other reasons (Luthy et al., 2004). There is no proactive routine screening of staff that might be affected by workplace challenges within the workplace or upon entering it.

According to a GMC (GMC, 2015) report F1s often enter into clinical practice and employment, from medical school with a diagnosed MH condition; the most common being depression, anxiety disorders, eating disorders and substance misuse. The F1s in this study were self-diagnosed (p,137).

Both of these conditions have been found to be consistently higher than in the general population (Beyond Blue, 2013; Dyrbye, Thomas, & Shanafelt, 2006), and are thought to develop during medical school (Thompson, McBride, Hosford, & Halaas, 2016). A systematic review estimated the prevalence of suicide ideation among medical students to be 11% (Rotenstein et al., 2016). Anecdotally, these doctors seemed to present in OH requiring psychological support during the first years at F1, and then F2 noted as experiencing difficulties (Pitkala et al., 2003; Lemp et al., 2004; Luthy et al., 2004). Luthy et al., 2004 found that the symptoms of stress and exhaustion were highest in the first year. The 2018 General Medical Council (GMC) national training survey found that almost a quarter of junior doctors in training experience burnout because of their work. A previous survey suggested that F1 and F2s experience the lowest overall satisfaction. Suicide rates among doctors, particularly junior doctors, are increasing and are two to five times higher than the general population (Gerada, 2018). Within the SW there has been an alarming rise in F1 suicide rates which has had a devastating impact for all concerned (Phillips, 2019). There is a poor understanding of how best to emotionally support doctors – F1s in particular, to sustain their mental well-being (MWB), reduce

their suicide risk and address any factors that might be associated with these phenomena (Brooks et al., 2011).

I set out to understand the role that OH played for this group and whether it could be enhanced.

1.3 OH and the Team

The OH participating in this study is run by an Acute Trust and provides a shared service across the County to all NHS trusts and other contractors. It is one of the smallest teams in the UK consisting of Multidisciplinary Specialists and non-specialist OH professionals including a Consultant, Specialist Nurse, Physiotherapist and administrative members required to deliver the OH requirements of the service provision.

OH accepts an average of 1000 psychological based referrals alone annually (2018–2019) from managerial and self-referral routes. OH undertakes pre-employment assessments to determine an employee's fitness for work. It can therefore be seen that OH, as gate-keeper or supportive service, has a key opportunity proactively to offer support to those F1s who disclose a mental or PH problem on their mental pre-employment form and or to support them if they are referred via either route at a later stage. This support depends upon the processes being in place and working relationships being effective. It also depends upon OH being the entry point for all pre-employment screening forms.

1.4 F1 Entry to the Hospital

Universities have formal responsibility for confirming that doctors at the end of F1 are eligible for full registration (The Medical Act, 1983). The transfer of Information (TOI) processes are a means of achieving this and supporting medical students during the transition from medical school to foundation school, and during the F1 year, until the

point of full registration with the GMC. At the time of thesis, F1 pre-employment checks were undertaken by the postgraduate centre via their TOI forms. These were not shared with OH who also undertook a pre-employment screening process but F1s might not declare MH or PH conditions. For these reasons there was often a discrepancy between the data shared with OH regarding an F1s mental or PH upon entering the hospital and starting work. This meant that OH was unable to perform its' duty to protect and be proactive in its support of F1s. It was requested that this process be altered and the TOI form be shared, with the F1's consent, the year prior to the start of this project. PH can affect MH and so data sharing, with consent, was agreed for both these disclosed conditions, given concerns.

1.5 Key Issues for F1

For the purposes of this thesis, a junior doctor is any qualified doctor below Consultant or GP still requiring supervision (BMA, 2021). The transition from medical student to junior doctor has long been considered a significant rite of passage (Blackwell, 1986) and is frequently experienced as stressful (Pitkala et al., 2003; Lemp et al., 2004; Luthy et a.l, 2004). Inadequate preparation during medical school, poor support and education for newly qualified doctors as they first enter clinical practice have been identified as contributory factors to this stress (Luthy et al., 2004; Lambert et al., 2015; Brennan et al., 2015). Goldacre et al., (2003) reviewed the literature on doctors' views of their first year of medical work and found that symptoms of MH problems, particularly depression, were highest as an F1. Individual factors such as family background, personality traits and workplace pressures, e.g., perceived overwork, emotional pressures, "Life cycle factors" (Carter & McGoldrick, 1989, Berge et al., 2012) or concerns relating to attachment theory (Ainsworth & Bowlby, 1991; Atwool, 2006; Adshead, 2010) such as leaving the security of medical school (Baptiste, 2016) are often predictive of future MH problems. F1s no longer operate within a team of medical colleagues known as "firms"

which in the past may have served to provide a “secure base”, mitigating experiences of poor social support and isolation (Adshead, 2010). Finally, when F1s change jobs there can be confusion regarding who is supporting them with health issues (Cohen, 2015). OH is mentioned within the key literature, often indicating that doctors have knowledge of OH but do not necessarily engage with the service when required (Cohen et al., 2016).

1.6 Role of OH

Key roles of OH are to ensure that staff are safe to practise, fit to work and that the environment they work within facilitates this. This includes managing any risks to injury or health in the workplace (Health and Safety at Work Act, 1974).

The World Health Organisation (WHO) proposes that:

“Occupational health deals with all aspects of health and safety in the workplace…including risk factors at the workplace, musculoskeletal diseases...stress related disorders… working hours, salary, workplace policies concerning maternity leave, health promotion and protection provisions.” (WHO, 2020)

OH has a preventative workplace function. Employees’ MWB is of paramount importance and a primary responsibility of all organisations (Sharma & Kumra, 2020). There is a growing interest in the concept of MWB among employers owing to its multiple benefits (Burford et al., 2017). Improved MWB makes employees good at decision-making, productive and resilient. It enhances capacity to manage uncertainty and change. These benefits ultimately culminate in reducing attrition, health care costs and attaining organisational objectives (Hillier et al., 2005). Today’s complex and dynamic business environment necessitates employers being proactive in ensuring MWB. People suffering from MH problems are as high as 13% of the world’s population (James et al., 2018). There is a burgeoning interest among researchers to understand

the antecedents of employees' MH and well-being (Spell and Arnold, 2007, Boorman, 2009). In this context, this thesis focuses on resilience, the need for recognition and self-compassion and their impact on F1s' MWB.

Several recent government-commissioned reports have examined the role of HWB in the workplace (e.g., Dame Carol Black's Working for a Healthier Tomorrow: Work and Health in Britain). Dr Steve Boorman's (2009) report raised a number of concerns about the provision and accessibility of OH services, the considerable quality variation, uncertainty over the role and function of OH services and inadequate funding and resourcing. Interviewees also raised concerns about senior management and board engagement with staff HWB. HEE (HEE, 2019) recommends that OH potentially have a pivotal role to play in shifting these imbalances.

My perception was that OH was not creating this "safety" aspect of the OH role for junior doctors and could be more proactive (HEE, 2019).

OH has a role to support staff and protect them (WHO, 1950). My clinical experience and the literature review identify that OH is often poorly utilised (Cohen et al., 2016), and there is a poor understanding of the most appropriate support for F1s and the factors influencing these phenomena. Many doctors go on to develop MH conditions throughout their career for example, depression, anxiety, addiction to drugs, burnout and suicidal thoughts (Brooks, 2011; Baptiste, 2016). PH is well documented (Cohen et al. 2016). These findings informed my view that a better understanding of the needs of F1s was necessary. How this could enhance the ability of OH to provide a proactively supportive or preventative role for F1s as well as for other doctors will be considered later.

1.7 OH and Stigma

The significance of the problem is briefly considered in context of organisation, its background and culture. Clinically, my experience of OH is that it can be stigmatised as

somewhere that an individual “gets sent to” because of illness, or as a result of having made an error (Smith et al., 2016). Avoidance of OH is often compounded by the stereotypical concept of the doctor who is a perfectionist and a *strong* individual, who is more likely to deny stress and utilise maladaptive coping strategies such as alcohol (Crawford et al., 2009; Baptiste, 2019; Jackson, 2021) rather than risk the stigma of approaching OH for support (Cohen, 2016).

Whilst the existence of my role in OH is to support NHS staff, I am aware that this attitude prevents some individuals seeking help when it is required (Henderson et al., 2012). Recently, OH departments, informed by systemic organisational culture and psychodynamic theory, are seeking to alter this view by improving the quality of training of OH staff (Cohen, 2014) so that doctors who require professional support can be viewed as *patients* (Lalloo, 2013).

1.7.1 Shame

Shame did not get mentioned overtly within the interviews it was covertly present. Its relevance to this thesis is worth discussing briefly.

1.7 2 Healthy Shame

Whilst shame is a negative experience for an individual, it is a normal and necessary part of human life.

Healthy shame can manifest as positive attributes including modesty, humility, gratitude, respect for self and others. Healthy shame can be a potent motivation for personal growth and as well as developing meaningful relationships with others (Sanderson 2015; Ng 2020) and setting important boundaries for prosocial behaviour.

1.7.3 Social Function of Shame

A related concept is that the positive catalytic function shame can serve motivating individuals to seek help. It prevents us damaging our social relationships and can motivate us to repair them (Sznyncer et al., 2018). History demonstrates that societies have universally made use of shame to express their values and enforce expectations for how their members ought to behave toward one another irrespective of wrongdoing or morality (Sznyncer et al., 2018, University of California (2018). According to recent studies in evolutionary science, human beings developed the ability to feel shame because it helped promote social cohesion. Sznycer et al. (2018) believe that much of the social function of shame relates to times when our survival depended heavily on close cooperation and adherence to tribal expectations for behaviour inherited emotions, including shame. Members who violated the rules would be shunned and shamed; fear of this encouraged members to obey the rules and work together for the "greater good". This behaviour is still evident in society today (Henderson et al., 2012). Knowledge of this research is a motivational force behind this thesis. It affords OH an opportunity to underpin an organisation's HWB agenda by supporting cultural change by reducing the stigma associated with MH and preventing further alienation or fatalities (Gerada, 2018) of those who are as yet unsupported.

1.7.4 Maladaptive and Toxic Shame

According to Stephen Pattison (2000), these usually occur in a chronic form. Pattison writes: "There is an enormous difference between acute, reactive shame and the chronic shame that shapes a whole personality and may last a lifetime. When individuals appear to experience the whole of life as actually or potentially shame-productive and manifest such symptoms as withdrawal, self-contempt, inferiority, and gaze aversion as a matter of course throughout their everyday lives, shame has become pathological and chronic." (Pattison, 2000, p. 83). Pattison (2000, 85) suggests that

chronic shame can be characterised by a “shame attitude” – one’s entire personality and character is structured around shame and shame avoidance.

Shame avoidance can take many forms and will be considered further in this section. It often involves conscious and unconscious coping strategies to avoid situations where it is anticipated that shame may arise (such as encounters with professionals –clinical supervisors, or situations where one may have to reveal something ‘shameful’ e.g., poverty, ARCP, addiction, trauma, fear of scrutiny with F1 e-portfolio)

Maladaptive (or toxic) shame can lead to behaviours and actions that are personally and socially harmful. Research demonstrates links between shame and Domestic abuse, Sexual violence, Addiction, Eating Disorders, Self-harm and suicide. All of which, but specifically the last four of which have relevance to medicine (Gerada, 2018; GMC, 2015).

1.7.5. Shame and Anxiety

Chronic shame is commonly characterised by the persistent possibility of shame-although generally shame itself is not necessarily realised in experience (Dolezal, 2021). Pattison and Dolezal (2000, 2021) research has found that instead individuals have an over-developed sense of anticipated shame, or a persistent and heightened “shame anxiety,” of which an individual may, or may not, be aware. This underlying shame is pernicious in that it dominates experience, manifesting as a corrosive, undermining and persistent fear or anxiety about being objectified, judged, labelled, and rejected by others; it is a persistent “fear of disgrace and being looked at by others with contempt” (Wilson, Droždek, & Turkovic, 2006, 125). .

1.7.6. Shame is Elusive

Chronic shame is difficult to identify and ‘diagnose’ because it is difficult to observe. Dolezal (2021) research indicates that externally, observers might notice, a fearful, shy,

hesitant, nervous, embarrassed individual who avoids eye contact, be evasive or defensive.

An individual's behaviour and actions will be shaped and guided by shame avoidance, when this is harmful, seem irrational or illogical. The relational psychotherapist DeYoung (2015, xii) proposes that it is an elusive experience that is often 'camouflaged' by other experiences and feelings. This is because those suffering from chronic shame, "may not daily or consciously expect to be annihilated by shame. However, the threat is always around somewhere, just out of awareness, kept at bay" (DeYoung 2015, 19) Bradshaw agrees noting, "everything is organized around preventing exposure" (Bradshaw 2005, 139).

1.7.8 Shame Avoidance

Shame indicates weakness, flaws, and vulnerability. Consequently, shame itself is shameful and taboo. Individuals go to great lengths both consciously and unconsciously to avoid shame- it often feels "critical" to avoid it. Pattison (2000, 83) writes, individuals who experience chronic shame "live their lives trying to avoid occasions and relationships that might provoke painful shame experiences." Shame, therefore, often becomes invisible- with an individual's experience being dominated by other behaviour or feelings, which help avoid, mask or cope with the pain of shame. As a result, living with chronic shame can lead to a range of compensatory behaviours; these are powerful strategies, or rules and habits of interaction, which make it possible for an individual to avoid the social threat, pain and emotional anguish that comes with shame.

1.7.9 Psychoanalysis and Shame

Freud first discussed the "painful affect" of shame in the context of an individual's fear of being exposed, denuded, the role of seeing and being seen and possible resistance (Freud, 1896, p. 170; 1916– 17a, p. 53). Shame has remained a recurrent theme within

psychoanalytic practice ever since (Weiss, 2016). Initially Freud considered it an expression of infantile sexual curiosity (Freud, 1905, p. 157), or a derivative of the super-ego and heritage of the Oedipus complex (Weiss, 2016).

There are various contemporary influences upon psychoanalytical thinking about shame. I focus on Steiner (2006, 2011) as his comprehensive Kleinian perspective on shame has relevance to this research. His contribution “Seeing and Being Seen: Shame in the Clinical Situation” summarizes the main arguments derived from his theory of psychic retreats (Steiner, 1993). Steiner’s formulations include shame as an experience which emerges when the patient leaves the protection of a narcissistic organization, the idea of a spectrum of shame experiences, ranging from shyness and embarrassment to humiliation and degradation, the role of the eye as a means to reverse the direction of gaze and to project shame into others, the relationship between shame and guilt in the Oedipal situation, its relation to the paranoid-schizoid and depressive positions, and finally the significance of shame in the transference and counter transference (Weiss (2016). This is significant for this research.

1.7.10 Alienation

A shame-related concept is alienation. Jaeggi’s (2014) concept of alienation was “resurrected” for social criticism when the previous theorists’ (Rousseau and Hegel, Marx, Kierkegaard & Heidegger) work had lain dormant for some time. Marx considers alienation as a social and economic phenomenon, whereas Kierkegaard and Heidegger treat it as an individual condition of inauthenticity. It is the latter tradition that Jaeggi (2014) follows. Jaeggi’s (2014) “reconstruction of the concept of alienation” (Sayer, 2018) and her focus, which is almost entirely on moral questions about the self and authenticity, is of relevance for this thesis.

Alienation is concerned with the ways in which we appropriate ourselves, the world, with others, and how we may fail to do so. It manifests itself as two inter-related concepts: a loss of meaning and as powerlessness Jaeggi (2014). Alienation is “relation of relationlessness” (Jaeggi, 2014). Jaeggi (2014) argues well that inauthenticity is concerned with an inability to be true to oneself, suggesting that this is as a failure to develop a determinate self rather than division of the self into “true” and “false” parts. Finally, she insists that the self is social and it is on this basis that the concepts of alienation and inauthenticity must be worked out Jaeggi (2014). Alienation, inauthenticity and social functions of shame will be discussed further in the discussion chapter. Criticisms of Jaeggi’s (2014) theory of alienation include that it avoids the problems of traditional theories of alienation: objectivism, paternalism, essentialism and the post-metaphysical agenda (Evans, 2021, Sørensen (2019). Both authors posit that this reflects some crucial displacements of contemporary critical theory rendering Jaeggi’s (2014) theory too ideological. However, for the purposes of this thesis it provides an alternative lens through which to view authenticity which is beneficial.

1.7.11 Cost Implications of Shame

Various costs are incurred related to shame of shame such as economic and psychic Some that are relevant to this thesis are considered below.

Stearns (2017: 114) writes that shaming is a cost-effective punishment tactic, in contrast to the high costs involved in incarceration in the prison system more generally. However, research has shown that shaming strategies often ‘backfire’ (Nussbaum, 2004, 227–250), and that very specific social conditions are needed for shaming to be re-integrative, rather than disintegrative (Braithwaite, 1989). Shaming punishments can exacerbate pre-existing shame and maladaptive responses to it in those who are shame-sensitive (Matthew Gibson, 2015, 2019) it has the potential to cause an individual more harm than good (Matthew Gibson, 2015, 2019). Therefore, the impact of

toxic and maladaptive shame might have implications for OH who could utilise this information to support F1s with their HWB requirements.

1.8 OH and Attachment Theory

This qualitative research is influenced by Attachment theory (AT) (Ainsworth & Bowlby, 1991: Atwool, 2006; Adshead, 2010) and my subjective experiences of working with F1s in the current healthcare culture and political climate (Triggle, 2016), rather than empirically measured attachment style.

AT stemmed from pivotal work in the 1940s and is rooted in informed ethnology and psychoanalysis. It examines the relationship between the infant and the caregiver rather than the individual characteristics of either party (Ainsworth & Bowlby, 1991). It has been described as a relational theory of human development and makes a significant contribution to the development of theory and practice in the field of clinical psychology and psychotherapy (British Psychological Society [BPS], 2007; Mikulincer & Shaver, 2018). Atwool (2006) argues that the quality of attachment relationships is fundamental to four specific areas associated with resilience: supportive family, individual personality, positive connections, and culture (Atwool, 2006).

Many F1s who consult OH in the Trust have little support available locally and anecdotally describe poor relationships with their families. Research that examines OH function for this group might enable development of theories about this transitional year contributing to possible correlations between this and the well-being of F1s.

1.8.1. OH as a Secure Base

This thesis is influenced by the related concept of a secure base which is rooted in AT (Ainsworth & Bowlby, 1991: Atwool, 2006; Adshead, 2010). OH serves to position itself as a service which is integral to an organisation to support staff in the workplace, yet simultaneously seeks to distance itself from the organisation to indicate a “protective”

confidentiality to employees so they feel able to access the support. This tension may inadvertently undermine OH's position as a 'secure base' (Ainsworth & Bowlby, 1991) for individuals who are sceptical that OH can maintain confidentiality as it attempts to operate both within and outside the organisation in which it resides. This scepticism may encourage individuals to seek alternative support services outside OH or for their health to decline.

Anxiety during the infant's period of absolute dependency is crucially managed by the vital attachment figure (Alwood, 2006). Ainsworth (1979) understood that the attachment figure develops the ability to tune into the infant and respond appropriately – ''sensitive responsiveness'' – helping the infant to form secure attachments. It is this that enables the infant to explore the world (Ainsworth, 1979) and which can serve to promote self-confidence, security and protect the individual in later life, fostering the ability to cope with separation and adversity (Harvey & Delfabro, 2004). Bartley et al. (2007) note that much of this work has resulted in observations that family relationships in childhood and later are key to positive HWB.

Bowlby (1988) believed a developing person needs a 'secure base', often provided by the family, to help the eventual adult to explore the outside world (Waters, Crowell, Elliott, Corcoran, & Treboux, 2002). It seems possible that such a secure base is just as vital for junior doctors when they arrive at a new hospital. It is possible that such a secure base is just as vital for junior doctors on arrival at a new hospital and throughout their F1 year, and that the postgraduate centre, OH can contribute to part of a secure base.

Attachment and resilience are often regarded as distinct concepts within the literature. Both have been found to have an impact upon well-being (Bartholomew & Horowitz, 1991; Allen & Land, 1999). As Atwool observes: "… *the concepts of attachment and*

resilience should be regarded as complementary and [that] each is strengthened by such an approach" (Atwool, 2006, p. 315).

Atwool (2006) considers the research exploring connections between attachment and resilience in depth in her paper. This includes the issue of underlying mechanisms pointing to the importance of *"secure and harmonious love relationships" and "success in accomplishing tasks"* (Rutter 1994). Secure attachment style is associated with self-regulation, healthy narcissism, ability to mentalise (Fonagy et al, 2001), to cope with stress, and maintain self-esteem and resilience throughout one's life (Holmes, 2010).

Bartley et al. (2007) consider that secure attachments offer a protective *'resilience factor'* evolving in infancy. When faced with risk and adversity, it is perceived as enabling an individual to effectively regulate and mitigate the strength of emotional responses to adverse health or personal events (Bartley, 2007). Secure attachments are therefore likely to be of relevance to students in terms of a supportive environment in which to sustain resilience.

Within medicine, it would seem that 'resilience' requires further defining as debate remains regarding definition, operationalisation, and its measurement (Bottrell, 2009). However, it is not within the scope of this thesis. For a comprehensive overview of resilience, it is worth referring to the "Handbook of Adult Resilience" (Reich, Zautra, & Hall, 2010).

In line with AT, the therapist as caregiver needs to be attuned to the client's emotional needs, and to provide a safe haven and secure base in the therapeutic relationship (TR) from which to explore the rupture and repair of relationships and painful emotions (Bowlby, 1988). Therapists' willingness and ability to become that secure base affects clients' sense of attachment security (Bowlby, 1988). In psychotherapy, providing a safe environment and secure base is important for the client's development of a secure attachment to the therapist and for efficacious therapy (Bowlby, 1988; Mikulincer,

Shaver, & Berant, 2013). In the TR clients and therapists project their Internal Working Models (IWM) onto one another (Bowlby, 1988), triggering their emotional arousal and ultimately affecting their ability to mentalise (Appendix1). Attachment theory is a lifespan theory that applies to all important relationships and contexts (Landa & Duschinsky, 2013). Aspects of these relational dynamics possibly occur in the OH client TR and influence the therapy process and outcome (Mikulincer et al., 2013, Gilbert 2014, Costello, 2020). Whilst the workplace is not a therapeutic environment, for some F1s, it may at times be the opposite: a place where they experience and seek to deal with fear, shame and anger (Costello, 2020), particularly during times of stress. OH, which has access to psychological support, might be one place that has a role to play in supporting F1s at such times. Whilst OH involvement might not be able to replicate some of the longer term psychological therapies it does have access to psychological support and therapies (cognitive behavioural, psychotherapy, psychology). Within these approaches elements of TR may be available to those accessing some OH services.

1.9 Secure Base: Containment, OH, and Psychoanalytic Theory

In the case of this thesis, a useful metaphor might be that OH is a safe base and so may be seen as a container to support staff when ill, offering a place for unpalatable emotions for either the self (Jaeggi, 2014) and or organisation. This can allow rehabilitation and re-integration of the self and into one's community (Jaeggi, 2014) in preparedness for work (WHO, 2020). The concept of a container is widely used in psychoanalytic psychotherapy and has theoretical relevance to both the psychoanalytic theory of the mind and to cognitive science.

Rosenbaum and Garfield (2001) write at length on the use of metaphor, mental space, psychodynamics and containers bringing psychoanalytic theory of the mind and cognitive science together as one model. They note that experimental evidence supports the hypothesis that an image-schematic level of cognitive processing plays a

fundamental role in an individual's ways of understanding and experiencing the world, themselves and others (Johnson, 1987; Lakoff, 1987; Sweetser, 1990). *Bions Reverie* (Vaslamatzis, 2012) is a necessary state for containment. Moreover, it has a long history in psycho-analytic descriptions of psychopathology (Bion, 1963, 1967; Meltzer, 1992; Steiner, 1993; Tustin, 1981) as well as in the psychotherapeutic field.

1.9.1 Secure Base: Containment, Bion, OH, Healthy Doctors, and Patient Care

Psychoanalytically, unconscious processes can serve to undermine an individual's ability to function competently within a healthcare setting thus having the potential to negatively impact patient care (Obholzer & Roberts 1994). *Bions Reverie* (Vaslamatzis, 2012) is a useful concept to theorise what might happen relationally (Costello, 2020) in OH. These ideas will be expanded in the next paragraphs. Bion (1963) describes the thoughts, felt sensations, images, sounds and feelings that go through the mother's mind in response to a distressed child and its developing insight into the internal world. Similarly, if a therapist enters a state of reverie, they gain insight into the world of the patient (Vapenstad, 2014). Through developing the state of reverie understanding is acquired about how the patient projects onto the therapist, and vice versa.

When working with F1s psychologically, OH aims to provide a space where thinking can take place. F1s tend to provoke practitioners into action and so 'containment' is an essential part of the work (Bion, 1984). Bion's concept of containment includes emotions and parts of the self and can be defined as follows: Containment is thought to occur when one person receives and understands the emotional communication of another without being overwhelmed by it, processes it and then communicates understanding and recognition back to the other person. This process can restore the capacity to think in the other person (Douglas, 2007, p. 33). Individual members of staff, plus the organisation as a whole, the professional networks along with the other ideas and concepts discussed in this section, might provide this containing function for F1s. The

provision of screening by OH, culture, organisation dynamics and previous MH challenges, highlight just some of the complexity when OH is presented with opportunities for supporting F1s. It is the combination of these ideas and working practices that create the therapeutic environment (Rose, 1999).

1.10 Relational Approach

The research undertaken for this thesis also draws on Costello's (2020) Relational Approach to workplaces. Costello's theory is grounded in the humanistic tradition emphasising empathy, congruence acceptance of self and other. It also unifies both compassion and self-compassion with a desire to support individuals to thrive (Costello, 2020). According to Costello, the values of the Relational Approach can successfully be transported from therapeutic arenas to the workplace and vice versa (Costello, 2020), [reversed order of sentences and combined] and it is possible for staff to adopt a code of conduct or attitudes to enhance working relationships characterised by mutual support, interdependency and trust (Costello, 2020). Given that the role of OH within the organisation is to provide support to staff, OH can offer relational skills therapeutically. Self-compassion, whilst not vital, can be enhanced if the subject is in receipt of an authentic relationship, which might also support the self-care essential for resilience when working in stressful environments. Through the use of a Relational Approach (2021), the secure base provided by OH can offer a place for the development of self-compassion. The role of OH is to provide support to staff within the organisation and offer relational skills when required in the form of therapeutic interventions. These may be delivered by a psychological therapist and intervention (e.g., compassion based therapy), or one to one contact during FU post screening over an agreed time period of one year and number of monthly sessions. This thesis has drawn on theories which may help inform the development of relational skills in F1s.

Nettleton et al. (2008) claim that doctors struggle to maintain a balance between having to perform as objective, competent medical clinicians whilst having to be simultaneously sensitive, caring, and emotionally intelligent. The GMC (2013) values these interpersonal skills which Nettleton et al. (2008) believe represents a form of emotional labour. These demands from patients and the workplace are particularly evident for F1s during the transition from student to doctor during this crucial year. It is often a time when they require assistance with developing the coping skills they need (Bu, 2019). Several studies have also demonstrated a link between burnout in doctors and reduced patient safety (Hall et al., 2016, Hall et al., 2017). Dyrbye et al. (2016) claim F1s report higher rates of depression and burnout even before they qualify as doctors (Ishak et al., 2013). Given the high rates of burnout and depression in F1s, and observed links between doctor stress and patient safety in this transition period, there is a need to develop diverse approaches to support F1s. This includes increasing the compassionate support from OH.

Developed by Paul Gilbert CFT is a lens through which to understand human thought, emotion, motivation and behaviour. At the heart of CFT is an evolutionary model of human motivational systems. Gilbert (2014) proposes a simple evolutionary model of human behaviour, comprising three types of affect regulation system (Gilbert, 2009, Fig.1). The model outlines how emotions interact and why and how compassion can affect and balance other emotions. According to the theory, our experiences of emotions and desires emerge from the patterns they create in our brains and bodies. The aim is to achieve balance so that we have a rich and fulfilling life. We experience well-being and resilience when we move between the three systems freely according to our situation and needs.

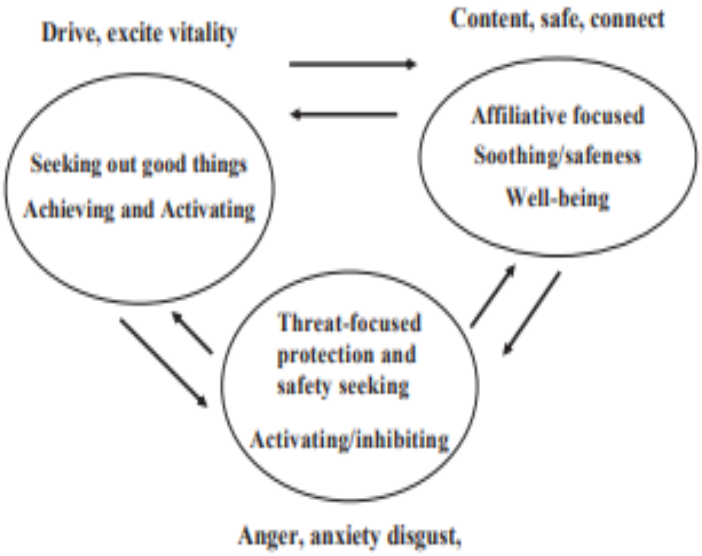

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Figure 1. Three types of affect regulation system. From P. Gilbert (2009). The compassionate mind. With kind permission from Constable Robinson

The Threat-Defence System ensures our survival and is activated when we perceive danger or threat. If overly activated it can contribute to excessive feelings of anxiety, and insecurity. If in doubt the individual may fear, attack, feel disgust or run away.

The Drive System motivates and energizes individuals to seek, to engage with the world, to meet perceived needs.It activates the reward centre, prompting the individual to action, to seize opportunities, to take on challenges and to accomplish..

The Soothing System leads to feelings of calm, warmth and contentment. It creates experiences of safeness, comfort and ease. These feelings are usually experienced as pleasurable due to feelings of affection and a sense of being connected to another, of belonging, being accepted, supported, cared for and valued by others. This powerful

system can moderate the other two systems of Drive and Defence when they are overly active.

According to Gilbert (2014), CFT is informed by evolutionary functional and social analysis that posits that people are motivated by certain factors; for example, they like to live in groups, share alliances, care for kin and operate within a hierarchy. In his article, “The origins and nature of compassion focused therapy” (2014), Gilbert outlines the principles behind the development of CFT and the benefits of training individuals to develop compassion-based skills. These have relevance for OH and include:

1) Seeking and responding to care. The human brain is particularly shaped and evolved for social processing. This is important when understanding current social contexts central to understanding MH problems. Mammals [or humans] developed motives and competencies to seek out and elicit care and to be responsive to being cared for, helped, supported, and encouraged by others because benefits. These include: attachment, interpersonal closeness, safe base, (Bowlby, 1969, 1973; Cozolino, 2007, 2013; Mikulincer & Shaver, 2007), affiliation and sense of connectedness (Cacioppo & Patrick, 2008; Wang, 2005)
2) Relationships, self-shame (Kim, Thibodeau, & Jorgensen, 2011) and self-criticism (Kannan & Levitt, 2013). These underline a wide range of mental health problems (Gilbert & Irons, 2005).
3) Desbordes et al(2013) have reported physiological and psychological benefits of compassion based-training.

Developing self-compassion is essential for F1s in order to self-care for example, their patients. Neff (2003, p. 87) defined self-compassion as:

"... *being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness*."

Jazaieri et al., (2014) report that self-compassion motivates individuals to adopt a compassionate mindset-a caring attitude towards themselves amid individual shortcomings and failures. Individuals with high levels of self-compassion experience fewer negative emotions when faced with adversity, are much more objective in understanding adverse life events (Neff and Vonk, 2009), are less likely to self-harm and have reduced suicidal ideation (Cleare et al., 2019). It also appears to have a protective function in individuals' psychological health.

In view of the reported high levels of MH illness in F1's and lack of insight into the MH when unwell, the ability to seek areas offering compassion and develop self-compassion has relevance for OH.

1.10.1 Schwartz Rounds

One way of enabling the development of compassion and self-compassion in F1s is by encouraging attendance at Schwartz Rounds. These Schwartz Rounds were established in America in 1997 to maintain compassion in healthcare communities Lown, (2018). Schwartz Rounds often provide the only community reflective space where staff from all parts of the organisation can share stories honestly, safely and confidentially and reflect about the work undertaken safely and confidentially (Lown, 2018). Attendance demonstrates improved psychological health among Schwartz Rounds participants compared with those who do not attend. This intervention can support the compassion and resilience of F1s helping them deliver compassionate, collaborative care to those who are vulnerable, ill and suffering (Maben et al., (2017). Further information can be found on the website: About Schwartz Rounds - Point of Care Foundation

1.10.2 Balint

Another means of supporting F1s and to develop is by accessing support that facilitates HWB and complements existing services and programs such as the Balint groups. Sir Robert Francis (2013) sought to reduce work stress amongst healthcare workers due to the negative impact upon patient care. The Balint group is probably one of the earliest methods of clinical supervision to be provided for family doctors Salinsky, 2003 (revised 2005, 2011, 2013). While Balint groups offer support for F1s they are not always available and proposes something different to reflective sessions.

1.11 Culture of the NHS

This thesis is influenced by the dynamic cultural context within which it is located.

HWB of NHS staff should no longer be a secondary consideration but needs to be at the heart of the NHS mission and operational approach (Boorman, 2009). HWB is impacted by positive and negative factors affecting productivity and performance, such as work engagement, job satisfaction, occupational stress, and (perceived) organisational support (Soh, Zarola, Palaiou, & Furnham, 2016). Keeping doctors healthy results in improved staff and patient satisfaction and outcomes, as well as reduced sickness, absence and burnout costs (Boorman, 2009).

The NHS is predominantly staffed at weekends by F1 and F2s in the first two years after qualifying as a doctor. Doctors (particularly trainees) are less likely than other healthcare workers to take time off work (Moberly, 2018). An NHS Staff Survey found that, in England, 53% of staff attended work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues, or themselves (NHS Staff Survey Coordination Centre, 2017). F1s often feel their career progression is reliant on more senior doctors for assessments and opportunities in order to develop essential

competencies and a good reference to progress their career. Consequently, they feel pressure to attend work exhibiting presenteeism though unwell.

Long's (2008) book concerning psychoanalysis and perverse organisations explores the harassment, denigration and scapegoating of those considered "weak". Long (2008) conceptualises this as organisations "turning a blind eye" to the culturally accepted norms where the unfit are unaccepted. This will be examined further in the discussion.

NHS England's (2016) commitment to providing OH services nationally to all GP's suggest that proactive OH intervention might have a role in changing negative perceptions and supporting F1s (Cohen et al, 2016). Past political debates concerning strike action by Junior doctors (BBC 2016) and more recently the pressures caused by Covid support this view (Workforce alliance, 2021).

1.11.1 Role of OH within the Organisation and Impact of Stress

More locally, the role of OH is to improve the HWB culture of an organisation. One way to do this is to monitor the stress placed upon individuals by auditing stress levels. Negative stress may adversely affect well-being, impacting their ability to function overall. The WHO (2020) defines workplace stress as:

"*the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope*.

Stress might occur when employees feel they have little support from supervisors and colleagues, as well as little control over work processes...and sometimes it is used to excuse bad management practice".

The WHO warn employers that *"stress can damage an employee's health and the business performance"* (WHO, 2020).

These definitions recognise the wider effects of stress and its manifestation in individuals i.e., having a negative impact upon health (NHS Employers & Zeal Solutions, 2014). Stress is not a medical condition, yet research shows that prolonged stress is linked to psychological conditions such as anxiety and depression, as well as physical conditions such as heart disease, back pain, and headache (Stansfield et al*,* 2000; Smith et al*,* 2000).

Organisationally covert stress related hazards at work can be divided into work content and context. The HSE Management standards are presented in Appendix 2.

Content within the stress standards are those challenges F1s regularly battle with, and are widely reported and are presented within the analysis chapter. These include working hours being too long, under pressure, lack of control, poorly designed shift patterns, work context and content.

WHO proposes that a healthy job is likely to be where:

"*pressures on employees are appropriate in relation to…abilities and resources,...the amount of control they have over their work,...support they receive from people who matter to them. ...a healthy working environment is one in which there is not only an absence of harmful conditions but an abundance of health-promoting ones*" *(*WHO, 2020).

This definition presents OH with an important opportunity to be proactive in improving HWB within the NHS, in particular F1s.

1.11.2 Relationship and Management Standards

I have selected ‘relationship’ from the list of HSE management standards because they indicate that being able to create a relationship with an individual attending an OH department is vital to successful outcome irrespective of need, whether it is an injection, physiotherapy or management in a suicidal crisis. Each individual in this situation is vulnerable and requires a relationship forming so they feel safe, confident in the care given and that their confidentiality will be protected. This is especially so with therapeutic concerns, for example, MH concerns, workplace challenges or whistle blowing. Individuals often seek protection, navigation with their employer and additional support. Being able to build a relationship is, therefore, in my opinion, central to creating a “safe space”, trusting rapport, a TR or whatever OH might provide to an individual seeking refuge and support at any particular time.

> Relationships have been shown to play a significant role in physician well-being (Loas et al., 2018). Physicians with lifetime suicidal ideation were significantly likely to be single (Loas et al., 2018), with divorce demonstrated as a significant risk factor in American surgeons (Shanafelt et al., 2011; Oskrochi et al., 2016). Conflict with co-workers and family problems increased Finnish anaesthesiologists’ risk of suicidal ideation by 3.9 and 5.8 times respectively (Lindfors et al., 2009). Experiences such as harassment at work were shown to have significant positive association with suicidal ideation (Fridner et al., 2011; Eneroth et al., 2014). Relationship to BO and poor MH was shown to have significant negative association with suicidal ideation, with marriage (Shanafelt et al., 2011; Oskrochi et al., 2016; Dyrbye, 2014) and children (Shanafelt et al., 2011; Oskrochi et al. 2016), both being protective factors. Screening for risk may be important for OH.

1.11.3 Culture in Relationship to HSE Management Standards

Work issues that generate stress and therefore associated with distress (Viogoda, 2002) are frequently articulated to OH. These issues may be related to career development, status, pay, control in work, role in the organisation but also interpersonal relationships (inadequate, inconsiderate or unsupportive supervision, poor relationships with colleagues, bullying/harassment and violence, isolated or solitary work, etc). These factors may relate to demands, control, managerial and peer relationships (HSE, 2019, Appendix 2).

Where an organisation is considered to have a problematic organisational culture – with poor communication, leadership and clarity about organisational objectives, structures and strategies, this will generate stress and the perception that the organisation will not be supportive of those experiencing the effects of this stress on their MH (HSE, 2019).

Viogoda, (2002) encapsulates all the HSE management standards within workplace attitudes. Viogoda, (2002) explores organisational politics and the relationship between these and stress-related factors; links connecting organisational politics, job distress, and more specific reactions such as aggressive behaviour of individuals (Viogoda, 2002). Viogoda (2002) confirms much of what is written but notes that other studies (e.g., Ferris et al., 1996; Folger, Konovsky, & Cropanzano, 1992) reported those who feel that they cannot cope with unfair and unjust environments (and at the same time have other employment alternatives), usually adopt a ‘flight’ response and quit their job. F1s are not in this position. If they feel they cannot cope or want to arrange a transfer to another training post, it is no easy task. They may choose to stay, but must decide whether to ‘fight’ the system or adjust and comply with its norms (Selye, 1975). Those who remain sometimes perceive the organisation to be

unjust, non-reciprocating and that they operate in an environment where people do not receive honest returns for their loyalty and personal investments. This is the case with junior F1s working long hours, often for less pay than their counterparts, whilst also undertaking extensive study, often necessarily undertaken in their own time. This renders them exposed to a higher risk of stress and BO due to their inability or unwillingness to play what Viogoda calls the “political game” as directed by others (Viogoda, 2002). In conclusion, Viogoda (2002) posits that stress reactions often have an impact upon family life or social connections (Jackson & Maslach, 1982; Cordes & Dougherty, 1993). The function of OH within organisations is to provide support to staff by offering individual treatments and interventions that aim to benefit them. Another function of OH is interdisciplinary working to achieve the same aim, i.e., support the HWB of the individual or teams, for example, using its sphere of influence organisationally, externally, and legislatively. Accepting it is possible that OH staff have the capability to utilise a Relational Approach (Costello, 2020), and that F1s might attend OH when mentally or physically unwell or experiencing shame (Costello, 2020) for example, which may impact negatively on their social connections (Cordes & Dougherty, 1993).

In the UK, organisations are legally required to try to address challenges that cause stress at work to improve staff well-being at work (HSE, 2019) via a range of corporate local or national processes. Locally these have included: Listening into Action, Freedom to Speak Up, staff survey and Being Brilliant programmes (NHS staff surveys, 2021; WHO, 2020). Yet stress continues. All of the stressors aforementioned might affect F1s at some point and present as challenges in the unconscious at work (Obholzer & Roberts, 1994) or via OH.

1.12 Health and Well-being in Context of Stress

Contextually it is important to briefly consider HWB in relationship to stress. Costello (2020) notes this is more than the absence of distress. He suggests organisations often give employee well-being responsibility to the individual whilst offering “soothing” solutions to manage workplace stress such as a resilience course, yoga, or online MH modules if staff are unable to attend (Costello, 2020). Costello (2020) argues stress is best understood holistically (i.e., politically, socially, and physiologically). He offers a holistic antidote to stress as connectedness and mutuality. This is some of the complexity of the Relational Approach, which promotes well-being, i.e., the sum is greater than its parts. He acknowledges that relationships at work are often entangled with communities that play roles inside of work as well as organisational and structural factors which can hinder healthy ways of organising working life (Costello, 2020). His other solution to this dilemma is to renegotiate aspects of how an individual views themselves with the workplace (Costello, 2020).

1.13 Resilience in the Face of Workplace Stress

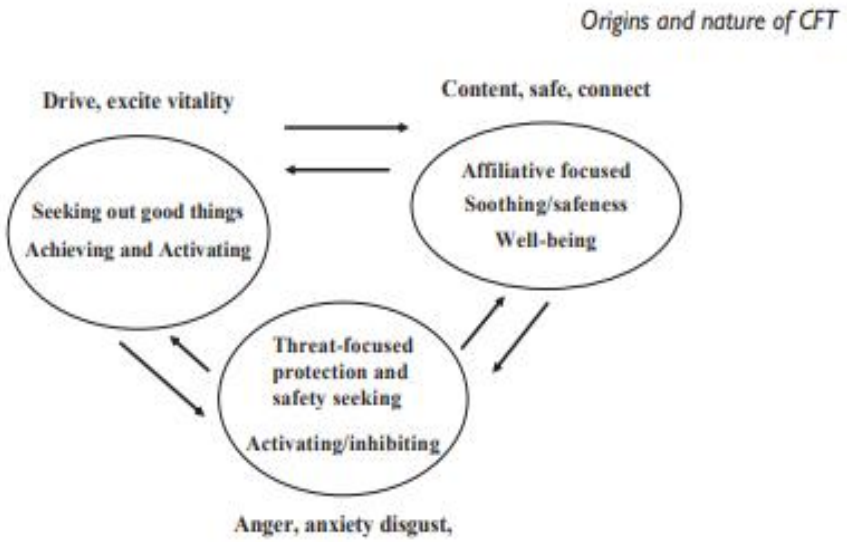

Figure 1. Three types of affect regulation system. From P. Gilbert (2009). The compassionate mind. With kind permission from Constable Robinson

An individual's ability to be resilient or maintain resilience in the face of stress might be an enabler to their well-being or an obstacle to it, promoting their mental and or PH depending on the person and situation at any given time. Its significance therefore is important to note in the introduction. The word 'resilience' hardly appears in the medical literature until about 10 years ago. Its definition is not universally agreed upon but recognition of the need to develop one has increasingly emerged in modern medical education (Marshall & Bleakley, 2017; Leslie et al, 2017).

Phaneuf (2003) explores a number of definitions of resilience, attachment and psychological theories and personality factors associated with resilience. In summary, resilience is aligned to stress, well-being, mental and PH and is generally accepted as the ability to recover from significant stress or adversity. Dunn et al., (2008) offer a coping reservoir model (Appendix 9) which provides a useful and easily understood visual concept. This model was developed after the authors reviewed literature on medical student stress, coping, and well-being. They termed the model as a "coping reservoir" which can be replenished or drained by various experience. Dunn et al., (2008) suggest coping reservoirs can help promote well-being, minimising burnout; medical schools can help fill the reservoir. Examples given are paying attention to students' self-care throughput their careers, promoting resilience which will enhance professionalism and patient care. Wilson and Arvanitakis (2013) note that the capacity to survive and thrive, with its links to well-being, has always been a cornerstone of human survival, long before it was named "resilience".

Most studies of resilience of medical doctors have been conducted in Australian and American healthcare systems and contain a wide range of resilience scores for physicians (Cooke et al, 2013; Bird et al, 2016; Olson et al, 2015; Waddimba et al, 2016; Eley et al, 2013; Eley et al, 2015). Factors influencing a doctor's resilience include personality factors, organisational factors, social support (both from colleagues and on a

personal level), having interests outside medicine and overcoming previous adversity (Winkle 2018). The GMC (2016) introduced resilience training to the UK medical school curriculum in 2014 acknowledging its importance. Despite this, limited information exists on resilience in NHS doctors (McCain, 2018). McCain found doctors were using maladaptive coping mechanisms to manage stress and when compared with the wider population some had other more extreme ill health conditions (McCain, 2018). This has potential implications for OH.

There is a demand for healthcare staff, including doctors, to meet targets and seemingly be more resilient than usual to cope with the on-going impact of demands, with fewer organisationally available resources (McCartney, 2015). The requirement to be resilient and to meet the demands also appears correlated with increasing absences in NHS staff with workplace stress-related absences. The BBC news (2015) reported staff absences for MH problems have doubled at hospital trusts across England in the past four years. Figures obtained by the BBC revealed 41,112 staff were absent with anxiety, stress and depression in 2014 – up from 20,207 in 2010.

In order to cope with stress, an individual, or F1, needs to be able to employ several factors. A F1 needs not only personal resources but also employer support. This is a challenge when stress levels are high. Costello (2020) suggests that absence of stress does not necessarily assure a flourishing workplace. In order to thrive, connectivity, relationship and community is vital (Costello, 2020).

1.14 Disclosure of Mental or PH Status in Healthcare: Doctors

For many employees, the decision whether to disclose mental or PH is viewed as choice, not an obligation. There are exceptions to this rule including for those doctors who have a duty to disclose any health condition which may negatively impact on their ability to safely conduct their duties. The GMC sets out regulations regarding professional standards for doctors overseeing postgraduate training in the UK. Ill health

alone is not automatically a reason to be barred from practice by the GMC. The guidelines on 'Good Medical Practice' (GMC, 2013a) state *"If your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary."*

Fitness to practise guidelines require F1s to disclose MH and PH during revalidation. The Equality Act (EA) (2010) defines a disability "*as a physical or mental impairment that has a substantial and long term adverse effect on a person's ability to carry out normal day-to-day activities".* OH is often involved in supporting individuals with this process, if aware, as an OH function. For workers whose mental or physical illness meets this criterion, the Act stipulates that employers are obligated to make "reasonable adjustments". In a general population study, disclosing to the workplace was seen as unavoidable for some individuals with MH (Brohan et al., 2014). To access adjustments, disclosure was a pre-requisite. This is within the bounds of OH routine work.

1.15 External OH Professional Support Services

Positive MH outcomes are associated with those doctors who engage with professional support services. Doctors attending the London Practitioner Health Programme (PHP) service for MH or substance abuse cited less distress and functional impairment at follow up (FU) (Brooks, Gerada, & Chalder, 2013). A five-year service review indicated that 76% of doctors using the provision remained in or returned to work (Practitioner Health Programme, 2013). Consequences of disclosing MH concerns are reported as including investigations by the GMC or arduous OH processes (BMJ, 1997; Student Doctor online forum, 2007). A UK study reporting on the external support service provision MedNet, showed that doctors had a good engagement rate and that the service was felt to be effective (Meerten et al, 2011). A later study helped dispel myths about doctors' careers ending after having sought treatment for psychological distress

and there was a shift from addressing somatic concerns to psychological ones (Davies, Meerton, Rost, & Garelick, 2016).

1.16 Rationale for this Research and Professional Guidance

The following summary provides context for this thesis. In 2008 the DOH suggested that when F1s join a new organisation a “transfer of personal information” form be completed. With permission, this could be shared by Deaneries with the OH department of the employing Trust. The information provided indicates both current and pre-existing mental and PH conditions which could assist an OH department being proactive with supporting and possibly reducing some of the negative impact of the F1s job role aforementioned. This recommendation, which has recently been instigated locally at Royal Cornwall Hospital Trust (RCHT) has not been routinely implemented nationally. This arguably denies some F1s the ability to access support available via OH. OH therefore has an opportunity to research and extend its supportive role to F1s in distress by developing a relationship with them during this transitional phase.

Chapter 2. LITERATURE REVIEW

2.1 Introduction

This chapter describes a structured review of published studies relating to literature about stress, resilience and MH of medical students and doctors, specifically F1s, the transition over the year to F2 and any consequent interactions with OH. Preliminary exploration of this topic in the literature had highlighted an emergent and poorly defined area. The review sought to identify the evidence base for OH and Health in F1s, particularly MH, and those factors which support or serve to undermine their MH status including PH. It aimed to further understand the relationship between OH and doctors with mental or PH and identify gaps in existing knowledge. It was a narrative structured review that allowed a comprehensive review of both quantitative and qualitative papers.

The review used the replicable steps followed in systematic review. I utilised studies that were no more than 20 years old retrospectively. Commentary regarding limitations and omissions in the key literature regarding the research question is applied in Tables 1,2,3,4 & 5 in Appendix 3.

2.2 Aim

The literature review summarises the current state of knowledge of OH, MH, stress and resilience and coping strategies in junior doctors.

Specifically, this attends to the following objectives:

- To provide greater understanding of the emotional and psychological health of F1s and support structures impacting on this.
- To understand the role of OH during the transition from F1 to F2 year.
- To identify perceived enablers and obstacles that affect an F1's ability to maintain resilience in the new workplace.
- To identify particular factors that seem to affect the relationship between OH and F1s, e.g., stigma and confidentiality.
- To make recommendations for the development of effective MH pathways of care for F1s using OH.

This broad approach was taken as psychological safety in the workplace is vital and HWB in the workplace is emerging as an area of interest and one in which OH is equipped to play a pivotal role (HEE, 2019). This review of the literature aims to clarify an understanding of the relationship between OH and F1s and to inform the development of any future supportive interventions.

The literature search questions focussed on the above in combination with any of the search terms in Table 1.

2.3 Literature Review Method

A structured literature search was undertaken across six databases: Medline (EBSCO), Pubmed, PsychInfo, Google Scholar, HMIC, and EMBASE. General search terms were junior, foundation, doctor, trainee, OH, resilience, attachment, and MH. This is further delineated in Table 2. In addition, a snowball technique was used from prior knowledge of key papers. “Snowballing” includes electronic citation tracking and investigating references cited in relevant sources. This technique can be powerful in identifying sources in obscure locations (Greenhalgh & Peacock, 2005). While this literature review followed structured steps, described transparently in the method, study outcomes were not combined, and treatment approaches were not synthesised. It is therefore not ‘systematic’ as defined by Cochrane but may be described as ‘structured’.

2.4 Quality Assessment

Quality assessment tools guided the appraisal of papers as shown in Table 1 below. Papers were divided into four categories for quality assessment and rigour: quantitative study; meta-synthesis; literature reviews, qualitative studies for quality appraisal (Appendices 5,6,7,8).

Category	**Quality assessment tool**
Quantitative study	the EPHPP (2010) Quality Assessment Tool for Quantitative Studies
Qualitative studies	CASP (2018) Checklist for qualitative studies
Literature Reviews	Evaluation criteria –Accuracy, Authority, Objectivity, Currency, and Coverage.

Table 1. Assessment Tools Used to Guide Quality Assessment of Papers

2.5 Search Strategy

The final search strategy is detailed in Table 2 below and an example of the literature search terms in one of the three literature searches is detailed in Appendix 4. This search was repeated on three separate occasions under a saved strategy; “Kirsten OH Doctors”- 403943/saved, for easy replication of repeated searches originally across year dates 1997-2017 and the final time to 2020.

Population	**Mental health issues**	**Occupational Health**
Trainee	Resilience	Occupational Health / service Health seeking
Doctor	Young doctors’ health	Promoting health
Physician role	Supporting staff in employment	Protecting
Physician Junior Doctor/F1/2 Medical profession	Stress Burnout Suicide Mentally ill Well-being Attachment	Supporting staff in employment Specialist services Illness behaviour Sickness in the medical profession
	Why do doctors leave the profession	
	Psychiatric morbidity in physicians	

Table 2. Criteria for Literature Search

2.6 Study Characteristics

An initial exploration was made using the literature research terms. Key texts and papers found were organised into groups of themes denoted in the Prisma chart- Figure 2. I critically evaluated the literature and most importantly, considered how this literature relates to my area of interest, particularly given this interest was stimulated by working with F1s and the paucity of literature in this area.

2.6.1 Excluded Searches

Several search terms were used and relevant to this thesis- for example, well-being and amongst medical students in England. There is a wealth of clinical and research literature addressing this topic (see, for example Farrell, et al., 2009). Furthermore, burnout and other symptoms of stress can occur within can occur in other health care professionals and those in the medical profession in the UK and abroad (Barakat, 2020; Williams, 2020). Although material relating to these groups is relevant, my focus in this literature review is on F1s, their MH and their relationship to OH.

2.6.2 Inclusion Criteria

The following inclusion criteria are used in selecting sources: for example, peer reviewed research, scholarly opinion pieces from professional journals, written in the English language, years 2000–2016. In conducting the review, I have also included one publication outside these criteria – Rees (2019) – because it offers a specific scholarly contribution to the wider context and is consistent with it. The relative lack of qualitative OH-specific research, alongside the commonplace omission of the research participants' voice, is evident in the current literature. Because search engines cannot determine whether articles relate specifically to

FIs and OH, in order to capture literature that is relevant to the thesis, I have also drawn on wider search terms using an algorithm that is not confined to OH but includes all related subsets of F1 and Occupational health, such as: occupational health service, junior doctor, foundation year one doctor, and doctors, with key terms in the abstract and title for example.

A systematic review has been defined as “the application of scientific strategies that limit bias by the systematic assembly, critical appraisal and synthesis of all relevant studies on a specific topic” (Cook et al., 1995). However, Wright et al. (2007) acknowledge that reviews can suffer from a variety of weaknesses during their preparation which may affect conclusions and alter the study. In the case of the literature search for this thesis, snowballing techniques were advantageous facilitating the emergence of key papers, for example, Cohen et al. (2016) Carreiri (2015, 2017), and Grant et al. (2019).

2.6.3 Exclusion Criteria

The principal exclusion criteria entails omitting scholarly and research material which does not directly or substantially address, when combined with search terms and specified cognates relating to MH and F1s.

The following exclusion criteria are applied:

1. An emphasis on medical speciality, e.g., psychiatry.
2. Sources that concern themselves with non-UK doctors.
3. Literature concerning generic medical OH concerns such as ill-health, retirement, PH conditions (without MH).

a. Literature concerning the general population and or healthcare professionals who might also fit some of the search criteria cognates relating to MH and OH.
b. Research that is unavailable on ATHENS (N.H.S) or university databases or requires specialist subscription.
c. Papers older than 20 years.

2.6.4 Operationalising OH and F1s with a MH condition as a Search Term

Basic searches across all databases for the terms Occupational health AND/ OR Occupational health services yield a raft of returns. For example, a basic search (English language and yr="2000 -Current") in EMBASE using these terms (including related terms) yields 45,237 results. Reviewing the first 200 of these results produced only one article obliquely relevant to OH, F1 and their MH. This kind of basic search typically treats OH and cognates as a homograph; namely, as a constituent term applied to a relationship between independent research variables, and/or OH used as a term denoting the moderating effects of a relationship between two or more research phenomena. To give just one example: 1. Wagner, et al. (2019) present findings reporting healthcare professionals' perspectives on working conditions, leadership, and safety climate: a cross-sectional study. Whilst these findings are of interest, they are not directly relevant to this research. In this example, the key search words all appear under the rubric of related terms. In other words, unless instructed otherwise, PsycINFO and other databases principally treat the term OH as a service relating to working conditions rather than a service with contextual relevance to F1s.

2.6.5 Focusing the Search – Systematic Literature Search

In light of the foregoing, it is necessary to specifically qualify the search term "Occupational Health' as referring to Occupational health, occupational health service or occupational health issues amongst doctors. Advanced searches across all databases for the terms (Occupational Health) OR (Occupational Health service) AND /OR doctor yield studies or articles similar in methods or focus to the present work using a combination of text word terms and thesaurus terms.

Table 3. below shows the Medline search strategy results when key free text search terms; and mesh headings doctor, and occupational health are combined, within a concept (resilience, sick doctors, health, stress) to include AND / OR on a range of search terms are used to locate publications investigating the relationship between F1s and OH in the literature. The same search was conducted across the other four databases and the same date limits applied.

Strategy 403943

#	Database	Search term	Results
1	Medline	(doctor*).ti,ab	110005
2	Medline	("occupational health").ti,ab	12046
3	Medline	"OCCUPATIONAL HEALTH"/	30234
4	Medline	(2 OR 3)	38827
5	Medline	(1 AND 4)	624

Table 3. Search strategy results

An example of the final search strategy in Embase is below. The years - 1997 to 2020 December.

1 (foundation doctor* or junior doctor* or trainee doctor*).ab,ti. 7315
2 (occupational health or mental health or resilience or stress or sick*).ab,ti. 1491561
3 occupational health/ 45237
4 mental health/ or psychological well-being/ 211538
5 psychological resilience/ or emotional vulnerability/ 8291
6 mental stress/ 95427
7 2 or 3 or 4 or 5 or 6 1649277
8 1 and 7 539
9 limit 8 to yr="2012 -Current" 185

The literature found was both qualitative and quantitative in nature. Of the total results, 37 studies and six reports, were of some relevance to doctors overall with only three pertaining to F1s and 19 empirical studies. This literature review was repeated three times to accommodate the interruption yielding few results. The Prisma chart –Figure 2. shows the number of studies found in the first literature search.

Of the studies identified, only 12 explicitly studied the use of OH among doctors. Attitudes towards disclosing MH tended to be part of studies looking more widely at the health, beliefs, resilience and wellness or illness behaviours of doctors. MH disclosure was primarily examined within the context of help-seeking with a small number of studies examining it from other perspectives, e.g., regulatory. Most papers are applicable to all grades of doctor. There appears to be scant information relating to the transition from medical student to F1, other than the development of maladaptive coping behaviour (Cohen et al., 2016), F1 to F2, and curricular changes to support the recognised difficulties with this period clinically (Brennan et al., 2010). Other limitations are considered later in the discussion.

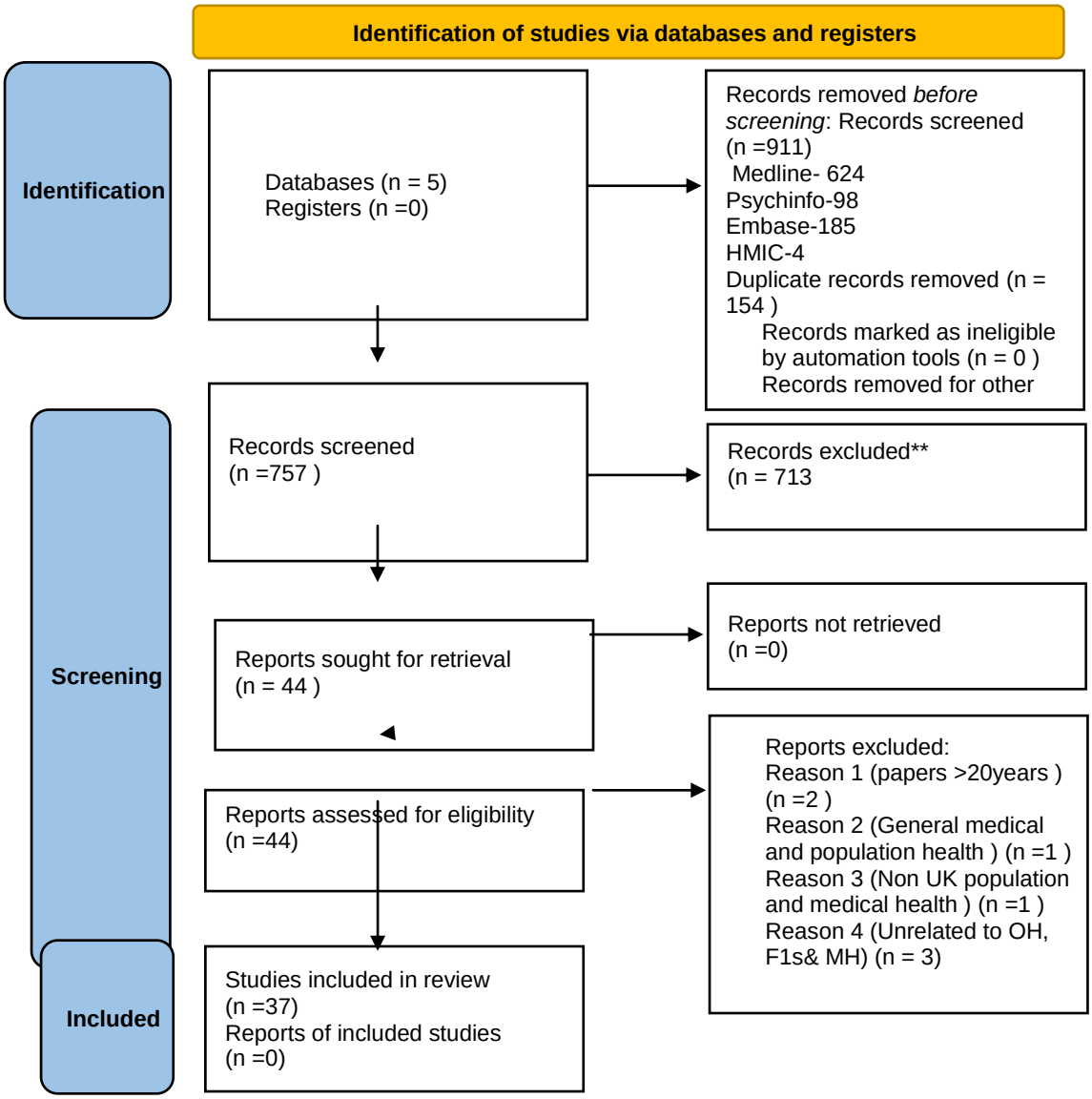

Figure 2. Prisma Flowchart indicating original literature review findings (McKenzie et al, 2020).

The papers relating to the literature review question were analysed by the four themes arising from the literature search; these are summarised in Figure 3.

The remaining papers relating to the literature review question were analysed by theme. As the search was specifically interested in the experiences of F1s during the first year as a trainee, including OH, mental and PH and ill health, health seeking behaviours, attachment, resilience, as well as how F1s perceive and relate to each other, papers

focusing on these areas were extrapolated from the search. Final adjustments were determined after discussion and recommendations made by a peer review supervision group as in Figure 3.

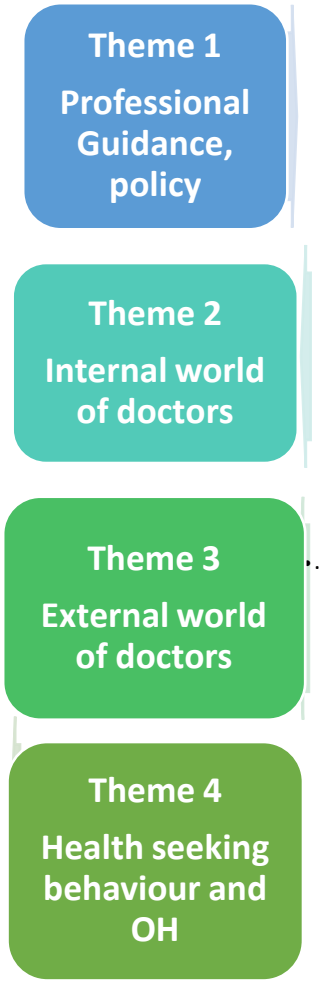

Figure 3. Themes arising from the literature search

The following sections describe the findings of the literature review according to the themes identified in Figure 3. A summary of the results is presented in Tables 1, 2, 3, 4, and 5. Here the major research literature findings with the appropriate qualitative (CASP, 2018), quantitative (EPHPP, 2010) or literature review (Run Run Shaw Library, 2022) quality ratings, implications, evaluation, limitations, and appraisal are to be found.

Key Literature findings from systematic and snowballing approach

Table 4. Professional guidance, OH, and Policy

Policy/ influential political papers Reference	Title	Themes	CASP/EHPP
Harvey,S,Laird,B. Hendersn,M. Hotopf,M.(2009) Institute of psychiatry	The mental Health of Health Care professionals; A review for the department of Health	This review examines evidence-based literature on the prevalence and consequences of mental health disorder amongst health care professionals (HCP) and the impact of poor mental health upon work. It is not systematic but provides a wide selection of mainly UK-based studies. It concludes that high numbers of HCP report high levels of workplace stress and burnout. It comments upon the difficulty with generalising evidence, yet comments that HCP work seems relatively unlikely to contribute to psychiatric morbidity, whereas the way work is organised and structured and the support available does. This seems to support the view that organisational support to enable is vital. It suggests that in part this might be via OH services offered. It also indicates that there is clear evidence that doctors are reluctant to seek help when suffering from MH concerns. This may be related to stigma, over self-reliance and worries about confidentiality. This is an area that OH need to be mindful about. It recommends ease of access to support services, that health is not medicalised and that possible screening is evaluated. Recommends further study in OH setting as research in this area is sparse.	CASP- 8
DOH (2010)	Invisible patients- Summary document. Summary of the report of the Working Group on	The purpose of this paper is to provide best practice guidance, by providing a brief overview of the evidence and good practice available nationally. It offers a framework to manage the health of HCPs and makes 7 key recommendations. With regards to OH it suggests that	CASP-8 EHPP-Moderate

	the health of health professionals.	features of an effective OH service include compliance to standard set out by the Faculty of Occupational Medicine, access to necessary specialist services for assessment and treatment of sick HCP, promotion of health and well-being of staff and provision tailored to organisational needs. It does not indicate how this might be achieved other than OH being accredited. It does recommend that maintaining good health and coping with ill health should be an integral component of under and post graduate curriculum for all HCPs. Another recommendation is also that further studies are undertaken exploring the health and well-being of specific groups of HCPs in different HC settings.	
Brooks, S. Gerada, C. & Chandler,T (2011). Journal of Mental Health; 1–11, iFirst article	Review of literature on the mental health of doctors: Are specialist services needed?	To review literature regarding risk factors and potential barriers to help-seeking unique to doctors; to consider the success of interventions by specialist services for doctors. There are contradictory reports about the prevalence of mental ill health in doctors but it is generally agreed that doctors face a large number of risk factors, both occupational and individual; and help-seeking is difficult due to complexities surrounding a doctor becoming a patient. Specialist services developed specifically for interventions for doctors with mental health problems tend to show promising results but further research is needed. Conclusions: The unique and complex situation of a doctor becoming a patient benefits from specialist services. Recommends such services should focus on early intervention and raising awareness	CASP-7

IOM (research Consulting services for occupational and health hygiene) (2009)	A systematic review of the health of health practitioners	A systematic review to address questions such as the nature and prevalence of poor health in practitioners and the impact upon service and patient safety (no empirical papers identified), referral, reintegration back into the workplace post absence, predisposition of risk (no examples identified) and health-seeking behaviours (limited data available, other than HCP work when sick, self-prescribe and don't use OH). Indicated gaps in high quality research, lack of good quality intervention studies and little evidence related to patient safety or service quality through ill health in HCPs	CASP-8
DOH (2008), DOH,London	Mental health and ill health in doctors	After the Daksah Emson Inquiry Report, Professor Appleby established a working group to consider steps required to make it less likely that doctors would become unwell and easier for them to seek help earlier. It outlines mental health, stressors, risk factors, stigma and culture. It considers current support available such as specialist care. It notes the role of OH and suggests that provision varies widely, with some having no medical input. It also suggests some OH departments have little MH awareness and that generally there may be a perceived lack of expertise and a concern regarding confidentiality due to its links with employers. It recommends links between deaneries and OH for trainees and clear policies so doctors can access appropriate support and also that doctors should understand the importance of managing their own mental health.	CASP-8 EHPP-Moderate

Table 5. What we know of junior doctors (the internal world of the junior doctor)

Resilience, attachment			
Reference	**Title**	**Themes**	
Fertleman,C. (2013) BMJ Editorial.	Protecting students and promoting resilience	A simple summary of the problem of mental health problems in medical students and its impact on their resilience towards other aspects of the course. It highlights the GMC and associated professional medical literature on managing students with mental health problems - culminating in recommendations that making mental health problems easier to address for students, beneficial for their long term resilience http://www.bmj.com/content/347/bmj.f5266.	CASP- 5
McCain, R McKinley, N, Dempster, M, Campbell, J., Kirk, S.(2018)Postgrad Med J;94:43–47. doi:10.1136/postgradmedj-2016-134683	A study of the relationship between resilience, burnout and coping strategies in doctors	Purpose of the study: the aim of this study was to measure resilience, coping and professional quality of life in doctors Study design: a cross-sectional study using an online questionnaire in a single National Health Service trust, including both primary and secondary care doctors. Results: 283 doctors were included. Mean resilience was 68.9, higher than population norms. 100 (37%) doctors had high burnout, 194 (72%) doctors had high secondary traumatic stress and 64 (24%) had low compassion satisfaction. Burnout was positively associated with low resilience, low compassion satisfaction, high secondary traumatic stress and more frequent use of maladaptive coping mechanisms, including self-blame, behavioural disengagement and substance use. Non-clinical issues in the workplace were the main factor perceived to cause low resilience in doctors. Conclusions: Despite high levels of resilience, doctors had high levels of burnout and secondary traumatic stress. Doctors suffering from burnout were more likely to use maladaptive coping mechanisms. As doctors already have high resilience, improving personal resilience further may not offer	EHPP- High

		much benefit to professional quality of life. A national study of professional Quality of Life, Coping and Resilience, which we are proposing to undertake, will for the first time assess the UK and Ireland medical workforce in this regard and guide future targeted interventions to improve professional quality of life.	
Teoh.K, Hassard, J. and Cox,T., (2018) Health Care Management Review, ISSN 0361-6274. (In Press) Downloaded from: http://eprints.bbk.ac.uk/23538/	Individual and organizational psychosocial predictors of hospital doctors' work-related well-being: A multilevel and moderation perspective	Background: The high prevalence of burnout and depression among doctors highlights the need to understand the psychosocial antecedents to their work-related well-being. However, much of the existing research has been a-theoretical, operationalized a narrow measurement of well-being, and predominantly examined such relationships at the individual level. Purpose: This study uses a multilevel perspective to examine individual (i.e., job demands and resources) and organizational level psychosocial predictors of three measures of work-related well-being: perceived stress, presenteeism and work engagement. The Job Demands-Resources (JD-R) theory underpins the postulated relationships. Methodology: The 2014 National Health Service Staff Survey was analyzed using multilevel modelling in MPlus. The dataset involved 14,066 hospital-based doctors grouped into 157 English hospital organizations (i.e., Trusts). Results: Congruent with the JD-R, job demands (workplace aggression and insufficient work resources) were stronger predictors of perceived stress and presenteeism than job resources. Equally, job resources (job control and manager support) were generally stronger predictors of work engagement than job demands. At the organizational level, bed occupancy rates and number of emergency admissions predicted work engagement. No hypothesized individual or multilevel interactions were observed between any of the job demands and resources. Practical Implications: The findings emphasize that a broader perspective of work-related well-being among hospital doctors should be employed, and the empirical value of examining such relationships from a multilevel perspective. Successful health intervention should target the	EHPP-Moderate

		appropriate antecedent pathway, and recognize the role of organizational level factors when trying to manage hospital doctors' work-related well-being. Useful for App HOWAMI	
McKinley N, McCain RS, Convie L, et al. BMJ Open 2020;10:e031765. doi:10.1136/ bmjopen-2019-031765	Resilience, burnout and coping mechanisms in UK doctors: a cross-sectional study	Aims: This cross-sectional study aimed to assess resilience, professional quality of life and coping mechanisms in UK doctors. It also aimed to assess the impact of demographic variables, such as sex, grade and specialty on these factors. Methods: During October and November 2018, medical doctors in the UK were eligible to complete an online survey made up of validated psychological instruments. Royal Colleges and other medical organisations invited their membership to participate via newsletters, email invitations, websites and social media. Results: 1651 doctors participated from a wide range of specialties and grades across the UK. The mean resilience score was 65.01 (SD 12.3), lower than population norms. Of those who responded, 31.5% had high burnout (BO), 26.2% had high secondary traumatic stress and 30.7% had low compassion satisfaction (CS). Doctors who responded from emergency medicine were more burned out than any other specialty group (F=2.62, p=0.001, df 14). Those who responded from general practice scored lowest for CS	EHPP- Moderate
Ciechanowski, P; Russo, J; Katon, W; Walker, E., (2004)..Medical education, Mar , vol. 38, no. 3, p. 262-270,	Attachment theory in health care: the influence of relationship style on medical students' specialty choice.	Converging sources suggest that patient-provider relationships in primary care are generally of greater intensity and duration than those in non-primary care specialties. We determined the relationship styles and demographic characteristics of 144 Year 2 medical students. We also gathered information regarding their predicted choices of postgraduate training, which were clustered into primary or non-primary care categories. We compared student choices with respect to their interpersonal relationship styles based on attachment theory. Prevalence of attachment styles were similar to those found in the general population, with 56% of students rating themselves as having a secure relationship style. Students with a secure style were more likely	EHPP-Moderate

		to choose primary care (61%) over non-primary care compared to those whose styles were characterised by self-reliance, support-seeking or caution (41% chose primary care). Compared to those with a secure relationship style, students with a cautious style [OR = 5.9 (1.9, 18.7)] and students with a self-reliant style [OR = 2.4 (0.96, 5.9)] were more likely to choose non-primary over primary care, after controlling for gender. Assessing relationship styles using attachment theory is a potentially useful way to understand and counsel medical students about specialty choice.	
Balme E., Gerada,,C, Page,L.(2015) Brighton and Sussex medical school. Individual Research Project Report	Structural, environmental and individual factors that promote or impede the development of resilience amongst training grade doctors in the NHS in England	A systematic review of the literature into what factors promote or impede the development of resilience amongst doctors. Identification of factors that promote resilience could pave the way for interventions at the level of organisations, environment and individual. This study aims to explore existing research on resilience. Resilient doctors are characterised by high levels of interest and motivation, employing time-management skills to maintain professional practices and foster supportive relationship, both personal and professional. Attitudes and mental strategies include: self-awareness; personal reflection; engagement with limitations of skills; self-demarcation; spiritual practices; acceptance & realism. Routines and behaviours include: taking time out for leisure activities and holidays; professional practices; time management - restricting working hours. However, there is very little research into what makes working environments foster resilience. Until that research is done it is difficult to suggest what structural changes will lead to increased job satisfaction and retention of healthy staff. A shift from pathology focused research on burnout and stress, towards resilience, may enable insight into what structural changes are necessary to promote resilience. Future research must focus on working environments to allow policy changes and implementation of reorganisation to reflect evidence-based practice. The development of resilience in individual doctors by organisations	Casp-7

		and working environments will have significant benefits not only for individuals but also to the workforce as a whole and ultimately the provision of quality patient care.	
Adshead, G. (2010) Medical education, Feb, vol. 44, no. 2, p. 125-131	Becoming a caregiver: attachment theory and poorly performing doctors.	Reviews a theoretical paradigm (attachment theory) which facilitates an understanding of how human care-giving and care-eliciting behaviours develop and are maintained over the lifespan. Argues that it has particular utility in: (i) the training of doctors; (ii) understanding why some doctors and medical students' experience of Insecure attachment is associated with impaired stress management and subtle deficits in care-giving sensitivity. It is reasonable to assume that a proportion of students entering medical training and doctors with performance problems may have insecure attachment styles which influence how they approach their training experience and how they manage occupational stress. Attachment theory is a useful paradigm for thinking about training as a professional caregiver. Insecure early attachment experiences may be a risk factor for poor stress management in some medical students and doctors who are exposed to increasing demands as carers. Suggests need for further study in this area.	CASP-6
Zwack J, Schweitzer J. Acad Med. (2013) Mar; 88(3):382-9.	If Every Fifth Physician Is Affected by Burnout, What About the Other Four? Resilience Strategies of Experienced Physicians	A number of physicians were assessed on their capacity to cope with stressors of the job. Following upinterviews assessed the methods of their stress management and resilience strategies for their personal lives. A number of strategies were highlighted. A useful paper, which applies its findings to constructing resilience teaching programs built around recognising and thereby supporting the factors of resource depletion. http://journals.lww.com/academicmedicine/Abstract/2013/03000/If_Every_Fifth_Physician_Is_Affected_by_Burnout,.29.aspx	CASP-7
Firth-cozens, J (1992) Journal of Occupational	The role of early family experiences in the	This longitudinal study monitoring 170 medical students as they transition to junior doctor aimed to explore causes of individual and	EHPP-HIGH

and Organisational Pychology,Vol.65(1), p.61-75	perceptions of organisational stress: Fusing clinical and organisational perspectives.	organisational job stress. It included predictors of job stress including personality, and family variables and parent's as as well as traditional variables such as initial stress and role satisfaction. Main predictors of job stress were father age and self-criticism and job attitudes related to mother relationship and student role satisfaction. Additionally, those who had experiences family separation pr parental loss were likely to develop clinical level of symptoms. Finally- the importance of both organisational and individual factors was predicted first by the type of hospital and almost as strongly as by relationship with father which was taken to be an empirical indication of psychoanalytic transference in job stress- this requires further assessment.	

Table 6.

The impact of the training and work environment (the external world)

Training and work Reference	Title	Key themes	
Stephenson AE[1], Adshead LE, Higgs RH. (2006) Med Educ. Nov; 40(11):1072-80.	The teaching of professional attitudes within UK medical schools: reported difficulties and good practice	This paper reviews the teaching of professional attitudes in medical schools. A qualitative in-depth interview study was based on a questionnaire survey of all UK medical schools. Six heads of medical schools or their nominated representatives were interviewed. Outcome measures were the perceptions and experiences of developing and assessing appropriate attitudes and behaviour in their undergraduate students. Arguing that resilience is still highly taught in medical schools where perhaps there is a more intimidatory teaching atmosphere. Resilience in this paper seems to be used in a few cases almost synonymously with mindfulness/self-awareness, as well as the more understandable associations	CASP- 7

		with managing stressful situations. **https://pubmed.ncbi.nlm.nih.gov/17054616/**	
Medisauskaite A, Kamau CBMJ Open 2019;9:e027362. doi:10.1136/bmjopen-2018-027362	Does occupational distress raise the risk of alcohol use, binge-eating, ill health and sleep problems among medical doctors? A UK cross sectional study.	Health problems (eg, insomnia, binge-eating, substance use and ill health) among UK doctors and to investigate whether occupational distress increases the risk of health problems. Design: This study reports the analysis of data collected at the baseline stage of a randomised controlled trial (protocol NCT02838290). Setting: Doctors were invited through medical Royal Colleges, the British Medical Association's research panel and a random selection of NHS trusts across various UK regions. Participants: 417 UK doctors with an equivalent split of gender (48% males) and seniority (49% consultants). Main outcomes and measures Outcomes were sleep problems (eg, insomnia), alcohol/drug use (eg, binge-drinking), ill health (eg, backache) and binge-eating (eg, uncontrollable eating). Predictor variables were occupational distress (psychiatric morbidity, burnout, job effort, work-life imbalance, coping with stress through self-blame or substances) and work factors (workplace and years practising medicine). Results: 44% of doctors binge-drank and 5% met the criteria for alcohol dependence; 24%–29% experienced negative emotions after overeating and 8% had a binge-eating disorder; 20%–61% had some type of sleep problem and 12% had severe/moderate insomnia; 69% had fatigue and 19%–29% experienced other types of ill health problems. The results show that occupational distress and job factors increase the odds of doctors using substances, having sleep problems, presenting with frequent symptoms of ill health and binge-	EHPP- Moderate

		eating. For example, burnout increased the risk of all types of sleep problems, eg, difficulty falling/staying asleep, insomnia (OR ≥1.344; p≤0.036). Even taking into consideration whether or not a doctor works in a hospital, the risk of health problems still rises when doctors have signs of occupational distress. Conclusion: Early recognition of occupational distress can prevent health problems among UK doctors that can reduce the quality of patient care because of sickness related absence. Useful for APP HOWAMI	
Bhugra, D et al. Inernational Review of Psychiatry 2019, Vol. 31, Nos. 7–8, 563–568 https://doi.org/10.1080/09540261.2019.1648621	A descriptive study of mental health and well-being of doctors and medical students in the UK	Doctors and medical students are working in a system which is affecting their mental well-being and their ability to provide the best possible care for patients. The British Medical Association conducted an online survey of doctors and medical students in October 2018. In total, 4347 responses were received and analysed. Doctors working the longest hours appear to be most vulnerable to psychological and emotional disturbance. Older and more senior doctors are most likely to report that their working environment has impacted on their condition. Medical students and junior doctors report the highest rate of having a formally diagnosed mental health condition in the last 12 months. This may be because they are in the vulnerable age group when psychiatric disorders start. Junior doctors were least likely to be aware of how to access help or support. Older doctors, those working as SAS (Staff, Associate Specialists and Specialty) doctors and overseas qualified doctors are most likely to say they have asked for support in managing a problem from their employer but that no support was provided.Findings- It is important to recognize that doctors, in spite of stress and poor well-being, continue to work hard, which has both advantages and disadvantages. These findings highlight that the environment in which doctors	EHPP-High

		work, train, and study affects their mental health, and for this reason careful consideration needs to be given to the type and level of support provision available to them, as well as the ease of access and awareness of such support	
Cherry, MG[1], Fletcher I, O'Sullivan H, Shaw N. (2102) Med Teach. ; 34(1):11-9.	What impact do structured educational sessions to increase emotional intelligence have on medical students?	This paper looks at the role of emotional intelligence on the medical curriculum. Specifically looking at the use of simulated patients, they argue, that 1) using simulated patients improves traits of one's emotional intelligence and that 2) somewhat less-thoroughly, that improved emotional intelligence. http://informahealthcare.com/doi/abs/10.3109/0142159X.2011.614293	CASP- 6
McKevitt, C., Myfanwy,M, Dundas ,R, (1997) Holland, w Journal of Public Health Medicine Vol. 19, No. 3, pp. 295-300	Sickness absence and 'working through' illness: a comparison of two professional groups	Few studies have investigated occupational groups reporting low rates of sickness absence because of an assumption that these rates indicate low morbidity. This is inconsistent with the view that sickness absence, which may be caused by social and psychological rather than medical factors, does not equate with morbidity. This paper investigates rates of sickness absence and factors influencing decisions not to take sick leave among doctors and a comparative professional group. A postal survey was sent to 670 general practitioners (GPs), 669 hospital doctors and 400 company 'fee earners'. Qualitative interviews were conducted with 64 doctors reporting an illness lasting one month or more in the last three years. Self-reported health status was similar for both groups but GPs reported higher levels of occupational stress. However, doctors were significantly less likely to report short periods of sick leave in the previous year. Over 80 per cent of all respondents had 'worked through' illness, citing cultural and organizational factors behind their decision not to take sick leave. Barriers to	EHPP- High

		sick leave among doctors included the difficulty of arranging cover and attitudes to their own health. Conclusions: Considerable emphasis has been given to the role of social factors in contributing to rates of sickness absence. These may also contribute to the decision not to take sick leave, resulting in possible inappropriate non-use. Measures to encourage and enable doctors to take sick leave might improve the management of their own health. Useful for HOWAMI App	
Sandars J[1], Patel R, Steele H, McAreavey M. (2014). Association for Medical Education Europe. Med Teach. Dec; 36(12):1015-26.AMEE Guide, No, 92.	Developmental student support in undergraduate medical education	This paper assesses what could be done to improve the personal development of UK med students during medical school. It again outlines why resilient med students are good for themselves, and then they present some ideas on how schools could encourage development and support resilience in students. They highlight the more common problems that stand in the way of resiliency. The paper reviews mentoring schemes, disability help, and careers guidance, and their use in resolving some of the problems. http://informahealthcare.com/doi/abs/10.3109/0142159X.2014.917166	CASP-5
Patterson F[1], Ashworth V, Zibarras L, Coan P, Kerrin M, O'Neill P. (2012). Med	Evaluations of situational judgement tests to assess non-academic attributes in selection	A literature review aiming to examine the value of SJTs in selecting candidates for training schemes, including GP training in the UK, who have the most developed non-academic attributes, including resilience. The paper discusses the extent to which SJTs can predict how developed candidates' non-academic attributes are and how reliable, valid, fair, cost-effective and well-received the SJT is.	CASP- 7

Educ. Sep;46(9):850-68		https://pubmed.ncbi.nlm.nih.gov/22891906/	
Howe A[1], Smajdor A, Stöckl A. (2012). Med Educ. Apr; 46(4):349-56.	Towards an understanding of resilience and its relevance to medical training.	An important piece, this looks directly at whether there is an ethical rationale for the inclusion of resilience training as part of medical training. Their arguments are, of course, incomplete and suggest a need for further debate and research. This paper is also a good form of literature review, citing a number of other more general papers. http://www.ncbi.nlm.nih.gov/pubmed/22429170	CASP-5
Goodyear,H.(2014). Int J Med Educ.; 5: 103–109.	First year doctors' experience of work-related well-being and implications for educational provision	Seeks to discover how Foundation Year 1 (FY1) doctors maintain their well-being and continue their education, based on narrative interviews. Develops the theory that FY1s first find an identity and then develop resilience, in order to maintain their well-being. Resilience is found to facilitate newly qualified doctors getting the help they require to tackle and learn from difficulties and challenges. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4207178/pdf/ijme-5-103.pdf	CASP-7
Henderson, Brooks,S, Busso, T.Chalder,T. Samuel,B.Harvey,S, Madan, I.Hatch S. (2012)	Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study	**Objective** To explore the views of sick doctors on the obstacles preventing them returning to work. **Design** Qualitative study. **Setting** Single participating centre recruiting doctors from all over the UK. **Participants** Doctors who had been away from work for at least 6 months with physical or mental health problems, drug or alcohol problems, General Medical Council involvement or any combination of these, were eligible. Eligible doctors were recruited in	EHPP-HIGH

Occupational & environmental medicine.BMJ Open; 2, 1-8. Retrieved on 17th February 2016 from **http://bmjopen.bmj.com/**	conjunction with the Royal Medical Benevolent Fund, the General Medical Council and the Practitioner Health Programme. These organisations approached 77 doctors; 19 participated. Each doctor completed an in-depth semi-structured interview. Study used a constant comparison method to identify and agree on the coding of the data and the identification of a number of central themes. **Results** The doctors described that being away from work left them isolated and sad. Many experienced negative reactions from their family and some deliberately concealed their problems. Doctors described a lack of support from colleagues and feared a negative response when returning to work. Self-stigmatisation was central to the participants' accounts; several described themselves as failures and appeared to have internalised the negative views of others. **Conclusions** Self-stigmatising views, which possibly emerge from the belief that 'doctors are invincible', represent a major obstacle to doctors returning to work. From medical school onwards cultural change is necessary to allow doctors to recognise their vulnerabilities so they can more easily generate strategies to manage if they become unwell

Brennan,N. & Corrigan,O. (2009).Institute of Clinical Education Peninsula Medical School	Longitudinal Evaluation of South West Peninsula Deanery F1 Doctors	A longitudinal mixed methods approach was adopted triangulating quantitative and qualitative data. The objectives of the study are: to provide a systematic evaluation of the performance and preparedness of the first and second cohorts of PMS graduates based in the F1 programme in the SWPD; to compare the performance and preparedness of PMS graduates with graduates of other medical schools based in the F1 programme in the SWPD; to explore F1 doctors' experience of transition from medical student to practising doctor in the SWPD; to make recommendations on PMS undergraduate curriculum reform and F1 education. This study shows that PMS graduates reported feeling as well prepared for F1 practice as graduates of other medical schools. Recommendations made regarding curriculum, including more support required by medical supervisors.	CASP-7 EHPP-Moderate

Table 7. Health-seeking behaviours (barriers and or enablers)?

Help-seeking behaviours Reference	Title	Key themes	
Baldwinn, P. Dodd, M.Wrate,R.(19	Young doctors' health 11- Health	There is little published information on the health of young doctors, apart from a number of studies which show increased rates of psychiatric symptoms. Nor is there much known of their health behaviour. Anecdotal	EHPP-Weak

97). *Soc. Sci. Med.* Vol. 45, No. 1, pp. 41~14.	and health behaviour	accounts suggest that doctors' own health care is poor, especially in terms of their willingness to consult other doctors. This paper presents data from a longitudinal study of a class cohort of young doctors first interviewed when they were students. Data show that they suffer from frequent minor physical ailments, with women reporting more ailments than men. Despite this, they took less sick leave. Overall, the doctors took very little time off work. Using the GHQ-28, with a threshold of 5/6, 30% of doctors fell into the "caseness" category for psychiatric symptoms. This is in keeping with findings elsewhere. From the doctors' own reported health behaviour, both in terms of their response to illness over the past year, as well as their predicted response to hypothetical illness, they have developed maladaptive patterns. These include continuing to go to work when unfit, self-prescribing, and consulting friends and colleagues rather than going for a formal consultation. This is seen as inappropriate, especially in cases of mental illness. A third of the young doctors are not registered with a local general practitioner and the majority have no clear idea of the role of the Occupational Health Service. The results are discussed in terms of the need to change attitudes to health care and to develop guidelines, staffing and services to enable doctors to take better care of themselves.	
Chambers, R. (1992) Occupational Medicine; 42: 69-78.	Health and lifestyle of general practitioners and teachers.	Sample: 850 GPs on General Medical Register of Staffordshire Family Practitioner Committee, response rate: 45% for questionnaire and 66% for health check. Secondary school teachers (sample size not mentioned) response rate: 25% for questionnaire and 88% for health check. Cross-sectional study + ** Self-administered questionnaires on health prevention, lifestyle, sickness absence and healthcare. For teachers used purposive sampling to have gender distribution be the same as doctors. Separate questionnaire for spouse/domestic partner to verify responses about health and lifestyle. Sub-section invited for health check on BMI, blood pressure, body fat percentage, grip strength, spinal flexibility, sit-ups, stepping test, blood test and health questions. In general, doctors less likely to take	EHPP-Weak

		sickness absence from work.	
Sauerteig, S., Wijesuriya, J.,Tuck , M.,Hannah Barham-Brown, H**.** (2019) International Review of Psychiatry , Vol 31, Nos. 7–8, 548–554 https://doi.org/10.1080/09540261.2019.1586165	Doctors' health and well-being: at the heart of the NHS's mission or still a secondary consideration?	It is well-recognized that staff health and well-being has a considerable influence on performance and productivity in any organization. The NHS is no different. Dr Steven Boorman's NHS health and well-being review made a powerful case for change in how staff health and well-being was understood, how it should be operationalized in the NHS, and how senior management must lead in developing new cultures that have health and well-being at their core. In particular, Dr Boorman demonstrated how staff health and well-being impacts on patient care. Ten years later, NHS staff remain more likely to incur a work-related illness or injury than staff in other sectors and NHS staff sickness absence is double the national average. In addition, doctors, particularly younger doctors, frequently feel the need to attend work despite ill health, and are taking breaks in training to avoid burnout. The views of doctors on the availability and access to occupational health services, as well as the support of their employer for their health and well-being, can provide a timely insight into the effectiveness of measures since the Boorman review to bring doctors' health and well-being to a central place in today's NHS. There have also been a series of initiatives announced in the nations of the UK to provide occupational health services to doctors in recent years. The effectiveness and implementation of these initiatives are important in understanding what progress has been made in supporting doctors' health and well-being. In order to gain such insights, we asked a series of questions to a panel of doctors through the regular online BMA Quarterly Survey. The survey results demonstrate that access to support for their health and well-being is inconsistent and sometimes non-existent. This article discusses these results and provides recommendations for the future	EHPP- Moderate CASP-7
Bhugraa , D., Sauerteigb , S., Blandb , D., Lloyd-Kendallb	A descriptive study of mental health and well-being	Doctors and medical students are working in a system which is affecting their mental well-being and their ability to provide the best possible care for patients. The British Medical Association conducted an online survey of doctors and medical students in October 2018. In total, 4347 responses were	EHPP-High

, A., Wijesuriyab , J.,Gurdas Singhc,G., Kochhare , A.,Molodynskif, A,Ventriglio.,A.(2019)International Review of Psychiatry, Vol 31, Nos. 7–8, 563–568 https://doi.org/10.1080/09540261.2019.1648621	of doctors and medical students in the UK	received and analysed. Doctors working the longest hours appear to be most vulnerable to psychological and emotional disturbance. Older and more senior doctors are most likely to report that their working environment has impacted on their condition. Medical students and junior doctors report the highest rate of having a formally diagnosed mental health condition in the last 12 months. This may be because they are in the vulnerable age group when psychiatric disorders start. Junior doctors were least likely to be aware of how to access help or support. Older doctors, those working as SAS (Staff, Associate Specialists and Specialty) doctors and overseas qualified doctors are most likely to say they have asked for support in managing a problem from their employer but that no support was provided. It is important to recognize that doctors, in spite of stress and poor well-being, continue to work hard, which has both advantages and disadvantages. These findings highlight that the environment in which doctors work, train, and study affects their mental health, and for this reason careful consideration needs to be given to the type and level of support provision available to them, as well as the ease of access and awareness of such support.	
Thompson, W, Cupples, M, Sibbett, C, Skan, D, Bradley, T.(2001) BMJ. Sep 29; 323(7315): 728–731. **doi: 10.1136/bmj.323.7315.728**	Challenge of culture, conscience, and contract to general practitioners' care of their own health: qualitative study	Objective: To explore general practitioners' perceptions of the effects of their profession and training on their attitudes to illness in themselves and colleagues. Design: Qualitative study using focus groups and in-depth interviews. Setting: Primary care in Northern Ireland. Participants: 27 general practitioners, including six recently appointed principals and six who also practised occupational medicine part time. Main outcome measures: Participants' views about their own and colleagues' health. Results: Participants were concerned about the current level of illness within the profession. They described their need to portray a healthy image to both patients and colleagues. This hindered acknowledgement of personal illness and engaging in health screening. Embarrassment in adopting the role of a patient and concerns about confidentiality also influenced their reactions to personal illness. Doctors' attitudes can impede their access to appropriate health care for themselves, their families, and their colleagues. A sense of	CASP- 6

		conscience towards patients and colleagues and the working arrangements of the practice were cited as reasons for working through illness and expecting colleagues to do likewise. Conclusions: General practitioners perceive that their professional position and training adversely influence their attitudes to illness in themselves and their colleagues. Organisational changes within general practice, including revalidation, must take account of barriers experienced by general practitioners in accessing health care. Medical education and culture should strive to promote appropriate self-care among doctors.	
Marshall, E. (2008). Occupational Medicine; 58; 334-340.	Doctors' health and fitness to practice; treating addicted doctors	Review about treating addicted doctors. Systematic Review - * Review of prevalence of alcohol and drug problems in Europe and North America among doctors and risk factors for development of misuse problems and treatment. In North America prevalence of alcohol problems in doctors may not be higher than general pop' and rates of illicit drug use less but higher rates of prescription drug use (self-medication). In UK study of 144 doctors with substance misuse problems: mean age at referral 43.1 yrs (24-69 yrs), 42% alcohol, 26% drug, 31% drug and alcohol. Drugs used: 30% opiates, 24% barbiturates, 21% benzodiazepines, 15% amphetamines. In more recent UK study with 62 healthcare workers (21 doctors): 59% alcohol use, 41% drug misuse (main drugs: opiates, anaesthetic agents), 72% reported use of several drugs, 43% history of psychiatric treatment prior to referral, 27% previous treatment for depression, 41% referred by employer or occup. Health physician. Risk facts for development of problem: personality problems, nonspecific drift into drinking, anxiety or depression, pain, injury or accident, stress at work, family stress, bereavement. Evidence indicates doctors respond well to specialist treatment, sooner referred on to such treatment the better. **Doi:10.1093/occmed/jqn081**	CASP- 7

Adams, E., Lee, A.., Pritchard, C.., & White, R., (2010). International Journal of Social Psychiatry, 56(4), 359-370	What Stops Us from Healing the Healers: A Survey of Help-Seeking Behaviour, Stigmatisation and Depression Within the Medical Profession.	**Background:** Doctors are poor at help-seeking, particularly for mental ill health; attitudes of colleagues reflecting stigmatisation may be important factors influencing decisions to seek support. **Aims:** This article focuses on doctors' attitudes to depression rather than mental illness in general. It seeks to determine the extent to which doctors perceive depression is stigmatised within the medical profession and whether the level of perceived stigma affects patterns of help-seeking behaviour. **Method**: A postal survey was sent to 1488 General Practitioners and 152 psychiatrists in Devon and Cornwall. Questions assessed stigmatising attitudes to depression; help-seeking behaviour and barriers to help-seeking. Prevalence of self-reported depression and time off work was measured. **Results:** The response rate was 76.6%. Doctors perceived that many of their profession hold stigmatising views of depression. Some 46.2% of respondents reported that they had suffered an episode of depression. Help-seeking was significantly reduced in those with a history of depression. Barriers to help-seeking were reported as letting colleagues down (73.1%), confidentiality (53.4%), letting patients down (51.9%) and career progression (15.7%). Gender and a history of depression significantly affected help-seeking behaviour and perceived stigmatisation. Higher levels of perceived stigma increased concerns about help-seeking and reduced help-seeking from own GP or colleagues. **Conclusion:** Stigma associated with depression in doctors is endemic in the medical profession and the level of perceived stigma is related to reduced help-seeking behaviour. Efforts need to be made by the profession to reduce the stigma anticipated by those who become depressed, to enable appropriate help-seeking and support	EHPP-High

Brooks, S., Gerada, C., & Chalder, T. (2017). Journal of Mental Health, 26(2), 161-166. doi: 10.1080/09638237.2016.1244712	The specific needs of doctors with mental health problems: qualitative analysis of doctor-patients' experiences with the Practitioner Health Programme.	Objectives: The current paper aimed to explore doctor-patients' views about their treatment from the Practitioner Health Programme (PHP), a UK-based service treating health professionals with mental health/addiction problems. Aims were to gain insights into the issues most important to patients and consider whether a service specifically for doctors is important in helping to overcome barriers to accessing mental healthcare. Methods: Nine doctor-patients attending PHP took part in semi-structured interviews between September 2010 and June 2011. Thematic analysis was used to explore recurring patterns in the data. 134 written comments from PHP patients were also included. Results: Participants reported difficulties in finding appropriate treatment; problems were often severe by the time PHP was involved. Concerns about confidentiality, judgement and impact on career were obstacles to help-seeking and important issues during treatment. Analysis of written comments provided further support for these findings. Conclusion: Whilst some of the needs of mentally unwell doctors mirror the needs of patients in general – e.g., a supportive and non-judgemental attitude from clinicians – they do have specific needs related to confidentiality and stigma.	EHPP-Moderate CASP-7
Bianchi, E. F., Bhattacharyya, M. R., & Meakin, R. (2016). BMJ Open, 6(e012598). doi: 10.1136/bmjopen-2016-	Exploring senior doctors' beliefs and attitudes regarding mental illness within the medical profession: a qualitative	Objective: To explore the views of senior doctors on mental illness within the medical profession. Background: There has been increasing interest on the issue of doctors' mental health. However, there have been few qualitative studies on senior doctors' general attitude towards mental illness within the medical profession. Setting: Large North London teaching hospital. Participants: 13 hospital consultants and senior academic general practitioners. Methods: A qualitative study involving semi-structured interviews and reflective work. The outcome measures were the themes derived from the thematic framework approach to analysis. Results: Four main themes were identified. (1) 'Doctors' attitudes to mental illness'—	CASP-10

012598	study.	doctors felt that there remained a significant stigma attached to suffering from a mental illness within the profession. (2) ‘Barriers to seeking help’—doctors felt that there were numerous barriers to seeking help such as negative career implications, being perceived as weak, denial and fear of prejudice. (3) ‘Support’—doctors felt that the use of support depended on certainty concerning confidentiality, which for occupational health was not thought to be guaranteed. Confiding in colleagues was rare except among close friends. Supervision for all doctors was raised. (4) ‘General Medical Council (GMC) involvement’—doctors felt uneasy referring colleagues to the GMC and the appraisal and revalidation process was thought not to be thorough enough in picking up doctors with a mental illness. Conclusions: Owing to the small size of this study, the conclusions are limited; however, if the findings are confirmed by larger studies, they suggest that greater efforts are needed to destigmatise mental illness in the profession and improve support for doctors. Additional research should be carried out into doctors’ views on occupational health services in managing doctors with mental illness, the provision of supervision for all doctors and the effectiveness of the current appraisal and revalidation process at identifying doctors with a mental illness	
Baldwin, P. J., Dodd, M., & Wrate, R. M. (1997) Social Science and Medicine, 45	Young doctors' health II. Health and health behaviour	There is little published information on the health of young doctors, apart from a number of studies which show increased rates of psychiatric symptoms. Nor is there much known of their health behaviour. Anecdotal accounts suggest that doctors' own health care is poor, especially in terms of their willingness to consult other doctors. This paper presents data from a longitudinal study of a class cohort of young doctors first interviewed when they were students. Data show that they suffer from frequent minor physical ailments, with women reporting more ailments than men. Despite this, they took less sick leave. Overall, the doctors took very little time off work. Using the GHQ-28, with a threshold of 5/6, 30% of doctors fell into the “caseness” category for psychiatric symptoms. This is in keeping with findings elsewhere. From the doctors' own reported health behaviour, both in terms of	EHPP=Moderate CASP-7

		their response to illness over the past year, as well as their predicted response to hypothetical illness, they have developed maladaptive patterns. These include continuing to go to work when unfit, self-prescribing, and consulting friends and colleagues rather than going for a formal consultation. This is seen as inappropriate, especially in cases of mental illness. A third of the young doctors are not registered with a local general practitioner and the majority have no clear idea of the role of the Occupational Health Service. The results are discussed in terms of the need to change attitudes to health care and to develop guidelines, staffing and services to enable doctors to take better care of themselves.	
Grant, A., Rix, A. & Shrewsbury, D. (2019). *. International Review of Psychiatry, 1-11. http://dx.doi.org/10.1080/09540261.2019.1586326	'If you're crying this much you shouldn't be a consultant': the lived experience of UK doctors in training with mental illness	Introduction There is some disagreement in the literature whether doctors in training suffer more from mental illness than an age-matched population. However, mental illness among doctors in training is a cause for concern because of the dual problems of reticence about accessing help and the clinical risk of doctors practising while mentally ill. The belief that is widely held among doctors in training is that to disclose a mental illness would be seen as weakness and may damage their career. Method: We used a biographical narrative interview technique that enables the informant to tell the story of a painful episode in their lives in their own way and in their own words. Interviews were transcribed, and a thematic framework developed by consensus and then used to analyse all of the narrative interview data. Results: Four major themes were detected. • Doing the job while ill, • Sick leave (initiating, being on, returning from), • Interaction with the employer and • Sources of support. Practising while mentally ill caused significant challenges. Interviewees did the minimum, hated having to make decisions and failed to study for postgraduate exams. All interviewees took sick leave at some stage. However, most were reluctant to do so. Being on sick leave meant being absent from the career that identified them and running the risk of being perceived as weak. Returning to work from sick leave was often difficult. Back to work interviews and occupational health support did not	CASP-8

		always happen. Discussion This study demonstrated the suffering encountered by doctors in training with mental illness. The job becomes much more difficult to do safely when mentally unwell. A great deal of presenteeism exists, which inhibits doctors in training from getting the medical care they need. It is imperative that confidential medical care is made available to doctors in training, which is sufficiently distanced from their place of work	
Forsythe, M, Calnan, M. Wall, B. (1999). BMJ; 319; 605-608.	Doctors as patients: postal survey examining consultants and general practitioners' adherence to guidelines.	Postal questionnaire of 595 UK Consultants, 1138 GPs with a response rate of 64% for GPs and 72% for consultants. Cross-sectional study + ** Postal questionnaire, participants randomly selected in London and counties. Questions included adherence to guidelines, use of occupational health, prescribing habits for self and family and response to vignettes 98% of GPs and 94% of consultants registered with a GP. 63% of GPs and 59% of consultants had not consulted a GP in the last 12 months. 71% of GPs and 76% of consultants self-prescribed. 11% of GPs had access to occupational health; 95% of consultants did but only 25% had used OH services. 12% of GPs and 8% of consultants were happy with the services provided to them. It is useful to note the poor uptake of OH and it would be valuable to try to understand the reasons for this.	EHPP-Moderate
Waldron, H. (1996). Annals of Occupational Hygiene*;* 40: 391-396.	Sickness in the medical profession.	Random sample of 200 doctors from the medical register. Response rate of 63%, N=110 as 16 were unable to complete the questionnaire Cross-sectional study - * Pilot study questionnaire no further details given. The majority of doctors had had at least one day off sick in the previous 2 years (5Chap%), of those who had taken leave, 13 had been treated in hospital and 36 had received other treatment. 13 identified that sick leave had been caused by working (including infections, violence and mental pressure). Fifty -one reported having access to occupational health but no one had consulted an occupational physician. The reasons for this are not explored. One limitation is that this was a pilot questionnaire and no further details regarding	EHPP-Weak

		procedure is mentioned.	
Toyry et al., (2000). Archives of family medicine, 9, 1079-1085.	Self-reported health, illness and self-care among Finnish physicians. A national survey.	Randomly selected population of 4474 licensed physicians in Finland. Response rate of 74% with n=3313. Cross-sectional + ** Questionnaire developed based on national population data studies questionnaire, included a list of diseases and further questions on treatment and sickness absence. No difference in perceived health between male and female physicians. Males reported more hypertension than female physicians, females reported more thyroid dysfunction. Compared to the general population, doctors' report more mental disorders, back disorders and digestive problems. Self-treatment often used (80-84%). Sickness absence increased with age of physicians but no difference between physicians and general population. Main reasons for sickness absence were acute infections (65% for men, 69% for women), followed by MSDs. Fewer males (43.6%) than female physicians (69.4%) had consulted a physician in the last 12 months. Study identifies that the usual care is self-treatment and working through illness.	EHPP-Moderate
Chambers, R. (1993) Family Practice; 10: 416-423**.**	What Should Doctors do if They Become Sick*?*	Twenty-two GP trainers were trained in questionnaire survey and 59 GPs completed the survey and 65 hospital specialists. Cross-sectional - * Assessed plan of actions for 10 medical condition scenarios as advised to other doctors and how they would self-treat. GPs were found to advise doctors as a whole to consult their own GPs but hospital specialists would self-medicate. Hospital specialists more likely to suggest direct consultation with a specialist. Two thirds of GPs thought it was nearly always acceptable to self-investigate urine tests, but never to initiate other tests. GPs found it	EHPP-Weak

		acceptable to self-medicate for topical anti-fungals and anatacids but never for antidepressants, benzodiazepenes, anti-hypertensives or opiates. This study is interesting because OH is not mentioned. This may not have been part of the questionnaire and is an interesting gap.	
Feeney, S, O'Brien K, O'Keeffe , N, Con Iomaire , A, Kelly , M, McCormack ,J, McGuire, F and Evans, D. (2016) Clin Med (Lond). Feb; 16(1): 12–18. **doi: 10.7861/clinmedicine.16-1-12**	Practise what you preach: health behaviours and stress among non-consultant hospital doctors	High rates of psychological distress, depression and suicide have been reported among doctors. Furthermore, many doctors do not access healthcare by conventional means. This study aimed to increase understanding regarding non consultant hospital doctors' (NCHDs') response to stress and barriers to accessing supports, and identify possible solutions. Medical manpower departments in 58 hospitals distributed a 25-item questionnaire to 4,074 NCHDs; we received 707 responses (response rate, 17.4%). 60% of NCHDs were unable to take time off work when unwell; 'letting teammates down' (90.8%) and 'difficulty covering call' (85.9%) were the leading reasons. 'Being too busy' (85%), 'self-prescription' (66.6%) and 'self-management' (53.1%) were ranked highest in deterring NCHDs from visiting a general practitioner (GP). 22.9% of NCHDs would not attend a GP with anxiety or depression until they began to feel hopeless, helpless or suicidal. 12.2% would not seek help at all. 55% of respondents (n = 330) had to move away from partners or dependants due to work, negatively affecting the social supports of 82.9%. Possible practical solutions were explored. NCHDS are a vulnerable population and have a particularly challenging lifestyle. Key recommendations include improved GP and counselling access for NCHDs, and addressing the culture of self-treatment and poor health behaviours through undergraduate and postgraduate education.	EHPP-Moderate

Cohen, D. Rhydderch, M. Reading, P.& Williams, S. (2015). Occ Med. Aug.Vol,65,no6 ,p459-465.Advance Access publication 12 June	Doctors' health: obstacles and enablers to returning to work	Conducted 11 telephone interviews. Data analysis identified four key themes of obstacles and enablers to returning to work: 'communication', 'return to work', 'finance and funding' and 'relationships and engagement'. Sub-themes relating to the organization and the individual also emerged. Organizations responsible for supporting doctors back to work reported poor communication as a significant obstacle to doctors returning to work after illness. They also reported differences between specialities, employing organizations, occupational health departments and human resources in terms of knowledge and expertise in supporting doctors with complex issues. Clear communication channels, care pathways and support processes, such as workplace advocates, were perceived as strong enablers to return to work for doctors after long-term absence. Interestingly, OH is not mentioned. doi:10.1093/occmed/kqv056	CASP-8
Lalloo, D.Ghafur,I. & Macdonald,E.(2013). *Occupational Medicine*; 63:291–293 Advance Access publication 26 April 2013	Doctor and dentist contacts with an NHS occupational health service	To improve our understanding of OH contacts by doctors and dentists and make some comparison of this with available sickness absence records. A retrospective descriptive evaluation of all doctor and dentist encounters with the OH service between April 2009 and March 2010 was undertaken. Doctor and dentist encounters from our electronic appointment system were analysed using Microsoft Excel. Comparisons were made with management-reported sickness absence data for this period. Mental health conditions were the main reason for referral (approximately one-third of all cases referred). In this group, a much higher number presented to OH, absent from work, than were recorded with sickness absence by management. Musculoskeletal, infection and skin complaints were other predominant reasons for referral. Inconsistency in the reporting of sickness absence in doctors with mental health problems has also been highlighted. This baseline information is a useful steppingstone to identifying and meeting the specific needs of doctors and dentists and can be used as a benchmark in other organizations.	EHPP-Moderate

		Limitations of this study include the retrospective approach which also considers dentists using OH too, which dilutes the information somewhat. doi:10.1093/occmed/kqt029	
Fox,F, Harris, M, Taylor,G, Rodham,K, Sutton, J, Robinson,B, and Scott,J. (2009) British Journal of General Practice; 59 **(568): 811-818.** DOI: **https://doi.org/10.3399/bjgp09X472872**	What happens when doctors are patients? Qualitative study of GPs	Background: Current evidence about the experiences of doctors who are unwell is limited to poor quality data. Aim To investigate GPs' experiences of significant illness, and how this affects their own subsequent practice. Design of study: Qualitative study using interpretative phenomenological analysis to conduct and analyse semi-structured interviews with GPs who have experienced significant illness. Setting: Two primary care trusts in the West of England. Method A total of 17 GPs were recruited to take part in semi structured interviews which were conducted and analysed using interpretative phenomenological analysis Results: Four main categories emerged from the data. The category, 'Who cares when doctors are ill?' embodies the tension between perceptions of medicine as a 'caring profession' and as a 'system'. 'Being a doctor–patient' covers the role ambiguity experienced by doctors who experience significant illness. The category 'Treating doctor–patients' reveals the fragility of negotiating shared medical care. 'Impact on practice' highlights ways in which personal illness can inform GPs' understanding of being a patient and their own consultation style. Conclusion: Challenging the culture of immunity to illness among GPs may require interventions at both individual and organisational levels. Training and development of doctors should include opportunities to consider	CASP-7

		personal health issues as well as how to cope with role ambiguity when being a patient and when treating doctor–patients. Guidelines about being and treating doctor–patients need to be developed, and GPs need easy access to an occupational health service.	
WHITE, A, SHIRALKAR, P, HASSAN, T, GALBRAITH, N, AND CALLAGHAN, R(2006) Psychiatric Bulletin (20 0 6), 3 0, 382-384	Barriers to mental healthcare for psychiatrists	Aims and Methods: To determine the opinions of psychiatrists on mental illness among themselves and their colleagues a postal survey was conducted across the West Midlands. Results: Most psychiatrists (319/370, 86.2%) would be reluctant to disclose mental illness to colleagues or professional organisations (323/370, 87.3%). Their choices regarding disclosure and treatment would be influenced by issues of confidentiality (n=245, 66%), stigma (n=83, 22%) and career implications (n=128, 35%) rather than quality of care (n=60, 16%). Clinical implications: The stigma associated with mental illness remains prevalent among the psychiatric profession and may prevent those affected from seeking adequate treatment and support. Appropriate, confidential specialist psychiatric services should be provided for this vulnerable group, and for doctors as a whole, to ensure that their needs, and by extension those of their patients, are met.	EHPP-Moderate

Cohen, D. Marfell N & Greene,G.(2014) Occupational Medicine Volume 64, Issue 2 Pp. 126-132	Standards for 'Health for Health Professionals' services in the UK	To develop consensus about standards for 'Health for Health Professionals' (HHP) services in the UK through a modified Delphi study. Methods: We conducted a two-stage Delphi study over 6 months. The questionnaire development took place during the UK Association of Physician Health (UKAPH) meeting in London in 2012, Forty-four people took part in round 1 and 40 in round 2. Participants were mainly GPs, occupational physicians and psychiatrists. Consensus was reached on major criteria for HHP services, with greatest consensus (45% agreement or greater) for four statements concerning the clarity and transparency of the services offered and one statement that anyone working within the service should have received suitable training in physician health. Consensus about some statements varied among the three specialities. This study was limited due to timescale which prevented a third Delphi round being completed. This may have resulted in additional consensus information being gathered. However, as the number of clinicians working in this field it is possible that this study is representative of the UK UKAPH population. **Conclusions** This study will assist discussion about providing and improving consistent services across the UK.	EHPP-Moderate
Fox, F., Doran, N. J., Rodham, K. J., Taylor, G. J., Harris, M. F., & O'Connor, M. (2011). Medical Education, 45,	Junior doctors' experiences of personal illness: a qualitative study.	Objectives: Professional status and working arrangements can inhibit doctors from acknowledging and seeking care for their own ill health. Research identifies that a culture of immunity to illness within the medical profession takes root during training. What happens when trainee doctors become unwell during their formative period of education and training? What support do they receive and how do they perceive that the experience of ill health affects their training trajectory? These research questions were developed by a multidisciplinary team of researchers and health professionals, who adopted a qualitative approach to investigate the experiences of personal illness among trainees in their Foundation Programme (FP) years.	CASP-7

1251-1261.		Methods: Semi-structured interviews were conducted with eight FP trainees from the Severn Deanery in southwest England who had experienced significant illness. Interpretative phenomenological analysis was used to conduct and analyse the interviews, resulting in a comprehensive list of master themes. This paper reports an interpretative analysis of the themes of *Support*, *Illness Experience*, *Crossing the Line*, *Medical Culture*, *Stigma* and *Disclosure.* Results: Ineffective communication within the medical education and employment system underpins many of the difficulties encountered by trainees who are unwell. Coping style plays a key role in predicting how trainees experience support during and after their illness, although this may be influenced by their particular diagnoses. The barriers to disclosure of their illnesses are discussed within the context of mobilising and maintaining support. Concern about the impact of missing training as a result of ill health appears to be significant in the transmitting of an ethos of invulnerability within the medical culture. Conclusions: Suggestions to improve support procedures for trainees who are unwell include the provision of greater flexibility within the rotation system along with independent pastoral support. Promoting the importance of disclosing significant illness as early as possible might go some way towards challenging the culture of invulnerability to illness that prevails among doctors.	
PHP (2013) Supporting the health of HCPs	The First Five Years of the NHS Practitioner Health Programme 2008 - 2013	This report provides an overview of the NHS Practitioner Health Programme service (PHP) and the support it has provided for its practitioner patients over this 5-year period. Independent research shows that patients attending PHP are as sick as any attending mental health services (see the following link http://bmjopen.bmj.com/content/2/5/e001776.long) and its outcomes far surpass any other treatment service dealing with similar patients, in terms of return to work; improvements in health and well-being; sickness rates and abstinent rates. It is emerging more clearly that certain professional and	EHPP-Strong

		demographic groups have been identified as more likely to present as practitioner patients, such as Training doctors	
M. Meerten, F. Rost, J. Bland and A. Garelick Occupational Medicine Advance Access published ***Occupational Medicine*** February 20, 2014	Self-referrals to a doctors' mental health service over 10 years	To investigate the change in self-referral rates to a doctors' mental health service, and associated morbidity over a decade. All doctors attending a doctors' mental health service between 1 January 2002 and 31 December 2011 were asked to complete the Clinical Outcomes in Routine Evaluation questionnaire and Maslach burnout inventory as part of routine assessment before treatment. Univariate analysis of variance was used to test for statistically significant differences between severity scores in different years. Between 1 January 2002 and 31 December 2011, 1062 doctors attended the service; 852 (80%) completed both questionnaires and 64 (6%) completed one of them. The overall response rate was 86% (916/1062). Referrals increased >4-fold, from 44 in 2002 to 185 in 2011. Sixty-one per cent scored above the threshold for psychological distress and 59% for burnout. There were no significant changes in morbidity over time. Increasing numbers of doctors sought help from the doctors' mental health support service. More than half scored above the thresholds for burnout and psychological distress and these proportions were consistent over 10 years. Doctors may be more willing to seek help than a decade ago. Further research is needed to confirm the underlying reasons for this. More resource is needed to meet the increase in demand. doi:10.1093/occmed/kqt177	EHPP-Strong

Hassan, T,Ahmed,S White,A and Galbraith,N Clin Med (Lond). 2009 Aug; 9(4): 327–332. **doi: 10.7861/clinmedicine.9-4-327**	A postal survey of doctors' attitudes to becoming mentally ill	A postal survey of 3,512 doctors in Birmingham was carried out to assess attitudes to becoming mentally ill. The response rate for the questionnaire was 70% (2,462 questionnaires). In total, 1,807 (73.4%) doctors would choose to disclose a mental illness to family and friends rather than to a professional. Career implications were cited by 800 (32.5%) respondents as the most frequent reason for failure to disclose. For outpatient treatment, 51.1% would seek formal professional advice. For inpatient treatment, 41.0% would choose a local private facility, with only 21.1% choosing a local NHS facility. Of respondents 12.4% indicated that they had experienced a mental illness. Stigma to mental health is prevalent among doctors. At present there are no clear guidelines for doctors to follow for mental healthcare. Confidential referral pathways to specialist psychiatric care for doctors and continuous education on the vulnerability of doctors to mental illness early on in medical training is crucial.	EHPP-Moderate
Smith,F. Goldacre,M. Lambert, T. (2016)JRSM Open. Apr; 7(4): 2054270416635035. Published online 2016 Mar 3.	Working as a doctor when acutely ill: comments made by doctors responding to United Kingdom	We undertook multi-purpose surveys of doctors who qualified in the United Kingdom between 1993 and 2012. Doctors were asked specific questions about their careers and were asked to comment about any aspect of their training or work. We report doctors' comments about working whilst acutely ill. **Design:** Self-completed questionnaire surveys. **Setting:** United Kingdom. **Participants :**Nine cohorts of doctors, comprising all United Kingdom medical qualifiers of 1993, 1996, 1999, 2000, 2002, 2005, 2008, 2009 and 2012.**Main outcome measures:** Comments made by doctors about working when ill, in surveys one, five and 10 years after graduation. **Results:** The response rate, overall, was 57.4% (38,613/67,224 doctors). Free-text comments were provided by 30.7% (11,859/38,613). Three-hundred and twenty-one doctors (2.7% of those who wrote comments) wrote about working when feeling acutely ill. Working with *Exhaustion/fatigue* was the most frequent topic raised (195 doctors), followed by problems with *Taking time off for illness* (112), and general comments on *Physical/mental health problems* (66). Other topics raised included *Support from others*, *Leaving or*	EHPP-Strong

		adapting/coping with the situation, Bullying, the *Doctor's ability to care* for patients and *Death/bereavement*. Arrangements for cover due to illness were regarded as insufficient by some respondents; some wrote that doctors were expected to work harder and longer to cover for colleagues absent because of illness. **Conclusions:** We recommend that employers ensure that it is not unduly difficult for doctors to take time off work when ill, and that employers review their strategies for covering ill doctors who are off work. doi: 10.1177/2054270416635035	
Cohen,D, Winstanley, S. Greene, G *Occup Med (Lond)* (2016)doi: 10.1093/occmed/kqw024First published online: March 29, 2016	Understanding doctors' attitudes towards self-disclosure of mental ill health	**Background:** Understanding of doctors' attitudes towards disclosing their own mental illness has improved but assumptions are still made. **Aims:** To investigate doctors' attitudes to disclosing mental illness and the obstacles and enablers to seeking support. **Methods:** An anonymous, UK-wide online survey of doctors with and without a history of mental illness. The main outcome measure was likelihood of workplace disclosure of mental illness. **Results:** In total, 1954 doctors responded and 60% had experienced mental illness. There was a discrepancy between how doctors think they might behave and how they actually behaved when experiencing mental illness. Younger doctors were least likely to disclose, as were trainees. There were multiple obstacles which varied across age and training grade. **Conclusions:** For all doctors, regardless of role, this study found that what they think they would do is different to what they actually do when they become unwell. Trainees, staff and associate speciality doctors and locums appeared most vulnerable, being reluctant to disclose mental ill health. Doctors continued to have concerns about disclosure and a lack of care pathways was evident. Concerns about being labelled, confidentiality and not understanding the support structures available were identified as key obstacles to disclosure. Addressing obstacles and enablers is imperative to	EHPP-Moderate

	shape future interventions. **doi: 10.1093/occmed/kqw024First published online: March 29, 2016**	

Table 8 **Interventions** **Reference**	**Title**	**Themes**	
Bu et al. Pilot and Feasibility Studies (2019) 5:61 https://doi.org/10.1186/s40814-019-0449-y	Mindfulness intervention for foundation year doctors: a feasibility study	Background: Mindfulness has been shown to reduce stress and burnout in medical students and healthcare professionals. This is a quality improvement study which assessed the feasibility of conducting a full-scale evaluation of a mindfulness intervention among UK foundation doctors to reduce stress and burnout. Methods: This is an uncontrolled before and after study taking place in a single university teaching hospital. The RE-AIM framework which comprises of five dimensions including Reach, Adoption, Effectiveness, Implementation, and Maintenance was used to guide this assessment. The intervention was a 6-week 'Mindfulness in the Workplace' course. The primary measure was change in self-reported levels of stress immediately before and after the course. Additional measures explored the subjective experiences of participating doctors through the use of questionnaires handed out before and after the course. Results: All 20 places on the course were filled from the population of 108 foundation doctors at the trust with an equal number of foundation year 1 (n = 10) and foundation year 2 (n = 10) doctors. Sixteen participants (80%) attended one or more sessions. The median baseline stress score of the participants was 6.5 (range = 2 to 9). The median post-course stress score was 5.0 (range = 2 to 8). The Mann-Witney test indicated that the stress levels of participants were significantly lower at the end of the course compared to baseline, U = 74.50, p = .04. Additional measures suggested that the intervention may be associated with	EHPP- Moderate

		some other potentially promising benefits for doctors including greater well-being, improved working life, and more satisfactory relationships with patients. Implementation of this intervention requires further work at the institutional level because only 35% of participants completed the full intervention, the main barrier being work commitments. Conclusion: This is the first programme of research to evaluate the feasibility of trialling and implementing a modified 'Mindfulness in the Workplace' intervention for foundation junior doctors in the UK. Based on the findings from this study, we conclude that this intervention is promising but further modifications are required such as the use of validated outcome measures and improving delivery aspects before this intervention programme is trialled among foundation doctors in the UK. Keywords: Mindfulness, Foundation, Junior doctor, Feasibility, Burnout	
Hancock,J, Mattick, K. (2020) Medical Education. 2020;54:125–137.	Tolerance of ambiguity and psychological well-being in medical training: A systematic review	Context: The prevalence of stress, burnout and mental health disorders in medical students and doctors is high. It has been proposed that there may be an association between levels of tolerance of ambiguity (ie an ability to tolerate a lack of reliable, credible or adequate information) in clinical work and psychological well-being within this population. The aims of this systematic review were: (i) to assess the nature and extent of the literature available, in order to determine if there is an association, and (ii) to develop a conceptual model proposing possible mechanisms to underpin any association, in order to inform subsequent research. Methods: MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PsycINFO databases were searched for articles published from inception to September 2018. Additional literature was identified by searching the reference lists of included articles, forward searches of included articles, hand searches of key journals and a grey literature search. Of the 671 studies identified, 11 met the inclusion criteria. A qualitative synthesis of included studies was performed. Results: All 11 included studies reported an association between a lower level of tolerance of ambiguity or uncertainty and reduced psychological well-being. Included studies were heterogeneous	Lit Review -5

		in terms of population and measurement approach, and were often of low methodological quality. Subsets of items from previously developed scales were often used without sufficient consideration of the impact of new combinations of items on scale validity. Similar scales were also scored inconsistently between studies, making comparison difficult. Conclusions: There appears to be an association between tolerance of ambiguity and psychological well-being. This provides new opportunities to understand and prevent the development of stress, burnout and mental health disorders in medical students and doctors. The conceptual model developed provides a framework for future research, which we hope will prevent wasted research effort through duplication and promote higher methodological quality.	
Carrieri D, Pearson M, Mattick K, Papoutsi C, Briscoe S, Wong G, Jackson M.. http://dx.doi.org/10.1136/bmjopen-2017-021273 Southampton (UK): NIHR Journals Library; 2020 Apr. PMID: 32271514.	Interventions to minimise doctors' mental ill-health and its impacts on the workforce and patient care: the Care Under Pressure realist review	**Background:** The growing incidence of mental ill-health in health professionals, including doctors, is a global concern. Although a large body of literature exists on interventions that offer support, advice and/or treatment to sick doctors, it has not yet been synthesised in a way that takes account of the complexity and heterogeneity of the interventions, and the many dimensions (e.g., individual, organisational, sociocultural) of the problem. **Aim** -to improve understanding of how, why and in what contexts mental health services and support interventions can be designed to minimise the incidence of doctors' mental ill-health. The objectives -review interventions to tackle doctors' mental ill-health and its impact on the clinical workforce and patient care- to produce actionable theory. To make tailored recommendations that can be implemented, monitored and evaluated to tackle mental ill-health and its impacts. **Data sources:** Bibliographic database searches were developed and conducted using MEDLINE (1946 to November week 4 2017), MEDLINE In-Process and Other Non-indexed Citations (1946 to 6 December 2017) and PsycINFO (1806 to November week 2 2017) (all via Ovid) and Applied Social Sciences Index and Abstracts (1987 to 6 December 2017) (via ProQuest) on 6 December 2017. Further UK-based studies were identified by forwards and	Lit Review -5

author citation searches, manual backwards citation searching and hand-searching relevant journal websites.

Review methods: all studies that focused on mental ill-health; all study designs; all health-care settings; all studies that included medical doctors/medical students; descriptions of interventions or resources that focus on improving mental ill-health and minimising its impacts; all mental health outcome measures, including absenteeism (doctors taking short-/long-term sick leave); presenteeism (doctors working despite being unwell); and workforce retention (doctors leaving the profession temporarily/permanently).

Results: A total of 179 out of 3069 records were included. Most were from the USA (45%) and had been published since 2009 (74%). More included articles focused on structural-level interventions (33%) than individual-level interventions (21%), but most articles (46%) considered both levels. Most interventions focused on prevention, rather than treatment/screening, and most studies referred to doctors/physicians in general, rather than to specific specialties or career stages. Nineteen per cent of the included sources provided cost information and none reported a health economic analysis. The 19 context–mechanism–outcome configurations demonstrated that doctors were more likely to experience mental ill-health when they felt isolated or unable to do their job, and when they feared repercussions of help-seeking. Healthy staff were necessary for excellent patient care. Interventions emphasising relationships and belonging were more likely to promote well-being. Interventions creating a people-focused working culture, balancing positive/negative performance and acknowledging positive/negative aspects of a medical career helped doctors to thrive. The way that interventions were implemented seemed critically important. Doctors needed to have confidence in an intervention for the intervention to be effective.

Limitations: Variable quality of included literature; limited UK-based studies

	or that pertaining to OH or OH intervention/ screening or F1s. A review warranting further research especially regarding belong, health promotion, well-being, relationship and doctors needing to believe in an intervention for its potential for successful outcome.	

2.7 Theme 1. Professional Guidance and Policy

This section outlines literature concerning professional guidance and policy statements about supporting doctors and medical students in distress.

There is a demand for doctors to meet targets and display unusual levels of resilience to cope with the on-going impact of workload despite few organisationally available resources and little support (McCartney 2015). Stress caused by excessive workload, shift working, and targets have all been cited as impacting economically on the NHS and OH in terms of absenteeism, presenteeism, poor patient care and medication errors (DOH, 2010, Boorman, 2009, Francis Report, 2013). The Boorman (2009) and Frances (2013) reports sought to address stress in the NHS by evidencing strong correlations between positive staff HWB and positive patient outcomes. The latter underlined the urgent need to address culture of NHS management staff in terms of access to improving evaluated, validated MH and well-being training. Subsequently, "Work and Well-being in the NHS: Why Staff Health Matters to Patient Care" (The Royal College of Physicians, 2015), also reiterate this conclusion.

In the wider literature there is a wealth of research available regarding medical students and the impact of their training upon their MH, levels of stress and BO (Dunn 2008, Mavor 2014). There is far less written on what happens during the transition to F1s. Acknowledging the burgeoning evidence available, the General Medical Council (2013) has produced the following guidance: "Supporting medical students with MH conditions". Fertleman and Carroll (2013) have reviewed this document critically and argue that it fails to indicate "how" to actually support students in distress, and or, escalate concerns.

UK doctors are leaving the profession at an alarming and increasing rate (Centre for Workforce Intelligence, 2014). Not only are older doctors taking early retirement, but young recently qualified doctors are leaving the country, or profession, in unprecedented numbers (Campbell, 2015). NHS figures indicate that the number of young medics

applying to continue their career in the health service has plunged to a new low, appearing to support fears that strike action will hit recruitment (Guardian, 2016). Since Covid has occurred this situation has worsened (Workforce alliance, 2021).

2.8 Theme 2. Internal World of Doctors

This section outlines literature concerned with attachment, resilience and coping styles. Adshead (2010) reviews attachment theory as a theoretical paradigm and its potential correlation to high stress levels, insecure attachment patterns and poorly performing doctors. She considers the training required for a professional caregiver and possible interventions for those who struggle to manage high work-related stress levels. In 2010, Adshead noted a deficit of studies related to attachment within the caring professions although this now appears to be an emerging field of interest (Kokkonnen et al, 2014). The wider literature indicates that students and doctors in practice have to engage professionally and relationally with their patients. In one of the only formal studies available in this area, Ciechanowski et al., (2004) explore attachment styles in students and found that 59% rated themselves to be securely attached although their study does not specifically consider the impact of this. Other studies informally consider the impact of attachment upon opting to become a medical student and also choice of career (Firth Cozens, 1992).

In the wider literature, Howe et al. (2012) outline other important factors associated with a student's ability to remain resilient, such as a supportive medical training with additional mandatory components such as resilience training (Peng et al., 2014), self-care management, e.g., mindfulness (Erogul, 2014), emotional regulation, and HWB options. Conceptually, these well-being strategies are illustrated in Dunn et al., (2008) model of a "coping reserve tank" (Appendix 4). The coping reservoir is a metaphor highlighting the dynamic nature of individual's experiences and potential outcomes. These include enhanced resilience and positive MH versus distress and burnout. Dunn

et al., (2008) believe using this model within medical education can offer enhanced resilience and personal enhancement of professionalism and patient care by equipping doctors with the skills needed to sustain well-being throughout their careers.

Findings by Ford and Summer (1998) and Roback et al., (2007), indicate a relationship between insecurely attached doctors and personality disorders (Cohen, 2007). Bennet (1987) postulates the existence of a “medical persona” which manifests as rigid adherence to hierarchical structures, distress intolerance and rejection of “others” all of which potentially reduce resilience to stress. Myers and Gabbard (2008) also found that insecurely attached doctors seem to possess personality traits such as compulsiveness, perpetual self-doubt, perfectionism and an exaggerated sense of responsibility which possibly make them more vulnerable to certain stressors. Eley et al., (2013) examined the relationship between resilience and personality traits in 479 family doctors, concluding that mature, responsible, optimistic, cooperative, and persevering traits positively align with optimal functioning and well-being. Whilst this is a different population from that studied, if the specific trait can be harnessed via well-being programmes this study may have significance for OH.

Similarly Fertleman’s (2013) paper outlines a simple summary of the issue of MH problems in medical students and their impact on resilience related to other aspects of the course. The importance of addressing MH problems is highlighted in the GMC and associated professional medical literature on managing students with mental health problems - culminating in recommendations that making MH problems easier to address for students would be beneficial for their long term resilience(Fertleman et al., 2013). Adams et al.’s (2012) paper ‘An exploratory prospective cohort study’ shows the significant association between the personal traits of medical student applicants (measured by non-cognitive tests) and their future scores in both non-cognitive and cognitive tests. One of these non-cognitive tests includes a self-appraisal inventory

(SAI) which measures resilience (and also, separately, self-control), by examining anxiety, moodiness, neuroticism and irrational thinking. These papers have implications for OH when targeting health promotion, training, screening, or education to support HWB programmes.

2.8.1 Attachment Style

Literature relating to attachment, such as Adshead's [paper] (2010) explores the previous relationship between junior doctor and the "firm" to which they were "attached". Like the "*Firm"*, or group of doctors ranging from F1 to consultant which functioned as a supportive team, groups of seven individuals can function effectively and supportively (Silverthorne, 2010, Carrieri et al, 2015, 2017,2020). Arguably, this provides a necessary secure base for F1s enhancing resilience during this transitioning period (Carrieri et al, 2015, 2017 & 2020, Carter & McGoldrick, 1989, Berge et al, 2012). Various re-organisations in the UK and the working time directive (2004) *mean* that firms and such groups no longer exist. In the rapid response paper, "*Why are so many doctors leaving the profession: is the answer one, seven or forty-two?",* - BMJ Open paper, Carreiri et al. (2015) set out their plans for a series of Symposia called "Care under pressure", seeking to explore stress and BO in health care professionals as well as to find solutions. This rapid response paper outlined initial proposals, highlighting that reasons for doctors leaving the profession include the erosion of the workforce, the lack of support, that individual function better within teams/ groups, that doctors find it difficult to take leave of absence for fear of appearing weak in front of colleagues, and the negative impact of technology all mean that often F1s are working alongside relative strangers (Carrieri et al,2015,).

Dysfunctional teams, poor communication, interpersonal conflict, and low levels of support might increase vulnerability to MH problems (DOH, 2010). Baptiste

(2016) notes the negative impact of F1s lacking a permanent location. During training, doctors usually rotate across various specialties, and or organisations every four to six months. This lack of stability can cause F1s to be uprooted and experience long periods of separation. Baptiste (2016) proposes that this can disrupt the doctor's support network, which includes OH (Cohen, 2016) that is so crucial to a healthy mental state. Greene & Conrads (2002) argue that resilience cannot develop without positive interaction with environmental resources; that is, it is positively or negatively affected by the external world (Luthar, Cicchetti & Becker 2000, Powers 2002, Cohen et al, 2016). It is possible that unconscious processes (Obholzer & Roberts, 1994) arising from lacking a secure base from which to work might have an impact upon F1s with a history of MH conditions.

2.8.2 Interventional review paper

Current demands on the NHS and F1s, and research highlighting the importance of fostering attachment and resilience has major ethical significance for OH whose role it is to determine how best to support those experiencing MH issues.

To date some of the most comprehensive literature reviews have been conducted by the 'Care under pressure Symposium' (Carreiri et al, 2017, 2020). The most recent paper is a literature review which has aimed to explore why the growing incidence of mental ill-health in health professionals, including doctors, is a global concern. The aim and objectives of conducting the review are to understand how to tackle doctors' MH, its impact at work and on patient care so as to develop theory that is applicable in practice. The results of this review include:

- 33% of included articles focused on organisational interventions;
- 21% of articles considered individual-level interventions whereas most incorporated the two (46%).

- Most interventions focused on prevention, rather than treatment/screening, and most studies referred to doctors/physicians in general;
- 19% of the included sources provided cost information;
- None reported a health economic analysis.

The paper referred to in the review demonstrated that doctors were more likely to experience mental ill-health when they felt isolated or unable to do their job, and when they feared repercussions of help-seeking. Other findings from this review included that healthy staff were necessary for excellent patient care. Interventions emphasising relationships and belonging were more likely to promote well-being. Interventions creating a people-focused working culture, balancing positive/negative performance and acknowledging positive/negative aspects of a medical career helped doctors to thrive. The way that interventions were implemented seemed critically important. Doctors needed to have confidence in an intervention for the intervention to be effective.

The limitations of these reviews are that they are not interventional to date, that the quality of included literature is variable by their own admission and there are limited UK-based studies or studies that pertain to OH, to OH intervention/ screening or to F1s.The continuous review and output from this research team however is promising and has relevance for this current study area, particularly with regard to the concepts of: “belonging”, health promotion, well-being, relationship and the need for doctors to believe in an intervention for its potential for successful outcome.

Current demands upon the NHS and F1s, and research highlighting the importance of fostering attachment and resilience has major ethical significance for OH whose role it is to determine how best to support those experiencing MH issues.

Fox et al, (2011) in a qualitative study about individual coping style, found that eight foundation trainees (F1 and F2 doctors) in one deanery with experience of significant illness (2 with MH), felt less able to discuss some health conditions than others. Fox et al. (2011) found that professional status and working arrangements can inhibit doctors from acknowledging and seeking care for their own ill health. These researchers investigated the experiences of personal illness among trainees in their trainee years using qualitative methods – Interpretative phenomenological analysis. They found that many difficulties encountered by unwell trainees related to poor communication within the medical education and employment systems. Coping style was a relevant predictor of how trainees experience support during and after their illness, and barriers to disclosure discussed as a concern regarding seeking support. In conclusion Fox et al. recommend improved pastoral support and rota flexibility for those trainees who are unwell. They also recommend challenging the culture of invulnerability to illness by promoting the importance of disclosure when unwell.

Grant et al. (2019) undertook a study which aimed to identify external factors and barriers that influence the recovery of doctors in training who were experiencing MH. They held interviews with stakeholders which included: members of national bodies with an interest in doctors' MH such as the GMC and the BMA; providers of support including for Doctors, PHP, the Doctors' Support Network; as well as members of HEE (the organisation responsible for the postgraduate training of doctors), associated support staff and educational supervisors. The study held focus group interviews with trainee doctors, and narrative interviews with trainees who had personally experienced mental illness. Ten F2 and junior doctors were interviewed although no F1s were involved. A number of the participants had knowingly continued working even though they knew they were ill and sometimes after they had been diagnosed and been advised to take sick leave. Having a MH problem interfered with doctors' ability to carry out one of the most fundamental tasks for any doctor – the ability to communicate with patients. It also

affected some doctors' cognitive function. Having a mental illness reduced some doctors' capacity for work and increased their need for rest. They describe doing the bare minimum to get by, being unable or unwilling to engage with patients and failing to remember the basic knowledge needed to practise. For the most part, they had sufficient insight into the consequences of such action yet felt they had no alternative but to continue working. The social pressures of the job pushed them to say that they loved it and to ignore their own needs, such as to get sufficient rest to remain well and to carry out the job safely. Any requests for support were apparently not met and were treated as unreasonable.

Presenteeism is an issue for doctors. In a Scottish study of doctors in training, only 12% surveyed said they would take time off work for low mood, and 14% for severe anxiety (Baldwin et al, 1997). In the qualitative component of a study, four of 24 doctors with a psychiatric disorder took no sick leave at all during their illness. A further three worked through 65 depressive symptoms, and some returned from sick leave earlier than they would advise a patient to do (McKevitt et al, 1997). In the quantitative aspect of the study, the majority of doctors surveyed (86% of GPs and 85% of hospital doctors) recognised that they had continued to work when it might have been better to take sick leave. One factor found to influence doctors who worked through illness was confidentiality. An Irish study of non-consultant hospital doctors found over two-thirds (69%) cited not wanting anyone to know about their illness as a factor influencing their decision to continue working (Feeney et al., 2016). One UK study found a link between sick leave for PH and experiencing MH. Less than a quarter of doctors surveyed who had been depressed had taken time off at all for stress or strain.

2.9 Theme 3. External World of Doctors

This section outlines the literature concerned with the impact of training and working environment on the external world of doctors.

Lambert et al. (2015) undertook a questionnaire survey of 3228 junior doctors' views about their work, education and training three years after graduation in 2008. Positive comments were made about levels of supervision, support, morale and job satisfaction, yet there was a perception that problematic rotas, and arrangements relating to cover and leave, had an adverse effect on work-life balance, relationships, morale and health. Baptiste (2016) reports that such issues possibly have a negative impact upon all doctors' MH and resilience. As F1s predominantly "man the NHS" it is possible that they are most affected. On-going deanery changes involving "outsourcing" of training may also have an impact on MH outcomes in the future (London Deanery, 2011). Covid may also alter these outcomes (Workforce alliance, 2021).

McKinley et al. (2020) measured resilience in 1518 doctors. This study is the largest published study of its kind with a wide range of doctors and specialities across the UK. It is the first time that resilience has been assessed in UK NHS medical staff with a combination of additional psychological measures. It included a 30-item Professional Quality of Life questionnaire composed of three subscales and aimed to measure the positive and negative effects of helping others. It assesses a broad range of coping responses (self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame. McKinley et al. (2020) discovered that F1s had lower resilience scores than other doctors and higher mean secondary traumatic stress (STS) than other doctors. Conversely, 120 (8%) F1s met the criteria for high burnout, high STS, and low CS (compassion). This is noteworthy and something that OH could pay particular attention to when F1s move to jobs in which they are unhappy and when cumulative factors may have a negative impact upon their MH and/or or PH.

McCain et al. (2018) study similarly demonstrates high burnout in almost one in every two doctors. Associated with this was an increased likelihood of maladaptive coping strategies such as substance use. 18% of doctors surveyed by McCain et al. (2018) were suffering from STS, BO, and low levels of CS. When doctors were invited to consider career time points when their resilience was low, they identified workplace and systemic factors as being significant contributors to low resilience (McCain, 2018).

McKinley et al. (2020) cited the predominant maladaptive coping strategy as self-distraction, followed by active planning, emotional support and self-blame which were frequently used. Infrequently, some men reported "*I've been using alcohol or other drugs to make myself feel better*". These men are significantly more likely to use denial and humour to cope, whereas women more frequently used emotional support, instrumental support and positive reframing.

Bhugra's et al. (2019) studies have consistently shown high levels of depression, anxiety and high burnout risk amongst doctors, related to work, training, or studying environment. Maslach & Leiter (2016), describe BO as a psychological syndrome characterized by overwhelming exhaustion, depersonalization, and reduced personal efficiency.

Teoh et al. (2018) assessed views of NHS staff about their work and well-being. The study's sample was restricted to the medical occupational group working in Acute or Specialist Trusts (England's 2014 NHS Staff Survey; NHS Staff Survey Co-ordination Centre, 2015). In total 157 Trusts were represented including 18 Specialist Trusts, with 94.1% of doctors from Acute Trusts. In 2014, over 624,000 employees from 287 NHS Trusts in England were surveyed, with 255,150 (42%) responses returned. This study aimed to test the predictive power of job demands, job resources and organisational demands in relation to three work-related well-being outcomes (perceived stress, presenteeism and work engagement) in a sample of hospital doctors in England. They

found that hospital doctors' job demands and resources predicted their work-related well-being i.e. job demands were more strongly associated with perceived stress and presenteeism than job resources. Work engagement, on the other hand, was primarily associated with more job resources.

Medisauskaites et al. (2019) investigated the prevalence of occupational distress and health problems such as ill health symptoms, and health-related problems among UK doctors. The results show that occupational distress increases the odds of doctors using substances, having sleep disturbances, experiencing frequent symptoms of ill health and binge-eating (Medisauskaite et al, 2019).

In response to *Tomorrow's Doctors* (GMC, 2009), which prescribes undergraduate curriculum change, Brennan et al. (2010) interrogated the experiences of F1s and whether or not medical school had provided a good foundation for the first year of clinical practice. The study found that despite the curriculum reforms, most participants still found the transition stressful and felt unsupported in areas such as dealing with responsibility, managing uncertainty, working in multi-professional teams and experiencing the sudden death of patients.

2.10 Theme 4. Health-Seeking Behaviour and OH

This section underscores literature related to health seeking behaviour - Seeking help to deal with health issues. This includes both formal and informal, issues surrounding disclosure, and OH.

Doctors who can maintain a self-construct of one who is invincible and strong (Hesse, 2008) may find this beneficial, if the requirement to maintain this is only necessary in the short term. Mavor (2014) proposes that professional identity and self-identity is a key area that is also likely to impact upon an individual's long-term resilience (Burford, 2012) positively or negatively (Hesse, 2008). However, in the face of relentless workload and

other demands (McCartney, 2015), the “professional identity” might prevent an individual requesting support, registering with a GP, or taking time off work (Harrison and Sterland, 2006, Davies M. 2015, Oxtoby K. 2015b, Oxtoby K. 2015a, Baptist, 2016).

Adams et al, (2010) explored help-seeking attitudes of UK GPs and psychiatrists found 90% of those surveyed would or did turn to friends and family if they felt their *“health was suffering due to strain or stress*” and would or had turned to sources of support at work in this situation. Informal consultations were found to be common among GPs in several UK qualitative studies (McKevitt et al., 1997) including for severe anxiety or low mood (Forsythe, Calnan, & Wall, 1999). This includes F1s with low mood (Baldwin et al., 1997).

Hassan et al. (2009) found most doctors were likely to disclose to family and friends before professional/government institutions, being less likely to share MH concerns with the latter (Hassan et al., 2009; White et al., 2006) or a spouse or partner (Cohen et al., 2016).

One in three UK junior doctors in Bhugra’s et al. (2019) study acknowledged that they were using alcohol, drugs, self-medication, or self-prescribing regularly or occasionally as a way to cope with their MH condition. 67% reported that they did not use the latter at all. 38% of men and older doctors were more likely to misuse substances, i.e., alcohol, drugs, or self-medication/prescribing as a means of coping than women (28%).

Only one qualitative study (Fox et al., 2011) of F1s with experience of significant illness (two with MH) reported the difficulty that doctors face in making decisions about disclosing their ill health. This included uncertainty about when to disclose, and with whom to disclose. A MedNet study (Garelick et al., 2007) found 72% of doctors stated they were encouraged to self-refer by another person, including GPs, senior colleagues, OH, postgraduate deanery, a psychology professional, or friends/family. 50% had

previously consulted a psychiatrist. Meerten et al., (2011) in a further Mednet study in 2011 reported similar findings.

2.10.1 Formal Health Seeking

Formal help seeking was examined in several studies. Various professional individuals and organisations offer MH care provision such as OH or specialist service providers.

2.10.2 Contacts with OH and Workplace

OH is mentioned in 12 studies identified in the literature review, seven of which were concerned with ill health of doctors or is about other services. (Chambers, 2014; Cohen, 2014). Lalloo et al. (2013) evaluated all doctor and dentist (960) encounters within an OH service over a year. MH concerns were the main reason for referral with more doctors presenting as absent via OH. Limitations of this study by Lalloo et al. (2013) include the retrospective approach and inclusion of dentists, which dilutes the information pertaining to doctors alone. Waldron et al., (1996) explored 110 doctors' general health in a random cross-sectional sample of 200 doctors from the medical register. The majority of doctors had had at least one day off sick in the previous 2 years. 51 reported having access to OH but no one had consulted an occupational physician. Critically, the reasons for this are not explored; it was a pilot study and details regarding procedure are not mentioned. Cohen et al. (2015) undertook telephone interviews with sick doctors and identified 4 key themes as enablers and obstacles relating to returning to the workplace but fail to mention OH. Grant et al. (2019) note that doctors often cite the decision to take sick leave caused distress. This includes inner conflict from letting colleagues down, feeling like a failure and some had been told at induction that they were not allowed to take time off work. However, whilst most of the ten participants had taken a period of sick leave, almost all had

resisted this and, in several cases, a friend, relative or colleague had persuaded them that they must take sick leave (Grant et al., 2019). OH advice was not always available to assist with liaising between the employer and the doctor's psychiatrist or GP. On return to work, Grant et al., (2019) report that in the absence of any contact with their manager, one participant took the initiative and made contact with OH, only to be sent an appointment for six months' time.

Forsythe et al. (1999) undertook a postal questionnaire of Consultants and GPs, examining their general health, the use of OH, and self-prescribing habits.11% of GPs had access to OH; but failed to use it, whereas 95% of consultants could access OH, but only 25% had done so. Doctors were asked whether they would consult formally or informally for a range of problems. For both severe anxiety and low mood, nearly half surveyed would consult formally (Forsythe et al., 1999). The most popular source of formal help for doctors was the GP (Adams et al., 2010). Counsellors, MH therapists and psychologists, i.e., those professionals working in disciplines associated with psychiatry, were also sources of formal support for doctors. In a UK study, just over a third of doctors surveyed would turn to a counsellor (Adams et al., 2010). It is useful to note the poor uptake of OH and it would be valuable to try to understand the reasons for this.

A UK study found that GPs and psychiatrists perceived OH and helplines such as Medline as less useful sources of support, although both of these options were still selected by over a fifth of respondents (Adams et al., 2010). Moreover, Bianchi et al., (2016) found that UK doctors have reservations about help-seeking from OH due to confidentiality concerns. Adherence to organisations' sickness absence management policies necessitated that those doctors who had experienced MH disclosed mainly to OH departments, and then colleagues and

line managers (Cohen et al., 2016). This is as a result of organisational regulations that staff have to follow which might include line managers reporting to OH.

Bhugra et al. (2019) found that 49% of junior doctors said they were not aware of how to access help or support from their employer. Additionally, where the employer offers support, Bhugra et al. (2019) found that attitudes differed as to whether it should be accepted, and, when it is accepted, if it met needs. 19% of respondents said they would not seek help or support from their employer. 45% of respondents with depression, anxiety, BO, stress, emotional distress, or a psychiatric condition had been offered support by their employer; women were more likely (34%) to find support acceptable than men (26%). Those who were older or working longer hours i.e. F1's (21%) were least likely to accept support if offered.

Sauerteig et al. (2019) considered results from a UK BMA Quarterly Survey. It was sent to 2300 doctors. The survey questions were developed by members of the BMA's Occupational Medicine Committee. 19% of respondents had taken a long-term absence due to disability or ill health. Although a majority of those returning from a long-term absence had had some form of assessment from an OH doctor or nurse at some point, 33% reported having no assessment by these professionals on returning to work. Moreover, of those who were assessed, 14% said that the OH report recommendations outlining the support necessary for optimal return to work to be carried out by the manager had not been implemented. 22% said that the recommendations were partially implemented, and more positively, 62% said the recommendations had been fully implemented.

The same study found that, whilst 27% of respondents were either very or quite confident, if their physical/MH was suffering due to work, their employer would provide help and support; 43% were either not, or not at all, confident of support (Sauerteig, 2019). This has significant importance for OH for this F1 group.

2.10.3 Internal Barriers to Disclosure of MH Issues

This section mainly focuses on why doctors don't disclose to OH sooner, and or not at all. There is considerable literature that focuses on why doctors delay seeking help or avoid disclosing MH issues to OH.

Feeney's et al., (2016) survey of non-consultant hospital doctors across Irish hospitals gives insight into those cases that aren't seen in OH unless screening occurs. This study examined attitudes towards health behaviours. One question asked was at what stage of anxiety or depression participants would seek help. 5% said that they would seek help for mild symptoms; 34% if their symptoms were impacting on other people, and 25% if symptoms were impacting on work. 23% – a significant number – said they would wait until feeling hopeless, helpless, or suicidal before accessing help**.**

2.10.4 Shame, Stigma and Fear

In Hassan's et al, (2009) survey of UK doctors, stigma was rated by a fifth (20%) of doctors as the most important factor affecting the decision to disclose their MH (Hassan et al, 2009). White et al, (2006) found that over a fifth (22%) of UK psychiatrists surveyed felt stigma would be a reason for not disclosing MH in the future. Psychiatrists with a personal MH history were more likely to give stigma as a reason. The literature indicates a degree of self-stigma, reflecting a perception that a physician 'should' portray a healthy and strong image. Adams et al, (2010) discovered that the majority of doctors (96%) surveyed in a UK

study agreed that doctors should portray a healthy image. Bianchi et al, (2016) in their qualitative study support this further by finding that there is a widely held view of UK doctors that seeking help is a weakness or confirms vulnerability.

Interestingly, this view is confined to how doctors see themselves and does not seem to extend to how doctors see patients with mental illness (Thompson et al, (2001). A qualitative study in Northern Ireland found that doctors held non-stigmatising views of patients with mental illness, reassuring them that “it’s just another illness”, yet viewed it as a weakness in themselves.

Some doctors believe that they will risk their career by disclosing MH issues (White et al, 2006, (Hassan et al, 2009). Adams’ et al, (2010) UK study showed that 14% of doctors cited career progression as a reason not to access support and found most respondents believed those doctors with a previous history of depression were discriminated against; the majority agreeing they would be less employable. UK senior doctors in Bianchi et al., (2016) study expressed concern about how colleagues would respond to them in their everyday work, for example, by distrusting their clinical decisions. Fear of regulatory involvement (e.g., GMC) in UK doctors was less of a concern to those who had experienced MH than to those who had not (Cohen et al., 2016). Stigmatising beliefs and discriminatory behaviour may contribute to an overall negative impression of the culture within medicine. A qualitative study of F1s in one deanery with experience of significant illness (two with MH) found that medical culture was a barrier to disclosure (Fox et al., 2011).

The DOH (2010), Baptiste (2016) & Cohen (2016) reported shame, stigma and fear of disclosure as a reason for doctors not seeking support, which has implications for OH.

Henderson et al. (2012) explored the views of sick doctors on obstacles preventing them returning to work. Participants were doctors who had been absent from work, 6 months with physical, MH, drug, or alcohol problems. They described feeling isolated and sad when absent, trying to conceal problems, fearing negative responses on resuming work. Self-stigmatisation and feeling a failure rather than doctors feeling they were invincible was a central finding. This DOH report fails to comment on any perceived limitations of the study.

Cohen et al. (2016) in their survey noted that stigma, blame and "not wanting to be labelled" was proffered as the predominant reason UK doctors surveyed gave for non-disclosure of MH to the workplace (Cohen et al., 2016). Senior doctors interviewed in a UK study mentioned a belief that MH issues are something that can be controlled, with a consequent fear of being blamed for MH should it develop, and being judged as a failure (Bianchi et al., 2016). Stigma has been found to impact considerably on help-seeking. Perceived stigma has been identified as a barrier to help seeking amongst many different groups of doctors. These include UK doctors (Adams et al., 2010) UK F1s (Fox et al., 2011).

2.10.5 Confidentiality and Official reporting (UK's GMC)

Some studies explored specific concerns about individuals or organisations (e.g., patients, medical schools) becoming aware of doctors'/medical students' MH issues, whereas others looked at broad confidentiality concerns. Rees (2019) provides an excellent review of the multiple concerns regarding disclosure for doctors. This includes the issues pertinent to maintaining their registration-integrity; probity, professionalism and concerns about the impact of disclosure might have upon them (Rees, 2019).

(Fox et al, 2011) interviewed UK doctors in training and found that their duty to health and safety had conflicted with their preference for privacy about their MH;

that is, they wanted to maintain personal privacy. This could prove challenging when managing work rotas, particularly if feeling compelled to give a reason for any rota change requested. Half the UK doctors surveyed by Adams et al., (2010) cited concerns over confidentiality when asked what prevented them seeking help for stress. This finding is confirmed qualitatively by Brooks et al, (2017). Brooks et al. (2017) conducted nine semi-structured doctor-patients interviews which aimed to gain insight into the issues most important to patients-including whether a specific service for doctors was important in helping to overcome barriers to accessing healthcare for mental health. T.A. was used to explore recurring patterns in the data. Analysis found concerns about confidentiality, judgement and impact on career were obstacles to help-seeking and were important issues during treatment. This study concluded that doctors have specific needs related to confidentiality and stigma (Thompson et al., 2001)

Cohen et al. (2016) provide evidence that fear of regulatory involvement (e.g., GMC) was less of a concern to UK doctors who had already experienced MH than had not. The limited data available suggests that, sadly, some doctors may become seriously unwell before they access services, and/or successfully complete suicide rather than doing so. Again, Grant et al. (2019) found that most UK participants, if they could avoid it, did not disclose their MH status to their educational supervisor or anyone else who may influence their F1 career. This suggests intervention by OH is a potentially lifesaving necessity.

These findings may mean some doctors prefer to disclose MH issues to specialist services.

2.10.6 Issues Relating to Support and Treatment

Disclosure may be related to the MH support available to doctors. Accessibility and time to access support are other potential obstacles. Brooks et al, (2017)

reported PHP service users mentioned not wanting to waste the time of healthcare providers. Grant et al. (2019) found that access to appropriate MH support was often limited in a variety of ways, e.g., in more rural areas doctors in training were more likely to be known to local practitioners such as psychiatrists and they did not wish to consult current or former colleagues. Such findings may have implications for OH departments or specialist services because of the anonymity that these services provide them.

2.10.7 Need for Specialist Services

NHS staff are the largest single group of patients in the NHS. This is largely unrecognised rendering them “invisible patients” (DH, 2010). In response to doctors in distress (DOH, 2010, Vijendren, Yung and Sanchez, 2015), there are several extremely effective support services available for doctors who are invisible patients (HPC, 2010, Fox et al, 2009) e.g. the Sick Doctors trust, PHP and Mednet which have diverse models of delivery and funding. Each service indicates high usage for qualified doctors with MH concerns, noting that suicide risk is significant (Garelick 2007, Garelick and Meerten 2014, PHP 2013). A retrospective data analysis of MedNet found that doctors most commonly presented with depression (81% of doctors attending). Doctors generally had multiple diagnoses and these often also included other issues such as anxiety (58% of doctors attending), interpersonal difficulties (46%), self-esteem issues (38%), work/academic issues (32%), personality disorders (24%), bereavement (15%), and trauma (10%) (Garelick et al, 2007). One study highlighted a possible concern for doctors seeking formal help from either a GP or OH service. A specialist service, practitioner Health programme (PHP) undertook a qualitative UK based study of doctors accessing the London service in 2017. Some participants indicated that they had been wary of help-seeking from their GPs or OH services due to concerns about boundary issues. Doctors worried that they

would not access the necessary expertise due to lack of understanding of doctors' specific needs (Brooks, Gerada, & Chalder, 2017). Cohen et al., (2016) UK study found that doctors surveyed were more likely to disclose depression, anxiety, or bipolar disorder than addictions when disclosing MH to the workplace. Specialist services often attend to these conditions.

One review specifies the need for specialist services (Brooks et al, 2011) resulting in the planned OH service for GPs (NHS England, 2016). Marshall's (2008) review indicates that tailor-made support when returning to work for *doctors in difficulty* is positive progress. Prior to attending the rate of attempted suicide was found to be greater for doctors attending a specialist doctors' service in the UK than that of the general population (Garelick et al, 2007). F1s work in the NHS; support should be readily available at the point of care rather than needing to seek support elsewhere. This would appear to be a necessary national investment.

Cohen et al. (2016) found the reasons for disclosing MH to the workplace given by doctors with and without personal history of MH, were professional responsibility, gaining emotional support and advice on managing work whilst dealing with their MH. The driving force for disclosure to the workplace was to obtain treatment. This indicates that OH has an important role to play in treatment provision.

2.11 Other Interventions

Although the problems of stress, burnout and MH disorders in doctors are well described (Dyrbye, 2006) less is known about individual, team, organisational or societal factors that increase the risk of doctors developing these problems (Hancock et al. (2019). It is likely that multiple factors contribute towards the increased prevalence in this population. Hancock et al. (2019) proposed a new conceptual model based on a

review of the literature. Their review, based on the hypothesis that there may be an association between levels of tolerance of ambiguity (i.e. an ability to tolerate a lack of reliable, credible or adequate information) in clinical work and psychological well-being within medical students and doctor population, supported the hypothesis (Hancock et al., 2019). There appears to be an association between tolerance of ambiguity and psychological well-being. Hancock et al. (2019) developed a conceptual model from this review, which provides a framework for future research. It also offers opportunities to prevent the development of stress, psychological distress and MH disorders in F1s. This may have some useful implications for OH in the future. This model could be adopted for preventative MH intervention strategies utilising a relational approach (Costello, 2020) to achieve them.

2.12 Discussion

This section identifies areas which are relevant to the issues explored in this thesis but which according to the/this literature review have either not been addressed, or addressed in depth, or where the research has been flawed or of limited value because of methodological issues.

2.12.1 Summary of Methodological Research Issues and Gaps

Key limitations emerge from this review. 14 studies consider medical students and doctors regarding resilience, attachment and stress, but fail to consider any potential conceptual correlations between the two (Adshead, 2010). Adshead, (2010) in her review of attachment theory, argues that it has particular utility in the training of doctors; and understanding that some doctors' experience of Insecure attachment is associated with impaired stress management and lowered resilience. Adshead (2010) suggests further research in this area.

There appears to be very little in the literature regarding routine screening of F1s by OH, or of their personal experiences of OH, their MH or PH on their MH. This

possibly sits within the current political climate whereby privatisation or quality of NHS OH services and their delivery nationally are variable. This might provide opportunities for other external specialist services (e.g., PHP) to flourish without examining reasons for the underutilisation of currently available OH NHS services, together with a failure to promote the use of these services. Research is needed to understand how pre-existing services could be more effectively utilised as a supportive resource.

Six policy documents such as those by the GMC (2016) note worsening MH of doctors and the difficulties of progressing from medical student to F1, but these tend to focus upon curricular changes and little else (Lambert et al, 2015). The report by HEE (2019) also has implications for a proactive role that OH could offer to its workforce including F1s.

None of the three papers (Garelick 2007; Garelick, & Meerten, 2014; Brooks, Gerada, & Chalder, 2017) on specialist services recognises the possibility that attachments to the same person in OH department as a "secure base" (Adshead, 2010) might intrinsically be of value. Relationships appear to also serve as being supportive in their own right (Silverthorne, 2010) and yet NHS changes (Act of Parliament, 2004) mean that many F1s no longer function in teams which leaves them increasingly isolated (Carrieri et al., 2015). If well-being is a relational concept (Carrieri et al., 2015) fostering relationships with OH may have an impact upon the first year F1.

I can find nothing on how F1s understand their emotional health or what support is necessary for enhancing emotional well-being, and no reference to OH in this context.

Three policy statements (GMC, 2012, 2016, DOH 2010) are reviews of the literature rather than empirical findings**.** Three statements (GMC, 2012, 2016,

DOH 2010) indicate a need for development of care pathways but are bereft of guidance for user involvement in this process.

Three studies (Fertleman, 2013; Adams et al., 2012; Brennan, 2009) have explored employing educational programmes, e.g., resilience training, as mechanisms to retain F1s or doctors and to help them either to complete their training or remain at work. There is a risk, however, that research into the role of OH might be perceived as aiming to keep F1s at work rather than as a genuine desire to support them (Cohen et al., 2016; Smith et al., 2016).

12 studies refer to the use of OH by doctors – most notably those by Lalloo et al., 2013; Chambers, 2014; Cohen et al., 2014, and Grant et al., 2019. Generally, literature pertains to an avoidance of using OH with doctors preferring to self-prescribe or seek collegiate support for consultations (Forsythe et al., 1999; Adams, 2010) rather than accessing OH for support or as part of routine preventative practice.

Three studies (Bhugra, 2009; Cohen, 2016; Sauerteig, 2019) identify that doctors do not understand the role of OH, and so do not use its support function, which may reduce participants' willingness to engage with studies. This is particularly true for junior doctors (Bhugra, 2019). Two studies (Cohen, 2016; Sauerteig, 2019) note that when doctors use OH, it is due to managerial processes which are often inconsistent in practice.

One study examines reasons for non-disclosure of MH to the workplace (Cohen et al., 2016). The same study outlines that doctors without personal experience of MH would wait until their MH was having a greater impact on their work before disclosing this to their workplace (Cohen et al., 2016). Contrastingly, their peers with previous MH history would disclose to the workplace more quickly (Cohen et al., 2016). It is unclear from Forsythe's et al., (1999) study why so few doctors

utilised OH services and it would be valuable to try to understand the reasons for this.

Overall, limited data suggests that doctors delay seeking help, particularly (F1s Bhurga, 2019) especially formally, if they have had a previous MH diagnosis. Therefore, lack of screening F1 doctors would seem to constitute a service provision gap and a risk, and it is reasonable to support this vulnerable group positively, especially as the service provided is offered by a psychological therapist.

2.12.2 Appraisal of Quantitative Studies

A summary of the appraisal can be found in Appendix 3 (Tables 1-4) where I have made further comments regarding limitations about each study. Using the EHPP rating system most papers referenced were graded between strong to weak. Those papers which score strongly across the main themes have already been described (Cohen et al., 2016; Feeney et al., 2016). They generally investigate a wide range of participants, medical grades often spanning multiple years. The studies are also well resourced and supervised which enabled them to utilise a wide array of methodology such as telephone interviews, face to face interviewing and surveys promoting accessibility and response rates. Themes across most qualitative studies focused upon understanding attitude to MH/PH, working as a doctor when ill and reasons for referrals to a MH service rather than OH, and interventions possible for F1s within the NHS, based on this knowledge.

One paper by Harvey et al. (2009) is worth comment although the review examines evidence-based literature on the prevalence and consequences of MH disorder amongst health care Professional (HCP) and its impact upon work. It posits that the way work is organised and structured and the support available are what makes the difference to a good or poor outcome. It is one of the only

studies mentioning OH, suggesting that it might have a role to play in the workplace. It also indicates that there is clear evidence that doctors are reluctant to seek help when suffering from MH concerns. This may be related to stigma, over self-reliance and worries about confidentiality. This study recommends further study in an OH setting indicating that research in this area is sparse.

2.12.3. Appraisal of Qualitative Studies

There are no absolute criteria for assessing qualitative research (Braun & Clarke, 2013). An added complication is that authors write for different audiences. Conducting formal reviews of research dissertations are likely to "tick more boxes" of articles written for professional journals. In this thesis the strengths and limitations of reviews are considered in relation to their relevance for the current study in line with the recommendation by CASP (2018). This recommends that studies are not given a numerical score or rating which inevitably brings a degree of reviewer subjectivity. Arguably such bias can occur in any study irrespective of whether qualitative or quantitative.

A summary of the appraisal can be found in Appendix 3 (Tables 1-4) where I have made further comments regarding limitations about each study. Most qualitative studies explored the experiences of doctors and/or trainees. Few explore the experiences specifically of F1s and not of their experience of OH. The aims of studies across the papers were clearly stated. Most papers outline their recruitment process and findings.

To varying degrees, all authors of studies reviewed reflect on the limitations of their research. All note their findings are not directly transferable to the wider medical population due of the heterogeneity of the population. Gill and Fox (2012) posited a benefit of a review is that it might be possible to identify themes across articles. With this in mind, qualitative articles were examined for themes

relevant to experiences of MH/PH, health seeking, policy and OH for F1s. Another report worthy of mention is the “Mental Health and Ill health in Doctors” (DOH, 2008). This report considers doctors’ ill health prevention and outlines MH, stressors, risk factors, stigma and culture. It makes recommendations for OH relating to role, provision and good working relationships organisationally.

2.13 Conclusion

A strength across all papers is that they have clear aims and summarise their key messages or findings. Weaknesses pertain to a paucity of information relating to OH and herein lies a research deficit.

The following chapters of this thesis focus on the two research questions below:

2.13.1 Future Directions for Research

The current review set out to examine the transition from medical student to F1 into clinical work, and the impact on MH/ PH, plus any role that OH can have during this time span. Current debate suggests that OH services have a key role in supporting doctors at all levels (BBC News, 2016, Forsythe et al, 1999, Lalloo et al, 2013) but that such services are poorly utilised for a variety of reasons (DOH, Cohen, 2015 & 2016, Forsythe et al, 1999, Chambers, 1993). If having a responsive and accessible OH department is considered helpful (GMC, 2009), this research exploring possible relationships between F1s and OH is timely, important and significantly identifies a gap in existing knowledge and research. The current study is anchored in Psychoanalytic theory, specifically Attachment theory, secure base and containment, as set out in Sections 1.8, 1.8.1 and 1.9.

2.14 Concluding Comments.

In summary the literature has identified that F1s dislike “showing vulnerability” 9 grant et al, 2019), lack insight into and have poor mental health (McKinley et al., 2020, Harvey et

al., 2009), that the transitional year is known to be a challenging year during which they often lack support. They are also moving into an alien environment, i.e., clinical workplace which is different to medical school with different demands, including long hours (Viogoda, 2002), reduced access to support, and shift patterns. Being cut off from their “safe base” may render F1s so vulnerable that they sometimes die for these preventable reasons (Carreri et al., 2015, 2017, 2020; Berge et al., 2012). OH is located within legislative and organisational frameworks (HEE, 2019), including health checks which assist its capacity to promote the HWB of F1s if its resources are utilised effectively. OH consequently is in a position to play a pivotal and privileged role to support F1s. The literature review and clinical practice identified a gap in the research that warranted further investigation- simply; F1s die especially when they lack insight and become too unwell to recognise this. A key question addressed in this thesis is: as OH possesses a HWB function does it have a role to play for this group? Given the gaps identified in research, this thesis set out to investigate the research questions outlined below.

2.14.1 Research Questions

- What factors have an impact upon F1’s ability to access support to maintain their MH during this transition period?
- What role might OH play during this first year?

Chapter 3: METHODOLOGY

I approached this thesis from a social constructionist position: a perspective that challenges views about the nature of knowledge and reality, arguing that meaning is socially constructed between people as they go about their daily lives (Burr, 1995; Robson, 2011). Informed by this view, I am not seeking to find objective truth, but to develop an understanding of the ways F1s involved in the thesis have constructed their views. In doing so I acknowledge my own role is also socially constructed. This

resonates with my personal comprehension of a psychoanalytic approach; that is, an individual's emotional state is often the result of their specific "social" life experiences. I wanted to explore the experiences of OH by F1s. This research has taken a qualitative approach, where rich and detailed accounts from participants are necessary to contextualise participants' meanings and interpretations. Sofaer (2016) indicates that one important value of the qualitative approach is its ability to deal with unforeseen events, such as political changes. The recent political climate of the NHS, particularly relating to the F1 population who are the focus of this thesis, is extremely fragile so I wanted to utilise a flexible method that would enable adjustments to be made if necessary.

My clinical knowledge and experience as a psychotherapist underscore this research. Just as a key feature of being a psychoanalytic practitioner is to acknowledge that one's presence within an interaction becomes part of the process, my presence within the research will have influenced what happened at all stages of the interview and thesis (Holmes, 2013). In common with other qualitative researchers, reflexivity is an important element of my methodology, which is also described in this methods chapter.

3.1 Introduction

The literature review highlighted a need for further understanding of how F1s experience OH, factors affecting their MH and the possible critical role OH could play to support MH. The review showed that studies have predominantly focused on the obstacles to seeking help for MH encountered by F1s (Cohen et al., 2016). This chapter reports on a qualitative study undertaken to understand the factors that F1s use when utilising OH and what could enhance the relationship between OH and, in particular, F1s who may benefit from its services.

This qualitative thesis used semi-structured interviews at two time points: T1 and T2. Its purpose was to understand and compare a range of experiences of those F1s using OH

who had mental and/or PH conditions. A qualitative approach was chosen due to its suitability for understanding attitudes and experiences.

The thesis explores how the views and experiences of F1s change over the course of one year.

3.2 Choice of Method: Defence for Using TA

I considered Interpretative phenomenological analysis (IPA) as a methodology. IPA tries to understand lived experience and how participants themselves make sense of their experiences. It increasingly plays a central role in qualitative research (Smith et al., 2009), as it is concerned with capturing individual's accounts and reflections to explore and interpret meanings (Ritchie, 2014). I wished to gain insight into the themes that emerge from F1s' experiences and so TA remains the most suitable approach for analysing qualitative data. Criticism of the qualitative approach, within which TA is located, often comes from positivist researchers who contest its rigour, validity, and replicability. Ritchie et al. (2014) believe that qualitative approaches draw increasingly from scientific methodology and utilise more robust analysis tools such as Nvivo, so if it is well designed and conducted then this thesis can produce well-founded, trustworthy evidence. This thesis seeks to explore the phenomenology of F1s' experiences of OH, together with the psychoanalytic concepts discussed e.g. secure base. TA is better suited to meet these aims than case studies, a narrative approach, or IPA which would elicit interesting information regarding individual or group experiences and possible meanings (Flyvbjerg, 2006; Murray & Sargent, 2012; Larkin & Thompson, 2012). Critically however, these approaches would fail to address my research question, due to limited population samples, as it would be too specific and would limit this research to those who had consulted OH. It would deny potential information to be elicited which might result in changes in OH service delivery, by, for example, encouraging future F1 non-users to access OH as a future supportive resource.

Critics consider TA to be an unsophisticated method which is atheoretical (Braun, Clarke &Terry 2015). Its sophistication, however, lies in correct application such as the interrogative approach I wish to use (Joffe, 2011). TA is theoretically flexible as it is not associated with any one epistemology (Braun & Clarke, 2006). It also allows for meaningful patterns to be explored within the data (Vaismoradi, Turunen, & Bondas, 2013) and acknowledges that participants' verbal expression of their experience is key to understanding this data Bryman (2001). Researcher's reflexivity, including cognitive and emotional processes (Holmes, 2018), facilitates the findings as researcher and participants are co-constructors of meaning (Baker, Pistrang, & Elliott, 2016). Location of the researcher and disclosure of their identity are necessary to provide the interpretative context for the analysis (Clarke et al., 2015).

There is valid criticism that fragmentation of data into themes detracts from seeing the research participant as a whole person (Bingley, Thomas, Brown, Reeve, & Payne, 2008; Riessman, 2008). In this thesis, one research question relates to discovering common experiences between all the participants when at medical school, therefore finding themes seemed the most appropriate method to answer the question about change in perceptions of OH during the first year as an FI.

3.3 Rationale

This chapter seeks to explain the rationale for my research methodology. The methodology of individual interviews was considered appropriate as individual interviews offer greater anonymity than focus groups which is a consideration when investigating a sensitive topic area. This thesis used semi-structured qualitative interviews with F1s with personal experience of mental and or PH who had consented to contact from OH via the TOI form. This will be elaborated in the ethics section in appendices 13 A&B.

I will clarify how I use a thematic analysis (TA) of participants' accounts utilising psychoanalytic theory to inform my analysis and the discussion of my findings.

I begin by examining how I have used the framework of psychoanalytic theory in this research and how this aligns with a social constructionist position. Subsequently, I explain the methods used and why comparative TA was an appropriate way to answer the research questions outlined in Chapter two, as well as to address information drawn from the literature review themes reviewed in chapter two.

3.4 Aims

Specifically, this study aimed to explore F1s' MH, their experiences of OH and factors that influenced this experience to discern any relationship with more clarity. This thesis explored measures for OH intervention in the future so that similar groups may be offered enhanced support.

3.5 Study Design and Method: Using Psychoanalytic Theory in Qualitative Research

A particular feature of qualitative research methodology is that it views the world through the lens of the participants being studied, whereas the key focus in quantitative studies is the researcher's interpretation of measurements or groupings (Silverman, 2014). "Qualitative research", on the other hand, denotes any research producing findings that are not derived from statistical or any other quantification procedures (Strauss & Corbin, 1988:11). Denzin & Lincoln (2000:3) capture the consensus of many definitions of qualitative research when they describe it as a naturalistic interpretative approach, interested in understanding the multiple subjective meanings and interpretations which people attach to phenomena such as beliefs, decisions and values within their social worlds.

Gibson (2015) notes that within the qualitative paradigm in social sciences there has been an 'affective turn' which has resulted in researchers bringing emotion into their research and incorporating new methodologies, often with a psychoanalytically informed

approach. My research has primarily been based on a comparative thematic analysis of participant interviews repeated at two time points, one year apart.

A qualitative methodology, with in-depth semi-structured interviews, was conducted using the same questions at T1 and T2 interview points in order to understand the F1s' experiences over this time span and make comparisons between them (Bryman, 2016).

3.5.1 Ontological and epistemological frameworks

Qualitative research is informed by the ontological and epistemological frameworks of the research and the subjects of research. Ontology and epistemology are respectively theories about the nature of reality or being and the nature of knowledge. Each demarcates what can and cannot count as meaningful knowledge.

3.5.2 Ontological frameworks

This study aims to identify how F1s experience their world in ontological terms - Crofty (1998, p.10) proposes that ontology is the study of being. It determines "whether or not we think reality exists separate from human practices and knowledge .... or whether we think it cannot be separated from human practices and so knowledge is always going to reflect our perspective" (Braun & Clarke, 2013, p. 27). Ontological assumptions are positioned on a continuum ranging from a view that reality is entirely independent of human ways of knowing (realism) to a view where reality is dependent on human interpretation and knowable (relativism). Braun et al. (2015) note that relativism rarely informs quantitative research but might inform qualitative research. Conversely, realism underpins most quantitative research but rarely informs qualitative research. In between the two is critical realism, which is based on an ontological acceptance of reality but a constructionist epistemology that premises an understanding of the world as imperfect and partial (Bhaskar,1989).

This study is informed by the relativist view that rather than being a single, pre-social reality or mind-independent truth, there are multiple constructed realities and that we can never get beyond these constructions (Cromby & Nightingale, 1999). What is “real” and “true” differs across time and context, therefore, what is known reflects where and how knowledge is generated.

The relativist approach informing this study focuses on the subjective meaning that experience has for an individual (Fielding, Lee, & Blank, 2008) and the understanding that meanings made of the world are therefore socially constructed. In light of this, Scotland (2012) proposes that researchers need to adopt a position regarding their understanding of the world and how it functions. This research is therefore located in a social constructionist framework which proposes that understandings of the social world are constantly defined and transformed (Bryman, 2001). It is through this ontological lens that F1s’ experiences are investigated - challenging the idea of a fixed view of the world. These constructions provide a version of experience mediated by sociocultural meanings and the participants’ and the researchers’ interpretative lenses (Finlay, 2002; Holmes, 2019). The figure below (Wikipedia, 2022) indicates that each person creates their own "constructed reality" that drives their behaviours.

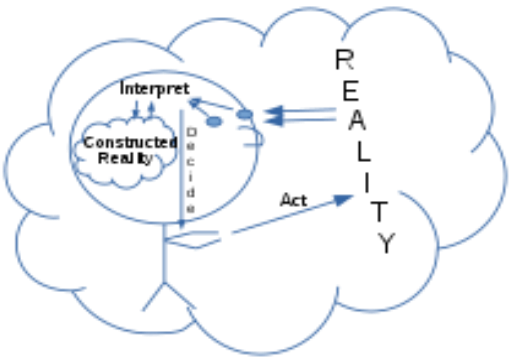

Figure 4. Wikipedia (MCEddy D.) (2020)

Diagram of constructed reality: svghttps://en.wikipedia.org/wiki/Social_constructionism

- **Postmodernism**

The relativist theory outlined above is partially aligned with postmodernist theory, Leary (1994) describes Postmodernism, as the “leitmotif of the latter part of the 20th century” (p. 435). Troyer (1993) describes it as ”not having a single statement or a single spokesperson” (p. 120) rendering it “a stance that one takes towards a theory and a way of looking at theory, rather than a theory itself” (Leary, 1994, p. 435). Postmodernism has been considered a move away from the homogeneity, singularity, predictability and objectivist principles so highly valued by modernism (Gitlin, 1990), towards the social consciousness of multiple belief systems and multiple perspectives (Gonzalez, Biever, & Gardner, 1994). Knowledge, or what we believe, is instead seen as an expression of the language, values and beliefs of the particular communities and contexts in which we exist. Postmodernism is based on the premise that no one true reality exists and it rejects the belief of an absolute truth (Becvar & Becvar, 2003) and this philosophy concentrates on the social and linguistic construction of the individual’s perspective on reality (Becvar and Becvar, 2003).

3.5.3 Epistemological frameworks

Topic sentence: Epistemology is concerned with the nature and forms of knowledge (Cohen et al., 2007. p.7) and therefore with how both F1s and researchers make meanings of the world. What counts as knowledge determines how meaningful knowledge can be generated and what it is seen to represent. The three broad epistemological positions are: positivism/postpositivism; constructionism; and contextualism.

Positivism assumes a straightforward relationship between the world and one’s perception of it and is closely aligned with realism and postpositivism. The latter

acknowledges that researchers are influenced by their context but still seek a truth within this (Guba & Lincoln, 2005). Young and Temple (2014) argue, “researchers and participants are involved in a creative process of producing reality/realities rather than reflecting them”. This perspective, therefore, extends to how epistemology is itself conceived of in relation to what it is to be an F1 (p. 181). **Constructionis**t epistemologies that are aligned to relativism argue that the world and what we know of it does not reflect a true nature of the world. Instead, what we know is constructed or produced through various discourses and systems of meaning that we all reside within (Berger & Luckmann, 1966, 1991; Burr, 2003; Gergen, 1985, 1999). As this changes, notions of truth change. Thus, there is no one truth and there are knowledges instead of knowledge. Knowledge of how things are is a product of how we come to understand them (Burr, 2005). This differs from realist and positivist positions in that “there is no singular underlying reality that is theorized as providing the foundation for true knowledge – constructionism is a non-foundational view of knowledge” (Braun & Clarke, 2013, p. 30).

Auerswald (1985, p. 1) defines epistemology as “a set of imminent rules used in thought by large groups of people to define reality” or, “thinking about thinking” and goes on to say that it is “the study or theory of the nature and grounds of knowledge”. Keeney (1983) argues that the term ‘epistemology’ indicates the basic premises underlying action and cognition.

Guba and Lincoln (1994, p. 108) explain that epistemology ask the question about *what it means to know, the nature of the relationship between the would-be-knower and what can be known? (*Scotland, 2012). The epistemology orientation for this study reflects the rules that individuals use for making sense out of their world (Hoffman, 1981).

3.5.4 **Constructionism and Social Constructionism**

Constructionism, like postmodernism, refers to the process by which understandings of reality are constructed by the observer as they give meaning to what they observe (Von Glasersfeld, 1988). Because it is argued that it is impossible to have objective access to the world, there can, therefore, be multiple views of it, rather than a single truth that reflects reality. According to the constructionist view, however, as long as it works within a particular context, (Dickerson & Zimmerman, 1996), any one person's construction is as 'true' as, and equal to, any other person's. Thus, from a constructivist position, it is difficult for an observer to criticise or question/challenge a client's story and is therefore an unhelpful model for the purposes of this study which involves encouraging F1s to explore the way they see the world.

Social constructionism, on the other hand, developed within postmodernism as a means of addressing the 'anything goes', 'all interpretations are equal' - problems inherent in constructionism. Owen (1992) argues that the way we construct the world is determined by our culture and social world. (?) That is, it acknowledges that multiple interpretations are possible without claiming that all interpretations are equal. It is, therefore potentially a productive model for understanding how F1s understand the world and how alternative understandings may be elicited.

According to social constructionism, language plays a central role in the ways we construct the world, and therefore in understanding how participants in this study understand their world. Berger and Luckman (1991) state that people socially construct reality by their use of agreed and shared meanings communicated through language. Thus, our beliefs about the world are social constructions and, like language, change over time and according to context

(Anderson & Goolishian, 1988). This theory challenges our assumption that there are 'facts' that we can come to know (Anderson & Goolishian, 1988) and suggests instead that our interpretations of the world are informed by the ways we use language. This does not mean that 'anything goes' (Gergen, 1985) as is implied by Constructionism. Knowledge and systems are inherently dependent upon communities of shared intelligibility and vice versa. They are, therefore, governed to a large degree by normative rules that are historically and culturally situated. As a result, social constructionists do not claim to provide the 'truth'. Gergen (1999) claims that in numerous instances, the criteria, which are invoked to identify 'behaviours', 'events', or 'entities', are largely circumscribed by culture, history, and social context. Therefore, a social constructionist perspective, as opposed to a constructivist perspective, "locates meaning in an understanding of how ideas and attitudes are developed over time, within a social, community context" (Dickerson & Zimmerman, 1996, p. 80).

Social constructionism is relevant to this study because of its focus on the normative narratives, or grand narratives, which are formed by and in turn influence people, and against which people measure themselves.

Normative narratives are supported by the weight of numbers, tradition, and firmly entrenched power structures (Doan,1997). White and Epston (1989) agree that the particular meanings we impose on behaviour are dictated and organised by whatever 'dominating analogies or interpretive frameworks' are currently available. Dickerson and Zimmerman (1996) postulate that narratives which dictate single accounts of reality form the context for the development of problems. They argue that people's personal stories are often marginalised, subjugated and denied in favour of the dominant belief system that tends to

pathologise those who do not meet its expectations (Doan 1997). As a result, people often begin to think about themselves and their relationships in ways that are consistent with problem saturated stories. Coale (1994) is of the opinion that clients/research participants usually discuss the dominant discourses of their lives with therapists /researchers. However, the non-dominant stories that clients/participants tell may contain possibilities that could facilitate change. For this reason Coale (1994) advises therapists/researchers to focus on the dominant stories of the participant [which may not reflect dominant belief systems].

Co-construction of new/alternative realities also assists in externalising the problem as opposed to looking for it inside the person. This allows the person to escape the domination of oppressive domains of knowledge (Doan,1997). Social constructionists view relationships between people as either conforming to or lacking a fit with the idealised roles or ways of relating to others (Owen, 1992). They therefore, focus on knowledge as power, believing that “cultural specifications” exert a real influence on people’s lives (Dickerson & Zimmerman, 1996, p. 80) and take a stand on the subjugating effect of dominant discourses. Although social constructionists acknowledge that more than one account of reality exists, they agree with postmodernists in asserting that all stories are not equally valid. Therefore some narratives are not respectful of, for example, gender, ethnicity, race, or religion (Doan, 1997). Social constructionists also concur with postmodernists and caution against the power of singular accounts which can further silence and marginalise those whose stories fail to fit the “norm”. Social constructionists are interested in narratives based on a person’s lived experience rather than on expert knowledge, that honour and respect the community of voices inherent in each individual and how these accounts can be respected within a particular system (Doan,1997). One aim is to deconstruct

stories that dominate others, allowing alternative choices to become available (Dickerson & Zimmerman, 1996). Social constructionists acknowledge the social nature of human life, while at the same time it encourages individuals to tell their own stories.

The HWB of F1s and the role of OH, particularly within a psychoanalytic context, is poorly understood within the literature. The underlying assumptions of social constructionism form the epistemological basis for the present study and inform the researcher's position in defining the focus and aims of this study, in designing the method, and in the discussion chapter. This study seeks to show that employing the lenses of reflexivity and psychoanalytic interpretation discussed in Chapter 6 (Discussion) may facilitate co-construction or elicit new meanings (Coale, 1994).

3.5.5 Epistemology and Analysis Methods

I chose to take a phenomenological approach in designing the study because such an approach focuses on lived experience – this was central to the research question which was an exploration of F1s' experiences and views. Social constructionism has more recently been rooted in phenomenology (Berger & Luckmann, 1966; Woodruff Smith, 2018). I understood phenomenology to derive from early twentieth century European philosophy, particularly the ideas of Edmund Husserl (Pivcevic, 2013) on the structures of experience and consciousness. I intended that this approach would produce detailed accounts of how participants felt about their experiences of OH, their MH experiences; that is, what meaning it had for them (Starks & Trinidad, 2007). I appreciated that this may depend on how conscious the participants were of what was going on for them, given that that as a psychotherapist I conceptualise the mind as having an unconscious level too. This was another reason to implement a reflexive

methodology for this study using a psychoanalytic theoretical framework, whereby I could explore unconscious meanings of the research process and results to interpret data as discussed in Chapter six. Such a phenomenological approach underpins the methodology informing the research activity: the interviews with the F1s. Thematic Analysis (TA; Braun & Clarke, 2006) was chosen for these datasets. TA lends itself to utilising approaches relevant to the ontology, research questions and population in a way that may not have been feasible within the other approaches considered.

Influences on this research additionally include health care culture (Baarts et al., 2000), reflexive practice (Jootun et al., 2009; Finlay, 2002; Holmes 2018) and Attachment theory (Ainsworth & Bowlby, 1991: Atwool, 2006; Adshead, 2010).

3.6 Thematic Analysis (TA)

Due to its theoretical flexibility across datasets, TA became my method of choice for identifying common themes disclosed during the interviews. TA has a long tradition in social psychology and has a core research focus on “thematising meanings” (Hollway & Todres, 2003, p. 347). This approach aligns with my underlying ontological stance. Until recently, TA was “poorly demarcated and rarely acknowledged” (Braun & Clarke, 2006, p. 77) and its breadth of approach initially resulted in criticism for its ‘anything goes’ style. However, more recently, the method and its application has become more rigorous and systematic (Robson, 2011). Gough (2009) argues that most qualitative data analyses should begin with some form of thematic analysis. Braun and Clarke (2013) outline how the researcher can conduct either an inductive or theoretical analysis of the data. Inductive TA “aims to generate analysis from the bottom (the data) up” whereas theoretical analysis is “guided by an existing theory and theoretical concepts” (Braun & Clarke, 2013, p. 175).

The Braun and Clarke framework (2006) distinguishes between a top-down or theoretical thematic analysis, that is driven by the specific research question(s) and/or the analyst's focus, and a bottom-up or inductive one that is more driven by the data itself. I was directed by the data itself as an initial focus.

This approach increases the transparency and quality of the research process (Silverman, 2014). I evaluated the data initially in its raw form, before any discussion within the theoretical approach. Data was subsequently analysed using TA, Word and Nvivo (Braun & Clarke, 2013).

"TA is a method for identifying, analysing and interpreting patterned meanings or 'themes' in qualitative data" (Braun, Clarke, & Terry, 2015, p. 95). It therefore enables a pragmatic approach to the needs of this research at a time of political uncertainty which has a possible impact on F1s conditions of employment, the organisation they work within and also OH (Triggle, 2016). Whilst widely used in different fields of research (Bazeley, 2009; Joffe, 2012; Bellamy, Gopolan, & Traube, 2010), TA has also been utilised clinically and within health research. Braun, Clarke, and Terry (2015) consider it an excellent tool for such research. It therefore complements the aims of this thesis. Braun and Clarke (2008) suggest that it can generate unanticipated insights and is useful for working with participants as collaborators in a participatory research paradigm. The latter seemed particularly appropriate when using the interview data to inform the development of ideas regarding support that OH may be able to offer from those experts supporting the junior doctor. TA can be used for individual experiences as well as for analysing the meanings participants construct. The constructionist/critical versions align well with the values and assumptions of initial (health/clinical) psychology (Braun, Clarke, & Terry, 2015). The data acquired in this study has been systematically analysed across the data set to identify patterns using the six-phase process recommended by Braun and Clarke (2006, 2012, 2013).

The six phases are:

Phase 1: familiarisation with the data

Phase 2: coding the data

Phase 3: searching for themes

Phase 4: renewing themes

Phase 5: defining and naming themes

Phase 6: producing the report.

King and Horrocks (2010) suggest a simpler 3 stage option but I preferred an approach that is well recognised to enhance credibility. The flexibility of TA allowed the TA theoretical framework to be applied alongside data analysis, as the research progressed, rather than beforehand (Braun & Clarke, 2006).

TA is an excellent method for extrapolating patterns and themes across individuals interviewed (Cresswell, 2013: 104–106). The interviews broadly explored participants' experiences of OH and MH as a doctor. The analysis focused specifically on the relationship between the two. Interviews incorporated PH as this was included in the screening process when MH was affected. This clear focus helped to overcome one of the disadvantages of TA when dealing with a potentially overwhelming number of areas of focus within a rich data set.

The importance of the frequency with which a theme arises is debatable – that is the greater number of times a theme arises versus the fewer times another one does (Maxwell, 2010). However, the count in qualitative research does provide an indication of the prevalence of themes which may provide an indication of generalisability and evidence for the interpretation of patterns (Maxwell, 2010). However, this thesis was not

a representative sample and generalisation to a similar user population should not be assumed.

3.7 Reverie-informed Research Interviewing

In Holmes' (2018) paper Reverie-informed research interviewing (RRM) is explored. This will be discussed further later in this chapter. Holmes (2018) views this approach as an opportunity to apply a positivist stance and supports to develop a culture of research in psychoanalysis as recommended by (Roth & Fonagy, 2006; Fonagy, 2000; Persons & Silberschatz, 1998). This position, advocated by quantitative research, has implications for unlocking government funding for psychological therapies (Layard, 2005). Holmes (2018) felt there was a problem in this for psychoanalytic research in the inherent contradiction between the scientific need for generalisability, and the specificity of the analytic relationship (Holmes, 2018). As such he proposed circumventing this with a method of augmenting subjectivity in research interviewing via RRM (Holmes, 2018).

3.8 Reflexivity

Reflexivity can often be confused with reflection and, indeed, in much of the literature, these terms are used interchangeably. Bolton (2018) in her book *Reflective Practice* presents reflexivity as a task separate to reflection which is something undertaken within my other area of clinical practice: nursing. Finlay (2002) argues they are on a continuum where reflection is concerned with "*thinking about*" something after the event whereas reflexivity relates to a dynamic subjective process. Both are "states of mind and pedagogical in approach" Bolton posits that reflection is concerned with challenging one's assumptions, thought processes, prejudices and unconscious bias with a view to further comprehend the nature and complexity of our role in relation to others (Bolton et al., 2018).

"*To be reflexive is ...becoming aware of the limits of our knowledge, of how our own behaviour plays into organisational practices and why such practices might marginalise*

groups or exclude individuals. And it is understanding how we relate with others, and between us shape organisational realities' shared practices and ways of talking." (Bolton et al., 2018, p. 9)

When being reflexive we cast a critical eye over situations and relationships, comprehending our active role in shaping our surroundings as opposed to reacting to them. This facilitates reviewing one's practice, engaging ethical ways of being and relating (Cunliffe 2009b). Reflexivity sits well within medicine. Baarts et al. (2000) argue the role of the GP has always been to integrate illness and that reflexivity can be used to implement a patient-centred approach in the consultation. Baart et al. (2018) explain it is possible to utilise patients' illness stories and other doctors' stories of patients' illness, with or without personal experiences, to assist this transformative process. In the same way, researcher self-reflection has been incorporated into 'reflexive' paradigms (Lucey et al., 2003). Over recent years the scientific tenets of 'objectivity' and 'detachment' expected in research have been challenged' (Oakley, 1981; Frosh et al., 2003) veering towards acceptance of the researcher's self-subjectivity and location within the research rather than seeking denial of its existence.

There are numerous reflexivity methodologies available which may have been applied to the study process (Kolb and Fry 201, Boud, 1985; Holmes 2018). The Kolb (1975) model essentially contains four elements: concrete experience, observation, forming of abstract concepts and testing in new situations. Kolb represented these in an experiential learning circle model which can help inform the reflexivity process. It involves:

- concrete experience followed by
- observation and experience followed by
- forming abstract concepts followed by
- testing in new situations (after Kur Lewin).

The learning cycle can begin at any one of the four points – and should be approached as a continuous spiral.

The Kolb model has helped to challenge models of learning that seek to reduce potential to one dimension, such as intelligence (Tennant 1997: 91). Smith (2021) suggests that *Kolb's scheme 'has been useful in assisting us in planning learning activities and in helping us to check simply that learners can be effectively engaged… it does not help… to uncover the elements of reflection itself'.*

This thesis draws upon Dewey's (1916) central themes of 'learning from experience' which are grounded in Dewey's notions of 'trying' and 'undergoing'. Dewey (1916) considered reflection a deliberate and active process. It is about thinking to learn.

Edge (2011) draws on Dewey's (1916) processes of 'trying' and 'undergoing,' arguing that "*reflexivity in qualitative research is concerned with the ongoing, mutually-shaping interaction between the researcher and the research*" (p. 35). He explains that as the researcher reaches out to shape his/her research, the experience has an impact personally and professionally and so this reflexivity continues in a circular nature.

Edge (2011) suggests that often what gets shared with others as what is learnt and acquired is "foreground material" as opposed to the undergone changes in the emergent researcher. This can misrepresent much of the reflexive process and learning, in the sense that the person entering the next experience is no longer the one who entered the last (p. 42).

To that end in order to avoid confusion for the reader, my reflexive process is contained within the chapter on reflexivity. It is in this chapter where I am able to engage with *both* elements of reflexivity necessary for a fuller experience, (Edge, 2011) as the

intimate union of activity and undergoing its consequences support recognition of meaning throughout the thesis and beyond (Dewey, 1916).

The introspective and intersubjective reflexivity stance informed in Holmes's (2018) RRM was originally initially considered for this thesis (Finlay, 2002). RRM is based on psychoanalytic intersubjectivity. It considers the interaction between participant and researcher and the emotional impact that this relationship has on the researcher (Holmes, 2018). This requires the researcher to be attuned to their bodily sensations, feelings, behaviours, images, and reverie, defined as a dream-like state of thought or processing throughout the research (Holmes, 2018). There are many aspects of this approach, particularly reverie, that resonate with this thesis. Its application was too complex to utilise as it ran the risk of transgressing therapeutic and research boundaries. As Holstein and Gubrium suggest: *"while most researchers acknowledge the interactional character of the interview, the technical literature on interviewing stresses the need to keep that interaction in check*" (Holstein & Gubrium, 2011, p. 141).

The model of reflexivity adopted for this research is Boud's model of Experiential Learning (1985). The core components are:

- Return to an event, incident or experience and record it.
- Consider it in detail at an emotional and cognitive level.
- Re-evaluate the event in the light of experience, knowledge & experimentation. Seek to understand the meaning of the experience.
- Plan for what you might change.

(Boud et al., 1985)

This basic model is easily applied and adapted to multiple situations. It is open to criticism as it fails to outline expected outcomes of reflection or its application to practice or from the learning. Its simplicity lends itself to this thesis, as it allows for reflection after interviews, at any time in between or during interviews.

This is the methodology used for this thesis, modifying it to utilise the “bearing witness” components of Holmes Reverie (2018). I wished to use the model of Dewey (1916), Edge (2011) and Holmes Reverie specifically. I did not adopt the approach of Braun and Clarke’s (2019) reflexive thematic analysis as it does not complement Boud et al.’s (1985) model for the purposes of this research.

The lack of empirical evidence in the field of F1’s experiences of OH allowed the initial focus of analysis to be grounded within the participants’ experiences, rather than focused on a theory.

3.9 Practical Application of Reflexivity

“Panels for data analysis” (Holloway & Jefferson, 2000, p. 162) are increasingly undertaken in qualitative research. This uses peer group research supervision as a recommended process to help make sense of the data. Garfield et al., (2010) considers using a panel which “*facilitated a more nuanced reading of the text and prevented one person from dominating the interpretive process”* (Garfield, Reavey, & Kotecha, 2010, p. 167). I accessed two group supervisory settings throughout the research. The first group was a learning set, a six-weekly research meeting supported by the doctoral course at Exeter University. It included another doctoral student, facilitated by an experienced researcher and clinician. It offered a consistent psychoanalytic framework, guarding against my blind spots and unsupported analysis, whilst providing a containing space to discuss the progress of my research (Elliott, Ryan, & Holloway, 2012). On return to the writing after interruption, I also went back through the research and interviews to check accuracy and coherence. Since interruption, I have been fortunate to have joined another group for my returning year to continue with the same process –the focus being on writing up the thesis.

The second group involved termly meetings with two peer doctoral students who were adult psychotherapists. There were numerous peer supportive elements from this

process including support with Nvivo. One moderation exercise identified a problematic pattern concerning five interviews I shared; I had not adequately recognised all the issues to do with the role of OH when coding. Consequently, I returned to all of the scripts to check them further. As all the individuals in the supervisory group were independent of my work in OH they assisted in the process of assuring data analysis trustworthiness within my research.

I drew on my understanding of analysis and counter transference (Freud, 1910/1959, pp. 144–145) when thinking about the research data and its impact upon me. I made detailed notes after each interview, and kept a reflective diary throughout the process on Nvivo. I continued to make observations during my interrupted year although these reflections were not analysed. I intentionally used responses to the interviews in both my field notes and the data analysis to help me understand the interviews and in order to maximise transparency.

3.10 Quality in Qualitative Analysis

To consider the quality of the research, a set of criteria in line with the epistemological and ontological assumptions underpinning the study were used. Guba and Lincoln (1994) recommend considering two criteria: trustworthiness and authenticity. I have adopted the Mays and Pope (2000) proposal that qualitative research attends to matters such as trustworthiness via reflexivity, triangulation, clear exposition of data collection and analysis, as well as negative cases to ensure the quality of a qualitative study.

Transparency in the co-construction of findings through reflexivity enhances the trustworthiness of the research (Guba & Lincoln, 1994). Deviant case analysis also allowed for contradictory positions and voices to be explored (Mays & Pope, 2000). Devereux (1980) writes that certain barriers such as denial, displacement and intellectualisation, are likely to reduce the capacity of a researcher to be effectively subjective, therefore a second coder (another researcher) also coded three transcripts

to ensure consistency in identified themes. Both coders identified similar codes and any discrepancies were discussed and resolved. Throughout data collection, analysis and write-up for this thesis, quality guidelines for qualitative research, such as the Critical Appraisal Skills Programme checklist (CASP, 2018) were consulted. Some authors (Etherington, (Stiles 1993; Braun, Clarke & Terry, Finlay & Gough, 2003; Etherington, 2004) posit that *reflexive awareness* reduces researcher bias when analysing data.

Recent years have seen qualitative research methods being increasingly utilised within health technology and medicine. This has aligned with a corresponding rise of scrutiny from proponents of other theoretical positions within the discipline regarding the claims made concerning findings using qualitative research (Pope & May 2000). This has necessitated publication of proposed standards which delineate quality of qualitative research such as CASP measures (CASP, 2018; Appendix 5,6,7,8). I have reviewed all of the papers within my literature review according to this process to ensure rigour. A data extraction sheet (see Appendix 3) was used for the literature search compiling key information about each article (including study population, recruitment, measures used, findings and conclusions). Quality appraisal criteria are discussed in the methodology chapter.

Antirealists argue that qualitative and quantitative research are incomparable and therefore it is impossible to judge the former using conventional criteria such as reliability, validity, and generalisability (May & Pope, 2000). They posit judgement occurs through the lens of validity and relevance or subtle realism which permits an underlying reality to be studied between the two paradigms; an attempt to represent reality rather than to attain “the truth” (Pope & May, 2000). This position, which is also my own, considers that all research involves subjective perception and that different methods produce different perspectives. It also presupposes that means of assessment may be modified to take account of the distinctive goals of qualitative research.

The instrument of observation within Psychoanalytic research is the unconscious and communication within the research setting, neither of which can be consciously controlled, making them appear less than scientific in approach, i.e., the variables are not controllable (Hinshelwood & Stamenova, 2018). In response some researchers have incorporated quantitative methodology into their work. I opted to attend to conscious processes at play using the TA method to analyse data, thus rendering it a more objective process within a qualitative psychoanalytic research approach. I propose, should this thesis be replicated, that some similar themes or concepts within other F1 doctors might be observed. This would make it more relevant to clinical practice than had I only considered a psychoanalytic approach or a case study. Some psychoanalysts might not believe TA to be fully consistent with a psychoanalytic approach, so I have then examined the unconscious processes in the research activity (Hinshelwood & Stamenova, 2018) so as not to undervalue the intent of the psychoanalytic endeavours of my thesis. This is not to forget the debates concerning analysing data once outside the clinic (Frosh 2008). I have sought to ensure quality via triangulation of my themes by involving another peer researcher for my data, incorporating a quality control tool to evaluate the literature included in my search using CASP (2018).

3.11 Sampling

There were two participant inclusion criteria: participants must be a F1 and have disclosed a MH or PH condition on their TOI form. All participants had a previous self-diagnosis of anxiety or depression using screening tool – PHQ9/ GAD7 (Appendix 13e). It was not necessary for participants to have had a formal diagnosis or to have disclosed their MH/PH to their workplace. The aim was to speak to those with a MH or PH condition who were using OH. Patients with a MH condition were invited to participate to the study via one of the OH team by referral to the researcher.

A positivist sampling strategy was used, with a minimum target of a total of 20 interviews with each participant being interviewed twice.

3.12 Interview schedule

A semi-structured interview schedule was developed (Appendix 11) and piloted on a previous year group. Participants were interviewed twice; once at the beginning of their F1 year (T1) and a second time at the end of the year (T2). All interviews were undertaken on a one-to-one basis in person. They aimed to explore participants' personal experiences about OH within hospitals, private business or medical school. The interviews began with an open question asking about personal experiences of working as a FI or studying medicine with MH/PH, e.g., specifically what contributed to factors affecting this experience.

Questions explored:

- What participants consider are the most important issues relating to mental or PH and self-care.
- Experiences of working/studying with mental and PH.
- Experiences of using OH in the workplace/medical school (advantages and disadvantages of utilising OH, what most influenced the decision to do so, whether someone outside of work/medical school was consulted regarding TOI form).
- What support was available from elsewhere.
- Experiences of MH on work/studies and personal life.

The second interview (T2) was at the end of the F1 year. It further considered questions from T1 and also what else OH could do to support junior doctors more.

Questions explored:

- Whether all F1s should be screened by OH and supported.

- If so, what would this intervention “look like” (including format, ways of accessing it)?

  An App called HOWAMI has been developed in conjunction with F1s as a result of this thesis and is being piloted.
- What were the MH, PH, OH and overall experiences of the F1s in the transition year between the F1 and F2 year.

To enhance the reliability and quality of the interview questions (Castillo-Montoya, 2016) the interview schedule was piloted on three F1s from the previous cohort in 2015. Verbal feedback from participants was used to adjust the measure. The pilot suggested that each interview would last approximately 60 minutes. Difficulties with some questions were discussed with supervisors. Changes were incorporated to the interview schedules. The schedule of the questions was altered with questions about OH being mentioned first although the interviews were fluid to enable follow up on participants’ responses in line with semi-structured interview techniques. Allowing this fluidity also enabled the participants to share information they felt to be important but which would not have been elicited had the focus been exclusively on the research questions.

3.13 Participants

Qualitative research generally uses a small sample of participants (Bryman, 2016) which is neither random nor (statistically) representative, but which is most relevant to the topic under investigation. This thesis used purposive sampling of the most typical F1s seen by OH who identified themselves as having a MH or PH concern on the TOI form. The participants experienced a full range of possible cases so that the research questions could be fully explored (Bryman, 2016). Participants were recruited through professional NHS networks.

An alternative way to view this recruitment process is that, by using the TOI form, a self-selecting sampling approach was used to determine and target F1s for screening by OH who had already disclosed physical or MH. A benefit of this approach is participants are likely to be engaged in study processes and also willing to provide insights. This could not be assumed with this thesis given the concerns around confidentiality and disclosure for doctors. Additionally, they may have felt obligated to provide information or not have consented to share anything more with OH than the TOI form and diagnosis and/or failed to attend any appointments. Other limitations to this approach mean there is a limited representation of the wider medical population. However, a generalisable sample was not the required outcome for this research. I have not delineated the participants who consented to be interviewed as they all had extremely different characteristics and life stories, ethnic backgrounds, circumstances and personal challenges. While these details would be of interest, disclosing them would break confidentially and jeopardise the anonymity of this small group.

It is also possible that there is a self-selection bias, where the decision to participate in the study may reflect some inherent bias in the characteristics of the participants. If information about mental or PH is not disclosed on the TOI, and it later becomes apparent that there was a concern prior to commencing employment, this could cause challenges for any individual in healthcare. This is particularly true for a doctor and it may risk not just their job but also career and registration (GMC). However, this does not mean that F1s or anyone else necessarily feel comfortable or “psychologically safe” to disclose any MH or PH issue on their TOI. It may be that there were those who were not available for interview because they did not disclose anything on their TOI form who had different experiences of OH, mental and PH. There is an inherent problem in gaining access to those individuals who have never disclosed to anyone. This study aimed primarily to understand the relationship that participants had with OH; whether a disclosure was made to OH initially was not the focus. To gain insights

from those who have never shared mental or PH issues to OH or on the TOI would be invaluable if we are to support these individuals in the future.

The thesis was time-limited; running the study over a longer period could have boosted recruitment. 10 F1's participated in the study from May 2016 to January 2017: 6 women and 4 men; and were from a variety of cultures. Demographic data is shown in Table 9. More female participants than male were recruited. This gender ratio may reflect gender differences in MH among doctors and medical students, i.e., female doctors report burnout more often than male doctors (Lemaire, Wallace, & Jovanovic, 2013).

Eight participants expressed a previous MH history; two of these were male and the rest were female. Two declared a PH and MH history which had an impact upon their possible need for OH input. Participants had varying degrees of experience with an OH department previously and predominantly this was in relation to medical school where there is an OH role in the fitness to practice process.

The 10 F1s who were recruited to the study were interviewed at the beginning and end of their F1 year (T1 and T2). No one dropped out of the study and all F1s who were recruited were interviewed twice. It was anticipated that there might also have been a T3 interview for those who presented in OH with a MH or PH condition other than via this screening route. This would have presented a comparison opportunity which did not occur.

In total there were 10 junior doctors who interviewed. These generated 20 interviews.

All F1s accessed monthly follow up (FU) appointments post screening consultation with the same OH practitioner during the thesis period and after if required. The participants could access support with the same practitioner in between appointment times if the need arose.

3.14 Ethical Issues

Ethical issues associated with this research project, and the researcher's responses to them are outlined below.

3.14.1 Consent

Before the first interview, each participant confirmed they had read the information sheet. They were then given the opportunity to ask any questions. Informed written consent was obtained before the start of the interview and participants were asked to read and sign a consent form (Appendix 13a&b). Those interviewed in person (at Royal Cornwall Hospitals NHS Trust) completed the consent form before beginning the interview. A debrief sheet was given to participants after the interview (Appendix 13c). This contained contact details of support services including OH.

Safeguarding concerns were shared with the relevant body as per standard practice, e.g., GP, Deanery, Community Mental Health Team. All tape recordings were kept in a locked cabinet and destroyed following the completion of the research. All names were anonymised at the point of transcription. A list linking participants' actual names and their allocated research ID was kept in case a trainee asked to be withdrawn from the research. All research findings were anonymised.

This study explores in depth the perceptions that trainees have about OH and their work experience. The initial interview took place around the time that the junior doctor commenced working in the region. It is always possible that an individual may share distressing information during an interview although they are not designed to be overly emotive. As an experienced psychotherapist, I consider distress management to be part of my core professional expertise. However, if the interview was distressing, I maintained contact with the participant to make sure they had on-going support. In

addition, I adhered to the code of professional conduct and ethics as laid down by the British Association of Counselling and Psychotherapy (BACP, 2015) and Nursing and Midwifery Council (NMC, 2015). No-one under 16 or with special needs was interviewed. No participant expressed concern about any aspect of the research process, but had they done so they had been made aware of the Trust complaints procedure.

3.14.2 Confidentiality

A key concern relating to the interview process related to confidentiality. Confidentiality processes are explained to all OH attendees, and as stigma continues to be associated with MH difficulties this was especially the case. Participants were reassured that disclosures would be treated as confidential and would be both helpful and not too distressing.

Risk of harm, suicide or worsening mental health was managed according to routine screening process via OH (Appendix 13e). The anxiety and depression screening tools (PHQ9 and GAD7) were routinely utilised to monitor all service users. Any individuals with a high score as outlined in Appendix 13e, would be offered appropriate treatment according to OH guidance. This would include referral to Mental health team, GP, counsellor. No cases of risk were identified or ineligible to enter the study or needed to withdraw from the study as a result on MH decline.

3.14.3 Demographic data

Below is a table showing the demographic data of participants.

Age	18–24 8 (7 female,1 male)	25–44 2 (1 male, 1 female)	

How would you describe yourself?	Doctor	Patient 2	Colleague 8
Pronoun / Gender assigned at birth if comfortable sharing	Male 2	Female 8	Other- if comfortable sharing
Do you describe yourself as having;	A physical disability (please explain) 2- also has an impact on MH as assessed using OHQ9 GAD7 questionnaire A) Diabetic B) Blood disorder	A mental health disability (please explain) 8 (2 with PH)	Other disability (please explain)
Do you have any additional responsibilities, e.g., carer?	Yes 4	No 6	
Is your first language English?	Yes 9	No 1	
Has you been screened using the PHQ GAD questionnaire meeting the threshold	Yes 10	No	

for treatment ?			

Table 9. Demographic data

3.14.4 Resilience of Interviewees

Another ethical issue related to the researcher and whether they were resilient enough to conduct the interviews. The interview process provided for the possibility of significant ill health, e.g., in-patient care or absence from work as a junior doctor under the care of a community psychiatry team which would preclude interviewing. Should this occur, it was determined that, once discharged and back at work an interview would be rescheduled when appropriate. As each junior doctor would have different levels of distress it was recognised that this may have an impact on findings which would need to be accounted for and render findings not generalisable.

For further ethical issues see Simons (2015) and my own considerations in Appendix 14 B & C.

After formally consenting to take part in the study all participants were invited to define themselves by completing a brief demographic questionnaire (Appendix 13d) – the results of which are summarised in Table 10 above. It was made clear that completing the questionnaire was not mandatory. To protect the anonymity of participants, the questionnaire did not collect data about ethnicity. Instead it asked a question about non-English speaking as a first language. The table in Appendix 12b has been completed to summarise participant data.

3.15 Interview Process

The researcher met the participants in OH clinic rooms or a place of their preference. There was no prior relationship with any of the participants.

In my research I set out to do a comparative thematic analysis at two time points one year apart. Interviews were conducted face to face roughly 9–12 (T2) months apart to

ensure all interviews could be completed in a timely fashion. The purpose of the interview in month 0–1 (T1) was explained again and participants were assured that withdrawal from the research would not affect their care within OH. Participants were able to disengage from the research process at any point or withdraw their consent for interview material to be used during the year period. Interviews lasted on average 90 minutes (max = 120 mins; min = 60mins); they were recorded, transcribed verbatim, anonymised, and destroyed when no longer required, as required by the NHS ethics procedure. Each interview was audio recorded on an Olympus DS-30 digital voice recorder.

3.16 Ethical Approval and Ethical Discomfort

The project was scrutinised by the University of Exeter Ethics Research Committee and ethical clearance was provided and NHS ethics Committee (Appendix 12). Participant information sheets and informed consent forms were used (Appendix 13). The potential emotional impact that the interview could have on F1s was a concern for the ethical committee. Participants were asked to keep themselves safe during and after the interview. The researcher had information available about counselling services (online and within participants' local communities) for signposting. All participants were offered an opportunity to discuss their participation prior to consenting into the project and to debrief after the interview. Ethically, my role as researcher and member of OH as a psychotherapist was likely to have an impact upon the research due to potential role conflict between the two positions. Positively, it enabled me to capture valuable information about my own researcher reflexivity by keeping my own reflective notes during the study period. Ingrassia, (2013, p. 139) details the "contributions that the understanding of reflexivity in thinking can make to medical practice". Professionally, it was critical to draw a clear boundary between my researcher and psychotherapy roles from the outset (King & Horrocks, 2010).

F1s who were significantly unwell, for example, were psychotic and considered unfit for practice, were automatically excluded for the study. Patients who were unfit for practice or inclusion to the study were not referred to the researcher. Participants for inclusion could be any age, gender, ethnicity, and any medical speciality. The sample will not be generalisable to the F1 population but will specifically provide insights into local obstacles and enablers.

Saville Young (2009) suggests treading with caution when transferring psychoanalytic concepts from a clinical context into a research landscape, particularly with regards to ethical considerations. She included examples of “How is informed consent managed when it is not at all clear from the outset where the “free association‟ interviews might take the participants’ narratives?” She discussed how researchers can guard against participants seeing them as therapists and disclose more information than they intend (Saville Young p. 9). One way that I managed this was by attending to the universal ethics to “do no harm”. Benjamin (1995) suggests this is possible by recognising the therapist’s potential need for domination through the use of knowledge to gain mastery over the other. Holloway and Jefferson (2000a) also advise of possible distress caused by interviews and the need for honesty, sympathy and respect as an antidote. Holloway (2008) posits that interviews might offer a place for containment, relationship and recognition. This is a position I take within this research as it reflects my experience and locates itself well within the work of psychotherapy. These are contemporary challenges that are importantly discussed within psychosocial research and psychoanalysis (Frosh, 2007; Frosh & Baraitser, 2008; Hollway, 2008b; Jefferson, 2008). The issues of reflexivity and validity are central to an ethical research practice that employs psychoanalysis and informs my use of them as frameworks within this thesis to further this topic.

Trustworthiness was built by engaging in ethical scrutiny, openness to F1s' experiences of OH, piloting the questionnaire, sharing analysis and using reflexivity. While findings of this small qualitative study are not generalisable to the wider F1 population, details of the participants' context have been included. Authenticity was built by ensuring that the range of experiences of participants was represented. Participants reported the usefulness of reflecting about their experience of OH, and its implications personally and professionally.

3.17 Data Collection

The interviews were semi-structured as the researcher wished to explore OH and participants' relationship to it. The researcher did not consider any emotional contradictions or inconsistencies in the participants' narratives. This was different to usual clinical practice. Occasionally there was a fine balance between clarifying what had been said to properly understand something and a deeper exploration of the participant's feelings. The latter would have seemed more akin to a clinical intervention. I did not make any links between the first and second interviews, either beforehand, afterwards or at any time in between. Whilst this type of linking is a recognised therapeutic technique, looking back over time, I wanted to see whether the participants would spontaneously make such links or talk about them unprompted, as this would suggest a reflective ability. The T2 interviews looked back over the previous twelve months with the purpose of finding out if and how the participants' understanding and perception of themselves had changed during the intervening year and if so how. After interviews I checked that the participants were not left feeling overly upset; this was important as two participants had cried and spoken about distressing personal issues. I also debriefed myself after each interview, noted my reflections and observations about the interview, the participant, as well as its impact on me. This is commonly part of the initial phase of data analysis (Charmas, 2006; Hollway & Jefferson, 2000) utilised by other qualitative researchers.

3.18 Data Analysis

3.18.1 Dataset

The audio files were transcribed, anonymised and imported into Nvivo (version 10) qualitative software package for analysis. The dataset was comprised of transcriptions and personal reflections.

3.18.2 Transcribing the Interviews

The interviews lasted between ninety minutes and one hour and twenty minutes. They were all digitally recorded and none of the participants objected to this. The full transcriptions were typed verbatim, including hesitation words, repetitions, and laughter.

3.19 Analysis Method

TA was used to analyse all transcripts to provide an accessible, systematic and rigorous approach to coding and theme development (Clarke, Braun, & Hayfield, 2015). Although the analysis was guided by the six stages described on pp.66-67, the analysis was recursive rather than linear (Braun & Clarke, 2008); stages were returned to as needed throughout the analysis process. An a priori coding frame was not established, but coding was influenced by prior knowledge of the subject area, and the pre-determined interview schedule questions. The coding process therefore could not be said to be truly inductive.

Braun and Clarke's 6-step TA process (2006) was followed by grounding the analysis on the data and staying close to participants' meanings, rather than imposing existing theories and concepts on it. It is impossible to proffer "pure" induction within qualitative research - analysis being shaped by a researcher's theoretical assumption, disciplinary knowledge, prior research experience, and personal and political standpoints" (Clarke et al. 2015, p. 225). As terms such as OH were used within the interviews this may also

have influenced how participants described their experience using OH and influencing the F1s' narratives.

Data was coded by reading and listening to interviews and simultaneously coding transcripts using Nvivo-12 (QSR, 2020). "Bearing witness" (Holmes, 2008) to emotional content and reactions of participants during analysis, together with the maintained fieldwork notes on emotional processes, meant that feelings experienced during the interview processes promoted further reverie. This reverie and fieldwork material was brought into the analysis to provide the emotional context influencing the researcher's interpretations and emergent themes during analysis. This "co-construction of meaning" material was described within themes but not analysed using Thematic analysis.

I went back through all the research material to check accuracy and coherence. I then listened again to the original audio recordings, and carried out a secondary analysis of the data by recording in red pen on the transcript, the implicit and explicit emotional content of the interviews. I did this because I had lost sense of the affective content and found it difficult to access the emotional tone of the interviews just from the text. Using the audios and transcripts together was the beginning of developing the analysis with each complementing the other (Ashmore & Reed, 2000). Holloway (2009) describes this process: "*I work with audio records alongside transcripts. Listening to the participant's voice...requires attention to the initial research encounter in which researchers can use their own relationship to the scene to register the ways that they are emotionally affected by it*" (p. 3).

Analysis of the interviews involved developing initial codes and preliminary descriptive themes. These were further developed into analytic themes, identifying aspects that coherently organised them (Bazeley, 2009). Throughout, some of the descriptive themes, less relevant to the research questions, were discarded. Once analytic themes had been identified they were checked for fit against the coded data and full transcripts.

Finally, themes were written up and shared with supervisors, peers and two participants for feedback (Draft analysis in word Appendix 16).

3.20 Data Management

Each audio file was labelled with a unique identifier on transfer from the audio-recorder to an encrypted password protected hospital computer. This identifier was also applied to the transcriptions. The audio recorder's 'format' function was used after data transfer to ensure that data could not be retrieved. Data were handled, stored and deleted securely in line with a regional hospital data protection policy. Junior doctors move around the hospital a great deal and so their reference to individuals by name did not happen. Their role at any one time covers a number of areas and personnel which further protects confidentiality by making it hard to determine area of employment. No personal participant information was stored and abided by UK General Data Protection Regulation (UK GDPR; DPA, 2018)

3.21 Service User Involvement

Involving service users is increasingly well recognised as an important aspect of the HWB of the workforce, improved delivery of clinical care and better outcomes for patients (Boorman, 2009). Likewise, service user engagement can also contribute to the research process as it is correlated both to individual well-being and organisational success (Boorman, 2009). Medical supervisors, OH, the Deanery and current F1 service users were all consulted prior to the inception of this project, all of whom endorsed the research, its aims and the collaboration with OH.

3.22 Summary

Ten doctors were recruited into this qualitative study based at my place of work. Recruitment and retention of participants was unhampered. Twenty T1 and T2 interviews, ten of each, were analysed using thematic analysis. In the next chapter I will discuss the themes from the T1 interviews.

Chapter 4: ANALYSIS

4.1 Introduction

In this section, the analysis of the interviews is contextually presented, grounded in the 10 participants' accounts. Transcript extracts are presented in order to offer an overview and case representing what the data means (Smith, et al., 2009, p. 109).

There were multiple themes evident from the interview data collected. After organising the data into codes, the themes outlined in this chapter are those that were emergent form the data. Following peer researcher and supervisor feedback, they have been adapted to provide the reader with a coherent narrative when reading the thesis (Tables 11i and 11ii). Whilst F1 and F2 interviews are analysed using the common themes outlined on p. 61, the ways the themes are explored differ and have also been adapted to reflect the differing focus and experiences as participants transition between the F1 and F2 interviews. Findings for T1 and T2 interviews are articulated throughout the narrative and in Tables 11i and 11ii. The key differences that occurred during the transition included participants':

- increasing use of OH as a safe base and its service provision to support their MH or PH;
- an acceptance of their MH or PH condition and being able to integrate this personally during the transition from medical student to F1;
- developing increased confidence as well as sense of belonging to a "medical profession" as a result of these changes.

The research also provided confirmation that screening and FU is a useful OH intervention to support the HWB of F1s. An unexpected finding was that the interviews were found to be valuable in their own right, providing an opportunity for a reflexive space. These findings will be discussed further during this chapter. A hypothetical

working model-through the lens of psychoanalysis, highlighting some key changes and processes that occurred during the F1–F2 year is shown in the Discussion chapter.

The overall framework matrix can be seen at Appendices 15 and 16. Working on an inductive principle moving from the smallest sections of data to the largest, the data was coded into four themes for both the T1 and the T2 interviews (Braun & Clarke; Manley & Hardy, 2022).

Analysis themes are presented in line with those from the literature review and in accordance with analysis findings. Each theme will be discussed in depth. The themes have been re-ordered to reflect the concerns of the study and the interviews are divided into T1 and T2 sections. The themes referred to in Chapter 2 were explored in the following order:

1. Health seeking behaviour and OH – the thesis begins with this theme as health seeking and its relationship with OH, past and present, is the focus of the thesis
2. Internal world of doctors – this encompasses the participants' internal experiences and other insights into their MWB during transition to the first year as F1
3. External world of doctors – this explores the transition and changes experienced by F1s during their year at T1 and then T2.
4. Professional guidance and policy – this will explore screening as an intervention for all F1s. This is left until last because the opinions of F1s were not fully formed until the end of the F1 year and the T2 interview.

Analysis of the first set of interviews (T1) related to themes 1 – 4, each with between 1 – 6 sub-themes. These were organised into four over-arching frameworks:

- Role and experience of OH
- Transition from medical school to F1
- Learning about organisational culture

- Interventions

Analysis of the second set interviews (T2) related to themes 1 – 4, each with between 3 – 4 sub-themes. These were also organised into four over-arching frameworks:

- Role and experience of OH
- Transition from F1 to F2
- Learning about organisational culture
- Interventions

The analysis is illustrated with extracts from interviews. The following chapter will reflect upon the above-mentioned frameworks. These themes and the overarching frameworks will be discussed.

There is often an interconnectedness of themes although presented as separate from each other. Classification into themes is never neat as it is an analytical attempt to manage ideas.

4.2 Tables of Interviews –Thematic Analysis: Themes and Sub-themes

The purpose of the research undertaken according to the themes and sub-themes outlined in Table 10i and 11.ii is to:

a) provide greater understanding of the emotional and psychological health of F1s and the support structures that facilitate this.
b) understand the role of OH during this transition period.
c) identify perceived enablers and obstacles which affect an F1's ability to maintain resilience in the new workplace.
d) identify practices that seem to directly affect the relationship between OH and F1s, e.g., stigma and confidentiality.
e) make recommendations for the development of effective MH pathways of care.

Table 10i. T1 Interviews

Theme	Sub-theme
Overarching Theme: Role and experience of OH	
1. Health seeking behaviour and OH Informal coping methods Formal health seeking Contact with OH and workplace Barriers to disclosure Confidentiality Other interventions Need for specialist services	1.1 Differences between OH - Medical school and work 1.2 OH as a place of safety and containment 1.3 Importance of a consistent relationship with someone in OH 1.4 Place to be authentic and be “seen” irrespective of health 1.5 Value in OH Screening Doctor and their Role in Doctor’s self-care 1.6 Support from peers
Overarching Theme: Transition from medical school to F1	
2. Internal world of doctors Attachment style Individual coping style Presenteeism	2.1 Coping styles 2.2 Increased competence 2.3 Sense of Purpose
Overarching Theme: Learning about organisational culture	
3. External world of doctors Work, education, and training Well-being	3.1 Orientation to workplace 3.2 Obstacles to transitioning positively through F1 3. 2.1 Inability to self-care 3.2.2 Difficult starts / relationships/ systems injustices 3.3 Enablers to transitioning positively through F1 3.3.1 Acclimatisation and Developing Resilience
Overarching Theme: Interventions	
4.Professional guidance, policy, and politics	4.1 HOWAMI App –based on HSE guidance

Table 10ii. T2 Interviews

Theme	Sub-theme
Overarching Theme: Role and experience of OH	
1. Health seeking behaviour and OH Informal coping methods Formal health seeking Contact with OH and workplace Barriers to disclosure Confidentiality Other interventions Need for specialist services	5.1 Developing a continued trusted relationship with OH 5.2 Importance of "Reaching out "/ follow ups 5.3 Support with workplace adjustments
Overarching Theme: Transition from F1 to F2	
2.Internal world of F1 Attachment style Individual coping style Presenteeism	6.1 Transitioning from F1- T2 6.2 Developing increased sense of Clinical competence 6.3 Developing increased sense of identity as a doctor
Overarching Theme: Learning about organisational culture	
3.External world of F1s Work, education, and training Well-being	7.1 Understanding Role 7.2 Belonging to the medical fraternity 7.3 Developing sense of meaning and purpose
Overarching Theme: Interventions	
4. Professional guidance, policy, and politics	8.1 Screening as an intervention 8.2 Benefits and pitfalls of screening 8.3 Barriers to intervention 8.4 Interview offered opportunity for reflection

For ease of reference throughout, quotes are presented with the participant names anonymised by identification in brackets/pseudonym. Confidentiality is protected in this manner but detail has been shared with consent. Participants' expression has not been changed but has been reproduced verbatim.

4.3 T1 Interviews Theme 1 – Health-Seeking Behaviour and OH

4.3.1 Role and Experience of OH

All participants had some frame of reference to OH. For MH conditions, this predominantly related to negative medical school experiences which they expressed tearfully during the T1 interview. Two individuals had also experienced OH interventions both within private and NHS settings, neither of which had been positive. Those who had not had any prior OH experience had either received some guidance from their medical school supervisor who had "warned" them against putting any personal data about their ill health on their TOI form. One individual had undertaken an internship in their 5th year and felt this to be an advantageous process. Two individuals with PH needs had first-hand experience of OH and described support they had received from their previous OH departments as excellent. When discussing concerns around confidentiality a widely held view was similar to that of Gabi- *"I don't feel like there's anything I wouldn't share [with OH]. Perhaps, because I've had the experience of having to have time off university, [not OH]. I now know it didn't affect anything... and that it's not the end of the world"* (lines 314–320).

4.3.2. Differences between OH - Medical School and Work

Those with experience of OH described it in a variety of ways, having had variable contact and experiences relating to their mental and physical ill health. At medical school, those who used OH for support for PH issues predominantly reported positive experiences, such as those described by Titan.

> *"OH spent time getting an idea about my lifestyle, my needs, the impact of my health condition on my day-to-day work, creating plans to make it easier for me on placements. They created a fairly lengthy letter which helped me to cope with both Type 1 diabetes and my job as a medical student." (Titan, lines 102–105).*

The OH facility was described as a complex welfare system at university in which OH had its own niche, integrated with aspects of professional standards and other welfare services. It was generally conceived as a supportive, "hands-off" environment dealing with public health issues such as vaccinations and immunity. Rachel explained *"I was under OH, but they never intervened. I just had a couple of check-ups. If I was having problems, you would go to your college welfare officers and there were people in charge of undergraduate welfare; they were very approachable*" (lines 111–128). Raquel on the other hand talked about being referred to OH at medical school as a result of a PH condition. This resulted in a fitness to practise challenge being raised which she reported as less than positive experience. This was not an uncommon experience when fitness to practise matters were raised and it caused concern about the current thesis OH experience.

Regarding services provided by OH Raquel indicated awareness that OH also offered generic staff wellness services. Gabi explained: *"I've only ever seen an OH consultant to review whether I'm fit to practice really. I know there's counselling and physiotherapy but I've never had anything. There are obviously the drop-in clinics for vaccinations and that sort of thing"* (124–130).

Others described OH intervention at medical school as indicative of recognition that an individual required MH support, or that someone was unwell. Peter explained: "*It seemed like the next step- as if you needed the 'big guns' or you needed to take large amounts of time off … I guess that's how I saw it"* (lines 90–92).

Some of the comments apply to MH and many of the participants talked about the

impact of PH, or how they were treated by others about their MH. There were more negative experiences surrounding MH and there are more examples as a consequence. At this stage most of the junior doctors had only had experience of medical school OH. Only one person had accessed an external OH system through other employment for vaccination checks virtually. Another F1 had contact for sickness absence reasons during an initial interrupted clinical year which is referred to in 4.3.5.

Along similar lines when asked if they perceived themselves to be doctor or patient when in contact with OH the responses were generally united- they found it hard to define themselves as one or the other. This continued into the T2 interviews. They were unsure of the reasoning behind this. Some reasons given seem to be related to identity, finding acceptable terminology to describe how it felt when stepping from one role (clinician to patient) into another as noted by Peter: “It’s difficult to categorise. When I go to the GP I’m definitely a patient. I don’t feel that here [OH] because I’ve just walked over from work- so I see myself as a semi-doctor, but less so than when on the ward- a bit Peter/doctor/patient. A bit of a mishmash.” (Lines 256–264).

A similar example is that of Titan who commented “it’s probably a combination of all three (patient, himself, doctor), (laughs), I know that’s a cop out. It feels like meeting member of staff because we’re all professionals, and yet, to some extent I’m a patient because I tell OH more than I would others [staff]. However, it feels more like a consultation with another staff member about my specific needs rather than being a patient” (Lines 203–219).

Many others also said that because a relationship that had been established with OH when they commenced clinical work with the screening programme they felt the power dynamic at the study OH was more equal than when at medical school. Ivy commented “I would see myself more as myself. I wouldn’t see myself necessarily as a patient or doctor. To me OH is much more like an informal experience-unlike going to see my GP.

I think it is also related to having met my practitioner as soon as I joined [work], them [practitioner] having more time and being more available- so I have got a relationship on that basis" (Lines 133–146).

4.3.3 OH as a Place of Safety and Containment

This section is predominantly about MH and how F1s felt about OH in the study centre. Many participants described OH as a place of understanding and containment, particularly given the context of the machinations of the organisation. Charlie described it thus: *"I feel, and not just here but previously with OH, quite understood. You go to the building which is always at some far end of the hospital and there everything is fine, and people understand you. But you leave – it's only in that little bubble that it seems that people get it*. "(Line 72-75)

Several participants talked of the value of OH once they had experienced all it had to offer and perceived it as an under-utilised service. There was discussion of its value being in its provision and accessibility, even if not needed immediately. Becca considered its existence served as a "*safety netting" value of itself. "I didn't know that it was there but now that I've needed it, I know that it's there. It's not like a fallback position, but it's like almost like even when I don't need it, the fact that there's the safety net there, is support enough".* Becca (Lines 57-59).

This was also true for those with PH needs. Jack explained: "*Yeah, I think it's good to know that I have a something I can fall back on if I do need it and I haven't had to resort to using OH beyond my baseline needs, routine follow up. But it's good to know it's there,* …" (lines 301–302) This was also true of those who had previously had MH issues but didn't feel they needed OH in an ongoing way during this year. They did feel, however, that they liked the safety net that the consistent relationship and contact provided, feeling it was important as it provided immediate access to services and

professionals to support them when experiencing MH issues, to capture any loss of insight and MH concerns.

4.3.4 Importance of a Consistent Relationship with Someone in OH

Most participants noted that the consistent relationship with OH was important. This facilitated ease of contact for the F1s who reported OH provided a pivotal role of contact for other support. This was perceived possible because of the approachable, confidential and consistent supportive relationship created.

" . . .*If I was completely on my own, everything was more stressful, even though it could be exactly the same day but the fact that you know that there is somebody consistent that you can ask, even though you don't need it, is critical ..they don't have to actually do anything"* Rachel (Lines 68–72).

Others noted this as a consistent anchor point of relationship provided by OH. Becca noted: "*I think the most useful thing about OH is having the same person*" Becca (Lines 483–484). … It *"was really helpful having a point of contact right from the beginning and meeting you really early and knowing that I can come and talk to you when there are problems; the same person is vital*" (Lines 484–486).

4.3.5 Place to be Authentic and be "Seen" Irrespective of Health

Many participants relayed a sense of only feeing acceptable or worthy of being a doctor if completely well. This was particularly true when referring to MH. There was often a sense of being suboptimal if not fully mentally fit. Many had challenging experiences at medical school involving welfare teams, the GMC and often poor communication between OH, the deanery, and other professional bodies. For some, this also applied to being physically unwell, although this was generally a less negative experience than that of those experiencing MH issues. Some F1s had also had experiences of other NHS OH services and private OH care. Reflecting, participants felt T1 presented the opportunity to recognise that their OH teams had good intentions, even if it had not always seemed

this way at the time due to the unpleasant nature of their experiences. Raquel observed: "*on reflection, I feel that OH were very pleasant and had my best interests at heart….the link with the hospital and the Deanery and wider organisation didn't seem to work very well"* (Lines, 259–261).

This feeling continued in the first part of the year. Charlie's words exemplify what most F1s expressed: "*if you're anything less than fit and healthy you don't feel you can be honest about what is going on. I had a meeting with my educational supervisor last week- it was mainly an hour long of "these are all the things you've not done" lecture. I learnt that we weren't even starting from a premise of you've been unwell or ~~e~~ that what I was stating was true. And so it felt like there was no point in even defending myself because he didn't believe anything I was saying*" (Lines 77–82).

OH, on the other hand, is seen as providing the opportunity to have MH experiences acknowledged and validated- "bearing witness".

4.3.6 Value in OH Screening Doctor and their Role in Doctor's Self-Care

Rachel's view about screening and its benefits is echoed by others: "*That's what I meant by the safety net. I did try CBT; I found it really was not for me. The screening and follow up approach – having monthly appointments with the same person who keeps an eye out for my "triggers" to catch me if I am struggling and I may not notice or ask me about things if I am trying to pretend everything is 'fine' – knowing that I can access and OH at any time is really invaluable to me*" (Lines 57–60).

OH screening may pick up F1s who would not otherwise seek help, either because, for example, of participants' sense of shame or that they are not acknowledging their need for help.

Several F1s recognised they felt unable to fully self-care and they needed to take responsibility for their mental and physical well-being, as well as develop an awareness

of when they need help, rather than waiting until it is "*time to call the crash bell*" (Rachel, lines 600–601). There appeared to be awareness that all of this is challenging and that the medical professional persona might prevent many acknowledging they needed help. There was recognition of MH being a long-standing issue that needs long-standing management and an understanding that OH might see some of F1s repetitively in departments and that there was a requirement to build strong relationships.

Some participants during the T1 interviews appeared to feel an unspoken shame associated with the need to seek help. Some participants who particularly valued the consistent safety net relationship with OH were those who found insight and acceptance of their long-standing MH challenges hard: "*I enjoy my job. I suppose I'm disappointed to be having the same problems I had before*" Charlie, lines 5–6). All those who had previous recurring MH issues utilised OH regularly even though it was hard for them to acknowledge their ill health. This was possibly related to cultural stigma and a reluctance to seek help rather than issues related to OH.

4.3.7 Support from Peers

Informal reliance on peers gradually developed later in the year of transition. Initially, the F1s noted relying on nurses in the workplace but gradually their support network seemed to expand. In the ward environment peers were also highly valued as colleagues. As Raquel put it: *"You rely on other F1s and maybe the F2s. The support you get is from the working dynamic with your close peers*" Raquel (Lines 88–93).

Peter also said "*I mainly share things with the friends I live with. We generally unburden the challenges of the day so if I was struggling now I think I would also try and talk with them." (Peter, lines 52–53).*

4.4 T1 Interviews Theme 2 – Internal World of Doctors

4.4.1 Transition from Medical School to F1

This section outlines how F1s expressed their internal experiences of the transition between medical student to becoming F1.

4.4.2. Coping styles

All F1s described a range of coping styles as actively contributing to their HBW as well as maintaining their resilience. These were different from those described at medical school. As F1s they became, for example, more concerned about earning money, having responsibility and learning personal hidden strength. As Raquel put it: "*I have definitely seen myself being bolder than I would have necessarily predicted*" Raquel (Lines 113–114).

Others felt that routine might be vital either when well or unwell; this was very different for each individual depending on a variety of factors. These included past experience, personality, job and working environment, ability to recuperate in between perceived or stressful jobs, ability to access personal coping strategies during "down time" and MH and PH or personal factors that were being managed at the same time.

As an F1, most participants described the need for less challenging jobs in between the more intense ones to provide a period of recuperation. "*I think the year has been in quite a good order because I did quite an intense [job] first and then I got liaison psychiatry which is 9 to 5 and then doing MAU last. The jobs which were on-call were first and last"* Thomas (lines 31–35). Raquel also found this to be the case: "*… psychiatry has been fine because its 9 to 5, it's quite specialist, you're quite supported by your seniors. You have quite a lot of time spent with seniors so that way you learn. I haven't felt overly challenged by psychiatry*". Raquel (lines 16–19)

F1s noted during the T1 interviews that they appreciated the opportunity to gain support from multiple sources, including OH and GPs. Nurses were also acknowledged as providing valuable support in the workplace.

"*Nurses often look out for F1s; the nurses always respect that when you can't escape, on a 12-hour shift, you're admitting all the patients and you're the only one there, people are piling up that need to be seen but you haven't had a break...it is very helpful ... at least they're on my side*" Becca (lines 185–190).

No-one said that they felt that childhood was relevant to their ability to cope "I haven't really been able to ever identify anything early on in my childhood that could have any effect. I had one supervisor who, when he found out that I was born overseas, kept going back to it a number of times. He seemed very keen to try and say, "are you the child of refugees and has that defined who you are?" I said "not really" (laughter)". (Charlie lines 224–30).

4.4.3 Increased Competence

At the end of T1 most participants noted that they felt more competent as a doctor as a result of repetitively practising skill sets. This was consolidated as they moved from post to post, increasing knowledge. Becca noted that she had previously learnt *"how to deal with situations, but, what daily life as a doctor will be- if you get rid of all of the actual medicine…there's a lot of admin, there's a lot of struggles…the rota changing , doing night and dayshifts… that's very different from med-school, where you just learn the medicine"* (Becca,197–202). She later observed: "*I guess you get more competent with the more you do, the more practice you have at something. Every situation is different but if you have lots of similar situations you learn how to deal with them ...*" (Becca, lines 434–436).

Other F1s defined increased competence as an increasing sense of purpose and value. With this, participants described enjoying the sense of responsibility, feeling part

of a team, that they were productive and of value to others. This contrasted with being a student which was described as a process of building up skills and competency to a point at which it is "*passable to actually start working and be paid for your time*" (Thomas, line 50).

4.4.4 Sense of Purpose

Integral to the above enabling themes that were expressed was the development of an understanding of role expectations and a sense of purpose. This seemed to bring meaning to the role of being a doctor whereby each F1 could apply medical knowledge to life in practice. Raquel explained:

"*I know my role, and I do have a sense of what is expected of me, what my role is and so I think in medicine, surgery and psychiatry I'm essential enough to feel like it's a worthwhile job*" Raquel, lines 75–76).

There was also a sense of belonging that was often associated with feeling an F1 was undertaking a worthwhile job which could only be achieved by having passed medical school. Jake says this: "*Whereas at least once you've got through medical school you've got that qualification; you've shown you've got the degree. You have finally achieved something concrete and purposeful"* (Lines 42–45). It is the medical degree that permits access to this F1 world and the connectedness and belonging to the medical identity and fraternity.

4.5 T1 Interviews Theme 3 – External World of Doctors

4.5.1 Learning about Organisational Culture

One feature that was a regular theme in the early T1 interviews was a recognition that individuals, in addition to learning about clinical medicine, were learning how hospital systems worked and this was stressful. One participant observed: "*The mechanics of how hospital referrals and patient flow works – it's not featured at all as a medical student, I found. I don't think it was ever really touched upon. It was always just*

assumed that you'd just pick that up as you went along" (Titan, lines 182–185). Those with prior experience as an F1 felt they benefitted from this prior knowledge and also that an internship for all would be useful.

Many also acknowledged the importance of developing key relationships to support one's HWB as often, as already noted, it was the nurses who ensured doctors got their breaks. It was often also the nurses who initially were most useful to the F1s in terms of supporting workflow and teaching them the essentials of the F1 job. Quite quickly, many began to recognise that part of being a good doctor was about good communication, not just about application of the clinical knowledge learnt at medical school… "*I get on with the nurses. I think I'm naturally quite polite and communicate in a polite way and so that helps to some degree."* Raquel, lines 153–158).

Learning about how hospital systems work began to develop over the year so that FIs recognised that it was necessary to develop this skill set all through the year and that it could be more challenging than imagined; for example, the NHS is perhaps more fractured than it seems. Many F1s described medicine as having different doctors coming and going so it was hard to keep up with patients' care plans. Surgery appeared to have the same care processes, but each surgeon liked things done "their way" and wards did not all share the same ways of doing things. This made it hard for F1s moving every 4 months, especially when not "belonging" to a firm. There was no "orientation" to a ward and the problem was worse for international F1s. Monica said: "*I find moving from ward to ward hard especially because I'm an international doctor. Orientation to each job is vital. I may not even know what people's uniforms are or what they do*". Monica, lines 120–123). She went on to say that this was the steepest learning curve for her.

4.5.2 Orientation to Workplace

Many F1s noted that during the initial stages of integration into the workplace and learning about being a doctor it was crucial to understand not just how hospitals work but also that each ward was different. Many commented on the disparity of how this was addressed in each area. Rachel said that orientation to each ward area was really important for everyone irrespective of "*familiarity with process and hospital as each department is unique which can be disorientating…it would be helpful to know where the nearest toilet was? You know like really basic things on your first day, then you'd at least have that in the background*" Rachel, lines 261–263)

4.5.3 Obstacles to Transitioning Positively Through F1

There were several factors that F1s noted as obstacles to transitioning.

4.5.3.1 Inability to Self-Care

A multitude of factors were viewed as contributing to the F1s' inability to self-care; these included: high workload, poor routine, workplace factors ("shouty" surgeons), isolation and poor sleep – all of which might impact on mood and ability for insight. Frequent moving from ward to ward also means that others are less likely to notice changes. One F1 referred to the exhaustion following a series of night shifts and "*being particularly tired after a final night shift, at the end of your fourth or fifth night shift*" impacted on the ability for self-care. Thomas, lines 15–16).

For others (Raquel, Monica, Iris, Jake, Charlie, to name a few) it was not feeling good enough that contributed to poor self-care. This was eloquently expressed by Thomas:" You're *working hard and still getting either shouted at or being told it's still not good enough, which occasionally happens.*" He went on to say: *"When consultants are stressed for various reasons, some have lower thresholds than others, particularly certain specialties (surgery); they're more shouty than others*" (Lines 24–26).

As a consequence of needing workplace adjustments because of personal situations, some F1s felt more Isolated from colleagues which, as Becca put it, has a negative impact on self-care: "*So, I think having the normal F1 experience …would have been a good start because you also meet all of the other F1s that are with you. I still feel very isolated from the rest of the F1s because I don't really do much in the evenings because I'm tired, and because I had a quiet job first …it's been lonely. I haven't been involved in any of the email chains either*" Becca, lines 293–300).

Others reflected on the sense of the F1 year presenting a poor work life balance with very little time off. Iris gave an example of how even limited time off was eroded: ..." I *have a week of annual leave, but I don't [take it] because the plan from my educational supervisor is mostly catching up on all the portfolio stuff I must do. Which isn't ideal*" (Iris, lines 326–328)

Another F1 continued with a similar comment…" *things are recognised as being hard … there are people senior to you who are not helpful or interested in you getting portfolios signed off. It's recognised but nothing is done about it. 'They say oh yes, that's hard – but that's the way it is"* Charlie, lines 46–49). This participant was older than others, so his understanding of is experience could have been particular to his stage in life and related to frustration and of lack of self-agency rather than organisational power and dynamics. Nevertheless, this sense of frustration and lack of autonomy and self-agency reducing one's ability to self-care further was also a familiar theme among younger participants,

4.5.3.2 Difficult Starts/Relationships/Systems injustices

Several F1s mentioned a related issue that impacted on well-being. They felt the rigidity of the system was unjust and hard to work with in terms of not being able to choose annual leave, attend friends' weddings and so on. This was perceived as being punitive when related to something feeling unjust, such as being required to make up work

required to complete their F1 training in their own time, even though it was missed because of competing work commitments. Charlie explained that: "*things seem unfair … you have to go to a certain percentage of your teaching sessions. I've gone to as many as I possibly could. I've missed some because I haven't been in the hospital that day - I've been working nights or post-nights. I have to make up in my own time. My own time is quite precious to me. The whole reason I came down here was to have a better quality of life and to be able to enjoy time off, have a better balance of work and home life… part of me is feeling a bit hard done by*" (Charlie, lines 35–42).

A few F1s mentioned challenges at the beginning of the year although they recognised that they could happen at any time. ..." *For a couple of months, I just felt like I was, on the back foot constantly trying to work everything out. I wasn't confident; because I wasn't enjoying it so my performance wasn't good at the beginning. There were a couple of points where I got picked up on it. Rightly or wrongly, but, overall, it didn't have an impact on me having to do anything extra or set me back. I just needed to use it as a bit of a wakeup call to make sure I didn't drop the ball*" (Thomas, lines 202–208).

Another individual reflected on situations which might leave them feeling tired, isolated and have an impact upon their mood. This was generally detrimental leaving the F1 reporting a sense of feeling vulnerable and brought down to size…*" It doesn't mean you're not in the wrong because someone is heavy handed or whatever. But you do feel very isolated at the time, you're made to feel very small and it does have an impact because it does make you feel uncomfortable. You can bounce back from it and you can learn from things, but it is always going to be there at the back of your mind"* (Jake, lines 261–266).

4.5.4 Enablers to Transitioning Positively through F1

4.5.4.1 Acclimatisation and Developing Resilience

As already discussed, addressing issues relating to obstacles to transitioning through F1 would enable positive transitioning through F1. Creating a structure, having routine as well as acclimatising to hospital routine were all factors seen by participants as enabling positive transition through F1. As noted previously, participants referred to the benefits of having a structure. As Thomas put it: "*I suppose I've quite liked having the structure, particularly the last couple of months having 9 to 5 is quite nice"* (Lines 34–35).

Thomas and others such as Charlie, Jake and Peter also noted the enabling impact of increased experience and responsibility, competence, of "*finally, feeling like there is direction now and you're progressing. When you're student it just feels like you're jumping through hoops constantly"* (Thomas, line 37). Many F1s such as Peter said that overcoming onerous shift patterns and workloads ultimately led to unexpected increased resilience. "*Yeah, I've learnt a lot about myself -I've learnt that my MH resilience, my stamina has increased over this year"* (Peter, line 136).

There was also an acknowledgement of increased resilience to hospital working demands once acclimatised to employer expectations. Individuals talked about an increased capacity to cope with long shifts, feeling less daunted by senior staff, personnel and colleagues, better able to make decisions, especially within a busy and stressful environment. They often described themselves as feeling more disciplined in time- management with a sense of time changing as they became more proficient over the year. Thomas observed: *"I seem to have noticed it this year– as in 12 hour shifts that seemed like they went on forever at the beginning of the year – they still seem long but they don't seem nearly as long, they go a lot quicker than they did. I think that's partly just getting used to the work* …" (Lines 152–156).

4.6 T1 Interviews – Theme 4: Professional Guidance, Policy and Politics

4.6.1 Interventions

• HOWAMI App

F1s felt that an App aligned with HSE management minimising stress guidance would be a useful OH screening tool. F1s believed it could provide a safety net but the ideas regarding what might help them as they transitioned from medical school to F1 were undeveloped. As their views developed during the course of the T2 interviews, this will be further discussed below.

4.7 T2 Interviews Theme 1 – Health-Seeking and OH

4.7.1 Developing a Continued Trusted Relationship with OH

During the course of the year with OH which was described as providing "consistency" and a "bubble" and "understood connection with OH" (Rachel lines 483) and Charlie explained that:" even *if it's only in this place and nothing changes outside of the OH bubble … being understood in that place rather than having no-one being empathetic is important"* Charlie, lines 138–140).

For some, the idea of OH purely as a "safety net" continued, especially if they had had a PH concern or perhaps an episodic MH challenge. Those with the former reported "*the screening process meant I trusted OH to support a workplace adjustment*" (Jake, lines 452–453), whereas Becca* (MH) noted the "*hospital can feel extremely barren and hostile at times and so I have relied on OH more and more at times to help support me, which I didn't think I would have done due to previous poor experiences*" (Becca*, line 602). Raquel and Charlie both observed that "*This relationship has been really reparative for me"* (Raquel, line 560, Charlie, line 555).

Several F1s also acknowledged that the approachability and accessibility of the service was extremely vital to them. They experienced it as a service which was tailored around them individually, supporting their emotional HWB. It was receptive to their needs rather

than treating them as a patient needing to work around service delivery- impossible with shift patterns. They felt they were much more collaborative partners in their health process than had previously been the case in healthcare relationships.

4.7.2 Importance of "Reaching Out"/Follow Ups

The majority of F1s described the transition from F1 to F2 year as potentially quite an isolating experience. This was particularly mentioned by Peter, Ivy and Charlie who referred to the importance of OH having automatic follow-up (FU) appointments rather than the F1 having to take responsibility for booking appointments themselves. As Ivy put it: "*I wouldn't come [to OH] if not for FU. I like to come to OH and have someone keep an eye on me; having someone reach out is helpful*" (Ivy, line 138–139).

Charlie shared a common view when he spoke about the importance of having a safety net, knowing regular reviews were in situ as well as being able to discuss things of concern at these reviews if needed. "*Having met you very early on, I now know that if things fall apart, I wouldn't feel uncomfortable about getting in touch and saying things are really bad – I need some help. I don't know if it's different because I came to you kind of relatively well, I've been quite good at the moment. In view of my previous experiences at medical school I don't know if it would have been different if I hadn't met you early on or if I'd tried to come and see you when unwell*" (Lines 144–151).

Along similar lines Rachel observed: *I am surprised I opened up to you [OH] especially with my previous experiences of OH and subsequent line of thinking. I got sent to occupational health because I'd gone over my quota of absences from work. I was sent to OH for an assessment – it felt very much like I was being told off. My perception at the time was "oh, they're trying to prove I haven't been ill and that I'm skiving off work and they are going to sack me and it's going to be awful"! So, I think I would have worried if I hadn't met you [OH screening] before that – coming here saying things were wrong and then you'd [OH]be like: "well, stop work". It just would have been a negative thing rather than*

a helpful thing – I might not have even come for my appointment if feeling unwell (Lines 158–165).

The fragility of the relationship when F1s are unwell and the need for OH to maintain underpins these comments.

FU and screening was also cited as being a useful intervention to support MH as a preventative measure and also as a point of validating contact. Rachel admitted: "*I'm rubbish at insight although I am getting better. I like the fact I have a relationship with OH. I still tend to leave things to the last minute. I don't have that chance to really think them through very much. Like I don't really do the internalising bit very much because I just plough on and then like collapse. I like you to reach out and connect; it also makes me stop and reflect about my internal world."* Rachel, lines 203–206).

4.7.3 Support with Workplace Adjustments

By the T2 interviews, OH had supported several individuals with workplace adjustments and implementation for a variety of reasons including caring, childcare, mental or PH. F1 individuals believed this OH support in the workplace was critical to self-care and functioning: Becca explained: "*I don't really have any time for me. I go to bed earlier than usual because I'm really tired. I'm up at 5 every morning whether I want to or not. But I have a lot to do in the morning…I'm just so tired by 9-10 o'clock and I've not really had a chance for me time…then I just sleep and then start again, but ...that's in part why the work adjustment stuff has been so important... it gives you the ability to go home and just sleep when you don't have that other safety valve"* Becca, line 608–612).

Peter shared a common finding *"I have found regular contact useful. I feel the team care and want to follow up, so that I feel that within that [OH] system; its allowed me to trust built has enabled me to ask for reduced hours t support my MH needs at work" I never thought I would do this*" (Lines 310–312).

Similarly Jake commented: *"it's good to know that I have a something I can fall back on if I do need it and I haven't had to resort to using occupational health beyond my baseline needs, beyond routine follow up and stuff. If there more issues arose that my supervisor couldn't cope with, I would definitely come to OH*" (Lines 301–309).

4.8 T2 Interviews Theme 2 – Internal World of F1

4.8.1 Transitioning from F1 to F2

F1s reported a continual use of both self-reliance as their competence, skill set and identity as a doctor formed during the transition period from F1 to F2 [or T2] yet they all reported using the support of others to develop on-going self-care. The support utilised was continuous where possible but when sharing mental and PH vulnerabilities regarding self-care, they were more circumspect regarding where they felt safe to be vulnerable. . For those with on-going MH, self-compassion and acceptance of their condition still seemed difficult. Peter echoed some other participants: "*I function okay until I fall off my perch, then I'm completely non-functional… Just don't have the energy to talk with my friends or do anything, I fall into pits where I'm completely wiped out and just lie down and allow time to pass before the brain turns on again. It's annoying. I'm gradually realising that I may have to consider it is part of who I am*". (Lines 24–28)

There was a recognition among all F1s that self-care was important as mental ill-health was high among doctors generally. This, however, ran counter to their ability to self-care as work was often prioritised over personal care needs. As Raquel put it: "*Long term, what I see is a rise in* mental ill-health *in all doctors; if it's really busy, doctors often carry on*" Raquel, lines 182–183). High workload, demands and long hours often prevented self-care, increasing the likelihood of MH issues. There was an acknowledgment that it was often other healthcare professionals who nurtured the F1s, ensuring they got their breaks rather than the other medics. Becca explained that usually "*you're basically the only doctor with seniors popping in now and again and then it's a team of nurses and*

when they are putting the pressure on you-it's quite stressful. If you say 'I haven't had a break yet,' health care staff respect that -at least they're on my side. So that's useful" Becca, lines 181–185).

4.8.2 Developing increased sense of Clinical competence

Coupled with the theme of increased ability to self-care was a growing clinical competence expressed by all T2 interviewees nearing the end of their year. All reported this competence was fragile, prone to fluctuation, even for those who considered themselves relatively mentally robust with good support structures. Iris expressed it well: "*It [sense of competence] definitely waxes and wanes, depending on who I have in my team. When it is stronger, it comes with a sense of purpose. I do now feel like a doctor most of the time. The only time I get shunted back into that sort of student persona is when some of the doctors I work with who are also strong personalities can be a bit arrogant*". Iris went on to say: *"Some F1s know a lot more than me, and that's fine. I've been aware of that since day one. Some people ask for advice and sometimes it's given nicely; some it isn't. The time I get shunted back into that student sort of area is when advice is given in a bolshie, egotistical way. I guess it just hurts my self-esteem. You don't need to do that*" (Lines 239–243).

Iris also had insight into occasional times when she behaved similarly and disliked herself. She understood it happened when she lacked confidence in herself which made her feel as if she was "*lagging behind others*" (Iris, line 265). As a result, given the opportunity, she sometimes would display the characteristics she disliked in others to prove she did have knowledge and make herself feel better about herself.

Another participant expressed the developing sense of competence in terms of reaping the rewards of meaningful and engaging work..." *I like that it's worthwhile, it's satisfying, you don't have to do a lot to help somebody and they really appreciate it. It is satisfying*

being able to solve problems, know why is somebody unwell and put them on the path to being right again." Charlie, line 11–14).

4.8.3 Developing Increased Sense of Identity as a Doctor

Most participants described that over the F1 year they had stepped away from the "medical student persona" into that of "doctor". They described the main challenges over the transitional year as "getting used to being a doctor", having the responsibilities that come with it, learning about how the hospital works, how to manage the stresses and strains, their own needs, education, career, and consultant expectations.

Thomas summed up the comments of many, explaining: "*staying on top of competency stuff, your portfolio - those are the challenges of this year. Overall, I found it challenging especially all the nights, difficult hours and weekends. At times I've enjoyed it, at times I've not*." (Lines 8–13).

Peter compared his increased sense of identity as a doctor as having "*a gradual increase in confidence, especially thinking back to 8 months ago. Getting positive feedback from different things has had an empowering effect of me feeling more confident and more like a doctor rather than a phoney pretend doctor" (*Peter, lines 202–206).

Several F1s described the irreversible impact of this transitioning year upon their cognitive approach to medicine as they transitioned from a student to a "clinician mind-set". This meant a gearshift into making decisions, delegating decisions or asking advice and definitely being part of the ""Firm" even if it doesn't exist in name anymore. All these changes were both internally registered and externally acknowledged as recognition that doctors transitioning from trainee to F2 have a number of skills that are required, valued and must be deployable as necessary. It also recognises their higher clinical decision-making skills in the organisational hierarchy and that, if they don't have the knowledge or authority to make decisions then they are expected to know to whom they should

refer. Thomas went on to elaborate the reflections of many..." *I think initially, as time goes on, I've found over this year my confidence has built up a bit and consultants don't seem quite as scary as they did when you started at times. Things come together in your head -you start to think like a clinician*". (Lines 63–69)

Rachel added that she had gained a sense of being relied upon more by the wider multi-disciplinary team who recognised her increased competence and confidence. This insight was also expressed by most of the participants. As Rachel put it: involved a "*kind of gently building up the duties a bit so you start off doing everything with a consultant and then gradually getting more autonomy and independence*" (Lines 34–37)

4.9 T2 Interviews – Theme 3: External World of F1

4.9.1 Learning about Organisational

Transition between T1 and T2 involved a growing understanding of the organisations culture of the study hospital, organisational life and healthcare.

4.9.2 Understanding Role

One shift in response in T2 interviews was in the way participants responded to adversity as they came to better understand the culture of the different specialties in which they worked. Several F1s utilised different coping mechanisms in different specialities. Thomas explained a change in the way he came to cope with criticism and that, where he first saw it as reflecting a superior's lack of understanding and bad mood, he came to see it in another light: "*In medicine it's generally a friendly environment but if you do something wrong and you got told off for it, it wouldn't just be they were in a bad mood and wanted to have a go at someone; it was more like you've fallen short, I think. But overall, I wouldn't say it's a huge issue, it's just as time goes on you start to know what is expected of you and consultants trust you more because you've been around for longer as well. You become better, more competent and slicker at doing things."* (Line

109–114). Jake, on the other hand found another way to cope with criticism: "*You've just got to take it on the chin. If you get told off in medicine it tends to be more personal, I find, when you've done something wrong. Whereas in surgery it's just part of the culture, so it's easier not to take it personally"* (Line 98–101).

Others mentioned ways they managed stress and tension they came up against even though they disliked being on the receiving end of any hurtful emotion such as anger, directed at them. Iris described one such tactic other than dealing with it head on, "*If something is irritating me, I have a bit of a deep breath and answer in a monotone, friendly way and try and forget the fact that I'm stressed. I try to remember that everyone else is stressed; has their own crap they're dealing with in their personal lives*" (Lines 204–207).

Part of understanding their role as doctors was learning to deal with associated stresses and strains in each department and job – whether it be differing shifts, cultures, characters, skill sets, pace of work or perhaps trying to alter medication to fit around work schedule without it having a detrimental impact on mental or PH. If changes to medication did have an adverse effect, for example, on depression or diabetic care, it may be that this would result in F1s seeking OH input for organising temporary workplace adjustments.

Others described feeling protective of other staff members, acknowledging the overall positive impact this compassionate approach can have upon teams generally. One example was given by Raquel. She explained a clinical situation where a highly competent nurse, who had regularly been supportive of Raquel, had omitted a blood test on a patient and a consultant was angry. This created anxiety in the team and nurse which surprised Raquel as she had experienced them as immune to emotional vulnerability. She explained how she responded to the nurse: "*…as soon as he arrived on the ward later, I went up to him and said I'm really sorry, this is what happened (gave*

explanation), and then requested the blood test. He responded well to my honesty and was fine. It gave me quite a bit of confidence" (Lines 125–134).

1.9.3 Belonging to the Medical Fraternity

Another clear difference in the T2 interviews was that F1s talked about feeling connected to and the importance of their peers as well as their more senior medical colleagues rather than health care professionals and nurses only. This presented thematically as belonging to the rest of the team more cohesively. As Monica put it: *That's probably one of the biggest things that have made a significant difference to me; feeling that your other senior colleagues now approach you, especially Consultants. Some even feel like they are friends-this is a big difference and makes me feel I'm actually contributing as part of the team." Monica,* Lines 160–162).

Similarly, Rachel referred to: "one *of the consultants – and she is head of the F1 programme … she was very keen to make sure that I got a good experience"* (Line 20–22).

Peter, when talking about his fellow colleagues, consultants, and educational supervisors also said "they were just really nice, very patient and very happy to answer questions and kind of point me in the right direction for things" (Lines 34–35). Peter spoke for the majority of F1s when he described gaining a *"gradual increase in confidence, especially thinking back to 8 months ago. Getting positive feedback from different things has had an empowering effect of me feeling more confident and more like a doctor rather than a phoney pretend doctor"* (Lines 202–206).

Another key change observed during the second interviews was the increased support that was available to F2 doctors who had access to the post graduate team as well as F2 mentors. Many participants also used the welfare support via the post graduate team: "*I've got an F2 mentor; I really appreciate this although I can always go and talk to my clinical and educational supervisor too"* (Iris, Lines 442–445).

4.9.4 Developing Sense of Meaning and Purpose

Many participants felt increasingly useful and purposeful as time went on during the F1 year as Charlie expresses: "*It is quite different. I feel there are bits of the job that I am more confident at. I was working a weekend; I had to phone someone's daughter and say: I think you might want to come back to hospital now because your mother is very unwell. Breaking bad news is easier having done it lots of times before. I remember the first time I had to do this; it was a horrible experience. I still don't look forward to it but there is a certain satisfaction in doing it well. I have seen it done incredibly badly"* (Lines 74–88).

Iris echoed the words of so many during this transition phase: *"I feel that I think the big difference between uni' and now is feeling useful. I'm doing and part of something, I'm part of a team, I'm not just swanning around. It's the only time I've ever really felt useful. Same as when happy in uni', is when I was on placement and I helped the other doctors by doing some blood tests or something. It didn't do anything for my learning, but it was a time I felt best because I was being helpful*" (Lines 134–139).

Another theme that arose for many participants was the value of receiving positive patient feedback whilst trying to juggle multiple responsibilities as well as being a junior doctor... "*I try to achieve balance in what I do every day and use positive patient feedback to do this. I know I make a difference to patient care. This helps me feel I've got a purpose and understand what I'm meant to be doing at work where I can flourish daily*." Monica (Lines 136–140).

4.9.4.1 Beginning to consider career choices

Many of the F1s began to appreciate that each job they were in afforded them the opportunity to learn more about the role and helped them consider career choices. It gave them the chance to understand the other kinds of individuals who worked in each

setting e.g. surgeons and their characteristics, the shift patterns and which life style and work area might not just suit their clinical interest but also their life style and future plans. Becca said the following: “I really think that that is the most negative part about being and F1/F2 – the lack of routine is what I find it particularly difficult. Because even if you did have friends within your year, you’re always moving and you’re never on the same shifts and your routine is different from their routine; that’s horrid and that is the worst thing about medicine really. I am beginning to aim towards GP training to get back to some sort of routine. I can see that that is the thing in my Dad’s life. that’s what he clings to – he knows that he can go cycling on a Saturday morning because he doesn’t have work on a weekend” (lines 630–641).

4.10 T2 Interviews Theme 4 – Professional Guidance, Policy, and Politics

4.10.1 Interventions

The final interview question related to the possibility of OH screening all F1s as an ongoing intervention and whether there was anything else OH could offer.

4.10.2 Screening as an Intervention

Those who had previously described an earlier poor experience with OH were able to acknowledge their role in it and describe a reparative experience. Gabi described an appointment arranged by OH to introduce her and her Consultant: ”*He just [implied] ‘okay it looks like everything’s been done and we’re always here in case anything were to go wrong’ so the transition’s been fine. I was worried that when I came here, they were going to want to root around everything again, whereas actually he’s taken what the other Consultant has said ...drawn a line under it – said I know these are the issues, if something were to arise, I know the history but I’m not going to go over the same things over and over which was really reassuring*” (Gabi, Lines 18–28).

Generally, there was a consensus that F1s didn’t feel there was much more that OH

could do to support F1s than was already being offered. Charlie' commented that there was: "*nothing I can think of. There does seem to be, I think I said last time, a more of a proactive effort now to help people and address these things. Perhaps I do my previous employers a disservice and had I been more open, things would have been easier but that's how it feels now".* (Charlie, Lines 540–543).

4.10.3. Benefits and Pitfalls of Screening

None of the F1s who had been screened identified any pitfalls – all
felt that it was beneficial and had given them extra confidence in OH as well as in their ability to request support when required. Gabi's comment exemplified how her views about OH had changed as a result of screening, "*I feel confident to ask for help now because I know OH".* She went on to point out that in some cases, those needing help would not ask for it: "*I feel if you're really struggling, and you don't know anyone, you go a bit flat and you don't want to ask for help. It's just a downward spiral from there. I don't know what you do about that. It's like those cases psychiatrists see when people attempt suicide. If they actually wanted to kill themselves, they'd jump off a cliff but you can't get those people can you, cos then they've just gone and done it and it's really difficult. I don't know what you do for these doctors – I suspect they may still come in and say I'm fine*" (Lines 386–394).

Participants suggested that the situation Gabi describes where F1s experiencing significant MH issues are unlikely to seek help could be mitigated by the screening process. The repetitive point made by all participants was that there were challenges to finding help when distressed and how hard it is to "reach out" when you have had no prior contact with OH. It is easier to have a point of contact already secured and known. The effort made by the local Deanery to look after their MH genuinely was also acknowledged and appreciated. "*I think sometimes when people put themselves out there I think especially with like the MH things when I came here, it was one of the first*

things mentioned. There have been incidents of doctor's suicide and I think sometimes people think 'oh they're just doing it to tick a box' and they don't believe that they're actually there to help them. It is difficult especially when you're in that state and vulnerable. When you're bad enough to need help, you don't want to ask for it, cos you need the confidence. At the moment I feel confident to kind of ring OH to say can I see somebody. The screening means they know you and to know this really helps." (Gabi, Line 371–384).

Peter's comment suggested another reason why some F1s may be reluctant to approach OH for help is they may be "*wary of bothering OH with 'minor' issues. This is because even if I'm having a bit of a difficult time, I may believe I just need to change my work or am just struggling a bit. It seems I would have to rid myself of feeling that to see you wouldn't be an inappropriate use of your time."* (Peter, Lines 71-75).

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Generally, it was felt that screening of F1s would be a valuable and effective way of establishing a relationship with OH which could be called upon at any time. As Thomas put it: "*It's a good way to get your foot in the door, establish a relationship, gain an understanding of the support that is available so when you need it you actually know it is there*" (Thomas, Lines 273–279). Iris also expressed the benefits of screening: "*In an ideal world you'd get to meet every single one of us quickly and just say, "look this is who I am, these are my contact details. If you have a problem just drop me a message"; the practicalities of that are really difficult. If I hadn't had that wobble in medical school, it probably wouldn't be until I was at breaking point until I came across OH, so it is difficult."* (Iris, Line 328–336).

Relapse wasn't specifically asked about in the interview questions but it surfaced as a theme with regards to screening and FU. Jake suggested the importance of FU in preventing relapse in some F1s:" *I think it's a perfectly reasonable thing to do in terms of*

relapse. It's a judgement call whether you think someone is high risk to have another episode and FU in that respect might be good …" (Jake, lines 146–152).

Peter and others felt that on-going FU would be useful in his case because it would address the changing conditions experienced as an F1 over time and because it "*supports the on-going fluctuating mood with changes with differing jobs, life changes and associated risk related to my changing mental and physical state"* (Lines 310–312).

Others suggested other ideas such as mentors, health champions to promote awareness of OH and enhance screening interventions through targeted programmes.

4.10.4 Barriers to Intervention

An emerging theme was the view that if F1s were unwell they were likely to lack insight to engage with the offer of screening. While screening was perceived as a valuable measure that should continue, it was certainly not a "failsafe" intervention as F1s may not be honest with themselves about their mental or PH status when screened. Several participants admitted had they not been offered screening and this experience they may well have not utilised OH, or as effectively as possible. Many F1s felt their colleagues may say: "I'm fine" even if they weren't for some of the reasons identified in the literature review. Jake and Thomas articulated some of the thoughts of the participants more fully. Jake commented: *"You might pick up some but in my experience when you are depressed and you are not at the point where you have realised that - you're in denial about it"* (Jake, lines 35–137).

Thomas observed that depression does not follow a clear-cut trajectory that makes it obvious when intervention is necessary. *"Depression isn't just a straight line [towards] a breaking point more than anything and you are not really going to catch people before this. Typically, the people you are dealing with are usually … robust and resilient and*

want to push on. So that just means that their crashes are just a much bigger step; it's difficult I think". (Thomas, Lines 55–158).

According to participants, another reason F1s may not wish to attend screening was the stigma attached to OH. This stigma was also discussed alongside the need for barriers to be broken down alongside more education, especially by those who had had placements in OH departments during their time at medical school and for whom there was no stigma attached; "*there has been stigma attached to seeing OH and as long as people are being educated that is not the case then you will probably start seeing that more as new juniors come through. You can't force people to come. You can only raise awareness that it is an option. You can't spoon feed people; they need to get the help themselves*." (Charlie, Lines 389–484).

4.10.5 Interview Offered Opportunity for Reflection

In addition to providing the opportunity to consider their experiences of OH, participation in the interviews also gave them the opportunity to reflect on the year as a whole. Peter, for example, commented: "*… getting through F1! Feeling very proud of myself"* (Line 328) and Iris similarly observed: *"I feel such a sense of achievement and having got through the year"* (Iris, Line 400).

4.11 Conclusion

In summary, in this chapter I have attempted to demonstrate how F1s answered the research questions posed in the introduction, and how themes were discerned from the F1s interviews. I wished my thesis to be coherent for the lay reader and to present a coherent narrative. I adopted an inductive approach with the coding and using the research questions as a guided for parent themes to assist with reader accessibility within the tabular format. The information presented within the narrative however is different as the F1s transition over the year.

The following chapter links the themes to the theory outlined in Chapter 3.

Chapter 5: REFLEXIVE OBSERVATIONS

5.1 Overview

This chapter seeks to explore 'reflexivity' as used within this thesis process and then outline how it applies to the participants and researcher in the T1 and T2 interviews respectively. Definitions of reflexivity and the approach used have been discussed in both the introduction and the methodology chapter. All names of participants were anonymised at the point of transcription and pseudonyms are used. Concluding remarks are summarised in comments about OH and reflexivity at the end of the chapter.

5.2 Reflexivity

In this thesis the term 'reflexive' describes both reflections about myself during the process of research, as well as the reflections of participants about themselves in the context of their relationship with me as the researcher and within the interview process at T1 interviews and at the end of T2 interviews. Finlay (2008) proposes that reflexivity can be an opportunity to examine the covert voice of both researcher and participants and any potential influences this may have upon the research itself.

Finlay's (2002) claim that by examining the impact of inter-subjective elements of data collection and analysis one can increase the trustworthiness of the research is also relevant. "*The need to be perfect in order to be accepted back in the workplace"* is a view that was articulated by participants and reflects my own experiences or counter transference, both during my interruption and interview processes. Lazard and McAvoy's (2017) discussion of the role and method of the reflexive process in psychological research and their claim that it is impossible to eliminate researcher subjectivity from the research process is relevant.

5.3 Introducing Researcher Reflective Notes T1

While struggling to begin this chapter, I was reminded of “The computer says no” sketch in *Little Britain*. At times my mind felt closed, shut down, unavailable and “offline”. My sense is this can be what happens organisationally and possibly for the participants in this thesis. They were all invited to reflect on their experiences during this T1–T2 year should they so wish, yet no one did. Instead, they chose to be reflective within the T1 and T2 interviews so I wondered if I should have been more directive with the research design. The time to reflect strikes me as important but it rarely occurs in healthcare unless during a Schwartz Round or Balint group. I was reminded of a paper which explored how often juniors were compassionate to patients (Davin et al., 2018) where one participant observed that they forgot about compassion in the course of a busy day and only reflected on it retrospectively. Yet it felt as if reflexivity was a valuable unintended outcome of this interview process.

5.4 Reflexivity – T1 F1 Interviews

Reflexivity occurred for the F1s within the T1 interview but at different points, particularly at the point at which participants considered their experiences with OH. Some participants had never shared these experiences previously and seemed to find doing so both cathartic and reparative, allowing them to have their experiences “witnessed” by another in a safe place. This seemed particularly to be the case for Charlie when reflecting on the positive impact of telling Charlie’s story and the importance of sharing with another. Preparing my NHS ethics proposal entailed considering how to cope with emotions - both my own and those of participants, during the course of the study. Such emotions often occurred at unexpected times; for example, I hadn’t anticipated emotion in participants such as Raquel recounting narratives never told before. She emotively recounted how she had been treated at medical school when unwell, how awful it was and how the "supportive" services within the university offered a ‘stiff upper lip’ approach rather than the emotional support she had needed and hoped for. After the interview, I

reflected that, naively, I didn't expect the reflexive elements of the interviews to be an overt outcome. I wrote reflections about the need for a relational approach (Costello 2021) and organisational processes as described by Greene and Conrad (2002) and the lack of felt humanity for an individual such as Raquel. Those expected to care for others, who may be taught about self-care at medical school, or F1, are in practice often denied permission to apply it in reality. This can have a negative impact on long term resilience and the need to be strong (Hesse, 2008) if there is no reparative opportunity. This and personal accounts resonated with my work and university interrupted year of feeling “cast out”.

In their reflections some participants shared some harsh accounts of GMC processes: being bullied because of race, being a single parent and experiences or behaviours which they perceived as traumatic. Of those reflections that can be shared, the main areas participants were particularly reflexive about were their mental and PH, how they saw themselves and what helped them at a particular time [resilience]. Reflections about these areas were generally born of previous positive or negative experiences with others and referred to insights gained over the years about what had helped or failed. Participating in the interview had also assisted some of them to recognise their own strengths and understand that perhaps there were other models of OH than they had previously experienced. This seemed to open up the possibility for repair and personal change.

5.5 T1 Personal

Some detail disclosed in interviews such as that of Raquel, Monica, and Charlie was quite emotive. Because of this, conducting research interviews was similar to the psychotherapy experience and indicated the importance of supervision for researchers. I hadn't anticipated the interviews would be so draining and that I would need to take care of myself and give myself permission to do so. It reminded me of working with those I

supervise in other organisations in the humanitarian sector and the need for self-care when writing up the research. It also helped me to understand why I had found it hard to navigate writer's block. These insights facilitated the same self-compassion that I would offer to the F1s and anyone else entering through the doors of OH. They also served as a reminder of the value of reflexivity and the danger associated with not having the space to reflect or to process so that one is unable to think or be creative and therefore to take care or oneself and others (Francis report, 2013; Boorman,2009).

Repetitively I was struck by the fragility and resilience of the human spirit in these F1s. I was acutely aware of the need to "catch" people at the right time yet the difficulty of doing so. The greatest hope seemed to lie in forging relationships where possible and by word of mouth. It was also necessary to really know F1s by, as in the case of Charlie, for example, reaching out if someone was out of contact and someone knew their pattern of behaviour was to withdraw if becoming unwell. This may represent a greater demand on time than some services are able to deliver. Often MH was described as a non-linear process and those experiencing illness, even when they have done so on many occasions, often don't listen to the signals until it is too late.

I was struck by how many insights I gained through interviewing and the reflexive process about the importance of reaching out. One participant, for example, reflected that whilst he had previous MH issues on his TOI form, he nearly didn't attend his appointment. A chance email prompted him to reach out to OH – which he probably would not have otherwise done, even though he was suicidal. I am reminded of the literature (Harrison & Sterland, 2006; Davies, 2015; Oxtoby, 2015b; Oxtoby 2015a; Baptist, 2016) and how important screening is to capture those who may have gone past the point of self-care or retreated into themselves (Steiner,1993).

Some of the stories told by participants, those who were fragile and had at times barely had the energy to eat, did not wash and had suffered great mental distress, highlighted

the need for safe places where they could be helped. I found it horrific to consider what may have happened to one participant had they not received the potentially life-saving email, or had they not responded to it and made it to OH.

Participants' reflections that they felt they needed to "just try to be fine" and keep going at all costs led me to consider how OH could be more proactive and offer more constructive alternatives. For many of the F1s having a named contact within OH who would "reach out" seemed to make a big difference. Helen and Peter, for example, both expressed the importance of being allowed to feel, to be seen, but also to be allowed to have connection with someone who understands. At times I had a sense that OH offered a transitory safe, secure place until the F1s got to know other F1s better and felt able to share past experience with those they could trust as friendships developed. OH may also be somewhere where it might be possible to share shameful things overtly or covertly. An example of this was the interview with Raquel where she shared a great deal which she indicated she would feel wary of sharing with other colleagues after her medical school experiences (Fox et al., 2011).

Building relations to enhance a sense of safety seemed to make OH less impersonal, more accessible and possible to break down barriers. On reflection, it seemed that some of the "hunches" on which this original hypothesis was founded were anecdotally correct (Kolbs,1975). Finlay's claim (2002) that by examining the impact of inter-subjective elements of data collection and analysis one can increase trustworthiness whilst accurate, was only half the tale. Without this research much would have been left unknown, losing the opportunity for change.

It was also useful to be able to test my hunch that OH served a role for this group of F1s by allowing them to usefully relate to past experiences (Boud,1985). I felt this could be utilised within the workplace by educating staff involved. An example might be that for some F1s, experience of medical school was paternalistic. They had felt that those they

came into contact with were disapproving, were dismissive of their MH/PH or viewed it as “burdensome”, as if it were getting in the way of the “real education task”, getting them through medical school or helping them leave. They described feeling vulnerable and isolated whereas within OH they felt safe and contained, as if there was a collaborative approach and there was the possibility of a reparative relationship being established if OH “reached out” should a poor experience have occurred previously. I was struck both at T1 and T2 that by being proactive it is possible to repair ruptures in the relationship with OH so that support can still be accessed and other possible counter-productive measures avoided. The participants who had submitted a TOI form appeared to welcome being contacted and may have been disappointed had they not been. As a researcher, due to the nature of the information, I had concerns of intruding but this was not borne out by experience.

I was aware that contacting all F1s would be an enormous task for OH; however, and in reality, Jake and others observed that F1s may be unlikely to admit that anything is wrong, even if all of them were screened (Cohen et al., 2016). I was aware that some of the desire to contact F1s was tied up in my own transferential and subconscious drives such as wanting OH to be meaningful to the F1s and my prior role as OH practitioner wishing to “look after them”, but that in order to attend to the needs of this group it was vital to be grounded in the research findings. Relationship, nevertheless, seems vital, as does having a personal contact rather than being a “faceless” department. It seemed to me that once an F1 has been introduced to OH, they are able to hold OH support in mind. This mentalisation (Fonagy, 2000) process creates a trusted relationship and sense of feeling supported if needed.

A positive experience of OH is vital to F1s trusting and reusing the service to ensure it is on their “radar”. It is, however, difficult to catch those who have not used it. This led me

to conclude that if F1s haven't used OH before, they are unlikely to reach out unless extremely unwell.

The need for recognition, to be known, to matter and to establish a personal relationship and trust was considered important by F1s, although they acknowledged that it may be impossible to meet and screen all F1s. My own experiences bore witness (Holmes, 2013) to how important it is to be "seen" in order to feel connected and of value; life force versus death knell. The F1s also noted that the OH service was genuinely accessible, supportive and will work in their best interests in the workplace if needed. It was important to them that an OH individual knows them and that they are in a position to recognise signs that things are "amiss", providing a safety net and a space where F1s can share things that are going wrong. As noted previously, most participants said they were unlikely to have reached out if OH had not made first contact. That they were all keen to participate in the T2 interview highlighted that self-reflexivity and insight gained from it can be used to appreciate and inform the research process. In this case, I recognised having the same response myself to any "self-care" appointment. I will attend if an appointment is made but, if it is not, work or the demands of others always feel more important.

5.6 Reflexivity – End of T2 F1 Interviews

At the end of the T2 interview I invited participants to add anything they believed relevant. Given this opportunity, they proved to be particularly reflexive. They recorded their achievements to date, e.g., passing their ARCP, "getting through the year" in their own way, feeling more of a doctor, having learnt a great deal more about themselves, as well as how to look after themselves and their MH along the way. There were so many examples of this, such as M who really struggled throughout the year but expressed being pleased to have returned to the Emergency Department: proud that she didn't give up. She also said how grateful she was to OH because counselling and workplace

changes had made a difference, giving her the opportunity to learn to ask for help and to get her needs met. She also urged others to speak to OH, as for her, her culture and language (NESB background) had also presented a problematic barrier.

5.7 Personal Reflections Post T2

My personal reflexive process after the T2 interviews again ranged from perceiving that the interviews had given the F1s time to reflect on their own behaviour and progress over the year. It had also offered them the opportunity to acknowledge their developing professional persona and their enhanced emotional regulation, both of which had developed throughout this transitional year. Both interviews appeared to present opportunities for the F1s. The T1 interview seemed to be quite cathartic for some, facilitating reflection upon experiences and learning to date, particularly focusing on OH and their knowledge of self and MH. The time between T1–T2 appeared to present the opportunity to specifically consider this time, to ask questions after the interview, to ponder their achievements over the year, to consider what may best support new F1s "starting out" and to better appreciate the true value of OH and therefore have their physical and MH needs appropriately met.

Whilst much of what emerged from the interview has been explained from T2 interviews, it is important to be reminded that researcher bias and dissonance will have an influence. It is challenging to outline everything when dealing with such a small sample size, since to include certain points in the analysis would enable identification of the source, and so breach confidentiality. The interview appeared to give the participants the opportunity to reflect on the year generally. They were able to identify learning points, what makes them tick, which areas of work they found more challenging and why, all of which may be useful for their long-term career options, if captured more systematically (Boud, 1985).

Protection is a function of OH and its practices are bound by the requirements of consent and confidentiality. The consent process in the case of this study wasn't intended to be overly protective regarding any potential personal bias and was informed by the requirements of OH and NHS ethics. Reflexively, I acknowledge a bias and duty to protect the F1s situated in my professional background as a nurse and therapist which and the need to abide by confidentiality. Additionally, my other roles within OH provided me with anecdotal information and experiences of F1s which inevitably will have altered my perspective when conducting the research. It is possible that my position within OH also granted me special access to this group of F1s because I worked within the department, although others do conduct research, so I am uncertain how valid this argument is on reflection. Nevertheless, it remains that my previous insight into experience of F1s and its likely bias requires acknowledgement.

5.8 Additional Personal Reflections Between T1 and T2 Interview Process

The predominant reflections that resonated and feel important to re-visit/record here relate to shame and the challenges around acceptance of being unwell, the importance of a supportive culture and the “need “to be normal”. During the reflexive process, I also became increasingly aware of other areas that may perform a similar or complementary function to OH. Group Schwartz Rounds or reflective sessions, for example, can create connection and relationships, operate within the bounds of psychological safety and provide the opportunity to have safe reflexive spaces. They may also serve F1s well. They do not, however, offer individualised psychological support based on need. The latter could be better promoted within the HWB sections of organisational policy for F1s and all staff (Boud, 1985). It is also important that the separate function of OH is recognised (HEE, 2019) but integrated so F1s can have their needs met legitimately without having to share too much or fear breach of confidentiality. OH can contain distress, manage it, and help with it, yet locally OH it is often under the threat of being outsourced. The information elicited during interviews, however, seems to illustrate the

importance of the continued integration of OH as a separate entity existing within each NHS institution (Boorman, 2009; Sir Francis, 2013).

Shame is something which the participants only verbalise covertly, so strong is the unconscious desire to repress this and be normal, so I did not register their “unspoken” sense of shame until I shared my interviews with a colleague for quality verification. I was then forcefully struck by this “shadow” of shame. Shame experiences are evident in those shared by Raquel and Charlie from medical school and most F1s recounting low mood and experiences of “shouty” surgeons. As the impact of shame can be paralysing and far-reaching,* it reminded me of the opportunities those in OH have to make every contact count and of the need to share information from this learning to create change (Boud, 1985). *moved from end of sentence.

Another concern relating to ‘unspoken’ issues was the perceived “bullying in surgery”. F1s said, for example, that if they admitted to needing help, it was suggested that they should consult their GP to prevent GMC involvement. The researcher has no reason to disbelieve various narratives such as this which amount to F1s feeling silenced. This seems to reiterate the view that having FU by OH when F1s “feel ok” is important because it offers the opportunity to confirm that help is available if and when needed.

With many participants, the conversation during interviews had felt as if it flowed easily and they were speaking freely, that is, until I asked the question about how they conceptualised OH and/or their own MH. They either had a great deal to say, were quite emotional, or had little to say. They also had relatively polarised views. I found very quickly that it was difficult to maintain my balance and not shift into therapeutic mode for those who had received poor OH care in the past. I was also aware that it was vital to maintain objectivity regarding OH and listen with curiosity and intent rather than defensiveness or collusion. The interview at times felt relatively easy and at other times

more challenging, for example, when hearing some of the more brutal accounts such as those of Charlie (p. 104). The contact F1s had experienced with OH departments varied depending on their respective organisational structure and process and their interactions. Had these experiences been related to my local area, I may have found it more difficult to be less biased. This is particularly true in the case of Charlie and Raquel; although their cases were not only OH related. Their distress did remind me of me of my motivations for commencing my study.

The parallel processes allied to the concepts of analysis, alienation (Jaeggi, 2014), shame (Burgos, 2019) and lack of recognition yet continual learning (Dewy, 1916; Edge 2011) which I too have experienced during the writing of this thesis, feel particularly pertinent. There is not time to fully develop this line of thinking within the bounds of this thesis for I know my cycles of reflexivity are not complete (Edge, 2011). This predominantly relates to my own counter transference, themes of shame and alienation (Sznycer et al. 2018; Jaeggi, 2014), and to those F1s who sought help at medical school or beyond and relayed not feeling heard or seen.

This thesis has relevance to F1s who did not attend OH. The shame, due to illness, work and university, for me were experienced as alienation and painful rupture from and others. I found myself unable to access an OH safe base to support my welfare requirements. I am unable to draw conclusions from this but there are possible parallels with F1s, nonetheless. The disconnect from my community and self is likely to have maintained my ill-health, reduced my mood, confidence and also to have increased my belief in the need to depend upon further future self-reliance when this was already extremely strong, as was the case with F1s (Hesse, 2019).

I have also made the conscious choice for a reparation, as did some of the F1s within this thesis, as a psychotherapist via therapy and supervision – choosing, like Raquel, to be sparing with what I share with others in the workplace in the future because of the

previous treatment received (Forsythe et al., 1999). I could have explored my counter transference experiences further in this thesis with a view to proposing a hypothesis about those who have not attended OH, or chosen a couple of those F1s within this thesis who had previous negative experiences of help-seeking at medical school and experienced challenges, as case studies. However, both would have felt self-indulgent and disrespectful to the other participants. This approach would not have been authentic to the essence of the research findings because all the F1s in this study experienced a reparative process.

That said, unlike Rachel, many F1s will not have received a reparative experience on which to build trust, supporting the institutional HWB agenda. Missed opportunities to support and acknowledge individuals and to achieve significant positives for minimal output most likely result in untold damage being done. This is a narrative that requires further investigation. It provides an ideal opportunity to bear witness (Holmes, 2008) to shame, alienation (Sznycer et al., 2018; Jaeggi, 2014; Long, 2008) and was the original motivation for this research (Dewey, 1916; Edge, 2018).

Throughout their year, particularly when the F1s described their shifting competence, for example, their change in identity from medical student to doctor, or a shift from identifying more with nurses to identifying more with other doctors, it sometimes felt as if I were mirroring them as I transitioned from novice to researcher. As a novice interviewer, I often felt incompetent and that I would be “found out”- mirroring the "transition year". The role of researcher can feel quite performance based with concerns such as: “Can I work the tape recorder? Will it let me down?” Additionally, I have had to make difficult decisions over the past couple of years to self-care which included taking time out due to ill-health. I had to suspend my research while being concerned about what people might think and whether I was being a burden. I also found the shame of being physically unwell difficult to accept. Returning to this study has also been hard but

I have been motivated by the conviction that the voices of those who so generously participated in the study should not remain unheard or go unnoticed.

5.9 Concluding Comments about OH and Reflexivity

5.9.1 Summary of Participants' Reflexivity

Participants found that the screening process and support received throughout the year was valuable, offering a safe haven to be authentic, seen and heard without the need to be perfect. It offered a confidential space, consistent relationship, opportunities for growth and to repair, if desired, as well as workplace adjustments if required to support on-going or future needs. It was recognised that it was unlikely to suit all doctors, because of the perceived stigma of accessing OH and the shame associated with being less than perfect or ill, with the consequent conclusion that one was not fit for practice. Judging by the accounts of those who had previous unpleasant experiences, this culture shift is unlikely to alter overnight.

5.9.2 Summary of Researcher's Reflexivity

Through the reflexive process I registered my unconscious need to substantiate the importance and value of OH for this group of F1s. The research, however, validated the extent to which the issues being explored are vitally important. Whilst the role of attachment theory is not fully clear, a secure base within OH (Adshead et al., 2010; Ainsworth & Bowlby, 1991) facilitated me and others to bear witness (Holmes, 2008) to the experience of F1s. This was vital to the interview, FU and screening process with regard to building a trusting confidential consistent relationship. My interpretation is that this further supported the development of increased safety in the "containment" that OH offered, facilitating enhanced resilience (Bartley, 2007). Poor rotas, cover and leave have an adverse effect on work-life balance, relationships, morale and

health (Baptiste, 2016) and cause individuals like Charlie to feel resentful about spending his free time studying. It could be interpreted that such workplace practices cause F1 alienation from themselves or their organisation (Jaeggi, 2014). This study facilitated my ability to research that which was observed in clinical practice by application of psychoanalytic concepts in action and considering the research questions in chapter two. This resulted in continuous reflective cycles of learning (Boud et al., 1985; Edge, 2010).

5.9.3 Concluding comments

OH departments must be valued by the Board and HR teams of the institutions in which they operate. Without institutional support, OH is unable to optimally support those it serves (Carding, 2021).

Chapter 6. DISCUSSION

6.1 Overview

This chapter seeks to interpret the data in relationship to existing literature, including how it answers the research questions and interprets the research findings. It will aim to identify correlations, themes, and relationships between the data and contextualise findings within previous research and theory. This will challenge and also illuminate findings of other studies, demonstrating whether my study outcome supports or contradicts the claims in existing literature. This section triangulates reflexivity and learning from the analysis in the recommendations. Unexplained results and their significance will be evaluated and possible alternative explanations and arguments considered in evaluating whether the study has answered the research questions. An appraisal of the strengths and limitations of this thesis will then be presented, followed by an examination of implications and future directions for research and practice in this area.

6.2. Introduction

As outlined in Chapter 1, a purpose of this thesis was to investigate junior doctors' relationships with OH in reference to their mental and PH. The literature review in Chapter two showed that to date the role of OH and doctors' MH has not received close attention and that no interventions existed for OH to actively support or engage with this population through the lens of shared understanding or recognition of need (Mead, 1934). The aim of this thesis was to determine:

1. What factors have an impact upon F1's ability to access support to maintain their MH during the transitioning period?
2. What role OH plays during this period?

This thesis has described two interviews, each with ten participants, held a year apart, a reflective process and novel findings informing recommendations for the development of future OH service delivery during the F1 year and thereafter. In this chapter, I examine the novel contribution that the work in this thesis has made.

The focus of the thesis was to better understand F1s' experiences to enhance support, pathways of care and inform any future interventions. The findings of the study draw attention to the complexity of roles that OH and others potentially fulfil for those doctors with mental and PH needs throughout the F1 year. The results demonstrate that compassion is valued and it is possible to repair a previously poor experience of OH through active screening and intervention with this group. The results also highlight the on-going challenges related to the existence of the "strong doctor" persona and the difficulty of determining ways to positively engage junior doctors, even those who have previously suffered tragically as a result of well intentioned HWB interventions or through lack of engagement. The analysis confirms that compassion and reaching out to another at a time of distress for this group is not only important, but can also be lifesaving. The data also suggests that, given the correct conditions, including the

availability of an approachable and trained individual, open access and opportunities for reaching out, OH can provide something different from, yet complementary to, other support currently available, such as Schwartz groups. It can offer safe containment, the opportunity to reflect, an individualised approach to support well-being or, if necessary, recovery back to work.

6.3 Interpretation and Discussion of Findings

According to Attachment Theory, attachment issues early in life (Adshead, 2010) are considered to potentially have a correlation with high stress levels, insecure attachment patterns and poorly performing doctors (Kokkonnen et al., 2014; Ciechanowski et al., 2004; Firth Cozens, 1992). This theory does not appear to be borne out by the F1s in this thesis. When asked, they felt that their early childhood was of little relevance in comparison to events in later life, such as how they had been treated relationally or by life events. Charlie account of his experience was expressed within the analysis (p.146) where he recounted that, although he could not identify any childhood issues that could have affected his MH, a supervisor seemed very keen to interpret Charlie's issues as arising from being the child of refugees

One reason for this disparity may have been because an attachment questionnaire wasn't utilised because the researcher did not have time to be trained in this area before the thesis commenced. However, crucially, Firth Cozens (2007), Valliant et al. (1972), and Katsavdakis et al. (2004) have all found an association between unhappy family or childhood experiences and the incidence of MH disorder in doctors but did not utilise specific attachment screening methodology to ascertain this information. This finding suggests that lack of attachment training was not necessarily a deficit and that attachment early in life is not necessarily related to F1s' mental or PH. Another crucial reason for the discrepancy between the findings of this study and others may be that the participants noted that it is not just childhood relationships that can have an impact upon later MH. Unconscious processes that Obholzer and Roberts (1994) mention arising

from lacking a secure base from which to work might have an impact upon F1s with a history of MH or physical conditions. The findings would suggest that perhaps attachment to a “secure base” such as medical school or OH may be more relevant than early life attachment issues (Baptiste, 2016; Adshead, 2010). In this case, OH supports resilience for F1s when feeling vulnerable medically or psychologically, providing the opportunity to be with friends and colleagues and to gain the connectedness and shared alliances (Gilbert, 2014; Shanafelt et al., 2011) for ongoing containment, support, and resilience.

The findings of this thesis correlate with those of Myers and Gabbard (2008) who reported that doctors who also seem to possess personality traits such as perfectionism and an exaggerated sense of responsibility might be more vulnerable to certain stressors. The burden of responsibility did appear to weigh heavily on the group of F1s interviewed, particularly if they felt they were struggling. Once they were “back on track”, they seemed to display the traits noted by Eley et al. (2013) whose study noted that resilience traits, such as mature, responsible, optimistic, cooperative and persevering personality characteristics tend to positively align with optimal functioning and well-being. What is novel about this study is that, as is discussed in Chapter 4, for most participants resilience also seemed to correlate positively with their transition from medical student to F1 to F2 at the end of the thesis. In the analysis Peter says; “*I think I do have a gradual increase in confidence, especially thinking back to 8 months ago. Getting positive feedback from different things has had an empowering effect of me feeling more confident and more like a doctor rather than a phoney pretend doctor”* (Peter, lines 202–206).

This may have been because they felt more confident in their identity, capability and competence as a doctor.

6.4 Secure Base

Adshead (2010) explores the previous relationship between junior doctor and the “firm” to which they were “attached”. This research (Silverthorne, 2010; Carrieri et al., 2015; Carter & McGoldrick, 1989; Berge et al., 2012) confirms the views of the participants in this research process who reported that support during the first year as a doctor is significant.

The F1s in this thesis reported similar findings to other studies that dysfunctional teams, poor communication, interpersonal conflict, and low levels of support increased their vulnerability to MH problems (DOH, 2010). Moreover, Baptiste (2016) notes the negative impact frequently moving has on resilience – participants in this thesis move every four months – with consequent disruptions to the support network, including OH (Cohen, 2016). Greene and Conrad (2002) observe that a healthy mental state cannot develop without positive interaction with the environmental resources and that it is positively or negatively affected by the external world (Luthar, Cicchetti, & Becker 2000, Powers 2002; Cohen et al., 2016). As discussed in Chapter 4, p.152, the experiences of participants in this thesis certainly seem to support this view experientially. Their resilience and MH declined when they were more isolated, were in a job they disliked, when they felt lonely, when something critical happened, when they lacked support and/or didn’t know who to turn to. It was often at these times that they felt that someone noticing, reaching out and showing compassion were vital and sometimes literally lifesaving as they felt unable to call the “crash bell" (p. 132) for themselves. In view of current demands upon the NHS, how to best support F1s has considerable ethical significance, not just for OH but for the whole of the NHS.

One of the unforeseen advantages of this thesis is that it highlights the therapeutic value of providing individuals with an opportunity to access personalised containment and

support tailored to their specific requirements at any given time, even outside the fixed appointments. This realisation occurred to participants when given the time to reflect in T2 about the enablers and obstacles to their MH and progression in the first year. OH offered something unique to this group not offered elsewhere within the organisation; it is the synergy, summing up and coordination of all the aforementioned component parts that is vital for OH and F1s. The relationship with OH is itself of value for some F1s in the wider context of their development over the F1–F2 year of friendships and other sustaining networks vital to their HWB.

A core finding of this thesis has been to identify that building a relationship with OH is valuable, offering a place for continued support and safe place rather than one-off episodes for some F1s. Many doctors believe they can control their mental ill health and stop it (Bianchi et al., 2016). Others won't seek help until they feel suicidal or helpless (Feeney et al., 2016) or use counselling services that are offered (Adams et al., 2010). OH has a crucial role in risk management and offering a safe base when the working environment or personal friendships no longer seem ~~so~~ supportive (Loas et al., 2018, Oskrochi et al., 2016). This thesis demonstrates the importance of building relationships early on and points to the value of an ongoing relationship and secure safe containing space (Ainsworth & Bowlby 1991; Bion, 1962). Arguably this is conceptually akin to the rupture experience within therapeutic relationships (Bowlby,1988) and bears relevance to Steiner's (1993) psychic retreat. The inference is that OH is like a container for the spectrum of shame (Steiner, 1993) for both the self (Steiner, 1993; Jaeggi, 2014) and narcissistic organisation (Steiner, 1993) until relational repair (Bowlby, 1988), and reintegration with the self, other, and organisation is possible (Steiner, 1993, Jaeggi, 2014).

Some key examples from the analysis follow. F1s experienced challenging experiences

at medical school involving poor communication between OH, and other professional bodies, such as Peter's experience described on p.140 where he felt

"*It seemed like the next step – as if you needed the 'big guns' or you needed to take large amounts of time off … I guess that's how I saw it"* … (lines 90–92). When OH intervened at medical school it indicated that an individual required MH support, or that someone was unwell.

The feelings of shame referred to by Charlie (p. 104) were overtly shared by most F1s in this study and one they seemed to think those who didn't attend OH might be expressing covertly when not seeking help (p. 134 & 345) [check all page refs once finalised].

The research suggests that OH provides the opportunity to have MH experiences acknowledged and validated as Becca and Charlie suggested in a view and which was shared by other participants (outlined on p.141 to whichever pages) that repair with OH and organizations was possible where a consistent relationship was established with the same person who understands you.

6.5 The Impact of the Training and Work Environment (the External World)

This thesis confirms the findings of Lambert's et al. (2015) survey of junior doctors' views about their work, education, and training three years after graduation in 2008. Positive comments were made about levels of supervision, support, morale and job satisfaction, yet, overall, there was agreement that poor rotas, cover and leave, had an adverse effect on work-life balance, relationships, morale and health.

6.6 Workplace/Stress

This thesis bore out similar self-reports of the research undertaken in 2014 when over 624,000 employees from 287 NHS Trusts in England were surveyed (Staff survey co-ordination centre, 2014). The study found that hospital doctors' job demands and resources predicted their work-related well-being. The participants in this thesis

appeared to mitigate work stress by developing coping mechanisms either acquired though professional support, such as OH, where authentic relationships and well-being opportunities could thrive, and/or by developing an increased sense of medical competence and identity over the year. Additionally, participants in this thesis reported positive factors such as peer support networks which lasted through the year, as well as temporary bonds with departmental colleagues such as nurses, and a shifting identity focus and allegiance with the medical fraternity throughout the F1 year. It was also a year when each F1 learnt a great deal about themselves and how they operated within the clinical world of the NHS as individuals. Many reported adopting coping strategies so they could function within the system. For some, by the end of the F1 year this may have meant using OH to provide workplace support and/ or greater acceptance of their mental or PH.

6.7 Mental Health Training

Brennan's et al. (2010) study reported that F1s found the transition year stressful and felt uncertain and unsupported dealing with demands and responsibilities, and when experiencing the sudden death of patients. All F1s in this thesis described similar challenges to those outlined by Brennen et al. (2010) depending on the support available at any given time in their post. All those interviewed at T2 claimed that one of the most stressful factors of the transition year was learning about hospital systems and processes. This is perhaps obvious in the absence of a "firm" (Carrieri et al., 2015) to provide support to F1s, explaining why the role of nurses and OH appears to have been valued by this participant group. During the T2 interviews all F1s reflexively noted a perceived shift in identity from medical student to doctor. This appeared to be associated with feeling more competent, being more able to rely on other doctors, and that they were accepted into this "medical fraternity". They had gained more insight into their health and well-being which facilitated their ability to self-care within the workplace.

They consequently felt better equipped to make improved career choices based on these insights, such as Becca's realisation that training to become a GP would best suit preferences she had come to identify (p. 165).

This development could be perceived by the researcher from both their language and reflections at interview. To the researcher's knowledge, this progress has not been charted in previous studies.

6.8 Help-Seeking Behaviours

In the face of a relentless workload and other demands (McCartney, 2015), the perceived imperative to conform to a "professional identity" might stop an individual requesting support, registering with a GP, or taking time off work (Harrison & Sterland, 2006; Davies, 2015, Oxtoby, 2015b; Oxtoby, 2015a; Baptist, 2016). The participants in this thesis, however, indicated that this was not the case for them. One plausible reason for this was their decision to self-disclose and their acceptance of their previous or current mental or PH. They all denied that their professional identity would prevent them from requesting support once they had developed a relationship with someone in OH or after a previously poor relationship with OH had been repaired (p. 141).There was a general recognition that it was likely to be challenging to engage those who had not previously utilised an OH service, for example, through screening and perhaps it was the concepts suggested by Mavor (2014) and Harrison and Sterland (2006), Davies (2015), Oxtoby (2015b), Oxtoby (2015a), and Baptist (2016) that were being articulated in their studies.

6.9 Obstacles to Seeking Help – Shame, Stigma and Fear

Fear of discrimination and stigma has consistently been cited as an obstacle to doctors and medical students accessing MH help (Adams et al., 2010; Dyrbye et al., 2015; Hassan et al., 2009; Henderson et al., 2012a; Kay et al., 2008).

This thesis found these factors had influenced decisions; particularly when F1s were at medical school. They described the relationship with medical school and OH to have a greater focus on professional practice rather than welfare, to be less collaborative and accessible. All this made the desire to ask for help less appealing if it would result in possibly being reported to the GMC. Fertleman and Carroll's (2013) review of the GMC (2013): "Supporting medical students with MH conditions" and the flaws they identified regarding how to support students and/or escalate concerns appear to correspond to the experiences of most of these participants.

Some doctors believe they risk their career by disclosing MH issues (Adams et al, 2010). The findings (Adams et al., (2010) also indicated that medical culture was not supportive of those with MH issues- this was consistent for these thesis participants. Those with MH challenges had generally had poor experiences at medical school and some external OH providers privately, particularly with MH conditions. This was not the case for those with PH conditions. The majority of those in this thesis expressed being more concerned about GMC involvement than OH. Fear of regulatory involvement (e.g., by the GMC) was shown in a study of UK doctors to be less of a concern for those who had experienced mental ill health than to those who had not (Cohen et al., 2016). One thesis participant had an extremely positive interaction with the GMC, although this was rare.

6.10 Formal Help-Seeking

The findings from this thesis suggest F1s can build up a relationship with OH based on confidence in and appreciation of the services OH could provide. This was not found within the original literature review and paves the way for other services to consider. The reparative relationship developed by the end of the end of T1 interview and certainly T2, contrasts starkly with some participants' previous medical school experiences where

they sought support and disclosed ill health as a last-ditch attempt to manage a crisis - the resultant outcome not always positive. Consistent with the literature reviewed, this thesis found that these earlier experiences still influenced disclosure decisions. The F1s remained concerned about GMC involvement. Trust in the service and relationship is vital as it will be when trying to reassure others who are unfamiliar with OH that it is a safe, confidential space.

Overall, the very complex and individual nature of disclosure decision-making has been emphasised. Among those disclosing their MH outside of friends and family for the first time, the majority in this thesis disclosed to the workplace or medical school. This differs from previous research that found that, after friends and family, doctors expressed a preference to disclose to their GP (Hassan et al., 2009). They felt screening via OH, once an F1, was a good option for them.

The disparity between what individuals think they might do and actions when disclosing MH is clear (Cohen et al., 2016). What is illuminating about this thesis is that screening provides the F1 with an opportunity to build a consistent relationship with OH in an environment where they are in control of the relationship and what happens in it; even if there is a perception of feeling alienated from themselves and the wider institution (Jaeggi, 2014). It also provides a reflective, safe base (Bowlby, 1988) and space where, at a critical time in their career, F1s may become aware of any ill health before reaching a crisis point. As an interpretation, this affords containment of emotions (Bion, 1962), a metaphoric psychic and “in- between institutional [OH]” retreat (Steiner, 1993) facilitating building of resilience until re-integration is possible (Jaeggi, 2014). Many of the participants noted the relationship with OH to be collegiate or collaborative, rather than reflecting a power imbalance as was often the experience at medical school where

participants were dependent upon a reference to get the next job and/or a good TAB to progress to the next year.

Some inconsistencies noted in the literature concerning the use of OH and disclosures might have arisen where an OH department had been outsourced. Participants in this thesis provided anecdotal evidence that sometimes OH is not well embedded and integral to the organisation. If this is not the case, it is possible for an individual to believe in that OH affords total confidentiality. However, addressing workplace solutions, accessibility and links with local services can be challenging, and potentially reduce F1 safety, if required. Participants implicitly expressed the view that the relational approach (Costello, 2020) to care they experienced in this OH department was of vital importance. This contrasts with the hierarchical structure of the NHS which underpins its leadership mode and often does not respect workers' autonomy. This is particularly so in the case of F1s, and, in contrast to the relational approach, can be alienating and prevent them from having a say about those things that affect them (Jaeggi, 2014).

The findings of the thesis are novel because they are informed by and support Ryan et al. (2005) dynamic authenticity model. This model posits that a trusting relationship enables well-being, authenticity and therefore one's health and needs to be attended to within the workplace as it also promotes the ability for connectedness to oneself and others (Ryan's et al., 2005; Jaeggi, 2014). This is aligned with Jaeggi's (2014) view of alienation. Many of the F1s in this thesis discussed feeling out of place when not fully fit either physically or mentally. The relationship with OH offered them an opportunity to work through this discord during this F1–F2 year, facilitating a place of authenticity promoting well-being and self-acceptance which enabled them to feel more connected to themselves and others. This sense of belonging and being "seen" is important in order for individuals, particularly doctors, to flourish (Carrieri et al., 2015). Another

salient paper is that of Dunn et al. (2008) and the “Coping reservoir tank”. A modification of this model could be applied to this thesis as it encapsulates the narratives participants implicitly expressed regarding what keeps them well. Both papers offer a plausible link between OH, individual resilience and coping capacity over a career of medical work. This thesis found that OH can create a safe and containing space where participants feel more comfortable admitting feeling mentally or physically unwell. This contrasted with previous experiences of feeling they could not admit to having any “flaws”, despite the organisations’ rhetoric that it supported health and well-being irrespective of status. Participants suggested they didn’t trust they would be treated in accordance with organisational policy when it was so often at odds with the actions and attitudes of senior staff. It is possible that some organisations struggle to integrate conflicting requirements within the organisation: the need to embrace employment and HSE law and policy – to be kind to staff yet also manage the workplace business which requires fit and well “foot soldiers”. Long (2008) describes something similar with regard to the armed forces. She examines perverse wrath in context of psychoanalysis, war, brutality, rage and the harassment, and denigration of those injured and therefore considered “weak”. Psychoanalytically Long (2008) suggests that vulnerability is targeted because it is feared. The “weak” are therefore “containers” for the strong who are unable to openly acknowledge vulnerability. In this case the organisation “turns a blind eye” even if it overtly acknowledges it via HWB policy. Thus the myth of the hero is upheld at all costs even though everyone knows, both in the army and NHS, they are vulnerable. To admit this means death. Long (2008) describes this as the emergence of a perverse culture. In the armed forces she cites cases where individuals have not been safe even in the rehabilitation centres – some taking their own lives – as do doctors. She posits that the projection and the unacceptable feelings causes vulnerability, unacceptable levels of anxiety and need for denial/splitting in the individual (Long, 2008). “Having purpose” was an important factor for F1s in this research, assisting their resilience. Given this and the

findings of this thesis, OH could serve as a safe place of containment to navigate any unacceptable feelings projected into F1s by the organisation/others or themselves- including alienation, and shame (Jaeggi, 2014; Steiner,1993). These psychoanalytic concepts warrant further investigation and application to OH/F1s.

OH often feels as if it sits in the “middle of nowhere” organisationally. Whilst necessarily preserving confidentiality, it is also a place which, rather than operating within the organisation as a whole, serves to contain workplace distress and mental and physical ill-health. In this way it becomes, metaphorically, a receptacle for the displacement of all that is negative: the anger, fear, envy, narcissism, uncertainty of others. Organisational managers and leaders can amplify the chronic stress and the adaptations necessary to cope with this (Costello, 2021). By consigning everything that seems negative to OH and then ignoring it, managers and leaders can exacerbate the MH and PH problems of those experiencing them. MH and PH issues are the concern of the whole organisation, and whilst OH is one department that deals with them, it does not operate in a vacuum. One way participants cope with this distress is to defend against it deploying unhelpful rituals which prevent thinking, feeling and learning (Costello, 2020) which are detrimental to all concerned (Bloom, 2011). According to the thesis, the participants OH helped to provide an antidote for these defence mechanisms or to prevent them being activated. Psychoanalytically, the alienation of OH from the wider organisation may play a valuable function by facilitating containment of unconscious processes that might otherwise serve to undermine the institutions’ aim to deliver optimal patient care (Obholzer & Roberts, 1994).

A contradiction to the positive views of the efficacy of OH intervention is that some participants, whilst they found the intervention useful and have continued to sustain the relationship post study, expressed uncertainty as to the benefit of screening all F1s. The main reasons given for this were related to concerns about disclosure and honesty

based on self-knowledge. Most participants thought they would probably say “I’m fine”, if asked how they were, even if they were not, if they hadn’t disclosed previous ill health on their TOI form. It seems likely that this would also apply to their peers, and that other interventions are important when attracting F1s to OH, such as drop in careers advice or coaching in order to support them further.

6.11 Importance of Health, Well-being and Prevention Within OH

Kotera et al. (2020) and Teismann et al., (2018) cite that the literature demonstrates a well-established relationship with PH, mortality, social connection and mental illness. Many of the thesis participants noted thriving in the presence of a supportive environment and/or if they were “noticed” and received compassion from OH or another “if struggling” when unwell: it had been, for some, lifesaving. Throughout this year F1s used the OH service to promote and support their well-being so they could continue to contribute fruitfully to the organisation and F1 community. One key yet underutilised function of OH, due to resources and stresses on services nationally, outlined in the introduction, is prevention, with the emphasis on well-being rather than reactive services only. These thesis findings pave the way for further development and investment.

The implications of the findings from each of the two thematic analysis sections reported in this thesis are now discussed in turn. These are discussed with reference to the research questions, the existing literature, the wider context of supporting junior doctors with mental ill health, and how findings might inform the development of an intervention.

6.12 Implications

This section will consider the implications of the findings for clinical practice, theory education and policy.

An unexpected feature of the interviews was the finding that this process had an intrinsically valuable role, providing a positive opportunity for individual reflective processing. As already noted in the introduction and reflexive section, many professions already utilise this process; this includes medicine (Baarts et al., 2016). However, this wasn't formalised as part of this process yet it seems that reflective spaces i.e. a space to step back and reflect, was immensely valuable and could be formalised within OH as has been effectively done externally in other professions such as BACP.

The importance of OH offering an organisational "safe container" function is interesting for two reasons. Firstly, the work that OH performs is fundamental to all that the HSE workplace and other national safety standards pertain to. Secondly, containment is all about a way in which an individual, in this case an individual in OH, holds the feelings of the other, turning it into a set of alternative emotions that are less anxiety-provoking. It is the process of integration, then resolving the good and bad of a group through boundaries e.g. like a child feeling overwhelmed by the good and bad in a parent (Costello, 2020). According to Winnicott's description of the "good enough' caregiver, it is about managing impulses effectively as opposed to defending against them (Costello, 2020). OH might be one vehicle through which to achieve this for some F1s.

Employees are often prevented from having a say about the things that affect them which can impact negatively on their sense of autonomy and respect and is inconsistent with building a Relational Approach (Costello, 2020). This can result in alienation from oneself and an institution (Jaeggi, 2014). This is particularly true for F1s who are told what to do, are unable to choose their holiday and yet are left in charge of large hospitals and seriously sick patients at night. Charlie in particular noted how irritating this was to him, affecting his mood. An antidote to the work stress for the F1s in this thesis was the sense of meaning and purpose at work via responsibility. I argue that

choice, support and compassion also support this. It is possible that a functioning collaborative integrated OH that is accessible according to need, provides choice regarding when to be seen, even in between appointments, can afford the opportunity to be heard and make shared decision-making choices as an autonomous individual. This in turn can support a sense of true health, authenticity, well-being and egalitarianism.

6.13 The Internal World

6.13.1 Resilience

Eley (2013) noted that resilience traits such as maturity, responsibility, optimism, cooperativeness and perseverance tend to positively align with optimal functioning and well-being. What is novel about this study is that for most participants resilience also seemed to correlate positively with their transition from medical student to F1 to F2 at the end of the study. This may have coincided with growing confidence in their identity, capability and competence as a doctor and has implications for education and theory (Hancock et al., 2020).

6.13.2 Shame and Stigma

Henderson's et al. (2015) exploration of sick doctors, on the obstacles preventing them returning to work reported similar feelings to those described amongst some of the participants of this study, particularly at previous medical schools, NHS OH and other workplace OH. As referred to in Chapter four, they often described feeling isolated and sad when absent, trying to conceal problems and fearing a negative response on resuming work. Becca spoke for others about experiencing a decline resilience and when more isolated in this study p.150, ch 4) Significantly, according to Cohen's et al.'s (2016) study, "not wanting to be labelled" was the dominant reason UK doctors gave for non-disclosure of MH to the workplace. Only one participant in my thesis mentioned this and did so in the

context of talking to friends rather than professional support services. However, during the course of the F1 year those who had an on-going mental or PH concern appeared to come to accept or accommodate it. Given some of the examples given at T1 and T2 interviews, it is uncertain if this would have occurred as quickly without OH emotional and practical support; for example, one participant may not have been able to access diabetic medication without OH input. Senior doctors interviewed in a UK study mentioned a belief that MH is something that can be controlled.

Stigma has been found to impact considerably on help-seeking (Hassan et al., (2009; see 2.10). The F1s in this thesis said that they did not worry about stigma or have confidentiality concerns (Hassan et al., 2009). One reason might be the self-selection to complete the TOI form and then participate in the thesis. Another might be that many of the F1s in this thesis had learnt how to self-regulate their mood or PH at medical school. During the F1 to F2 transition year they learnt “how to help keep themselves well whilst working clinically”. They may have found this more challenging requiring additional support from external services e.g. GP/ OH because they could not always access the mechanisms that usually stabilised their MH or PH. These mechanisms included “enablers” – contact with family and friends, together with other health and well-being strategies, including regular sleep and shifts, exercise, access to medication, healthy food. “Enablers” were perceived as vital to resilience, supporting well-being throughout the year. When they were unavailable, participants felt that their mental and PH declined. This could be one reason why having the consistency of an available approachable OH department was valuable. All but one participant in this thesis denied that stigma for mental and certainly PH was a concern. Raquel felt she would be able to share it with OH but would not wish to share it with her medical colleagues because of how she had been treated at

medical school (Fox et al., 2011). Such comments were similar for others with MH concerns. They were unsure whether intervention or screening would be helpful. This has negative implications for the possibility of “blanket” intervention of screening F1s.

Shame was not registered overtly by the participants. Nor was this shame fully registered by the researcher, despite being glaringly obvious, until noted by the second researcher checking coding – such is the desire to hide the stigma and not accept illness which might render one “faulty”, unable to function in the workplace, making one dispensable. A possible reason for this omission may have been the reflections identified by the researcher in the reflexive chapter explaining that the finding resonated strongly because PH had impacted negatively on MH and was a significant factor necessitating interruption to studies. This interruption resulted in a sense of perceived shame and of being “cast out” by the institutions that could have provided support. No conclusions can be drawn from this. However, if argued that, metaphorically OH functions as a psychic retreat (Steiner, 1993) and container (Bion, 1962; Winnicott, 1953) separate to the organisation/workplace, it is plausible to infer that any perceived shame during an F1’s current episode of ill health was contained within the OH experience, and therefore soothed and not registered by the F1, contributing to their overall well-being. OH provided the opportunity to have experiences acknowledged and validated – “bearing witness” including shameful ones. It is also plausible that F1s themselves did not recognise their feelings of shame. Many F1s, for example, expressed feeling tired and isolated when moving from role to role in ways that affected their mood. Jake, for example, qualified his claim that he felt vulnerable and “*brought down to size*” after experiencing heavy handed criticism with the apparently positive comment that “*you can bounce*

back from it and you can learn things". Jake's positive framing, however, covertly disclosed his feelings of shame when he added: "*but it is always going to be there at the back of your mind"*. (Jake, lines 261–166, quoted on p. 152).

Those F1s who had been screened and utilised OH FU provision continued to do so. No other F1s attended. It would seem to correlate with the findings of Adams et al., (2010) and Bianchi et al., (2016) who discovered that the majority of doctors (96%) surveyed in a UK study agreed that doctors should portray a healthy image or that seeking help is a weakness, or confirms vulnerability (Cohen, 2016).The economics and politics surrounding this is another concern (Evans, 2021) and (Sørensen, 2019). This is summed up by Charlie" "*if you're anything less than fit and healthy you don't feel you can be honest about what is going on. I had a meeting with my educational supervisor last week … it felt like there was no point in even defending myself because he didn't believe anything I was saying*" (Lines 77–82).The implication from this study is that these F1s felt that screening offered the opportunity for a reparative experience with OH, irrespective of previous interaction, and to have a consistent relationship with someone in OH and to know that help is available if needed. In view of how F1s might be feeling when unwell, or struggling to cope within an organisation but not wishing to share this with a supervisor or colleague, the ramifications for OH and its potential to offer a confidential safe place for F1s are significant.

In this thesis the majority of F1s described the transition from F1 to F2 year as potentially quite an isolating experience. This was particularly mentioned by Peter, Ivy and Charlie who referred to the importance of OH having automatic FU appointments rather than the F1 having to take responsibility for booking appointments themselves. "*I wouldn't come [to OH] if not FU. I like to come to*

OH and have someone keep an eye on me; having someone reach out is helpful" (Ivy, line 138–139).

The research of McKinley et.al. has shown that F1s have poor insight, denial and ill health (McKinley et al., 2020). This important finding has implications for OH practice given the capacity of F1s to cease contact with OH, even when known to the service. They may do so because of feelings of shame, or another vulnerability such as fear of being a burden, or that they are unimportant or are wasting resources – all of which have an impact on their ability to self-care and on their possible future MH trajectory. Peter's wariness about approaching OH for help referred to on page 132 [check] exemplifies these fears: he described feeling "*wary of bothering OH with 'minor' issues. This is because even if I'm having a bit of a difficult time, I may believe I just need to change my work or am just struggling a bit. It seems I would have to rid myself of feeling that to see you wouldn't be an inappropriate use of your time"* (Peter, lines 71–75).

Clinically the implication for OH is to recognise the importance of maximising its service provision to this group of F1s by offering screening and reflexive practice to all F1s, by offering flexible appointments and a consistent relationship with one practitioner. This will provide a confidential secure space and immediate access to services and professionals to support them when experiencing MH issues, to address any loss of insight and MH concerns.

6.13.3 Shame, Authenticity and the Importance of Being "Seen"

A doctor remains a doctor whether sick or well or somewhere on the continuum, yet according to this thesis and other studies the feeling of shame arises if unwell. Despite the positive rhetoric of most workplaces relating to increased diversity and acceptance of MH conditions into the workplace, many continue to be unobserved in practice. This may be for genuine practical reasons and

because of professional fitness (GMC) to practice dilemmas (Reed, 2019). I argue that the concepts of Steiner (1993), Jaeggi, (2014), and Bion (1962) can be adapted usefully to interpret what was occurring psychoanalytically in their {F1} endeavour to manage their {F1} shame, self-acceptance and re-integration when unwell. Organisations require competent, high functioning, well doctors for optimal performance in the workplace. If workplace stressors and demands become too high (HSE, 2019) they may enter a schizoid-paranoid or depressive (Steiner,1993) position fragmenting their organisation of self. Some F1s may seek refuge and resolution to this emotional rupture and discord within analysis (Steiner,1993). The study participant F1s found OH a safe base (Bion, 1962) to resolve internal struggles, reintegrate, gain insight, become more authentic (Jaeggi ,2014) and continue working. The implication for clinical practice, workplace and an individual are numerous if OH is able to utilise this theory in practice to proactively facilitate and promote the HWB of F1s so they can flourish both in the workplace and personally. Interventions might be screening, FU, therapeutic and HWB approaches, as well as referral to external groups.

6.13.4 Poor Insight

UK doctors often failed to report MH issues because they felt they could deal with them alone, or considered their symptoms to be mild and therefore saw no reason to inform their workplace (Cohen et al., 2016). This finding rings true with the “crash bell” comments made by participants in this thesis (p.132)and clinically would appear to be of significance given F1s have a high propensity for denial, lack of insight and high suicide rate (Garelick & Meerten, 2014; PHP 2013) – and that they may not wish to be screened, it’s important that they are provided with the opportunity OH can provide to discover that challenges presented by MH, once acknowledged, can be managed. Charlie (lines 5–6 p.

112) indicated a view held by others as they progressed over the F1 year registering that it was perhaps necessary to accept a relationship with his MH challenges which would require managing rather than denial: "*I enjoy my job. I suppose I'm disappointed to be having the same problems I had before*".

This thesis indicates that it is definitely worth having a screening programme for those who state that they have a MH/PH issue on their TOI form. This approach appears to afford organisations, via OH, the opportunity for a reparative relationship to be developed which can be a positive outcome for all parties involved going forwards, as it has been for the F1s who anecdotally continued to use OH after this study ended. Certain studies suggested that "professional identity" might stop an individual requesting support, registering with a GP, or taking time off work (Harrison & Sterland, 2006; Davies, 2015, Oxtoby, 2015b; Oxtoby, 2015a; Baptist, 2016). The participants in this study indicated that this was not the case for them. One plausible reason for this is their decision to self-disclose and acceptance of current or past mental or PH issues. They all denied that their professional identity would prevent them requesting support once they had developed a relationship with someone in OH or once previously poor relationship with OH had been repaired. Gabi's comment quoted on p. 128. exemplifies a realisation shared by other F1s, including those who had had previously bad experiences: *"I* don't feel like there's anything I wouldn't share [with OH]. I now know it didn't affect anything.. and that it's not the end of the world*"* (Lines 314–320).

Utilising OH as a metaphoric psychic retreat (Steiner,1993) between self and organisation, similarly F1s chose not to determine themselves as doctor or patient (Thompson et al., 2001) when attending OH. If OH were to take these research findings (Thompson et al., 2001) on board fully it could arguably resolve

transference dilemmas for those F1s wishing to use OH but who have concerns about their identity, role and expectations within this “structure” e.g. patient/ doctor rather than themselves (p. 130). Further exploration of this might reduce stigma, shame and alienation, allow for acceptance of MH condition thereby facilitating well-being. Approaches would include those suggested in this current study- HWB reflexive practice sessions, ad hoc coaching and HWB sessions, MHW sessions and continuation of screening and FU.

6.14 The External World

6.14.1 Mental Health Training

Cohen’s et al., (2016) UK survey explored whether doctors had ever received information or training on how to support their own MH and well-being. Most participants said they had received very little input on this topic having mainly learnt about their well-being needs via trial and error. No conclusions can be drawn from this thesis but levels of denial, lack of insight and acceptance of ill health remained high in this cohort of F1s. However, the F1s in this thesis recognised they and felt perhaps others had limited insight at times. Therefore, they acknowledged that screening and FU was a useful intervention to support MH as a preventative measure and point of initial educational contact. Rachel’s admission, quoted on p. 122, (lines 203–206) exemplifies both lack of insight in F1s and the efficacy of OH intervention.

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F1s also indicated however, that their professional identity and fear of confidentiality in OH would not stop them seeking help, which seems potentially contradictory. They also felt it was likely to be the case for their colleagues even though they were aware of training available and were aware of colleagues who had taken their own lives. One role for OH may be to have processes in place,

such as prior involvement and a screening program, which allow navigation and intervention in this contradictory territory for when an F1 does not recognise their own ill health, yet requires support. The F1s in this thesis noted an unspoken shame associated with the need to seek help. They expressed valuing the consistent safety net relationship with OH, yet finding acceptance of their long-standing MH challenges hard (Charlie, lines 5–6, p. 112).

Whilst no definite correlations can be confirmed, the participants in this study made their own covert approaches to seeking MH care either via the TOI form or via the interview process and answers given and/or the insights gained via the reflexive links made at the end of both T1 and T2 interviews. This original finding is perhaps a result of the opportunity provided by OH and this study process. It is different from the offering of Balint (Balint et al., 1993), Schwartz Rounds (Lown, 2018) and Reflective practice groups. These are areas for further exploration and/or education at medical school and F1 generic sessions regarding self-care. Balint, reflective sessions and Schwartz Rounds offer group clinical supervision and education concerning clinical content. They all differ in format and while they provide supportive learning environments the intent is not for personal reflexive processing. The F1s in this thesis reflected in the process of this study that they benefitted from the time and space to reflect in a one to one confidential environment. They found it gave them the opportunity to reflect upon challenges, their accomplishments and any insights learnt about the mental and physical health which they were able to use to further support their onwards HWB in the future. This unanticipated valuable finding could be utilised by OH in clinical practice in its adoption of reflexive practice sessions and working more collaboratively with the Deanery to provide education sessions regarding mental health to enhance F1s ability to self-care.

6.14.2 Internship

When being interviewed at T2 all participants, whether they were new to medicine, were re-taking the year or had an internship, felt that a significant aspect of the transition, which was not addressed at medical school, was learning about hospital systems, personnel, and processes. Those who had experienced an internship said they would recommend including training in/education about this neglected area at medical school.

6.14.3 Joining the Medical Fraternity

As discussed in Chapter 4, during the T2 interviews, what the participant groups all noticed reflexively was a perceived shift in identity from medical student to doctor. This appeared to be associated not only with a greater sense of competence in their skills but also a greater reliance on other doctors and acceptance into this “fraternity”, insight into their health and well-being and ability to self-care within the workplace, all of which contributed to their ability to make improved career choices based on these insights.

In this thesis, participants described a shift as they transitioned from medical student to “doctor”. They engaged more with medical life, feeling more accepted by the rest of the medical hierarchy – an unspoken “rite of passage”. For those with MH/PH condition(s) it could be interpreted that professional identity and self-identity (Mavor, 2014) is a key area likely to impact upon an individual’s long-term resilience, as in the case of Raquel who opted not to disclose for fear of discrimination (Bianchi et al., 2016) in current medical culture (Fox et al.). Some participants described needing to find their own coping methods which might align with the McKinley et al. (2020) tool, including deciding who to trust, who will accept them and how to gradually accept their condition themselves.

Similarly, participants experiences a shift in cognitive function from a student to a clinician mind-set. This shift entailed making and/or delegating decisions or asking advice, as Thomas put it, because "*Things come together in your head - you start to think like a clinician*" (Thomas, Lines 63–69). Rachel explained it as developing competence and confidence: "*kind of gently building up the duties a bit so you start off doing everything with a consultant and then gradually getting more autonomy and independence"* (Lines 34–37).This may have relevance for future researchers wishing to investigate the impact of increased self-confidence and perceived confidence as these F1s progressed through this year and any relationship it might have to medical identity, connection (Costello, 2020) and resilience (Burford, 2012). Mavor (2014) proposes that professional identity is a key area that can positively (Burford, 2012) impact upon an individual's long-term resilience. However, in the face of a relentless workload and other demands (McCartney, 2015), the "professional identity" might prevent an individual requesting support, registering with a GP, or taking time off work (Harrison & Sterland, 2006; Davies, 2015; Oxtoby, 2015b; Oxtoby, 2015a; Baptist, 2016). This is illustrated well by participants in this thesis and is a reminder that clinically OH needs always to actively engage with its clientele.

6.15 Formal Health-Seeking.

In those studies, evaluating doctors and OH (Chambers, 2014; Cohen, 2014; Lalloo et al., 2013; Lalloo et al., 2013; Waldron et al., 1996) noted various reasons for why they fail to attend appointments. None of the F1s in this thesis failed to attend appointments but did believe it would be a challenge to screen all F1s. It would be beneficial to research this further by offering screening to all F1s. They could be offered an appointment and reasons for not attending could be followed up and investigated via an anonymous survey or questionnaire and or confidential focus groups.

F1s in this thesis gradually utilised OH as a resource to support their mental and PH needs as required. This is a function of OH and is likely to reduce the need for doctor sickness absence and possibly reduce the internal conflict described by Grant (2019). OH was not always available to liaise between the employer and the doctor's psychiatrist or GP (Sauerteig et al., 2019; Grant et al., 2019). F1s in this thesis commented relating to previously co-ordinated care or OH that they had not been "listened to" or heard when they knew what was required regarding their self-care needs but this study rectified this past experience. This finding has implications for OH clinically. F1s felt listened to and cared for. They found this to be a reparative experience (p. 131), indicating this is possible if a service which has regular FU is easily accessible, contacts them if they are unable to do so, and is tailored to their requirements if necessary.

6.16 Disclosure to the Workplace

It is difficult to confirm or dispute whether the findings of this study are similar to those of Cohen et al. (2016) who examined what proportion of doctors in a UK-wide survey would or did disclose MH to the workplace, for any reason. However, the data from these study participants based on their previous personal experiences, recent responses and their view on screening, continues to confirm the current literature available that doctors delay seeking help, especially formally (Forsythe et al., 1999). What was different about the F1s in this thesis is that they appeared to use OH more proactively to support their HWB. Examples included accessing physiotherapy, counselling, OH practitioner or consultant when needing to arrange workplace adjustments if unwell, if work was negatively impacting on their mental or PH needs. Previously, they had described using the service out of need because they had reached a "crisis" point, needing an intervention or treatment (Cohen et al., 2016). This may provide new insight into what might be a positive use of OH to support HWB, even when an F1 is at crisis point, as OH is readily available to make swift workplace adjustments.

Another implication clinically is that participants noted the positive value of having an accessible and approachable OH.

6.17 Knowledge of How to Access OH

This thesis does not align with Bhugras et al. (2019) study that (49%) junior doctors said they were not aware of how to access help or support from their employer. Additionally, where the employer offers support, Bhugra et al. (2019) found that attitudes differed as to whether help or support should be accepted, and when it is accepted, whether it met needs. A possible explanation may be related to previous experience of OH. Another reason is that the postgraduate school was described as having a positive approach to HWB and OH access is highlighted at induction. Moreover, this may account for the discrepancy with other findings in the literature regarding confidentiality, disclosure and help-seeking, e.g., Bianchi et al., (2016) found that UK doctors have reservations about help-seeking from OH due to confidentiality concerns. The participants in this thesis denied this to be a factor in either of these areas. This may provide a new insight when screening F1s known to have a mental or physical health condition into the possible opportunities for OH or others to support the HWB of this group during this transitional year and it would be a useful area of research to investigate this area further via those who attend OH or surveying the next cohort.

6.18 Policies and Processes – TOI – Screening for A

The following findings support the continuation of screening and could inform the development of other proactive approaches by those supporting FIs and continued digital interventions. As the year passed, as, recounted in Chapter four/Section 4.7.3 participants in this thesis used more of the services that OH provided, such as workplace adjustments, not only as they gained confidence in themselves but also as they understood its potential to benefit them in a number of different ways.

Some participants who had a condition that required attention used the physiotherapy and counselling services to maintain their HWB. They also used it to support them with appropriate adjustments as necessary but this was an active decision and choice which many talked about in the T2 interviews. This was different from the findings of Forsythe et al. (1999) and Cohen et al. (2016). This is pertinent as many of the participants in this thesis had previously needed to take time off work or away from their studies because of the impact of their symptoms.

This thesis findings support the literature (Brooks et al., 2017; McKevitt et al. 1997; White et al., 2006; Haasan et al., 2009) that F1s are unlikely to disclose physical and MH issues until severely unwell, in some cases, because of previous negative experiences (Fox et al., 2011). Contrastingly this thesis highlights the implications on policy and the potential for continuation of a screening delivery.

6.19 Interventions

The findings of this thesis, an "Investigation of Junior Doctors' Contact with an Occupational Health Department and their Transitional Year" highlights the benefits of screening an FU by OH as an intervention to support the HWB of F1s. However, lack of insight may also be an obstacle to individuals seeking out interventions. It was clear both from T1 and T2 interviews that decisions to disclose were emotive and were not always well received, and therefore had the potential to be more harmful than helpful. However, this current thesis contributes the new finding that that screening of F1s can facilitate a reparative process and can inform an understanding of the contribution that OH can make to support the HWB of F1s.

Many strategies for improving doctors' MH focus on overcoming obstacles when they are help-seeking. The participants described feeling more "equal" in the relationship with OH in this thesis than when at medical school or in other OH/workplace services

experienced. Interventions, which involve collaborative processes described by these study participants may help instil a greater sense of autonomy and enable clearer and better thought-through decision making. This reflects the aims of shared decision making (NICE, 2021) whereby the patient's view is equal to the clinical opinion within the decision-making process. An involved and engaged patient is more likely to sign up to their self-care, take responsibility, and is less likely to complain. This also seems important for F1 in terms of co-creating valid, useful and user-friendly interventions that work for a variety of individuals across differing clinical environments at different stages of need and insight. A case in point may be that although they felt that screening of all F1s was unlikely to be effective, those participants who took the opportunity to engage with OH, continued to use OH as needed and often more. One plausible reason for this is that these participants were collaborators in the process and, more importantly, had to some degree acknowledged and begun to accept their condition for themselves because writing it on their TOI form enabled them to take responsibility and so access and engage with support. Other F1s may not be in this situation and certainly have no idea that they are unwell. F1s may otherwise not look to access support or know what it looks like or who to go to if they suddenly "crash" (Cohen et al,2016). One more useful clinical intervention might be for OH to be more accessible, available, on "radar" and watching for these "vulnerable individuals" with others. Options might be accessing OH via more informal routes such as offering career advice drop-in sessions and other HWB sessions for this group. This would allow the opportunistic "every contact counts" moments to capture doctors in need and for trusting relationships to be co-developed to facilitate support as needed.

6.20 OH and Professional Guidance

OH is often situated within HR departments and embedded within health and safety and legal frameworks and the Equality Act (2010).This presents OH with an ideal opportunity

to support F1s who are fearful of any GMC repercussions concerning disclosure about health status as it affords mitigating circumstances and protection legally when navigated with professional culpability and fitness to practice concerns. This information is a vitally important aspect of psycho- education for those who may have had either a prior poor experience of OH or none at all. OH should utilise initial F1 entry to the workplace optimally.

Charlie's case, in Section 4.5.3.2 p.151, particularly demonstrates the importance of OH screening, validating Viogada (2002) who argues that lack of perceived organisational fairness results in distrust in the system, especially when combined with a lack of autonomy. Combined with an inability to be autonomous at work, according to Jaeggi (DOH, 2010, Jaeggi, 2014) rigid systems by default separate F1s, particularly those most vulnerable from support systems, including OH, which are most important to them and crucial to remaining well-being (Adshead, 2010; Baptiste, 2016; Cohen et al., 2016). Greene and Conrads (2002) argue that resilience cannot develop without positive interaction with environmental resources. Keeping an F1 safe is a risky balance, if feeling unconnected, lacking perceived autonomy and support networks at any one time, both the individual and organisation are unnecessarily vulnerable.

It is argued in this thesis that the opportunity for a consistent relationship with OH provides a safe base for F1s to trust, reflect and become authentic in the external world (Jaeggi, 2014; Bion, 1962). Balint and Schwartz offer complementary but different support but lack the consistent relationship necessary for the ongoing reflective insights and authenticity and reintegration suggested by this thesis (Jaeggi, 2014). Parallels might be made between the rupture and repair process in the therapeutic relationship for both (Bowlby, 1988).

Given this thesis indicates that there is an opportunity for reparation, it would seem sensible to continue using the TOI form to screen and FU F1s to continually build trust in

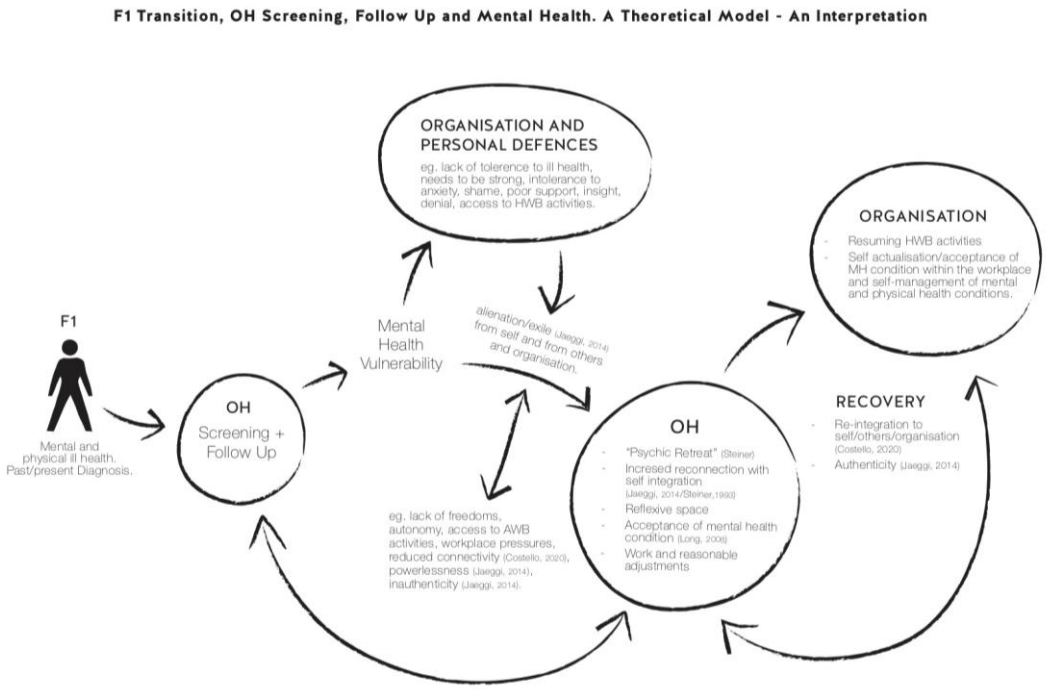
OH where clearly the current literature indicates there is continued mistrust (Brooks et al., 2017). It is vital to build in additional outcome and screening measures. The F1s in this thesis gave clear examples of this bias continuing at medical school demonstrated by the suggestion that they do not to disclose MH on their TOI.

When examining the themes of alienation, shame, helplessness and the feeling of dehumanisation (Jaeggi, 2014; Steiner, 1993) and the “back office function of OH” (HEE, 2019) explored within this thesis, these parallel process are at play. OH has shamefully underfunded services which are often barely visible and hard to find (HEE, 2019). OH sits within the economic and political environment described by Evans (2021) and Sørensen (2019) who criticise Jaeggi’s (2014) theory. Evans (2021) and Sørensen (2019) do not believe Jaeggi’s theory can be isolated from fiscal and political commentary. Whilst true, and OH is located within the politics of the NHS, her theory usefully informs thinking behind this thesis.

This thesis argues that the positive social functions of shame which promote the health of F1s, OH and organisation, rather than jeopardising welfare need to be acknowledged (Sznycer et al., 2018). This is achievable as demonstrated by this research. F1s confirmed increased confidence and acceptance of their health, irrespective of status, with OH support at the end of this study. Therefore, I argue that one function of shame is to facilitate OH in supporting HWB goals. It achieves this by the provision of a safe base, allowing authenticity which promotes personal re-integration, social cohesion (Jaeggi, 2014) and reconnectivity (Costello, 2020) with the organisation. Again, there are parallels with rupture and repair in the therapeutic process (Bowlby,1988).

A hypothetical working model- which aims to highlight some key changes and processes that occurred during the F1–F2 year through interpretive lens of psychoanalysis is shown below;

Figure 5:



6.21 Views on Other Possible Interventions

Thesis participants gave a varied range of positive and negative perspectives on an intervention, including both its potential, and the challenges it may bring. It was reassuring that many participants viewed the idea of an intervention favourably, although this cannot be generalised to the wider F1 population. Participants spoke widely of the value of the OH intervention, having the opportunity to be screened and supported, confirming the wish to see this service continued. They valued “having a face to a name” which made the service approachable, as well as the flexibility and confidentiality. Participants were asked to think broadly about a potential intervention including a self-care APP and screening across the board. Participants did like the idea of an APP and some agreed to participate in its development. Comments on the potential scope and content of an intervention, however, were mainly abstract. Participants tended not to focus on the process of decision-making itself, instead highlighting the obstacles such as lack of insight, denial and pretending “all’s well”.

6.21.1 App Development

Following the work described so far in this thesis, funding was secured from Health Education England to develop an App. This was further developed and created collaboratively with participants and others from this thesis, Falmouth University and other NHS Trusts locally. Falmouth University supported the development of an App named by participants as HOWAMI. A pilot evaluation of the app is underway. This further development work was beyond the timescale available for this thesis.

6.21.2 Dissemination of information on Interventions

Regarding dissemination of information on interventions, participants gave a selection of ideas on how an intervention could be advertised, hosted, and incorporated into training curricula and promoted via the welfare leads in the Postgraduate centre. The variety of responses indicate that it is necessary to advertise widely, as methods used regularly by some (e.g. Facebook / WhatsApp) may not be used at all by others. Due to the lack of insight and denial in doctors, it seems most likely that access to generic teaching, curricular activities and OH being integral to this, e.g., career coaching, as well as F1 health checks and so on might be the best approach.

6.22 Analysis Recommendations

Based on the discussion of this analysis, the following recommendations for practical implementation and further research are suggested.

Further research is needed to establish whether it would be worth screening all F1s as participants in the thesis suggested. A further pilot to test this hypothesis, particularly in the wake of a pandemic and its associated OH issues, is a worthwhile next step.

6.23 Recommendations

OH could:

- Continue to screen those who choose to be screened. This opens up reparative relationship opportunities with OH, improved individual and possible organisational benefits.
- Offer the screening programme to all, irrespective of take-up. Future studies should take into account that F1s may not wish to be screened and there are numerous barriers in the way of supporting them. Indicators suggest that they have a high propensity for denial, lack of insight and also suicide rate. Nevertheless, much knowledge is gained from medical school or positive experiential use of service delivery via screening. This study has demonstrated that OH has an opportunity to utilise the function of shame as a social motivator to positive reparative effect (Sznycer, 2018; Jaeggi's 2014). These factors ought not to be ignored but put to optimal effect for the HWB for future F1s, reducing the spectrum of shame experiences (Steiner, 1993).
- Provide an established pathway to support.
- OH, where possible, should apply and maintain the consistency of relationship for each F1 by having one individual as a key worker and another in case of absence.
- Provide improved consistent messaging, resources and pathways that are transparent and confidential, as well as easily accessible.
- Be creative in its offers of engagement and support with F1s, e.g., consider other welfare opportunities e.g. drop-in, HWB/career advice, coaching workshops; so "every contact counts" not just for the F1 year but throughout a doctor's career.

- Consistent messaging for F1s wanting to disclose may be helpful.
- Offer a clear development of process and procedural pathway highlighted via “hot topics“ in communications and more education of key staff to elucidate the importance of supporting F1s.
- Work with the Postgraduate centre and other areas in an integrated way.
- Continue MH staff training (including ward sisters, postgraduate teams, welfare officers, up-skilling other staff) regarding how to respond appropriately, maintain confidentiality and signpost to available pathways.
- Provide F1 with additional opportunities for access, e.g., more shadowing/ mentoring opportunities.
- Medical students who have been offered an internship year value this enormously. Offering all students this opportunity could be considered.
- OH could make individual reflective practice available with the same practitioner through the F1 year.
- The importance of recognising, “bearing witness “to another’s human experience by another should not be underestimated.

6.24 Research Application from Analysis

- OH could offer an optional screening programme to all F1s measuring uptake and reasons for those not participating.
- Piloting self-compassion and monitoring impact on MWB and self-care. Neff (2003). MacBeth and Gumley (2012) reported a positive relationship between self-compassion and MWB.
- Further research and recognition of the role that OH plays in supporting health and well-being. This thesis supports the need for possible OH investment in this area of health promotion and prevention such as individual reflective practice measures.

- The F1s described feeling they could admit to feeling either physically or mentally ill when at work or having any “flaws”. The participant interview reflections seem to suggest that one function of OH is to offer a place of recognition, authenticity and connection rather than adaptation demanded of the workplace. This is an avenue that warrants further investigation.
- Further exploration into the use of the Resilience model (McKinley, 2020) with this group of F1s as described in the Introduction.
- Further investigation of Longs (2008) perverse culture and other psychoanalytic concepts (Steiner, 1993) and application to OH/F1s.

6.25 Strengths and Limitations of the Study

The study has enabled a new understanding of the relationship between OH, F1s and mental well-being. Like any other study, however, some limitations should be noted. It makes a contribution to existing psychoanalytic knowledge and literature. The strengths and limitations of the study are now discussed.

6.25.1. Interview Methodology

The research aimed to elicit the factors that have an impact upon F1s’ ability to access support to maintain their MH and PH during this transition period and to identify the role OH plays during this first year. Qualitative research was therefore an appropriate methodology as qualitative methods allow for rich data to be generated and for the language used by participants to be studied. It was important to keep the data collection and contact time as brief as possible to enable the collection of data around doctors’ varying shift rotas and to ensure that confidentiality was preserved.

6.25.2. Recruitment and Sampling

The generalisability of the results of this thesis are limited as it is only applicable to one sample of F1s. A positivist sampling approach was used, as this sampling method is the most efficient at targeting suitable candidates – in the case of this thesis, those FIs who had identified themselves as having experienced mental or PH on their TOI form. A benefit of this approach is that participants are more likely to be committed to taking part in the study and willing to provide more of their own insights. The non-probability nature of this type of sampling means that there is a limited representation of the wider medical population; however, a generalisable sample was not aimed for. It is also possible that there is a self-selection bias, where the decision to participate in the study may reflect some inherent bias in the characteristics of the participants. In view of the literature regarding OH disclosure (Cohen et al., 2016), the F1 comments regarding the unlikely uptake of all F1s in a screening process could be representative of other F1s who might be well or unwell and "unseen" institutionally within their own "psychic retreat" (Steiner, 1993).

6.25.3. Interviews

Interviews were chosen as the most appropriate method of fulfilling the research aims- to collect doctors' experiential accounts. Limiting factors of this approach are that experiences are subjective; those interviewed may omit information, their recall may be poor and MH perception may have distorted events. It appears that the benefit of this method is that it gave the opportunity for a reflexive space. According to Taylor (1992) the opportunity for recognition of one's identity is both a fundamental need and a right, and non- or misrecognition is a form of oppression. Given the findings respecting "bearing witness" (Holmes, 2018), supporting authenticity and "seeing" F1s, one deficit of this thesis is that Taylor's (1992) concept wasn't explored further, other than psychoanalytically (Steiner, 1993; Bowlby,1988; Jaeggi, 2014) but is useful for future research. For others, it may also have created the beginnings of a relationship or

positively repaired previous misconceptions about the role of OH and the support available; these benefits outweigh the limitations.

6.25.3.i Interview Questions

This section describes how foreseen possible limitations of the interview questionnaire were pre-emptively addressed.

The semi-structured interview guide was developed to elicit participants' personal experiences of OH, their experience of mental or PH as an F1 or medical student and their progress through their first year to F2. Participants were first asked about their experiences of OH and what they considered were the most important issues relating to enablers and barriers for MH. This pre-empted any possible omissions in the questions and ensured that any new and unanticipated topics were captured. The term 'occupational health' was used in the information sheet and pre-interview questionnaire, but questions in the interview schedule were more general, for example, "you mentioned your medical school…". This allowed participants to use their own vocabulary to describe their experiences. This study focused on MH, PH, OH experiences of workplaces and medical school, but some participants also spoke more generally of disclosures outside the workplace or medical school to MH professionals, friends and family, especially when feeling at a "low ebb" and had felt too low to ask for help or lacked insight.

6.25.4. Reflexivity

The research questionnaire was piloted and amended prior to its final use. With hindsight, it would have been useful to have asked a specific question about the value of reflexivity. That said, the finding that F1s positively utilised OH to support their HWB and prevent it declining was unexpected and provided a new insight. This novel discovery, and detection that the opportunity for a reflective individual safe space was beneficial,

indicates the potential for taking this work further. Further exploration of this finding during the thesis may have assisted with appropriate interventions. Equally, this may have led to more questions than answers but is nevertheless valuable for future research.

The findings of this thesis support the current literature sources that F1s predominantly fail to disclose MH or PH to OH verbally or possibly on the TOI a limitation (Cohen et al., 2016). The development of a quantitative screening tool might have elicited additional information (burnout, STS, Risk, McKinkley et al., 2020). However, given the apparent openness of the F1s in this study, it seems that this approach would be more useful for those non-service users.

It is important to acknowledge the likely bias that the duplicity of roles afforded me as therapist and researcher as previously outlined in the reflexivity chapter, however much I attempted to mitigate this bias by using transparency and forces of external peer researcher review (Berger, 2013).

One function of OH which was noted as being highly valued was its ability to recognise the needs of the individual. It was impossible to write about these experiences and maintain confidentiality. A case study at a later date might present an alternative contribution in this field. Similarly, it would have been good to have explored the role of reflexivity of self-esteem; currently no generalisations can be drawn from this data.

6.25.5 Quality of data

Validity within quantitative research is a measure of how accurately the study answers the questions it intends to answer, using appropriate research methods, questions, attending to bias as well as sample size and type (Bryman, 2016) .

The reliability of this data is impacted by the knowledge that some participants indicated that they chose to disclose their MH status on the TOI, although they had been advised not to do so by their previous medical school. No one expressed concern about disclosing a PH condition. Gaining access to those individuals who have never disclosed to anyone, or who have perhaps not accessed OH support before, is a challenge. This thesis wished to understand the MH and PH trajectory of F1s first year and the role of OH. Whilst disclosure was not the focus, the experiences of those who did not access OH for support may have been different from the experiences of participants in this sample. They may have been prevented as a result of either their own or other's perception that there is stigma attached to accessing help. Gaining the input of those who have never attended OH before would be a valuable research avenue. The sample was self-selective – it was recognised that this would bring diversity of experience, and that these experiences may vary substantially by age or stage in training. The number of different genders, race and diversity taking part was very varied. It felt impossible to share some of the valuable contributions from individuals as this would have compromised anonymity and this is a limitation of a small-scale study as it loses some of the rich data available which necessarily needs be generalisable.

The thesis was time-limited; running it over a longer period could have boosted F1 recruitment. More female than male participants were recruited. This gender ratio was reflected in more females expressing interest in the study. This may reflect gender differences in MH among doctors and medical students; for example, female doctors report burnout more often than male doctors (Lemaire, Wallace, & Jovanovic, 2013).

Due to the lack of available data, the results cannot confirm whether this is a significant finding. McKinley et al. (2020) discovered that F1s had lower resilience scores than other doctors and higher mean secondary traumatic stress (STS) than other doctors. They also had high burnout, high STS and low CS (compassion). This is noteworthy and a limitation of this thesis. Further OH screening could pay particular attention to this, particularly at key points, e.g., when F1s move to jobs in which they are particularly unhappy which, with other cumulative factors may have a negative impact upon their mental and/or PH screening for risk (Garelick & Meerten, 2014; PHP 2013) maladaptive behaviour and workplace stress (McCain, 2018). This is particularly the case for men as they are possibly more vulnerable to unreported MH issues (Feeney's et al. (2016). Participants were predominantly female and findings related mainly to MH, rather than PH, issues. Having gained confidence in research skills, a wider research strategy could be developed for future proposals to gather a wider population. A more representative sample might thereby be attained, using snowballing techniques, for example.

It is regrettable that some reflections and observations from an interrupted year could not be included. The findings of the thesis suggest future continuation would be valuable, over a longer period, focusing on F1s who go on to be F2s. MH or PH is on a continuum. If F1s develop a relationship with OH at an early stage in their career, they may go on to use it again, as observed during my interrupt year. Running the thesis over a longer period would have facilitated the patterns being investigated to emerge more fully. This study does answer the research questions.

6.25.6 Transparency and Trustworthiness of Data

One focus of this study was improving the HWB of F1s during this first year. Currently the access that OH has to F1s is limited to screening those who become unwell or to note previous ill health on their TOI forms. Therefore, the reliability of this data is impacted by the issues already noted. Gaining the input of those who have never

attended OH before would therefore be a valuable further step in future work and consideration.

Regrettably, some “stories” of those interviewed will never be fully shared to protect anonymity. Yet it does render findings more generalisable and replication of a larger study with bigger sample size would possibly remedy this concern. This was never going to be within the remit of this study.

6.26 Limitation or future research options?

Another limitation can be inferred from this thesis; that is:if asked verbally, it remains highly likely, in the presence of other competing demands, and/or having no prior relationship with OH (Cohen et al., 2016) that for most doctors, OH will still be a last resort. F1s are at risk (McKinley et al., 2020). Future modification of the TOI form incorporating risk, maladaptive behaviour, workplace stress and personality factors would be useful. Opportunities lost were questions regarding shame, the importance of being held in mind/ “mentalisation” (Fonagy, 2000) and self-compassion (Neff.,2013). Such questioning may have been too directive and reductive as I wished to learn from participants’ experiences.

6.27 Overview

Overall, although there are limitations, strengths of the findings suggest that research questions are informative about the key role that OH can hold for F1s and the aforementioned limitations do not undervalue the findings.

6.28 Clinical Implications of Research Study for OH Workplaces

Many participants experienced long-term MH/PH conditions rather than isolated episodes of MH. Ongoing support is vital, not only through OH and a consistent approach but also organisationally, with regards to training and on-going service review

and development throughout their career. Utilised effectively in clinical practice, screening and FU has a valuable function supporting F1s' MH and PH. Containment, relationship and reflective sessions were also identified as particularly valuable. Areas for further research have been identified both clinically and psychoanalytically.

There is a requirement for a national strategy for OH service delivery which is well resourced, standardised and offers consistent individualised OH support for F1s.

6.29 Summary

The work described in this thesis has made a novel contribution through its broad focus on furthering a more in-depth understanding the role of OH, screening, mental and PH of F1s at this locality, and how they utilise the service and transition through the year as F1s. Using the work of Stenier (1993) and Jaeggi (2014) offers an alternative view of the role and function of OH psychoanalytically.

CHAPTER 7. CONCLUSION

7.1 Overview

The thesis has considerable theoretical and practical significance. The positive results imply that, in practice, FIs' transitional year could be supported by OH, adopting a collaborative screening approach to improve their HWB. This thesis enriches established literature about F1s, their MH and PH, their transitional year related to OH as well as making a contribution to psychoanalytic literature. It brings new and illuminating insights to broaden understanding and offers direction for future research.

7.2 Key Findings and Contribution

This thesis investigated F1s' relationships with OH and their MH and PH. It drew on a structured literature review and qualitative interviews. Its main focus was to understand F1s' experiences to enhance support, provide improved pathways of care and inform

any future interventions. The aims and objectives and the research questions have been addressed in depth in Chapter two of this thesis. Novel findings include the beneficial use of OH, screening and FU to support F1s as an intervention in its own right. It outlines the potential for OH to repair a previously ruptured relationship, offering a safe place for individual reflective space in ways that differ to other support on offer, such as Schwartz rounds, counselling and Balint groups. The literature review identified gaps for the research facilitating both methodology analysis and discussion. The paucity of research about OH and F1s paved the way for this thesis to examine attitudes and behaviours about mental and PH and OH within a population of F1s transitioning over the time span of a year. It moved beyond understanding MH to principles of self-care, HWB and the preventative role of OH for this study group. The use of this approach afforded OH the opportunity to tailor care to F1s whilst facilitating a reflexive safe space for this group of F1s. Psychoanalytic concepts taken from Steiner (1993), Bowlby (1988), and Jaeggi (2014) in particular can be inferred as having relevance to how F1s manage their health during this transitional year – finding solace in the containment (Bion, 1962; Winnicott,1953) offered by OH on a path to authenticity (Jaeggi, 2014).

7.3 Contributions of this Thesis for F1s who Use OH in Practice

This thesis has identified knowledge gaps. These can support education and future OH service delivery. FI's transitional year could be supported by OH, adopting a collaborative screening approach to improve their HWB.

Table 11. Contributions to Practice

1. Clarified existing knowledge in the literature about OH, mental and PH in F1s and disclosure.
2. Provided a more in-depth understanding of MH disclosure decision-making among F1s, including the services available to them and the role of OH.
3. Charted changes as the F1 transitions through the year, for example:

• Developing an understanding of OH as a place where F1s were able to develop authentic relationships and acceptance of themselves and condition to cope in the external environment/ work; • Developing increased sense of medical competence and identity over the year; • Developing peer support networks which lasted through the year as well as temporary bonds with departmental colleagues e.g. nurses and a shifting identity focus and allegiance with the medical fraternity throughout the F1 year.
4. Considered OH through a psychoanalytic lens – role of shame, alienation, safe base (Steiner,1993, Jaeggi,2014, Bowlby, 1988)
. Identified ways that OH offers a place to be reflexive, to chart progress and to keep well. Opportunity for development of self-compassion facilitating compassionate focus (Neff,2003).
6. Surveyed the participants regarding the use of a self-care App as an intervention based on their responses to continuation of study.
7. Surveyed the participants regarding F1s use of screening overall and the need for a robust approach. The quality of OH service nationally is variable in its ability to support MH or PH needs (Sauerteig et al. 2019, Grant et al., 2019).

7.4 The Key Thesis Findings are summarised in the table below:

Table 12. Key Thesis Findings

1. Use of OH to screen F1s affords the opportunity to further support HWB as an intervention in its own right to assist with well-being, help with support as required, to allow for reflection, access counselling workplace adjustments and to "just know it was there if needed" – i.e., OH offers ongoing support as well as support at times of crisis during career. **See- 4.7:T2 Interviews - Theme 1: Health-Seeking and OH :4.7.1 Developing a Continued Trusted Relationship with OH & 4.7.3 Support with Workplace Adjustments (p. 188 &190)**
2. OH has the ability to repair a previously ruptured relationship with it as a service. Help-seeking was again a main reason for further disclosures, but additional reasons included work implications, and a desire to be open and honest. Unhelpful responses to disclosures had considerable negative impact, such as delaying further help-seeking for several years or forcing participants to take extended sick leave **See- 4.7- T2 Interviews - Theme 1: 4.7.2 Importance of "Reaching Out"/Follow Ups (p. 189)**
3. OH potentially offers a "container" function for some F1s for two reasons. Firstly, it is fundamental to OH work and all that the HSE workplace and other standards pertain to. Secondly, containment is about a way in which an individual, e.g., an F1 in OH, holds the feelings of the other, turning it into a set of alternative emotions (Bion,1962; Costello, 2020).

See- 4.3: T1 Interviews - Theme 1 Health-Seeking Behaviour and OH:4.3.3 OH as a Place of Safety and Containment (p. 176)
4. OH offers a safe place for individual reflective space; the offering of which complements but differs to other support on offer, e.g., Schwartz rounds, counselling, Balint groups **See section: 4.10 :T2 Interviews :Theme 4: Professional Guidance, Policy and Politics 4.10.4, Interview Offered Opportunity for Reflection (p. 201)**
5. This thesis argues that OH can promote the positive social function of shame which promotes the health of F1s, OH and organisation rather than jeopardise welfare (Sznycer et al., 2018).
6. This thesis has applied psychoanalysis and philosophical theoretical concepts and knowledge of alienation (Jaeggi, 2014), shame (Steiner,1993) and reflexivity (Edge, 2010) and its relevance to practice and research to support changes in the workplace (Costello, 2010).
7. Future studies could investigate previous experiences along the spectrum of shame, narcissistic organisations (Steiner, 1993) and alienation by the participants in this study who requested help at medical school and future research participants who choose not to attend OH, for whom this is an issue.
8. Future studies should take into account that whilst F1s may not wish to be screened and there are numerous barriers in the way of supporting them, indicators suggest that they have a high propensity for denial, lack of insight and also suicide rate (Garelick & Meerten, 2014; PHP 2013). Additionally, much knowledge is gained from medical school or positive experiential use of service delivery via screening. These factors ought not to be ignored. Modifying the TOI form to incorporating risk, maladaptive behaviour and

workplace stress and personality factors would be useful for all those consenting for its use.
9. OH could continue to screen those who choose to participate in such a programme due to the reported reparative possibilities for relationship, improved individual and possible organisational benefits as a consequence of preventative and positive impact on long term well-being. MH and PH outcome evaluation measures are recommended with any future research intervention. **See-4.3 :T1 Interviews - Theme 1 Health-Seeking Behaviour and OH 4.3.6: Value in OH Screening Doctor and their Role in Doctor's Self-Care p. 179**
10.Disclosure can have considerable emotional impact, both for those choosing to disclose and those choosing otherwise. It can have a lasting emotional impact if the experience is negative, resulting in the desire not to repeat it unless given the opportunity to do so, for example, via a reflexive process /counselling. If this opportunity is provided by OH it might heal this relationship and the individual may use the service again in the future. Similarly, if the experience is fruitful they are likely to continue to use it. **See: 4.10: T2 Interviews Theme 4: Professional Guidance, Policy and Politics: 4.10.3.: Benefits and Pitfalls of Screening (p. 199)**
11. Ryan's et al. (2005) paper outlining their dynamic authenticity model emphasises that a trusting relationship enables well-being, authenticity and one's health needs to be attended to within the workplace. The F1s in this thesis felt better able to be authentic within OH gradually, until acceptance of their condition using support from OH and others, rendered it more acceptable by the end of the year. Adopting the findings of this thesis and

those of Ryan et al. (2005) would be useful to apply in practice. Another salient paper is that of Dunn et al. (2008) and the “Coping reserve tank”. Adapting this concept for this thesis would be a useful model to encapsulate the narrative of these participants who implicitly describe what keeps them well as they reflect in T2 interviews. Both papers might offer a plausible link between OH, individual resilience and coping capacity over a lifespan of medical work.
12. The finding that F1s still believe that lack of insight and denial and/or acceptance or adjustment to their mental or physical ill health, once diagnosed, remains prevalent, also supports not only the continuation of screening by OH, but also other innovative interventions and consideration of the recommendations mentioned within the thesis. **See 4.3: T1 Interviews - Theme 1 Health-Seeking Behaviour and OH 4.3.6: Value in OH Screening Doctor and their Role in Doctor's Self-Care p. 179** **See: 4.10: T2 Interviews Theme 4: Professional Guidance, Policy and Politics: 4.10.2: Screening as an Intervention (p. 198)**
13. Recognition and validation by others; “bearing witness” (Holmes,2008) for these F1s was vital. This research shows that even if F1s have previously experienced shame and alienation, repair of the relationship is possible (Bowlby,1988). Screening and FU by OH offers F1s the opportunity for reflection. The conditions described facilitate insight-enabling authentic self-acceptance, the opportunity for reparation with OH, the self and others (Jaeggi, 2014). **See-4.3: T1 Interviews - Theme 1 Health-Seeking Behaviour and OH: 4.3.5 Place to be Authentic and be “Seen” Irrespective of Health**

(p. 178)
14. The development of a hypothetical psychoanalytic working model to interpret the findings of this study demonstrates how crucial psychoanalytic concepts are to further understand and support the needs of F1s within the workplace. This might facilitate OH services and therapists alike with ideas and evidence for future practical use.

7.5 Dissemination of the Findings

The findings will be disseminated through signed, spoken and written communication as follows:

1) A summary will be prepared and the findings will be presented to RCHT OH and the postgraduate forum.
2) A summary will be prepared and the findings will be presented at BMA and/or other relevant conferences.
3) Regular feedback and engagement with F1s and those supporting F1s, via forums available to promote opportunities for OH, research, HWB eg Facebook, induction, development HOWAMI App.
4) Papers will be submitted to professional journals including Psychoanalytic Psychotherapy.

7.6 Reflexive Practice

It has become apparent through the iterative process of writing, how embedded the concepts of shame and alienation are to health care and F1s mental and PH. The process will inevitably evolve and inform future publications. In engaging in the research process, and taking a reflexive stance, I have been able to demonstrate how, unknowingly, I too am a part of this wider problem. Accepting this inevitability and

exposure to my own shame and alienation has been the same risk taken by the F1s in this study, and transformative (Edge, 2010) as my cycle of learning continues.

7.7 Summary

7.7.1 Implications for Future Practice

This thesis outlines the opportunity for a modified TOI screening process which includes STS, burnout, and score risk to assist those F1s who dislike disclosing verbally. This would provide OH and other organisational structures to support the F1 more optimally at induction. Many suggestions from this thesis could be harnessed to galvanise a standardised consistent approach to support F1s HWB in the future within OH, integral to the NHS, such as: coaching sessions, HWB events, teaching self-compassion (Neff, 2013), allowing OH to fulfil all components of its role and providing opportunities for further psychoanalytic research.

7.7.2 Solution to the Void

This original thesis has demonstrated that establishing a relationship early on with OH was of value for this group of F1s – that screening and FU was of benefit and it should be continued in order to reduce future harms and enhance their health and well-being.

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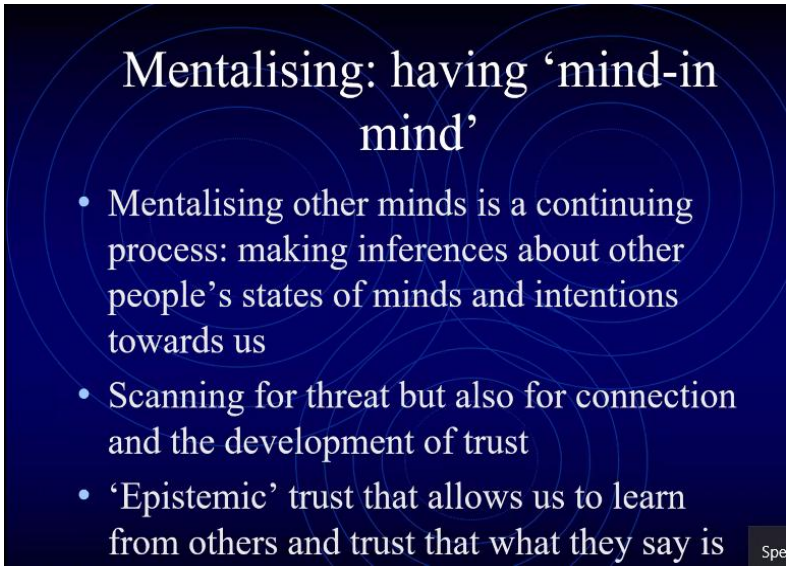
Appendix 1. Slide on Mentalisation – Gwen Adshead seminar attended 17/03/22



Appendix 2. Stress Management Standards

HSE Management Standard	Composite Parts
Demand	Workload, work environment, work patterns
Control	Autonomy over the way work is completed
Support	Encouragement, sponsorship and resources
Relationships	Promoting positive working, dealing with unacceptable behaviour
Role	Understanding your part in the organisation, ensuring there is no role conflict
Change	Management of organisational change, communication of change

Table 1 - HSE Management Standards – roles of the organisation to reduce stress. [2019]

Appendix 3. **Key Literature**

Table 1. Professional guidance, OH and Policy

Policy/ influential political papers Reference	Title	Themes	CASP/EHPP
Harvey,S,Laird,B. Henderson,M. Hotopf,M.(2009) Institute of psychiatry	The mental Health of Health Care professionals; A review for the department of Health	This review examines evidence-based literature on the prevalence and consequences of mental health disorder amongst health care professionals (HCP) and the impact of poor mental health upon work. It is not systematic but provides a wide selection of mainly UK-based studies. It concludes that high numbers of HCP report high levels of workplace stress and burnout. It comments upon the difficulty with generalising evidence, yet comments that HCP work seems relatively unlikely to contribute to psychiatric morbidity, whereas the way work is organised and structured and the support available does. This seems to support the view that organisational support to enable is vital. It suggests that in part this might be via OH services offered. It also indicates that there is clear evidence that doctors are reluctant to seek help when suffering from MH concerns. This may be related to stigma, over self-reliance and worries about confidentiality. This is an area that OH need to be mindful about. It recommends ease of access to support services, that health is not medicalised and that possible screening is evaluated. Recommends further study in OH setting as research in this area is sparse.	CASP- 8
DOH (2010)	Invisible patients- Summary document. Summary of the report of the Working Group on	The purpose of this paper is to provide best practice guidance, by providing a brief overview of the evidence and good practice available nationally. It offers a framework to manage the health of HCPs and makes 7 key recommendations. With regards to OH it suggests that	CASP-8 EHPP-Moderate

	the health of health professionals.	features of an effective OH service include compliance to standard set out by the Faculty of Occupational Medicine, access to necessary specialist services for assessment and treatment of sick HCP, promotion of health and well-being of staff and provision tailored to organisational needs. It does not indicate how this might be achieved other than OH being accredited. It does recommend that maintaining good health and coping with ill health should be an integral component of under and post graduate curriculum for all HCPs. Another recommendation is also that further studies are undertaken exploring the health and well-being of specific groups of HCPs in different HC settings.	
Brooks, S. Gerada, C. & Chandler,T (2011). Journal of Mental Health; 1–11, iFirst article	Review of literature on the mental health of doctors: Are specialist services needed?	To review literature regarding risk factors and potential barriers to help-seeking unique to doctors; to consider the success of interventions by specialist services for doctors. There are contradictory reports about the prevalence of mental ill health in doctors but it is generally agreed that doctors face a large number of risk factors, both occupational and individual; and help-seeking is difficult due to complexities surrounding a doctor becoming a patient. Specialist services developed specifically for interventions for doctors with mental health problems tend to show promising results but further research is needed. Conclusions: The unique and complex situation of a doctor becoming a patient benefits from specialist services. Recommends such services should focus on early intervention and raising awareness	CASP-7

IOM (research Consulting services for occupational and health hygiene) (2009)	A systematic review of the health of health practitioners	A systematic review to address questions such as the nature and prevalence of poor health in practitioners and the impact upon service and patient safety (no empirical papers identified), referral, reintegration back into the workplace post absence, predisposition of risk (no examples identified) and health-seeking behaviours (limited data available, other than HCP work when sick, self-prescribe and don't use OH). Indicated gaps in high quality research, lack of good quality intervention studies and little evidence related to patient safety or service quality through ill health in HCPs	CASP-8
DOH (2008), DOH,London	Mental health and ill health in doctors	After the Daksah Emson Inquiry Report, Professor Appleby established a working group to consider steps required to make it less likely that doctors would become unwell and easier for them to seek help earlier. It outlines mental health, stressors, risk factors, stigma and culture. It considers current support available such as specialist care. It notes the role of OH and suggests that provision varies widely, with some having no medical input. It also suggests some OH departments have little MH awareness and that generally there may be a perceived lack of expertise and a concern regarding confidentiality due to its links with employers. It recommends links between deaneries and OH for trainees and clear policies so doctors can access appropriate support and also that doctors should understand the importance of managing their own mental health.	CASP-8 EHPP-Moderate

Table 2. What we know of junior doctors (the internal world of the junior doctor)

Resilience, attachment			
Reference	**Title**	**Themes**	
Fertleman ,C. (2013) BMJ Editorial.	Protecting students and promoting resilience	A simple summary of the problem of mental health problems in medical students and its impact on their resilience towards other aspects of the course. It highlights the GMC and associated professional medical literature on managing students with mental health problems - culminating in recommendations that making mental health problems easier to address for students, beneficial for their long term resilience http://www.bmj.com/content/347/bmj.f5266.	CASP- 5
Adam J[1], Bore M, McKendree J, Munro D, Powis, D. (2012).BMC Med Educ. Aug 8;12:69.	Can personal qualities of medical students predict in-course examination success and professional behaviour?	An exploratory prospective cohort study. This paper shows the significant association between the personal traits (measured by non-cognitive tests) of applying potential medical students and their future scores in both non-cognitive and cognitive tests. One of these non-cognitive tests includes a self-appraisal inventory (SAI) a measure of one's resilience (and also, separately, self-control), by examining anxiety, moodiness, neuroticism and irrational thinking. http://www.biomedcentral.com/1472-6920/12/69	EHPP-Strong
McCain, R McKinley, N, Dempster,M, Campbell,J., Kirk, S.(2018)Postgrad Med J;94:43–47. doi:10.1136/postgradmedj-2016-134683	A study of the relationship between resilience, burnout and coping strategies in doctors	Purpose of the study: the aim of this study was to measure resilience, coping and professional quality of life in doctors Study design: a cross-sectional study using an online questionnaire in a single National Health Service trust, including both primary and secondary care doctors. Results: 283 doctors were included. Mean resilience was 68.9, higher than population norms. 100 (37%) doctors had high burnout, 194 (72%) doctors had high secondary traumatic stress and 64 (24%) had low compassion satisfaction. Burnout was positively associated with low resilience, low compassion satisfaction, high secondary	

		traumatic stress and more frequent use of maladaptive coping mechanisms, including self-blame, behavioural disengagement and substance use. Non-clinical issues in the workplace were the main factor perceived to cause low resilience in doctors. Conclusions: Despite high levels of resilience, doctors had high levels of burnout and secondary traumatic stress. Doctors suffering from burnout were more likely to use maladaptive coping mechanisms. As doctors already have high resilience, improving personal resilience further may not offer much benefit to professional quality of life. A national study of professional Quality of Life, Coping and Resilience, which we are proposing to undertake, will for the first time assess the UK and Ireland medical workforce in this regard and guide future targeted interventions to improve professional quality of life.	
Brodkin, A.; Shrier, D; Angel, R; Alger, E; Layman, W.;Buxton, M.(1984) Journal of the American Academy of Child Psychiatry, Jul, vol. 23, no. 4, p. 479-485	Retrospective reports of mothers' work patterns and psychological distress in first-year medical students.	In a survey designed to measure stress, 164 1st-yr medical students reported on the working status of their mothers in early childhood. Relatively high levels of psychological distress in medical school were associated with having had full-time working mothers in early childhood. Ss who indicated that their mothers had been unemployed before their 6th birthdays scored lower than the class mean on the distress scale. Ss who remembered having had part-time employed mothers reported relatively low levels of distress. Findings are consistent with the interaction explanation of the effects of insecure early attachment.	EHPP-Moderate
Teoh.K, Hassard, J. and Cox,T., (2018) Health Care Management Review, ISSN 0361-6274. (In Press) Downloaded	Individual and organizational psychosocial predictors of hospital doctors' work-related well-being: A multilevel and	Background: The high prevalence of burnout and depression among doctors highlights the need to understand the psychosocial antecedents to their work-related well-being. However, much of the existing research has been a-theoretical, operationalized a narrow measurement of well-being, and predominantly examined such relationships at the individual level. Purpose: This study uses a multilevel perspective to examine individual (i.e., job demands and	

from: http://eprints.bbk.ac.uk/23538/	moderation perspective	resources) and organizational level psychosocial predictors of three measures of work-related well-being: perceived stress, presenteeism and work engagement. The Job Demands-Resources (JD-R) theory underpins the postulated relationships. Methodology: The 2014 National Health Service Staff Survey was analyzed using multilevel modelling in MPlus. The dataset involved 14,066 hospital-based doctors grouped into 157 English hospital organizations (i.e., Trusts). Results: Congruent with the JD-R, job demands (workplace aggression and insufficient work resources) were stronger predictors of perceived stress and presenteeism than job resources. Equally, job resources (job control and manager support) were generally stronger predictors of work engagement than job demands. At the organizational level, bed occupancy rates and number of emergency admissions predicted work engagement. No hypothesized individual or multilevel interactions were observed between any of the job demands and resources. Practical Implications: The findings emphasize that a broader perspective of work-related well-being among hospital doctors should be employed, and the empirical value of examining such relationships from a multilevel perspective. Successful health intervention should target the appropriate antecedent pathway, and recognize the role of organizational level factors when trying to manage hospital doctors' work-related well-being.
McKinley N, McCain RS, Convie L, et al. BMJ Open 2020;10:e031765. doi:10.1136/ bmjopen-2019-031765	Resilience, burnout and coping mechanisms in UK doctors: a cross-sectional study	Aims: This cross-sectional study aimed to assess resilience, professional quality of life and coping mechanisms in UK doctors. It also aimed to assess the impact of demographic variables, such as sex, grade and specialty on these factors. Methods: During October and November 2018, medical doctors in the UK were eligible to complete an online survey made up of validated psychological instruments. Royal Colleges and other medical organisations invited their membership to participate via newsletters, email invitations, websites and social media. Results: 1651 doctors participated from a

		wide range of specialties and grades across the UK. The mean resilience score was 65.01 (SD 12.3), lower than population norms. Of those who responded, 31.5% had high burnout (BO), 26.2% had high secondary traumatic stress and 30.7% had low compassion satisfaction (CS). Doctors who responded from emergency medicine were more burned out than any other specialty group (F=2.62, p=0.001, df 14). Those who responded from general practice scored lowest for CS (F=6.43, p	
Coulston C[1], Vollmer-Conna U, Malhi G. (2012).Psychiatry Res. Dec 30;200(2-3):457-63	Female medical students: Who might make the cut?	This paper examines the character traits of female medical students who wish to pursue a career in surgery. This study examined personality and other attributes of female medical students attracted to the surgical profession. A total of 580 second-year medical students in Australia completed questionnaires that measured their likelihood of considering various medical specialties, personality traits using the NEO Five-Factor Inventory (NEO-FFI), and the importance of several other parameters in directing career choice. Significantly fewer females than males rated surgery highly likely as a career. Females interested in surgery had higher Neuroticism and Agreeableness scores, and placed greater importance on ability to help people, and less importance on prestige and financial reward compared to males interested in surgery. Their findings suggest that the typical masculine characteristics of surgery: “tough mindedness, resolute, less patient friendly and less empathic” appeared not to apply to female medical students	EHPP-Weak
Cherry, G; Fletcher, I; O'Sullivan, H (2014) Medical education, Oct, vol. 48, no. 10, p. 988-997	Validating relationships among attachment, emotional intelligence and clinical communication.	Emotional intelligence (EI) mediates the negative influences of Year 1 medical students' attachment styles on their provider-patient communication (PPC). Year 2 medical students completed measures of attachment (the Experiences in Close Relationships-Short Form [ECR-SF], a 12-item measure which provides attachment avoidance and attachment anxiety dimensional scores) and EI (the Mayer-Salovey-	EHPP-Moderate

		Caruso Emotional Intelligence Test [MSCEIT], a 141-item measure on the perception, use, understanding and management of emotions), prior to their summative PPC OSCE. Provider-patient communication was assessed using OSCE scores. Structural equation modelling (SEM) was used to validate our earlier model of the relationships between attachment style, EI and PPC. A total of 296 of 382 (77.5%) students participated. Attachment avoidance was significantly negatively correlated with total EI scores	
Hojat, M.(1998) The Journal of Genetic Psychology: Research and Theory on Human Development, Jun, vol. 159, no. 2, p. 203-220,	Satisfaction with early relationships with parents and psychosocial attributes in adulthood: Which parent contributes more?	The relationships between perceived satisfaction with early relationships with parents and adults' psychosocial attributes were addressed in this study. The participants were 928 medical students (37% women) who completed a set of personality questionnaires. The results indicated that perceived satisfaction with the mother in childhood was significantly associated with less intensity and chronicity of loneliness, less depression, less anxiety, a less negative view of stressful life events, higher self-esteem, and more satisfaction with peer relationships. No significant association was found between perceived satisfaction with the father and these personality measures. The results are discussed in the context of attachment theory and internal working models	EHPP-Weak
Ciechanowski, P; Russo, J; Katon, W; Walker, E., (2004)..Medical education, Mar , vol. 38, no. 3, p. 262-270,	Attachment theory in health care: the influence of relationship style on medical students' specialty choice.	Converging sources suggest that patient-provider relationships in primary care are generally of greater intensity and duration than those in non-primary care specialties. We determined the relationship styles and demographic characteristics of 144 Year 2 medical students. We also gathered information regarding their predicted choices of postgraduate training, which were clustered into primary or non-primary care categories. We compared student choices with respect to their interpersonal relationship styles based on attachment theory. Prevalence of attachment styles were similar to those found in the general population, with 56% of students rating themselves as having a	EHPP-Moderate

		secure relationship style. Students with a secure style were more likely to choose primary care (61%) over non-primary care compared to those whose styles were characterised by self-reliance, support-seeking or caution (41% chose primary care). Compared to those with a secure relationship style, students with a cautious style [OR = 5.9 (1.9, 18.7)] and students with a self-reliant style [OR = 2.4 (0.96, 5.9)] were more likely to choose non-primary over primary care, after controlling for gender. Assessing relationship styles using attachment theory is a potentially useful way to understand and counsel medical students about specialty choice.	
Balme E., Gerada,,C, Page,L.(2015) Brighton and Sussex medical school. Individual Research Project Report	Structural, environmental and individual factors that promote or impede the development of resilience amongst training grade doctors in the NHS in England	A systematic review of the literature into what factors promote or impede the development of resilience amongst doctors. Identification of factors that promote resilience could pave the way for interventions at the level of organisations, environment and individual. This study aims to explore existing research on resilience. Resilient doctors are characterised by high levels of interest and motivation, employing time-management skills to maintain professional practices and foster supportive relationship,both personal and professional. Attitudes and mental strategies include: self-awareness; personal reflection; engagement with limitations of skills; self-demarcation; spiritual practices; acceptance & realism. Routines and behaviours include: taking time out for leisure activities and holidays; professional practices; time management - restricting working hours. However, there is very little research into what makes working environments foster resilience. Until that research is done it is difficult to suggest what structural changes will lead to increased job satisfaction and retention of healthy staff. A shift from pathology focused research on burnout and stress, towards resilience, may enable insight into what structural changes are necessary to promote resilience. Future research must focus on working environments to allow policy changes and implementation of reorganisation to reflect evidence-based practice.	Casp-7

		The development of resilience in individual doctors by organisations and working environments will have significant benefits not only for individuals but also to the workforce as a whole and ultimately the provision of quality patient care.	
Adshead, G. (2010) Medical education, Feb, vol. 44, no. 2, p. 125-131	Becoming a caregiver: attachment theory and poorly performing doctors.	Reviews a theoretical paradigm (attachment theory) which facilitates an understanding of how human care-giving and care-eliciting behaviours develop and are maintained over the lifespan. Argues that it has particular utility in: (i) the training of doctors; (ii) understanding why some doctors and medical students' experience of Insecure attachment is associated with impaired stress management and subtle deficits in care-giving sensitivity. It is reasonable to assume that a proportion of students entering medical training and doctors with performance problems may have insecure attachment styles which influence how they approach their training experience and how they manage occupational stress. Attachment theory is a useful paradigm for thinking about training as a professional caregiver. Insecure early attachment experiences may be a risk factor for poor stress management in some medical students and doctors who are exposed to increasing demands as carers. Suggests need for further study in this area.	CASP-6
Zwack J, Schweitzer J. Acad Med. (2013) Mar; 88(3):382-9.	If Every Fifth Physician Is Affected by Burnout, What About the Other Four? Resilience Strategies of Experienced Physicians	A number of physicians were assessed on their capacity to cope with stressors of the job. Following upinterviews assessed the methods of their stress management and resilience strategies for their personal lives. A number of strategies were highlighted. A useful paper, which applies its findings to constructing resilience teaching programs built around recognising and thereby supporting the factors of resource depletion. http://journals.lww.com/academicmedicine/Abstract/2013/03000/If_Every_Fifth_Physician_Is_Affected_by_Burnout,.29.aspx	CASP-7

Table 3. The impact of the training and work environment (the external world)

Training and work Reference	Title	Key themes	
Stephenson AE[1], Adshead LE, Higgs RH. (2006) Med Educ. Nov; 40(11):1072-80.	The teaching of professional attitudes within UK medical schools: reported difficulties and good practice	This paper reviews the teaching of professional attitudes in medical schools. A qualitative in-depth interview study was based on a questionnaire survey of all UK medical schools. Six heads of medical schools or their nominated representatives were interviewed. Outcome measures were the perceptions and experiences of developing and assessing appropriate attitudes and behaviour in their undergraduate students. Arguing that resilience is still highly taught in medical schools where perhaps there is a more intimidatory teaching atmosphere. Resilience in this paper seems to be used in a few cases almost synonymously with mindfulness/self-awareness, as well as the more understandable associations with managing stressful situations. **https://pubmed.ncbi.nlm.nih.gov/17054616/**	CASP- 7
Medisauskaite A, Kamau CBMJ Open 2019;9:e027362. doi:10.1136/bmjopen-2018-027362	Does occupational distress raise the risk of alcohol use, binge-eating, ill health and sleep problems among medical doctors? A UK cross sectional study.	Health problems (eg, insomnia, binge-eating, substance use and ill health) among UK doctors and to investigate whether occupational distress increases the risk of health problems. Design: This study reports the analysis of data collected at the baseline stage of a randomised controlled trial (protocol NCT02838290). Setting: Doctors were invited through medical Royal Colleges, the British Medical Association's research panel and a random selection of NHS trusts across various UK regions. Participants: 417 UK doctors with an equivalent split of gender (48% males) and seniority (49% consultants). Main outcomes and measures Outcomes were sleep problems (eg,	

		insomnia), alcohol/drug use (eg, binge-drinking), ill health (eg, backache) and binge-eating (eg, uncontrollable eating). Predictor variables were occupational distress (psychiatric morbidity, burnout, job effort, work-life imbalance, coping with stress through self-blame or substances) and work factors (workplace and years practising medicine). Results: 44% of doctors binge-drank and 5% met the criteria for alcohol dependence; 24%–29% experienced negative emotions after overeating and 8% had a binge-eating disorder; 20%–61% had some type of sleep problem and 12% had severe/moderate insomnia; 69% had fatigue and 19%–29% experienced other types of ill health problems. The results show that occupational distress and job factors increase the odds of doctors using substances, having sleep problems, presenting with frequent symptoms of ill health and binge-eating. For example, burnout increased the risk of all types of sleep problems, eg, difficulty falling/staying asleep, insomnia (OR ≥1.344; p≤0.036). Even taking into consideration whether or not a doctor works in a hospital, the risk of health problems still rises when doctors have signs of occupational distress. Conclusion: Early recognition of occupational distress can prevent health problems among UK doctors that can reduce the quality of patient care because of sickness related absence.
Bhugra, D et al. Inernational Review of Psychiatry 2019, Vol. 31, Nos. 7–8,	A descriptive study of mental health and well-being of doctors and medical students in the UK	Doctors and medical students are working in a system which is affecting their mental well-being and their ability to provide the best possible care for patients. The British Medical Association conducted an online survey of doctors and medical students in October 2018. In total, 4347 responses were received and analysed. Doctors working the longest hours appear to be most vulnerable to psychological and emotional disturbance. Older and more senior doctors are most likely to report that

563–568 https://doi.org/ 10.1080/0954 0261.2019.16 48621		their working environment has impacted on their condition. Medical students and junior doctors report the highest rate of having a formally diagnosed mental health condition in the last 12 months. This may be because they are in the vulnerable age group when psychiatric disorders start. Junior doctors were least likely to be aware of how to access help or support. Older doctors, those working as SAS (Staff, Associate Specialists and Specialty) doctors and overseas qualified doctors are most likely to say they have asked for support in managing a problem from their employer but that no support was provided. It is important to recognize that doctors, in spite of stress and poor well-being, continue to work hard, which has both advantages and disadvantages. These findings highlight that the environment in which doctors work, train, and study affects their mental health, and for this reason careful consideration needs to be given to the type and level of support provision available to them, as well as the ease of access and awareness of such support	
Cherry, MG[1], Fletcher I, O'Sullivan H, Shaw N. (2102) Med Teach. ; 34(1):11-9.	What impact do structured educational sessions to increase emotional intelligence have on medical students?	This paper looks at the role of emotional intelligence on the medical curriculum. Specifically looking at the use of simulated patients, they argue, that 1) using simulated patients improves traits of one's emotional intelligence and that 2) somewhat less-thoroughly, that improved emotional intelligence. http://informahealthcare.com/doi/abs/10.3109/0142159X.2011.614293	CASP- 6
McKevitt, C., Myfanwy,M, Dundas ,R, (1997) Holland, w	Sickness absence and 'working through' illness: a comparison of two professional groups	Few studies have investigated occupational groups reporting low rates of sickness absence because of an assumption that these rates indicate low morbidity. This is inconsistent with the view that sickness absence, which may be caused by social and psychological rather than medical factors, does not equate with morbidity. This paper investigates rates of sickness	

Journal of Public Health Medicine Vol. 19, No. 3, pp. 295-300		absence and factors influencing decisions not to take sick leave among doctors and a comparative professional group. A postal survey was sent to 670 general practitioners (GPs), 669 hospital doctors and 400 company 'fee earners'. Qualitative interviews were conducted with 64 doctors reporting an illness lasting one month or more in the last three years. Self-reported health status was similar for both groups but GPs reported higher levels of occupational stress. However, doctors were significantly less likely to report short periods of sick leave in the previous year. Over 80 per cent of all respondents had 'worked through' illness, citing cultural and organizational factors behind their decision not to take sick leave. Barriers to sick leave among doctors included the difficulty of arranging cover and attitudes to their own health. Conclusions: Considerable emphasis has been given to the role of social factors in contributing to rates of sickness absence. These may also contribute to the decision not to take sick leave, resulting in possible inappropriate non-use. Measures to encourage and enable doctors to take sick leave might improve the management of their own health.	
Sandars J[1], Patel R, Steele H, McAreavey M. (2014). Association for Medical Education Europe. Med Teach. Dec; 36(12):1015-26.AMEE	Developmental student support in undergraduate medical education	This paper assesses what could be done to improve the personal development of UK med students during medical school. It again outlines why resilient med students are good for themselves, and then they present some ideas on how schools could encourage development and support resilience in students. They highlight the more common problems that stand in the way of resiliency. The paper reviews mentoring schemes, disability help, and careers guidance, and their use in resolving some of the problems. http://informahealthcare.com/doi/abs/10.3109/0142159X.2014.917166	CASP-5

Guide, No, 92.			
Patterson F[1], Ashworth V, Zibarras L, Coan P, Kerrin M, O'Neill P. (2012). Med Educ. Sep;46(9):850-68	Evaluations of situational judgement tests to assess non-academic attributes in selection	A literature review aiming to examine the value of SJTs in selecting candidates for training schemes, including GP training in the UK, who have the most developed non-academic attributes, including resilience. The paper discusses the extent to which SJTs can predict how developed candidates' non-academic attributes are and how reliable, valid, fair, cost-effective and well-received the SJT is. https://pubmed.ncbi.nlm.nih.gov/22891906/	CASP- 7
Howe A[1], Smajdor A, Stöckl A. (2012). Med Educ. Apr; 46(4):349-56.	Towards an understanding of resilience and its relevance to medical training.	An important piece, this looks directly at whether there is an ethical rationale for the inclusion of resilience training as part of medical training. Their arguments are, of course, incomplete and suggest a need for further debate and research. This paper is also a good form of literature review, citing a number of other more general papers. http://www.ncbi.nlm.nih.gov/pubmed/22429170	CASP-5
Goodyear**,H.(** 2014). Int J Med Educ.; 5: 103–109.	First year doctors' experience of work-related well-being and implications for educational provision	Seeks to discover how Foundation Year 1 (FY1) doctors maintain their well-being and continue their education, based on narrative interviews. Develops the theory that FY1s first find an identity and then develop resilience, in order to maintain their well-being. Resilience is found to facilitate newly qualified doctors getting the help they require to tackle and learn from difficulties and challenges.	CASP-7

		http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4207178/pdf/ijme-5-103.pdf	
Brennan,N. & Corrigan,O. (2009).Institute of Clinical Education Peninsula Medical School	Longitudinal Evaluation of South West Peninsula Deanery F1 Doctors	A longitudinal mixed methods approach was adopted triangulating quantitative and qualitative data. The objectives of the study are: to provide a systematic evaluation of the performance and preparedness of the first and second cohorts of PMS graduates based in the F1 programme in the SWPD; to compare the performance and preparedness of PMS graduates with graduates of other medical schools based in the F1 programme in the SWPD; to explore F1 doctors' experience of transition from medical student to practising doctor in the SWPD; to make recommendations on PMS undergraduate curriculum reform and F1 education. This study shows that PMS graduates reported feeling as well prepared for F1 practice as graduates of other medical schools. Recommendations made regarding curriculum, including more support required by medical supervisors.	CASP-7 EHPP-Moderate

Table 5. Help-seeking Behaviours (Barriers and or Enablers)?

Help-seeking behaviours Reference	Title	Key themes	
Baldwinn, P. Dodd, M.Wrate,R.(1997). *Soc. Sci. Med.* Vol. 45, No. 1, pp. 41~14.	Young doctors' health 11- Health and health behaviour	There is little published information on the health of young doctors, apart from a number of studies which show increased rates of psychiatric symptoms. Nor is there much known of their health behaviour. Anecdotal accounts suggest that doctors' own health care is poor, especially in terms of their willingness to consult other doctors. This paper presents data from a longitudinal study of a class cohort of young doctors first interviewed when they were students. Data show that they suffer from frequent minor physical ailments, with women reporting more ailments than men. Despite this, they took less sick leave. Overall, the doctors took very little time off work. Using the GHQ-28, with a threshold of 5/6, 30% of doctors fell into the "caseness" category for psychiatric symptoms. This is in keeping with findings elsewhere. From the doctors' own reported health behaviour, both in terms of their response to illness over the past year, as well as their predicted response to hypothetical illness, they have developed maladaptive patterns. These include continuing to go to work when unfit, self-prescribing, and consulting friends and colleagues rather than going for a formal consultation. This is seen as inappropriate, especially in cases of mental illness. A third of the young doctors are not registered with a local general practitioner and the majority have no clear idea of the role of the Occupational Health Service. The results are discussed in terms of the need to change attitudes to health care and to develop guidelines, staffing and services to enable doctors to take better care of themselves.	EHPP-Weak

Chambers, R. (1992) Occupational Medicine; 42: 69-78.	Health and lifestyle of general practitioners and teachers.	Sample: 850 GPs on General Medical Register of Staffordshire Family Practitioner Committee, response rate: 45% for questionnaire and 66% for health check. Secondary school teachers (sample size not mentioned) response rate: 25% for questionnaire and 88% for health check. Cross-sectional study + ** Self-administered questionnaires on health prevention, lifestyle, sickness absence and healthcare. For teachers used purposive sampling to have gender distribution be the same as doctors. Separate questionnaire for spouse/domestic partner to verify responses about health and lifestyle. Sub-section invited for health check on BMI, blood pressure, body fat percentage, grip strength, spinal flexibility, sit-ups, stepping test, blood test and health questions. In general, doctors less likely to take sickness absence from work.	EHPP-Weak
Sauerteig, S., Wijesuriya, J.,Tuck , M.,Hannah Barham-Brown, H**.** (2019) International Review of Psychiatry , Vol 31, Nos. 7–8, 548–554 https://doi.org/10.1080/09540261.2019.1586165	Doctors' health and well-being: at the heart of the NHS's mission or still a secondary consideration?	It is well-recognized that staff health and well-being has a considerable influence on performance and productivity in any organization. The NHS is no different. Dr Steven Boorman's NHS health and well-being review made a powerful case for change in how staff health and well-being was understood, how it should be operationalized in the NHS, and how senior management must lead in developing new cultures that have health and well-being at their core. In particular, Dr Boorman demonstrated how staff health and well-being impacts on patient care. Ten years later, NHS staff remain more likely to incur a work-related illness or injury than staff in other sectors and NHS staff sickness absence is double the national average. In addition, doctors, particularly younger doctors, frequently feel the need to attend work despite ill health, and are taking breaks in training to avoid burnout. The views of doctors on the availability and access to occupational health services, as well as the support of their employer for their health and well-being, can provide a timely insight into the effectiveness of measures since the Boorman review to bring doctors' health and well-being to a central place in today's NHS. There have also been a series of initiatives announced in the nations of the UK to provide occupational health services to doctors in recent years. The effectiveness and implementation of these initiatives are important in	

		understanding what progress has been made in supporting doctors' health and well-being. In order to gain such insights, we asked a series of questions to a panel of doctors through the regular online BMA Quarterly Survey. The survey results demonstrate that access to support for their health and well-being is inconsistent and sometimes non-existent. This article discusses these results and provides recommendations for the future
Bhugraa , D., Sauerteigb , S., Blandb , D., Lloyd-Kendallb , A., Wijesuriyab , J.,Gurdas Singhc,G., Kochhare , A.,Molodynskif, A,Ventriglio.,A.(2019)International Review of Psychiatry, Vol 31, Nos. 7–8, 563–568 https://doi.org/10.1080/09540261.2019.1648621	A descriptive study of mental health and well-being of doctors and medical students in the UK	Doctors and medical students are working in a system which is affecting their mental well-being and their ability to provide the best possible care for patients. The British Medical Association conducted an online survey of doctors and medical students in October 2018. In total, 4347 responses were received and analysed. Doctors working the longest hours appear to be most vulnerable to psychological and emotional disturbance. Older and more senior doctors are most likely to report that their working environment has impacted on their condition. Medical students and junior doctors report the highest rate of having a formally diagnosed mental health condition in the last 12 months. This may be because they are in the vulnerable age group when psychiatric disorders start. Junior doctors were least likely to be aware of how to access help or support. Older doctors, those working as SAS (Staff, Associate Specialists and Specialty) doctors and overseas qualified doctors are most likely to say they have asked for support in managing a problem from their employer but that no support was provided. It is important to recognize that doctors, in spite of stress and poor well-being, continue to work hard, which has both advantages and disadvantages. These findings highlight that the environment in which doctors work, train, and study affects their mental health, and for this reason careful consideration needs to be given to the type and level of support provision available to them, as well as the ease of access and awareness of such support.

Thompson, W, Cupples, M, Sibbett, C, Skan, D, Bradley, T.(2001) BMJ. Sep 29; 323(7315): 728–731. doi: **10.1136/bmj.323.7315.728**	Challenge of culture, conscience, and contract to general practitioners' care of their own health: qualitative study	Objective: To explore general practitioners' perceptions of the effects of their profession and training on their attitudes to illness in themselves and colleagues. Design: Qualitative study using focus groups and in-depth interviews. Setting: Primary care in Northern Ireland. Participants: 27 general practitioners, including six recently appointed principals and six who also practised occupational medicine part time. Main outcome measures: Participants' views about their own and colleagues' health. Results: Participants were concerned about the current level of illness within the profession. They described their need to portray a healthy image to both patients and colleagues. This hindered acknowledgement of personal illness and engaging in health screening. Embarrassment in adopting the role of a patient and concerns about confidentiality also influenced their reactions to personal illness. Doctors' attitudes can impede their access to appropriate health care for themselves, their families, and their colleagues. A sense of conscience towards patients and colleagues and the working arrangements of the practice were cited as reasons for working through illness and expecting colleagues to do likewise. Conclusions: General practitioners perceive that their professional position and training adversely influence their attitudes to illness in themselves and their colleagues. Organisational changes within general practice, including revalidation, must take account of barriers experienced by general practitioners in accessing health care. Medical education and culture should strive to promote appropriate self-care among doctors.	
Marshall, E. (2008). Occupational Medicine; 58; 334-340.	Doctors' health and fitness to practice; treating addicted doctors	Review about treating addicted doctors. Systematic Review - * Review of prevalence of alcohol and drug problems in Europe and North America among doctors and risk factors for development of misuse problems and treatment. In North America prevalence of alcohol problems in doctors may not be higher than general pop' and rates of illicit drug use less but higher rates of prescription drug use (self-medication). In UK study of 144 doctors with substance misuse problems: mean age at referral 43.1 yrs (24-69 yrs), 42% alcohol, 26% drug, 31% drug and alcohol. Drugs used: 30% opiates,	CASP- 7

		24% barbiturates, 21% benzodiazepines, 15% amphetamines. In more recent UK study with 62 healthcare workers (21 doctors): 59% alcohol use, 41% drug misuse (main drugs: opiates, anaesthetic agents), 72% reported use of several drugs, 43% history of psychiatric treatment prior to referral, 27% previous treatment for depression, 41% referred by employer or occup. Health physician. Risk facts for development of problem: personality problems, nonspecific drift into drinking, anxiety or depression, pain, injury or accident, stress at work, family stress, bereavement. Evidence indicates doctors respond well to specialist treatment, sooner referred on to such treatment the better. **Doi:10.1093/occmed/jqn081**
Adams, E., Lee, A.., Pritchard, C.., & White, R., (2010). International Journal of Social Psychiatry, 56(4), 359-370	What Stops Us from Healing the Healers: A Survey of Help-Seeking Behaviour, Stigmatisation and Depression Within the Medical Profession.	**Background:** Doctors are poor at help-seeking, particularly for mental ill health; attitudes of colleagues reflecting stigmatisation may be important factors influencing decisions to seek support. **Aims:** This article focuses on doctors' attitudes to depression rather than mental illness in general. It seeks to determine the extent to which doctors perceive depression is stigmatised within the medical profession and whether the level of perceived stigma affects patterns of help-seeking behaviour. **Method**: A postal survey was sent to 1488 General Practitioners and 152 psychiatrists in Devon and Cornwall. Questions assessed stigmatising attitudes to depression; help-seeking behaviour and barriers to help-seeking. Prevalence of self-reported depression and time off work was measured. **Results:** The response rate was 76.6%. Doctors perceived that many of their profession hold stigmatising views of depression. Some 46.2% of respondents reported that they had suffered an episode of depression. Help-seeking was significantly reduced in those with a history of depression. Barriers to help-seeking were reported as letting colleagues down (73.1%), confidentiality (53.4%), letting patients down (51.9%) and career progression (15.7%). Gender and a history of depression significantly affected help-seeking behaviour and perceived stigmatisation. Higher levels of perceived stigma increased concerns about help-seeking and reduced help-seeking from own GP or colleagues.

		Conclusion: Stigma associated with depression in doctors is endemic in the medical profession and the level of perceived stigma is related to reduced help-seeking behaviour. Efforts need to be made by the profession to reduce the stigma anticipated by those who become depressed, to enable appropriate help-seeking and support
Brooks, S., Gerada, C., & Chalder, T. (2017). Journal of Mental Health, 26(2), 161-166. doi: 10.1080/09638237.2016.1244712	The specific needs of doctors with mental health problems: qualitative analysis of doctor-patients' experiences with the Practitioner Health Programme.	Objectives: The current paper aimed to explore doctor-patients' views about their treatment from the Practitioner Health Programme (PHP), a UK-based service treating health professionals with mental health/addiction problems. Aims were to gain insights into the issues most important to patients and consider whether a service specifically for doctors is important in helping to overcome barriers to accessing mental healthcare. Methods: Nine doctor-patients attending PHP took part in semi-structured interviews between September 2010 and June 2011. Thematic analysis was used to explore recurring patterns in the data. 134 written comments from PHP patients were also included. Results: Participants reported difficulties in finding appropriate treatment; problems were often severe by the time PHP was involved. Concerns about confidentiality, judgement and impact on career were obstacles to help-seeking and important issues during treatment. Analysis of written comments provided further support for these findings. Conclusion: Whilst some of the needs of mentally unwell doctors mirror the needs of patients in general – e.g. a supportive and non-judgemental attitude from clinicians – they do have specific needs related to confidentiality and stigma.

Bianchi, E. F., Bhattacharyya, M. R., & Meakin, R. (2016). BMJ Open, 6(e012598). doi: 10.1136/bmjopen-2016-012598	Exploring senior doctors' beliefs and attitudes regarding mental illness within the medical profession: a qualitative study.	Objective: To explore the views of senior doctors on mental illness within the medical profession. Background: There has been increasing interest on the issue of doctors' mental health. However, there have been few qualitative studies on senior doctors' general attitude towards mental illness within the medical profession. Setting: Large North London teaching hospital. Participants: 13 hospital consultants and senior academic general practitioners. Methods: A qualitative study involving semi-structured interviews and reflective work. The outcome measures were the themes derived from the thematic framework approach to analysis. Results: Four main themes were identified. (1) 'Doctors' attitudes to mental illness'—doctors felt that there remained a significant stigma attached to suffering from a mental illness within the profession. (2) 'Barriers to seeking help'—doctors felt that there were numerous barriers to seeking help such as negative career implications, being perceived as weak, denial and fear of prejudice. (3) 'Support'—doctors felt that the use of support depended on certainty concerning confidentiality, which for occupational health was not thought to be guaranteed. Confiding in colleagues was rare except among close friends. Supervision for all doctors was raised. (4) 'General Medical Council (GMC) involvement'—doctors felt uneasy referring colleagues to the GMC and the appraisal and revalidation process was thought not to be thorough enough in picking up doctors with a mental illness. Conclusions: Owing to the small size of this study, the conclusions are limited; however, if the findings are confirmed by larger studies, they suggest that greater efforts are needed to destigmatise mental illness in the profession and improve support for doctors. Additional research should be carried out into doctors' views on occupational health services in managing doctors with mental illness, the provision of supervision for all doctors and the effectiveness of the current appraisal and revalidation process at identifying doctors with a mental illness

Baldwin, P. J., Dodd, M., & Wrate, R. M. (1997) Social Science and Medicine, 45	Young doctors' health II. Health and health behaviour	There is little published information on the health of young doctors, apart from a number of studies which show increased rates of psychiatric symptoms. Nor is there much known of their health behaviour. Anecdotal accounts suggest that doctors' own health care is poor, especially in terms of their willingness to consult other doctors. This paper presents data from a longitudinal study of a class cohort of young doctors first interviewed when they were students. Data show that they suffer from frequent minor physical ailments, with women reporting more ailments than men. Despite this, they took less sick leave. Overall, the doctors took very little time off work. Using the GHQ-28, with a threshold of 5/6, 30% of doctors fell into the “caseness” category for psychiatric symptoms. This is in keeping with findings elsewhere. From the doctors' own reported health behaviour, both in terms of their response to illness over the past year, as well as their predicted response to hypothetical illness, they have developed maladaptive patterns. These include continuing to go to work when unfit, self-prescribing, and consulting friends and colleagues rather than going for a formal consultation. This is seen as inappropriate, especially in cases of mental illness. A third of the young doctors are not registered with a local general practitioner and the majority have no clear idea of the role of the Occupational Health Service. The results are discussed in terms of the need to change attitudes to health care and to develop guidelines, staffing and services to enable doctors to take better care of themselves.
Grant, A., Rix, A. & Shrewsbury, D. (2019). *. International Review of Psychiatry, 1-11.	‘If you're crying this much you shouldn't be a consultant’: the lived experience of UK doctors in	Introduction There is some disagreement in the literature whether doctors in training suffer more from mental illness than an age-matched population. However, mental illness among doctors in training is a cause for concern because of the dual problems of reticence about accessing help and the clinical risk of doctors practising while mentally ill. The belief that is widely held among doctors in training is that to disclose a mental illness would be seen as weakness and may damage their career. Method: We used a

http://dx.doi.org/10.1080/09540261.2019.1586326	training with mental illness	biographical narrative interview technique that enables the informant to tell the story of a painful episode in their lives in their own way and in their own words. Interviews were transcribed, and a thematic framework developed by consensus and then used to analyse all of the narrative interview data. Results :Four major themes were detected. • Doing the job while ill, • Sick leave (initiating, being on, returning from), • Interaction with the employer and • Sources of support. .Practising while mentally ill caused significant challenges. Interviewees did the minimum, hated having to make decisions and failed to study for postgraduate exams. All interviewees took sick leave at some stage. However, most were reluctant to do so. Being on sick leave meant being absent from the career that identified them and running the risk of being perceived as weak. Returning to work from sick leave was often difficult. Back to work interviews and occupational health support did not always happen. Discussion We demonstrate the suffering encountered by doctors in training with mental illness. The job becomes much more difficult to do safely when mentally unwell. A great deal of presenteeism exists, which inhibits doctors in training from getting the medical care they need. It is imperative that confidential medical care is made available to doctors in training, which is sufficiently distanced from their place of work	
Forsythe, M, Calnan,M. Wall,B. (1999). BMJ; 319; 605-608.	Doctors as patients: postal survey examining consultants and general practitioners' adherence to guidelines.	Postal questionnaire of 595 UK Consultants, 1138 GPs with a response rate of 64% for GPs and 72% for consultants. Cross-sectional study + ** Postal questionnaire, participants randomly selected in London and counties. Questions included adherence to guidelines, use of occupational health, prescribing habits for self and family and response to vignettes 98% of GPs and 94% of consultants registered with a GP. 63% of GPs and 59% of consultants had not consulted a GP in the last 12 months. 71% of GPs and 76% of consultants self-prescribed. 11% of GPs had access to occupational health; 95% of consultants did but only 25% had used OH services. 12% of GPs and 8% of consultants were happy with the services provided to them. It is useful to note the poor uptake of OH and it would be valuable to try to	EHPP-Moderate

		understand the reasons for this.	
Waldron, H. (1996). Annals of Occupational Hygiene*;* 40: 391-396.	Sickness in the medical profession.	Random sample of 200 doctors from the medical register. Response rate of 63%, N=110 as 16 were unable to complete the questionnaire Cross-sectional study - * Pilot study questionnaire no further details given. The majority of doctors had had at least one day off sick in the previous 2 years (5Chap%), of those who had taken leave, 13 had been treated in hospital and 36 had received other treatment. 13 identified that sick leave had been caused by working (including infections, violence and mental pressure). Fifty -one reported having access to occupational health but no one had consulted an occupational physician. The reasons for this are not explored. One limitation is that this was a pilot questionnaire and no further details regarding procedure is mentioned.	EHPP-Weak
Toyry et al., (2000). Archives of family medicine, 9, 1079-1085.	Self-reported health, illness and self-care among Finnish physicians. A national survey.	Randomly selected population of 4474 licensed physicians in Finland. Response rate of 74% with n=3313. Cross-sectional + ** Questionnaire developed based on national population data studies questionnaire, included a list of diseases and further questions on treatment and sickness absence. No difference in perceived health between male and female physicians. Males reported more hypertension than female physicians, females reported more thyroid dysfunction. Compared to the general population, doctors' report more mental disorders, back disorders and digestive problems. Self-treatment often used (80-84%). Sickness absence increased with age of physicians but no difference between physicians and general population. Main reasons for sickness absence were acute infections (65% for men, 69% for women), followed by MSDs. Fewer males (43.6%) than female physicians (69.4%) had consulted a physician in the last 12 months. Study identifies that	EHPP-Moderate

		the usual care is self-treatment and working through illness.	
Chambers, R. (1993) Family Practice; 10: 416-423**.**	What Should Doctors do if They Become Sick*?*	Twenty-two GP trainers were trained in questionnaire survey and 59 GPs completed the survey and 65 hospital specialists. Cross-sectional - * Assessed plan of actions for 10 medical condition scenarios as advised to other doctors and how they would self-treat. GPs were found to advise doctors as a whole to consult their own GPs but hospital specialists would self-medicate Hospital specialists more likely to suggest direct consultation with a specialist. Two thirds of GPs thought it was nearly always acceptable to self-investigate urine tests, but never to initiate other tests. GPs found it acceptable to self-medicate for topical anti-fungals and anatacids but never for antidepressants, benzodiazepenes, anti-hypertensives or opiates. This study is interesting because OH is not mentioned. This may not have been part of the questionnaire and is an interesting gap.	EHPP-Weak
Feeney, S, O'Brien K, O'Keeffe , N, Con Iomaire , A, Kelly , M, McCormack ,J, McGuire, F and Evans, D. (2016) Clin Med (Lond). Feb; 16(1): 12–18. doi: **10.7861/clinmedicine.16-**	Practise what you preach: health behaviours and stress among non-consultant hospital doctors	High rates of psychological distress, depression and suicide have been reported among doctors. Furthermore, many doctors do not access healthcare by conventional means. This study aimed to increase understanding regarding non consultant hospital doctors' (NCHDs') response to stress and barriers to accessing supports, and identify possible solutions. Medical manpower departments in 58 hospitals distributed a 25-item questionnaire to 4,074 NCHDs; we received 707 responses (response rate, 17.4%). 60% of NCHDs were unable to take time off work when unwell; 'letting teammates down' (90.8%) and 'difficulty covering call' (85.9%) were the leading reasons. 'Being too busy' (85%), 'self-prescription' (66.6%) and 'self-management' (53.1%) were ranked highest in deterring NCHDs from visiting a general practitioner (GP). 22.9% of NCHDs would not attend a GP with anxiety or depression until they began to feel hopeless, helpless or suicidal. 12.2% would not seek help at all. 55% of respondents (n = 330) had to move away from partners or dependants due to work, negatively affecting the social supports of 82.9%. Possible practical solutions were explored.	

1-12		NCHDS are a vulnerable population and have a particularly challenging lifestyle. Key recommendations include improved GP and counselling access for NCHDs, and addressing the culture of self-treatment and poor health behaviours through undergraduate and postgraduate education.	
Cohen, D. Rhydderch, M. Reading, P.& Williams, S. (2015). Occ Med. Aug.Vol,65,no6 ,p459-465.Advance Access publication 12 June	Doctors' health: obstacles and enablers to returning to work	Conducted 11 telephone interviews. Data analysis identified four key themes of obstacles and enablers to returning to work: 'communication', 'return to work', 'finance and funding' and 'relationships and engagement'. Sub-themes relating to the organization and the individual also emerged. Organizations responsible for supporting doctors back to work reported poor communication as a significant obstacle to doctors returning to work after illness. They also reported differences between specialities, employing organizations, occupational health departments and human resources in terms of knowledge and expertise in supporting doctors with complex issues. Clear communication channels, care pathways and support processes, such as workplace advocates, were perceived as strong enablers to return to work for doctors after long-term absence. Interestingly, OH is not mentioned. doi:10.1093/occmed/kqv056	CASP-8

Lalloo,D.Ghafur,I. & Macdonald,E.(2013). *Occupational Medicine* ;63:291–293 Advance Access publication 26 April 2013	Doctor and dentist contacts with an NHS occupational health service	To improve our understanding of OH contacts by doctors and dentists and make some comparison of this with available sickness absence records. A retrospective descriptive evaluation of all doctor and dentist encounters with the OH service between April 2009 and March 2010 was undertaken. Doctor and dentist encounters from our electronic appointment system were analysed using Microsoft Excel. Comparisons were made with management-reported sickness absence data for this period. Mental health conditions were the main reason for referral (approximately one-third of all cases referred). In this group, a much higher number presented to OH, absent from work, than were recorded with sickness absence by management. Musculoskeletal, infection and skin complaints were other predominant reasons for referral. Inconsistency in the reporting of sickness absence in doctors with mental health problems has also been highlighted. This baseline information is a useful stepping stone to identifying and meeting the specific needs of doctors and dentists and can be used as a benchmark in other organizations. Limitations of this study include the retrospective approach which also considers dentists using OH too, which dilutes the information somewhat. doi:10.1093/occmed/kqt029	EHPP-Moderate

Fox,F, Harris, M, Taylor,G, Rodham,K, Sutton, J, Robinson,B, and Scott,J. (2009) British Journal of General Practice; 59 (568): **811-818.** DOI: **https://doi.org/10.3399/bjgp09X472872**	What happens when doctors are patients? Qualitative study of GPs	Background: Current evidence about the experiences of doctors who are unwell is limited to poor quality data. Aim To investigate GPs' experiences of significant illness, and how this affects their own subsequent practice. Design of study: Qualitative study using interpretative phenomenological analysis to conduct and analyse semi-structured interviews with GPs who have experienced significant illness. Setting: Two primary care trusts in the West of England. Method A total of 17 GPs were recruited to take part in semi structured interviews which were conducted and analysed using interpretative phenomenological analysis Results: Four main categories emerged from the data. The category, 'Who cares when doctors are ill?' embodies the tension between perceptions of medicine as a 'caring profession' and as a 'system'. 'Being a doctor–patient' covers the role ambiguity experienced by doctors who experience significant illness. The category 'Treating doctor–patients' reveals the fragility of negotiating shared medical care. 'Impact on practice' highlights ways in which personal illness can inform GPs' understanding of being a patient and their own consultation style. Conclusion: Challenging the culture of immunity to illness among GPs may require interventions at both individual and organisational levels. Training and development of doctors should include opportunities to consider personal health issues as well as how to cope with role ambiguity when being a patient and when treating doctor–patients. Guidelines about being and treating doctor–patients need to be developed, and GPs need easy access to an occupational health service.
WHITE, A, SHIRALKAR, P, HASSAN, T, GALBRAITH, N, AND CALLAGHAN, R(2006)	Barriers to mental healthcare for psychiatrists	Aims and Methods: To determine the opinions of psychiatrists on mental illness among themselves and their colleagues a postal survey was conducted across the West Midlands. Results:Most psychiatrists (319/370, 86.2%) would be reluctant to disclose mental illness to colleagues or professional organisations (323/370, 87.3%). Their choices regarding disclosure and treatment would be influenced by issues of confidentiality (n=245, 66%), stigma (n=83, 22%) and career implications (n=128, 35%) rather than quality of care (n=60, 16%). Clinical implications: The stigma

Psychiatric Bulletin (20 0 6), 3 0, 382-384		associated with mental illness remains prevalent among the psychiatric profession and may prevent those affected from seeking adequate treatment and support. Appropriate, confidential specialist psychiatric services should be provided for this vulnerable group, and for doctors as a whole, to ensure that their needs, and by extension those of their patients, are met.	
Cohen, D. Marfell N & Greene,G.(2014) Occupational Medicine Volume 64, Issue 2 Pp. 126-132	Standards for 'Health for Health Professionals' services in the UK	To develop consensus about standards for 'Health for Health Professionals' (HHP) services in the UK through a modified Delphi study. Methods: We conducted a two-stage Delphi study over 6 months. The questionnaire development took place during the UK Association of Physician Health (UKAPH) meeting in London in 2012, Forty-four people took part in round 1 and 40 in round 2. Participants were mainly GPs, occupational physicians and psychiatrists. Consensus was reached on major criteria for HHP services, with greatest consensus (45% agreement or greater) for four statements concerning the clarity and transparency of the services offered and one statement that anyone working within the service should have received suitable training in physician health. Consensus about some statements varied among the three specialities. This study was limited due to timescale which prevented a third Delphi round being completed. This may have resulted in additional consensus information being gathered. However, as the number of clinicians working in this field it is possible that this study is representative of the UK UKAPH population. **Conclusions** This study will assist discussion about providing and improving consistent services across the UK.	EHPP-Moderate
Fox, F., Doran, N. J., Rodham, K. J., Taylor, G.	Junior doctors' experiences of personal	Objectives: Professional status and working arrangements can inhibit doctors from acknowledging and seeking care for their own ill health. Research identifies that a culture of immunity to illness within the medical profession takes root during training. What happens when trainee doctors become	

J., Harris, M. F., & O'Connor, M. (2011). Medical Education, 45, 1251-1261.	illness: a qualitative study.	unwell during their formative period of education and training? What support do they receive and how do they perceive that the experience of ill health affects their training trajectory? These research questions were developed by a multidisciplinary team of researchers and health professionals, who adopted a qualitative approach to investigate the experiences of personal illness among trainees in their Foundation Programme (FP) years. Methods: Semi-structured interviews were conducted with eight FP trainees from the Severn Deanery in southwest England who had experienced significant illness. Interpretative phenomenological analysis was used to conduct and analyse the interviews, resulting in a comprehensive list of master themes. This paper reports an interpretative analysis of the themes of *Support*, *Illness Experience*, *Crossing the Line*, *Medical Culture*, *Stigma* and *Disclosure.* Results: Ineffective communication within the medical education and employment system underpins many of the difficulties encountered by trainees who are unwell. Coping style plays a key role in predicting how trainees experience support during and after their illness, although this may be influenced by their particular diagnoses. The barriers to disclosure of their illnesses are discussed within the context of mobilising and maintaining support. Concern about the impact of missing training as a result of ill health appears to be significant in the transmitting of an ethos of invulnerability within the medical culture. Conclusions: Suggestions to improve support procedures for trainees who are unwell include the provision of greater flexibility within the rotation system along with independent pastoral support. Promoting the importance of disclosing significant illness as early as possible might go some way towards challenging the culture of invulnerability to illness that prevails among doctors.

PHP (2013) Supporting the health of HCPs	The First Five Years of the NHS Practitioner Health Programme 2008 - 2013	This report provides an overview of the NHS Practitioner Health Programme service (PHP) and the support it has provided for its practitioner patients over this 5 year period. Independent research shows that patients attending PHP are as sick as any attending mental health services (see the following link http://bmjopen.bmj.com/content/2/5/e001776.long) and its outcomes far surpass any other treatment service dealing with similar patients, in terms of return to work; improvements in health and well-being; sickness rates and abstinent rates. It is emerging more clearly that certain professional and demographic groups have been identified as more likely to present as practitioner patients, such as Training doctors	EHPP-Strong
M. Meerten, F. Rost, J. Bland and A. . Garelick Occupational Medicine Advance Access published ***Occupational Medicine*** February 20, 2014	Self-referrals to a doctors' mental health service over 10 years	To investigate the change in self-referral rates to a doctors' mental health service, and associated morbidity over a decade. All doctors attending a doctors' mental health service between 1 January 2002 and 31 December 2011 were asked to complete the Clinical Outcomes in Routine Evaluation questionnaire and Maslach burnout inventory as part of routine assessment before treatment. Univariate analysis of variance was used to test for statistically significant differences between severity scores in different years. Between 1 January 2002 and 31 December 2011, 1062 doctors attended the service; 852 (80%) completed both questionnaires and 64 (6%) completed one of them. The overall response rate was 86% (916/1062). Referrals increased >4-fold, from 44 in 2002 to 185 in 2011. Sixty-one per cent scored above the threshold for psychological distress and 59% for burnout. There were no significant changes in morbidity over time. Increasing numbers of doctors sought help from the doctors' mental health support service. More than half scored above the thresholds for burnout and psychological distress and these proportions were consistent over 10 years. Doctors may be more willing to seek help than a decade ago. Further research is needed to confirm the underlying reasons for this. More resource is needed to meet the increase in demand. doi:10.1093/occmed/kqt177	EHPP-Strong

Hassan, T,Ahmed,S White,A and Galbraith,N Clin Med (Lond). 2009 Aug; 9(4): 327–332. doi: **10.7861/clinmedicine.9-4-327**	A postal survey of doctors' attitudes to becoming mentally ill	A postal survey of 3,512 doctors in Birmingham was carried out to assess attitudes to becoming mentally ill. The response rate for the questionnaire was 70% (2,462 questionnaires). In total, 1,807 (73.4%) doctors would choose to disclose a mental illness to family and friends rather than to a professional. Career implications were cited by 800 (32.5%) respondents as the most frequent reason for failure to disclose. For outpatient treatment, 51.1% would seek formal professional advice. For inpatient treatment, 41.0% would choose a local private facility, with only 21.1% choosing a local NHS facility. Of respondents 12.4% indicated that they had experienced a mental illness. Stigma to mental health is prevalent among doctors. At present there are no clear guidelines for doctors to follow for mental healthcare. Confidential referral pathways to specialist psychiatric care for doctors and continuous education on the vulnerability of doctors to mental illness early on in medical training is crucial.	
Smith,F. Goldacre,M. Lambert, T. (2016)JRSM Open. Apr; 7(4): 2054270416635035. Published online 2016	Working as a doctor when acutely ill: comments made by doctors responding to United Kingdom	We undertook multi-purpose surveys of doctors who qualified in the United Kingdom between 1993 and 2012. Doctors were asked specific questions about their careers and were asked to comment about any aspect of their training or work. We report doctors' comments about working whilst acutely ill. **Design:** Self-completed questionnaire surveys. **Setting:** United Kingdom. **Participants :**Nine cohorts of doctors, comprising all United Kingdom medical qualifiers of 1993, 1996, 1999, 2000, 2002, 2005, 2008, 2009 and 2012.**Main outcome measures:** Comments made by doctors about working when ill, in surveys one, five and 10 years after graduation. **Results:** The response rate, overall, was 57.4% (38,613/67,224 doctors). Free-text comments were provided by 30.7% (11,859/38,613). Three-hundred and twenty-one doctors (2.7% of those who wrote comments) wrote about working when feeling acutely ill. Working with *Exhaustion/fatigue* was the	EHPP-Strong

Mar 3.		most frequent topic raised (195 doctors), followed by problems with *Taking time off for illness* (112), and general comments on *Physical/mental health problems* (66). Other topics raised included *Support from others*, *Leaving or adapting/coping with the situation, Bullying,* the *Doctor's ability to care* for patients and *Death/bereavement*. Arrangements for cover due to illness were regarded as insufficient by some respondents; some wrote that doctors were expected to work harder and longer to cover for colleagues absent because of illness. **Conclusions:** We recommend that employers ensure that it is not unduly difficult for doctors to take time off work when ill, and that employers review their strategies for covering ill doctors who are off work. doi: 10.1177/2054270416635035	
Cohen,D, Winstanley, S. Greene, G *Occup Med (Lond)* (2016)doi: 10.1093/occmed/kqw024First published online: March 29, 2016	Understanding doctors' attitudes towards self-disclosure of mental ill health	**Background:** Understanding of doctors' attitudes towards disclosing their own mental illness has improved but assumptions are still made. **Aims:** To investigate doctors' attitudes to disclosing mental illness and the obstacles and enablers to seeking support. **Methods:** An anonymous, UK-wide online survey of doctors with and without a history of mental illness. The main outcome measure was likelihood of workplace disclosure of mental illness. **Results:** In total, 1954 doctors responded and 60% had experienced mental illness. There was a discrepancy between how doctors think they might behave and how they actually behaved when experiencing mental illness. Younger doctors were least likely to disclose, as were trainees. There were multiple obstacles which varied across age and training grade. **Conclusions:** For all doctors, regardless of role, this study found that what they think they would do is different to what they actually do when they become unwell. Trainees, staff and associate speciality doctors and locums appeared most vulnerable, being reluctant to disclose mental ill health. Doctors continued to have concerns about disclosure and a lack of care	EHPP-Moderate

		pathways was evident. Concerns about being labelled, confidentiality and not understanding the support structures available were identified as key obstacles to disclosure. Addressing obstacles and enablers is imperative to shape future interventions. **doi: 10.1093/occmed/kqw024First published online: March 29, 2016**

Interventions		
Reference	**Title**	**Themes**
Bu et al. Pilot and Feasibility Studies (2019) 5:61 https://doi.org/10.1186/s40814-019-0449-y	Mindfulness intervention for foundation year doctors: a feasibility study	Background: Mindfulness has been shown to reduce stress and burnout in medical students and healthcare professionals. This is a quality improvement study which assessed the feasibility of conducting a full-scale evaluation of a mindfulness intervention among UK foundation doctors to reduce stress and burnout. Methods: This is an uncontrolled before and after study taking place in a single university teaching hospital. The RE-AIM framework which comprises of five dimensions including Reach, Adoption, Effectiveness, Implementation, and Maintenance was used to guide this assessment. The intervention was a 6-week 'Mindfulness in the Workplace' course. The primary measure was change in self-reported levels of stress immediately before and after the course. Additional measures explored the subjective experiences of participating doctors through the use of questionnaires handed out before and after the course. Results: All 20 places on the course were filled from the population of 108 foundation doctors at the trust with an equal number of foundation year 1 (n = 10) and foundation year 2 (n = 10) doctors. Sixteen participants (80%) attended one or more sessions. The median baseline stress score of the participants was 6.5 (range = 2 to 9). The median post-course stress score was 5.0 (range = 2 to 8). The Mann-Witney test indicated that the stress levels of participants were significantly lower at the end of the course compared to baseline, U = 74.50, p = .04.

		Additional measures suggested that the intervention may be associated with some other potentially promising benefits for doctors including greater well-being, improved working life, and more satisfactory relationships with patients. Implementation of this intervention requires further work at the institutional level because only 35% of participants completed the full intervention, the main barrier being work commitments. Conclusion: This is the first programme of research to evaluate the feasibility of trialling and implementing a modified 'Mindfulness in the Workplace' intervention for foundation junior doctors in the UK. Based on the findings from this study, we conclude that this intervention is promising but further modifications are required such as the use of validated outcome measures and improving delivery aspects before this intervention programme is trialled among foundation doctors in the UK. Keywords: Mindfulness, Foundation, Junior doctor, Feasibility, Burnout
Hancock,J, Mattick, K. (2020) Medical Education. 2020;54:125–137.	Tolerance of ambiguity and psychological well-being in medical training: A systematic review	Context: The prevalence of stress, burnout and mental health disorders in medical students and doctors is high. It has been proposed that there may be an association between levels of tolerance of ambiguity (ie an ability to tolerate a lack of reliable, credible or adequate information) in clinical work and psychological well-being within this population. The aims of this systematic review were: (i) to assess the nature and extent of the literature available, in order to determine if there is an association, and (ii) to develop a conceptual model proposing possible mechanisms to underpin any association, in order to inform subsequent research. Methods: MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PsycINFO databases were searched for articles published from inception to September 2018. Additional literature was identified by searching the reference lists of included articles, forward searches of included articles, hand searches of key journals and a grey literature search. Of the 671 studies identified, 11 met the inclusion criteria. A qualitative synthesis of included studies was performed. Results: All 11 included studies reported an association between a lower level of tolerance of ambiguity or uncertainty

		and reduced psychological well-being. Included studies were heterogeneous in terms of population and measurement approach, and were often of low methodological quality. Subsets of items from previously developed scales were often used without sufficient consideration of the impact of new combinations of items on scale validity. Similar scales were also scored inconsistently between studies, making comparison difficult. Conclusions: There appears to be an association between tolerance of ambiguity and psychological well-being. This provides new opportunities to understand and prevent the development of stress, burnout and mental health disorders in medical students and doctors. The conceptual model developed provides a framework for future research, which we hope will prevent wasted research effort through duplication and promote higher methodological quality.
Carrieri D, Pearson M, Mattick K, Papoutsi C, Briscoe S, Wong G, Jackson M.. **http://dx.doi.org/10.1136/bmjopen-2017-021273** Southampton (UK): NIHR Journals Library; 2020 Apr. PMID:	Interventions to minimise doctors' mental ill-health and its impacts on the workforce and patient care: the Care Under Pressure realist review	**Background:** The growing incidence of mental ill-health in health professionals, including doctors, is a global concern. Although a large body of literature exists on interventions that offer support, advice and/or treatment to sick doctors, it has not yet been synthesised in a way that takes account of the complexity and heterogeneity of the interventions, and the many dimensions (e.g. individual, organisational, sociocultural) of the problem. **Aim** -to improve understanding of how, why and in what contexts mental health services and support interventions can be designed to minimise the incidence of doctors' mental ill-health. The objectives -review interventions to tackle doctors' mental ill-health and its impact on the clinical workforce and patient care- to produce actionable theory. To make tailored recommendations that can be implemented, monitored and evaluated to tackle mental ill-health and its impacts. **Data sources:** Bibliographic database searches were developed and conducted using MEDLINE (1946 to November week 4 2017), MEDLINE In-Process and Other Non-indexed Citations (1946 to 6 December 2017) and PsycINFO (1806 to November week 2 2017) (all via Ovid) and Applied Social Sciences Index and Abstracts (1987 to 6 December 2017) (via ProQuest) on

32271514.	6 December 2017. Further UK-based studies were identified by forwards and author citation searches, manual backwards citation searching and hand-searching relevant journal websites. **Review methods:** all studies that focused on mental ill-health; all study designs; all health-care settings; all studies that included medical doctors/medical students; descriptions of interventions or resources that focus on improving mental ill-health and minimising its impacts; all mental health outcome measures, including absenteeism (doctors taking short-/long-term sick leave); presenteeism (doctors working despite being unwell); and workforce retention (doctors leaving the profession temporarily/permanently). **Results:** A total of 179 out of 3069 records were included. Most were from the USA (45%) and had been published since 2009 (74%). More included articles focused on structural-level interventions (33%) than individual-level interventions (21%), but most articles (46%) considered both levels. Most interventions focused on prevention, rather than treatment/screening, and most studies referred to doctors/physicians in general, rather than to specific specialties or career stages. Nineteen per cent of the included sources provided cost information and none reported a health economic analysis. The 19 context–mechanism–outcome configurations demonstrated that doctors were more likely to experience mental ill-health when they felt isolated or unable to do their job, and when they feared repercussions of help-seeking. Healthy staff were necessary for excellent patient care. Interventions emphasising relationships and belonging were more likely to promote well-being. Interventions creating a people-focused working culture, balancing positive/negative performance and acknowledging positive/negative aspects of a medical career helped doctors to thrive. The way that interventions were implemented seemed critically important. Doctors needed to have confidence in an intervention for the intervention to be effective.	

	Limitations: Variable quality of included literature; limited UK-based studies or that pertaining to OH or OH intervention/ screening or F1s. A review warranting further research especially regarding belong, health promotion, well-being, relationship and doctors needing to believe in an intervention for its potential for successful outcome.	

Appendix 4. Examples of search terms repeated three times – strategy- 403943

Strategy 403943

#	Database	Search term	Results
1	Medline	(doctor*).ti,ab	110005
2	Medline	("occupational health").ti,ab	12046
3	Medline	"OCCUPATIONAL HEALTH"/	30234
4	Medline	(2 OR 3)	38827
5	Medline	(1 AND 4)	624
6	EMBASE	(doctor*).ti,ab	155786
7	EMBASE	("occupational health").ti,ab	14271
8	EMBASE	"OCCUPATIONAL HEALTH"/ OR "OCCUPATIONAL HEALTH SERVICE"/ OR "OCCUPATIONAL HEALTH SERVICES"/	47719
9	EMBASE	(7 OR 8)	54191

Appendix 5. Main Characteristics of Papers and Quality Assessment Tools

Table 1. Assessment tools used to guide quality assessment of papers

Category	Quality assessment tool
Quantitative study	the EPHPP (2010) Quality Assessment Tool for Quantitative Studies
Meta synthesis	the CERQual Meta-synthesis Approach (Lewin et al., 2018)
Case reports	The CARE guidelines for **CA**se **Re**ports (CARE, 2013)
Qualitative studies	CASP (2018) Checklist for qualitative studies

Appendix 6. EPHPP: Quality Assessment Tool (2010) for Quantitative Studies

Component Ratings

A) Selection bias

B) Study design

C) Confounders

D) Blinding

E) Data collection methods

F) Withdrawals and drop-outs

G) Intervention integrity

H) Analyses

Global rating

1. Strong

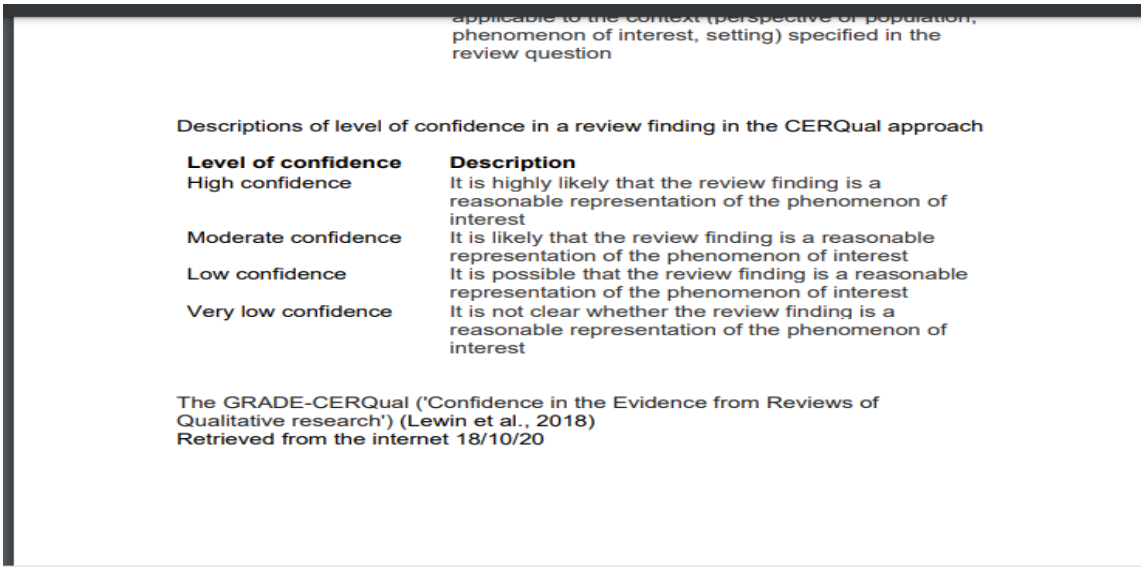
2. Moderate

3. Weak

EPHPP Quality assessment tool for quantitative studies (2010) Retrieved from the internet Date 19/11/21

Appendix 7.

CERqual Meta-synthesis Review Assessment Tool CERQual approach to qualitative evidence synthesis findings

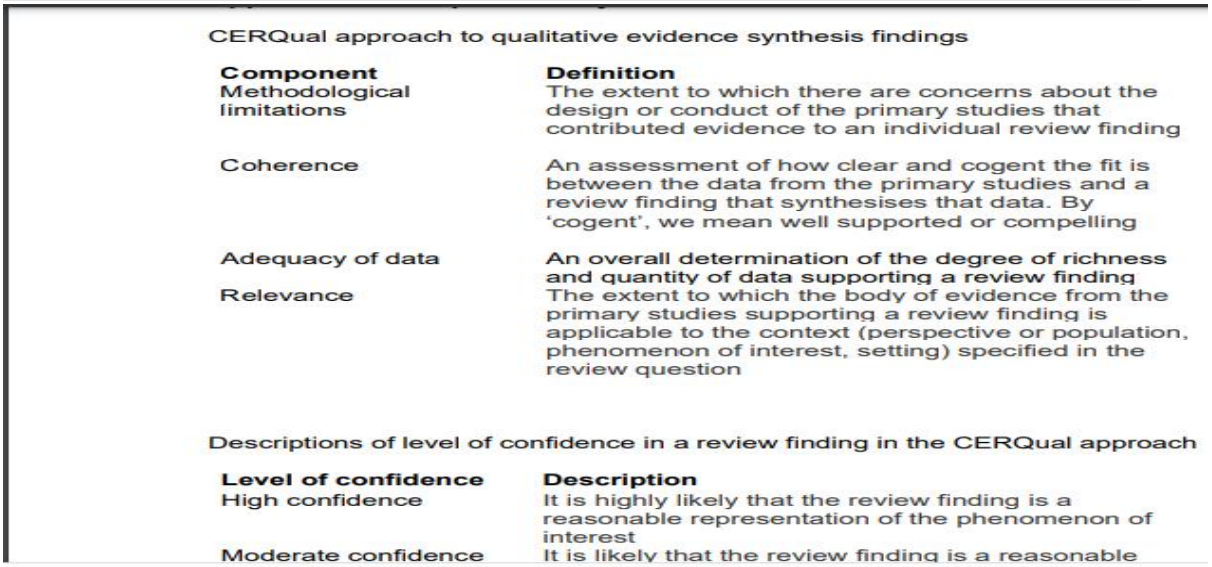


applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question

Descriptions of level of confidence in a review finding in the CERQual approach

Level of confidence	Description
High confidence	It is highly likely that the review finding is a reasonable representation of the phenomenon of interest
Moderate confidence	It is likely that the review finding is a reasonable representation of the phenomenon of interest
Low confidence	It is possible that the review finding is a reasonable representation of the phenomenon of interest
Very low confidence	It is not clear whether the review finding is a reasonable representation of the phenomenon of interest

The GRADE-CERQual ('Confidence in the Evidence from Reviews of Qualitative research') (Lewin et al., 2018)
Retrieved from the internet 18/10/20



CERQual approach to qualitative evidence synthesis findings

Component	Definition
Methodological limitations	The extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding
Coherence	An assessment of how clear and cogent the fit is between the data from the primary studies and a review finding that synthesises that data. By 'cogent', we mean well supported or compelling
Adequacy of data	An overall determination of the degree of richness and quantity of data supporting a review finding
Relevance	The extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question

Descriptions of level of confidence in a review finding in the CERQual approach

Level of confidence	Description
High confidence	It is highly likely that the review finding is a reasonable representation of the phenomenon of interest
Moderate confidence	It is likely that the review finding is a reasonable

Appendix 8. Literature Review Evaluation Criteria

Evaluation Criteria

Accuracy, authority, objectivity, currency and coverage are the five basic criteria for evaluating information from any sources.

	Questions to ask:
Accuracy	• Is the information reliable? • Is the information error-free? • Is the information based on proven facts? • Can the information be verified against other reliable sources?
Authority	• Who is the author? • Does he or she have the qualifications to speak/write on that topic? • Is the author affiliated with a reputable university or organization in this subject field?
Objectivity	• What is the intended purpose of the information? • Is the information facts or opinions? • Is the information biased?
Currency	• When was the information published? • Is the information current or out-dated? • Does currency matter in this topic?
Coverage	• Does the information covered meet your information needs? • Does it provide basic or in depth coverage?

https://libguides.library.cityu.edu.hk/litreview/evaluating-sources

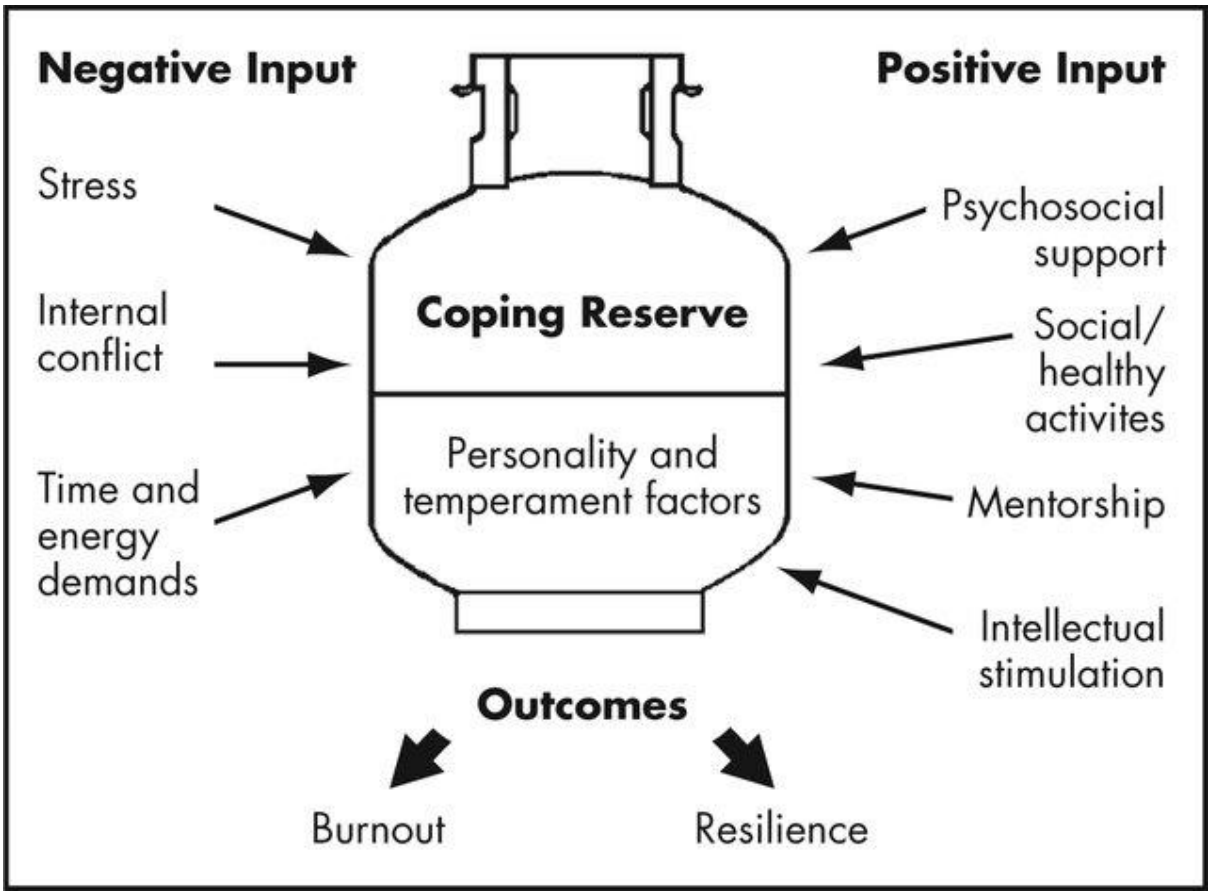
Run Run Shaw Libray Hong Kong Retrieved December 22, 2022

Appendix 9. CASP:(2018) Quality checklist for qualitative studies

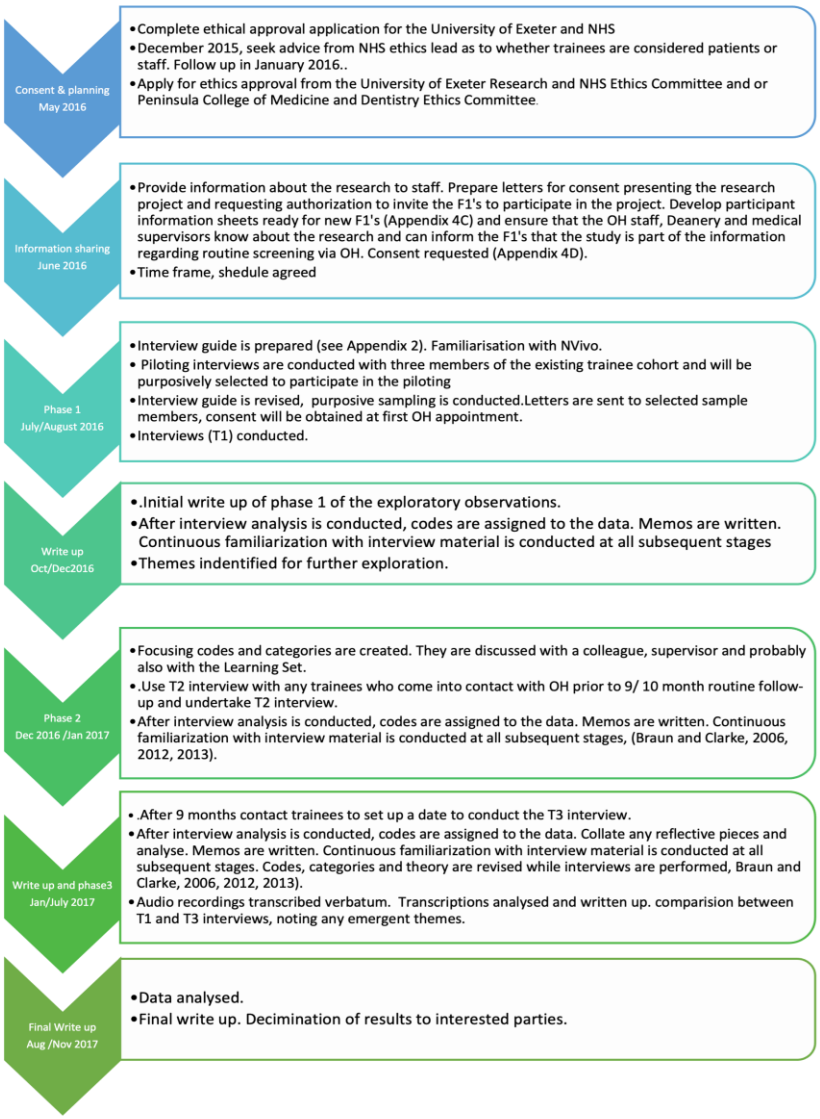
1. Was there a clear statement of aims?
2. Is a qualitative method appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate?
5. Was data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

Critical Appraisal Skills Programme (CASP) Qualitative Checklist (2018) Retrieved from the internet 19/11/21

Appendix 10. Dunn's Coping Reserve Tank (2008) Promoting Resilience and Preventing Burnout



Appendix 11. Original Thesis Timeline



Appendix 12. Semi-Structured Interview Questions

T1

What do you know about the role of OH? (Possible fears/ concerns)?

What shapes your beliefs about OH?

What personal support do you have (incl buddy scheme?)

Can you tell me about the transition from being a medical student to a Foundation doctor? (Prompt: What are you excited about/ worried about?)

What helps or hinders your ability to be resilient currently, e.g. job, isolation, friends, family?

Transition from medical student to F1 is known to be a stressful time e.g. changing environments, Isolation, limited friendship groups, which may have an impact upon how one copes in the workplace. One role of OH is to provide support to individuals who might face these difficulties. What do you think about this?

How could OH reach out/ engage with F1s?

Could you describe what well-being and resilience mean to you?

Have you learned to employ any strategies that help you cope with stressors or adversity that you hope will help you cope with this coming year?

How well do you manage uncertainty?

How do you *see* your mental health?

Are there factors that might affect this? (Prompt: workplace, relationships, personality)

OH is often separate to the organisation to promote the idea of confidentiality and so be accessible as a supportive resource. What are your thoughts about this?

What factors will maintain your well-being long term?

Any other obstacles?

Any other enablers?

T2

Tell me about the role of OH? (Possible fears/ concerns)?

What shapes your beliefs about OH?

Can you tell me about the transition from being a medical student to a Foundation doctor? (Prompt: What is going well, not so well, and what has surprised you?)

What personal support do you have (incl buddy scheme?)

Could you describe what well-being and resilience mean to you?

Have you learned to employ any strategies that help you cope with stressors or adversity?

How well do manage uncertainty/ in your current work?

How do you *see* your mental health?

Transition from medical student to F1 is known to be a stressful time e.g. changing environments, Isolation, limited friendship groups; they may have an impact upon how one copes in the workplace. One role of OH is to provide support to individuals who might face these difficulties. What do you think about this?

How could OH reach out/ engage with F1s?

Have there been things that have reduced your resilience but you have felt unable to share with someone e.g. Deanery for fear of it adversely affecting you training programme/ next job/ reference/ OH records/ confidentiality?

What has been your experience of communication between OH, Deanery and medical supervisors? Supportive, unsupportive?

What factors will maintain your well-being long term?

Is there anything that has not happened that you would like to see alter?

T3 - For those who are referred or self-refer with a MH issue.

What has brought you to OH?

At the time when your MH first presented itself what were some key events that were happening in your life?

What has been your experience of the OH service?
Did you present to OH as soon as you noticed your emotional health changing?

What prevented/ helped you to come?

What do you think has contributed to your current situation e.g. personal health, underlying issues, personal, work-place?

What personal support do you have (incl buddy scheme?)

Role of medical persona?

Role of attachment; does it matter?

Would you consider yourself resilient?

What do you mean by resilient?

What has been your experience of communication between OH, Deanery and medical supervisors? Supportive, unsupportive?

What helps or hinders your ability to be resilient currently, e.g. job, isolation, friends, family?

How could OH reach out to F1s in the future?

Anything else?

What can we help you with e.g. workplace changes, counselling?

If you had the ability, what changes would you like to see that would help future F1s?

Anything else?

Appendix 13a- Information sheet for particants

IRAS ID: 236254

PARTICIPANT INFORMATION SHEET

Title of Project: Junior Doctors experience of Occupational Health in Foundation Year 1.

Name of Researcher: Kirsten Leslie

I am currently in the third year of a Doctorate in Clinical Practice at the University of Exeter, and I am undertaking a research project for my dissertation. I was wondering if you would be willing to be interviewed, at a time and place convenient to you, as part of this research. The interview should take no longer than an hour.

Please read this information sheet which tells you about the study and take time to decide whether or not to take part.

What is the aim of the project?

The aim of the project is to explore your experience of using Occupational Health services (OH) throughout your first year as a trainee, and aspects such as personal characteristics, qualities and experiences, that doctors might attribute to the maintenance of their well-being, as well as methods and strategies employed to maximise self-care. I would like to conduct interviews so that I can consider how Occupational Health works in practice with a view to offering my findings regarding improving future support available.

Description of participants required

I am particularly interested in interviewing junior doctors with a mental health concern who used Occupational Health services last year and those who have been referred or utilise Occupational Health services as a Foundation year doctor. I am seeking to gather the views of those who are not just referred but also have utilised the service last year to make sure I have a range of experiences. Therefore inclusion criteria for participants is: practicing trainees, referred to OH by the Deanery or those who self-refer for support with a prior or current mental or physical health condition in the first year of employment, as well as those who used the service in the year prior to this Foundation year i.e. 2016 intake.

What will participants be asked to do?

Should you agree to take part in this project you will be asked to attend 2 interviews in the Occupational Health Department or other venue at RCHT or by telephone. One interview will occur at the beginning of the Foundation Year and the second one at the

end of that year. If you are asked if you would like to participate during this year there will be one interview only. All interviews will take no longer than one hour. With your permission the interview will be audio recorded and transcribed. You will be free to withdraw from the research at any time and/or request that your transcript not be used.

What data will be collected and what use will be made of it?
This study involves an open-questioning technique where the precise nature of the questions asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the School of Psychology Research Ethics Committee is aware of the general topics to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel uncomfortable, you may decline to answer any particular question(s). You can also withdraw from the study at any stage for any reason, without any disadvantage to yourself of any kind. If you find certain topic areas emotive and would like some support following the interview the interviewer can signpost and or refer you to an appropriate service with your consent.

Interviews will be audio recorded, transcribed anonymised and analysed for themes.

Will the data collected be confidential?

All information which is collected about you during the course of the research will be kept strictly confidential and be held in accordance with the Data Protection Act 1998. Your name and personal details will be removed from the data so that you cannot be recognised from it. If you discuss any patient cases in interview this information will also be anonymised.

All electronic data including audio recordings and transcripts will be stored on a password protected RCHT computer with access to the files restricted to the researcher. All personal information will be stored separately from the interview data. Files will be backed up on a secure, encrypted server and a password protected external hard drive. After the project is finished, in accordance with the University of Exeter and RCHT recommendations, the anonymised data will be held and stored in an electronic database. Your anonymity will be maintained at all times and no comments will be ascribed to you by name in any written document or verbal presentation. Nor will any data be used from the interview that might identify you to a third party. The interviewer will not access any of your Occupational health or medical records for this study.

Results of this project may be published but any data included will not be individually identifiable. If you wish, copies of publications resulting from research will be available via SW Deanery.

What are the possible disadvantages and benefits of taking part?

You will not be exposed to any hazards or risks by taking part in this study. By taking part in interview you will have the opportunity to reflect on your own beliefs, practices

and experiences as an expert clinician, share your views with others through publication and ultimately contribute to best end-results for support and care pathways for junior doctors in the Foundation year. Any F1 requiring onwards referral for support will be signposted accordingly as part of routine practice.

What will happen to the results of the research study?

The resulting thesis will be openly available upon completion. The results of this study will be written up in an academic paper and submitted to a journal as well as presented at conferences and other research events. If you wish you will be provided with copies of any publications resulting from the research. Please be assured that you, or any patient cases you discuss in interview, will not be identified in any report or publication.

Who is organising and funding this research?

The research is coordinated at the Psychology department at the University of Exeter. Kirsten Leslie, who is a PhD student at the University of Exeter, will be leading the study. Kirsten Leslie also works in Occupational Health at Royal Cornwall Hospital Trust (RCHT). The project is supervised Dr Elizabeth Weightman and Dr Nicholas Sarra from University of Exeter. The study is self- funded.

What happens if you would like more information about the study?

If you have any questions, either now or in the future, please contact either:

Kirsten Leslie: kirsten.leslie@exeter.ac.uk/ kirsten.leslie@nhs.net 01827 252770

Dr Elizabeth Weightman : E.Weightman@exeter.ac.uk 01392 491910

Complaints

If you have any complaints about the way in which this study has been carried out please contact the Chair of the University of Exeter Research Ethics Committee:-

Lisa Leaver

Senior Lecturer in Animal Behaviour
University of Exeter
Ext: 01392 724641
http://psychology.exeter.ac.uk/staff/index.php?web_id=lisa_leaver
Washington Singer, University of Exeter, Exeter, EX4 4QG

Email: l.a.leaver@exeter.ac.uk

Finally, can I thank you for taking the time to consider my request. If you would like to be involved in the project please can you let me know by responding to me at your earliest convenience by email?

Yours sincerely

Kirsten Leslie

This project has been reviewed and approved by the University of Exeter Research Ethics Committee: 2016/1281

South West Deanery are aware and agreeable to this this project being undertaken

IRAS Project ID : 236254, Version 1 , 19/10/2017

Appendix 13b - RESEARCH INTERVIEW CONSENT FORM

Evaluation of junior doctors contact with an Occupational health department.

If you are happy to participate, please complete and sign the consent form below:

1) I confirm that I have read the attached information sheet on the above study and have had the opportunity to consider the information, and ask questions if necessary and have these answered satisfactorily.

2) I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason.

3) I understand that the interviews will be audio recorded.

4)I agree to the use of anonymous quotes. I agree to take part in the above study.

…… …… ……

Name of participant ……Date……..

Signature ……

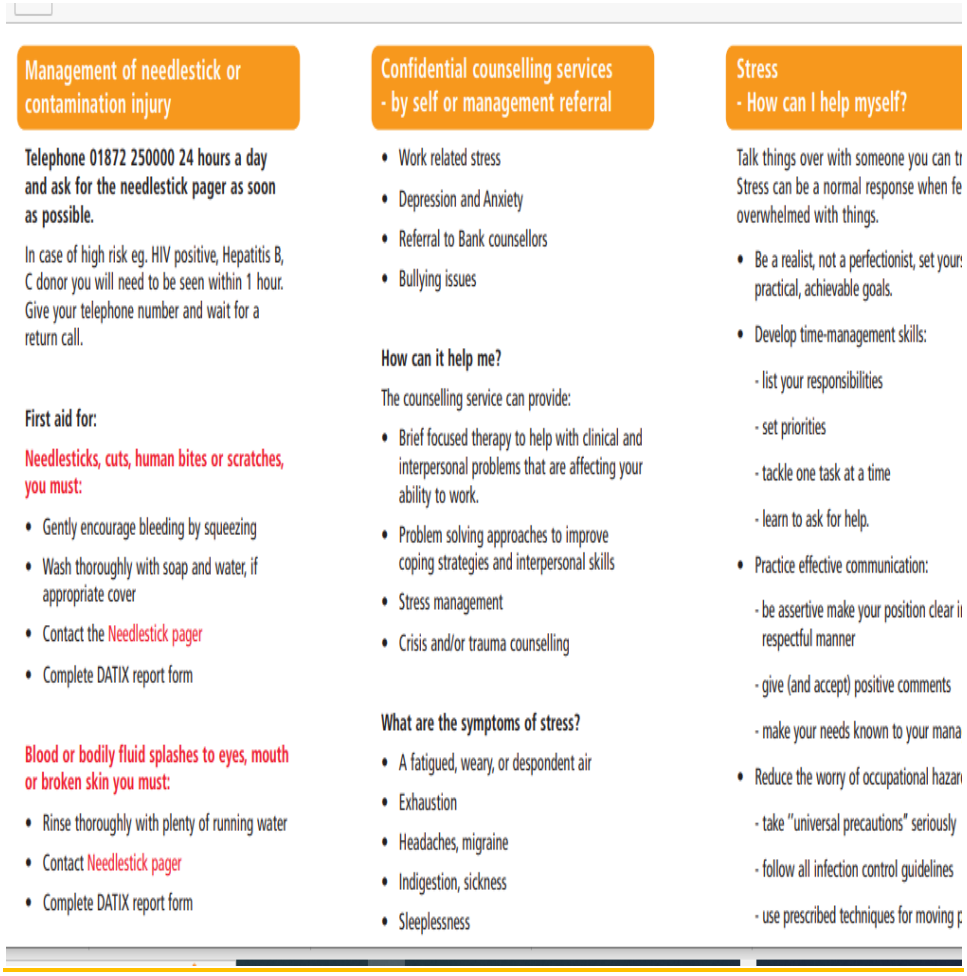
Appendix 13c Debrief Sheet – OH signposting information

- Hepatitis A
- Hepatitis B
- Influenza (seasonal)
- Measles, Mumps and Rubella

- **Health Surveillance**
  - Spirometry
  - Skin surveillance
- **Full range of OH blood tests**
- **Physiotherapy service**
  - Accessed via self or management referral
- **General Health / work related issues**
  - Advice on blood / body fluid exposure

- Contact your GP for advice sometimes emotions are masking a medical condition
- Stress Winners - www.stresswinner.com
- Sick Doctors Trust - www.sick-doctors-trust.co.uk
- www.livemindfully.co.uk
- www.moodgym.anu.edu.au
- John Horner - OH Physiotherapist
  Tel: 01872 252770
  Email: Johnhorner@@nhs.net
- Main Switchboard 01872 250000 to contact the Needlestick Pager
- Linda Carpenter - IWL and child care coordinator
  Tel: 01872 252476
- Health & Safety Department

KESPOSOW Staff Health & Wellbeing



Management of needlestick or contamination injury

Telephone 01872 250000 24 hours a day and ask for the needlestick pager as soon as possible.

In case of high risk eg. HIV positive, Hepatitis B, C donor you will need to be seen within 1 hour. Give your telephone number and wait for a return call.

First aid for:

Needlesticks, cuts, human bites or scratches, you must:

- Gently encourage bleeding by squeezing
- Wash thoroughly with soap and water, if appropriate cover
- Contact the Needlestick pager
- Complete DATIX report form

Blood or bodily fluid splashes to eyes, mouth or broken skin you must:

- Rinse thoroughly with plenty of running water
- Contact Needlestick pager
- Complete DATIX report form

Confidential counselling services - by self or management referral

- Work related stress
- Depression and Anxiety
- Referral to Bank counsellors
- Bullying issues

How can it help me?

The counselling service can provide:

- Brief focused therapy to help with clinical and interpersonal problems that are affecting your ability to work.
- Problem solving approaches to improve coping strategies and interpersonal skills
- Stress management
- Crisis and/or trauma counselling

What are the symptoms of stress?

- A fatigued, weary, or despondent air
- Exhaustion
- Headaches, migraine
- Indigestion, sickness
- Sleeplessness

Stress - How can I help myself?

Talk things over with someone you can tr
Stress can be a normal response when fe
overwhelmed with things.

- Be a realist, not a perfectionist, set yours practical, achievable goals.
- Develop time-management skills:
  - list your responsibilities
  - set priorities
  - tackle one task at a time
  - learn to ask for help.
- Practice effective communication:
  - be assertive make your position clear i respectful manner
  - give (and accept) positive comments
  - make your needs known to your mana
- Reduce the worry of occupational hazar
  - take "universal precautions" seriously
  - follow all infection control guidelines
  - use prescribed techniques for moving p

Appendix 13d Demographic Questionnaire

(To be completed by participants after consenting at interview)

Study Title: **"Investigation of Junior Doctors' Contact with an Occupational Health Department and their Transitional Year"**

Chief Researcher: Kirsten Leslie

Please circle the answers that best describe you.

Age	18-24	25-44 2 (1 male, 1	

	8 (7 female,1 male)	female)	
How would you describe yourself?	Doctor	Patient 2	Colleague 8
Pronoun / Gender assigned at birth if comfortable sharing	Male 2	Female 8	Other- if comfortable sharing
Do you describe yourself as having;	A physical disability (please explain) 2- also has an impact on MH as assessed using OHQ9 GAD7 questionnaire C) Diabetic D) Blood disorder	A mental health disability (please explain) 8	Other disability (please explain)
Do you have any additional responsibilities e.g carer?	Yes 4	No 6	
Is your first language	Yes	No	

English?	9	1	
Has you been screened using the PHQ GAD questionnaire meeting the threshold for treatment ?	Yes 10	No	

Thank you for filling in the questionnaire.

Appendix 13e -Clinical Questionnaires and interpretation of scoring

Patient Health Questionnaire 9 (PHQ-9)

0 = Not at all - 1 = Several days - 2 = More than half the days - 3 = Nearly every day

Using the scale above please enter one number in the space next to each statement.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1.	Little interest or pleasure in doing things	0
2.	Feeling down, depressed, or hopeless	0
3.	Trouble falling or staying asleep, or sleeping too much	0
4.	Feeling tired or having little energy	0
5.	Poor appetite or overeating	0
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0

Total = /27 ; Depression Severity: **0-4 none**, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

Generalised Anxiety Disorder 7 (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1.	Feeling nervous, anxious or on edge	0
2.	Not being able to stop or control worrying	0
3.	Worrying too much about different things	0
4.	Trouble relaxing	0
5.	Being so restless that it is hard to sit still	0
6.	Becoming easily annoyed or irritable	0
7.	Feeling afraid as if something awful might happen	0

Score 0-4: Minimal Anxiety. Score 5-9: Mild Anxiety. Score 10-14: Moderate Anxiety. Score greater than 15: Severe Anxiety.

Local Risk strategy- component

- Example of what is included in local Risk policy

The table below provides information for factors that increase or decrease suicidal risk (protective factors)

Suicide: Assessment of Risk Table

The table below provides information for factors that increase or decrease suicidal risk (protective factors)

14.Suicide: Assessment of Risk Table

Assessment of Risk Table	
Factors which increase suicide risk	**Factors which decrease suicide risk**
Strongest risk factor: Past suicide attempt.	
Males are 3x more likely than females.	
Age range: Males, 40-44 years of age and Female, 50-55 years of age.	
Mental health conditions. Diagnosis of mental health condition(s): Depression (highest), schizophrenia / psychosis, personality disorder.Irrational and erratic thought patterns and behaviour. Feelings of hopelessness, despair, shame and / or guilt.	Stable mental status. Strong inner resources / resilience and the ability to use coping strategies.Sense of humour. Positivity.
Lack of access to mental health treatment.	Good and consistent access to mental health support services and treatment.
Presence of a clear plan.	Absence of a clear plan.
Access to means for self-harm or suicide.	Lack of access to means of self-harm or suicide.
Past family history of suicide.	
Isolation / lack of a support network.	Presence of a supportive, positive and consistent support network (personal and professional).
Alcohol / drug abuse.	
Impulsive and / or aggressive tendencies.	Good ability to recognise destructive tendencies and a strong ability to utilise constructive coping strategies.
History of child abuse	
Cultural beliefs (e.g., belief that suicide is a noble resolution of a personaldilemma).	Cultural beliefs which discourage suicide.
Physical or medical illness.	Good and consistent access to health support services and treatment.
Unwillingness to seek or accept help.	Willingness to seek or accept help.
Recent significant bereavement / loss.	Presence of a supportive, positive and consistent support network
Personal conflicts / relationship breakdowns / child custody issues.	(personal / professional).
On-going legal prosecution / battles.	
Bullying.	Strong inner resources / (resilience) and ability to utilise coping strategiesstable mental status. Presence of a supportive, positive and consistent support network (personal / professional).
Unemployment or financial difficulties	Access and participation in social activities. Ability to plan and utilise practical strategies in dealing with difficulties.

Suicide statistics reports 2014-2015/UK/ Samaritans

15.Suicide Risk Assessment Questions

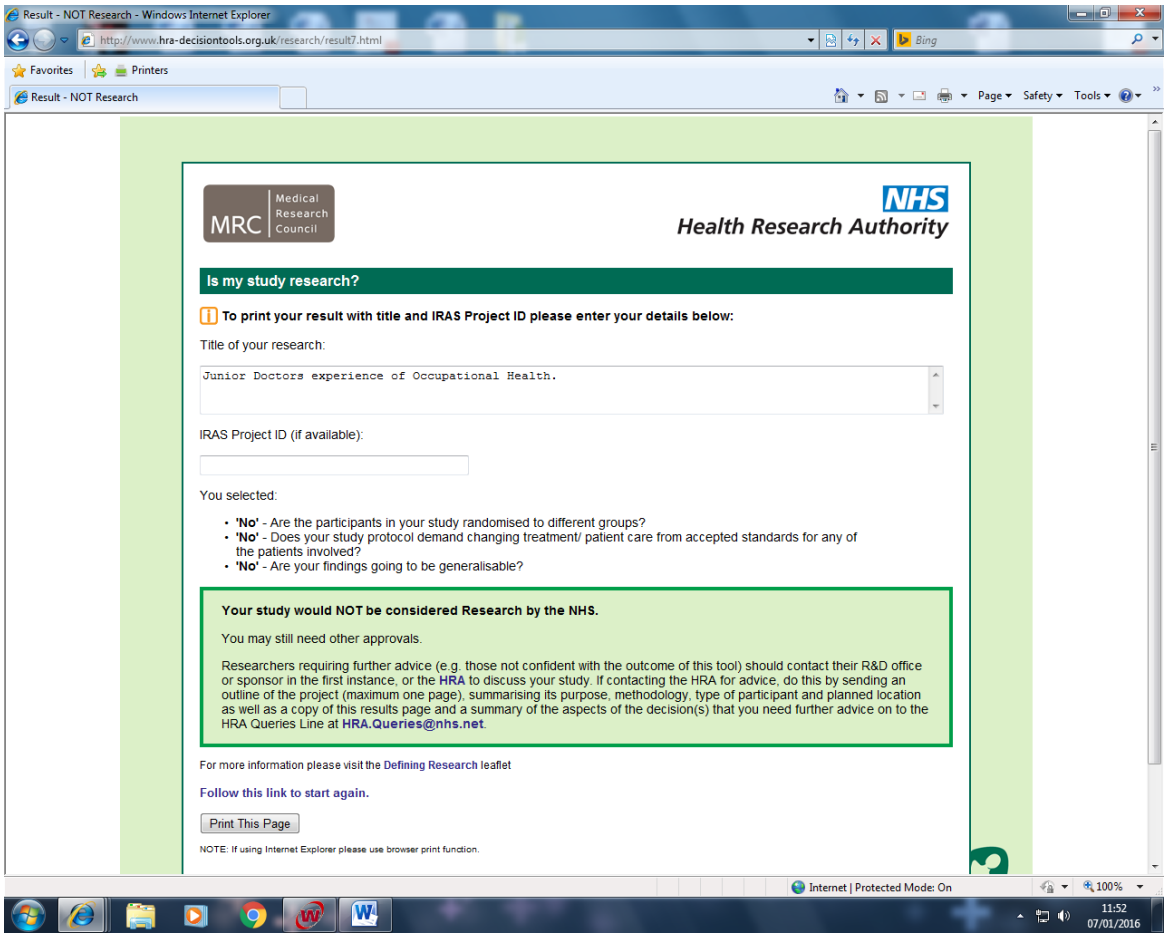
Guidelines for Clients Presenting at Risk of Suicide

The following questions present criteria which are provided as a guide in assessing the type and level of risk that exists for the client or third party. These questions can be used by the counsellor in the process of gaining relevant information, in order to assess the level of risk and to plan appropriate action and support strategies for the client at risk.

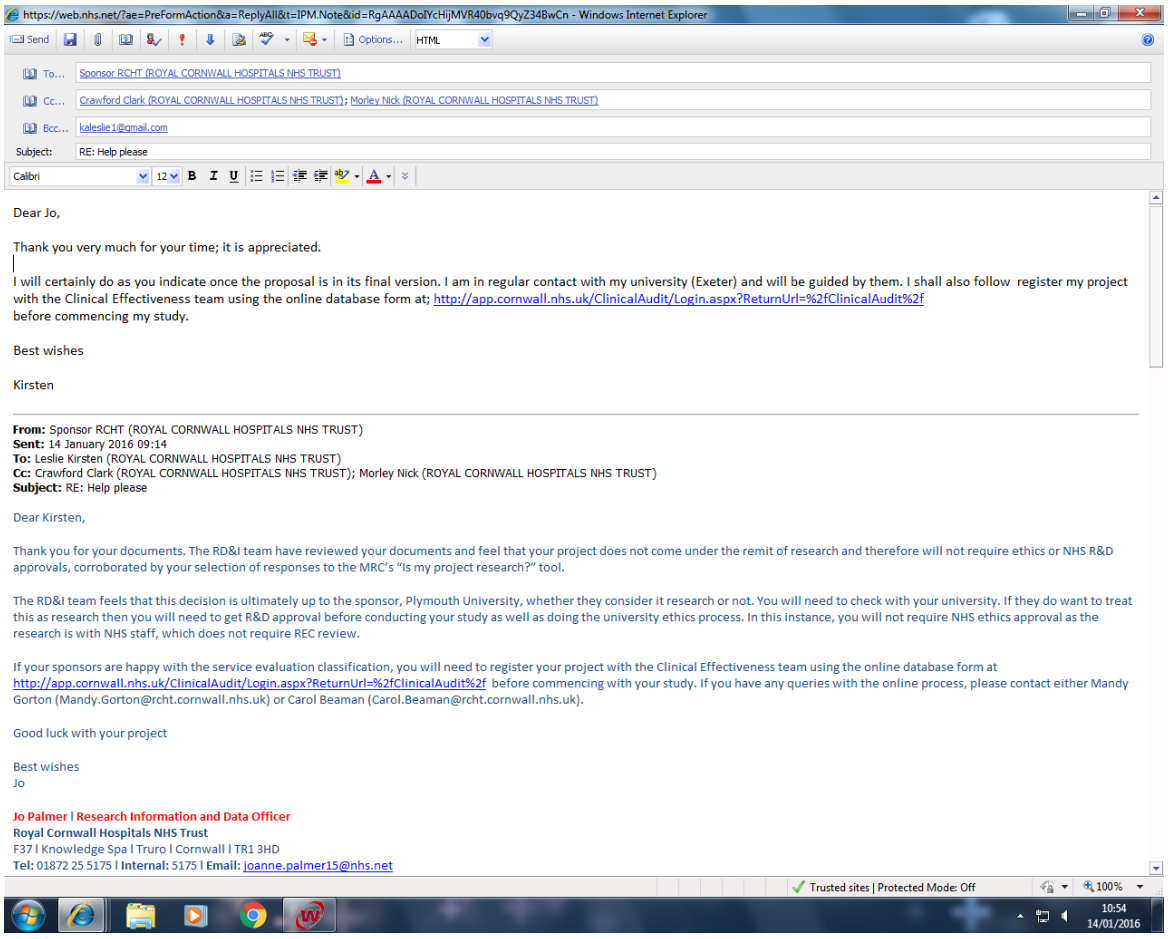
1. Is the client thinking about ending his / her life?
2. How likely does the client feel he / she will take action?
3. How long has the client been dealing with suicidal thoughts / intent?
4. Is there a family history of suicide?
5. Does the client have concrete plans?
6. Has the client previously suffered from or is suffering from any conditions, which could lead to suicidal ideation or self-harm, such as depression, psychological diagnosis of schizophrenia, sexual/physical/emotional abuse or neglect?
7. What personal and work stress factors exist?
8. How isolated is the client?
9. What is the client's support network: Family, Friends, work, social activities / clubs?
10. What medical input does the client have? - Who, when & how is this given?
11. Is the client on medication? If so what is the medication & dosage?
12. What are the client's internal and external resources in being able to cope with the situation?
13. How well can the client assess his / her own needs?
14. Is there alcohol/ substance abuse present and at what level?

Appendix 14A

A. NHS ETHICS OUTCOME - http://www.hra-decisiontools.org.uk/research/



Consent…… Name of person taking consent Date



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To… Sponsor RCHT (ROYAL CORNWALL HOSPITALS NHS TRUST)

Cc… Crawford Clark (ROYAL CORNWALL HOSPITALS NHS TRUST); Morley Nick (ROYAL CORNWALL HOSPITALS NHS TRUST)

Bcc… kaleslie1@gmail.com

Subject: RE: Help please

Calibri 12 B I U

Dear Jo,

Thank you very much for your time; it is appreciated.

I will certainly do as you indicate once the proposal is in its final version. I am in regular contact with my university (Exeter) and will be guided by them. I shall also follow register my project with the Clinical Effectiveness team using the online database form at; http://app.cornwall.nhs.uk/ClinicalAudit/Login.aspx?ReturnUrl=%2fClinicalAudit%2f before commencing my study.

Best wishes

Kirsten

From: Sponsor RCHT (ROYAL CORNWALL HOSPITALS NHS TRUST)
Sent: 14 January 2016 09:14
To: Leslie Kirsten (ROYAL CORNWALL HOSPITALS NHS TRUST)
Cc: Crawford Clark (ROYAL CORNWALL HOSPITALS NHS TRUST); Morley Nick (ROYAL CORNWALL HOSPITALS NHS TRUST)
Subject: RE: Help please

Dear Kirsten,

Thank you for your documents. The RD&I team have reviewed your documents and feel that your project does not come under the remit of research and therefore will not require ethics or NHS R&D approvals, corroborated by your selection of responses to the MRC's "Is my project research?" tool.

The RD&I team feels that this decision is ultimately up to the sponsor, Plymouth University, whether they consider it research or not. You will need to check with your university. If they do want to treat this as research then you will need to get R&D approval before conducting your study as well as doing the university ethics process. In this instance, you will not require NHS ethics approval as the research is with NHS staff, which does not require REC review.

If your sponsors are happy with the service evaluation classification, you will need to register your project with the Clinical Effectiveness team using the online database form at http://app.cornwall.nhs.uk/ClinicalAudit/Login.aspx?ReturnUrl=%2fClinicalAudit%2f before commencing with your study. If you have any queries with the online process, please contact either Mandy Gorton (Mandy.Gorton@rcht.cornwall.nhs.uk) or Carol Beaman (Carol.Beaman@rcht.cornwall.nhs.uk).

Good luck with your project

Best wishes
Jo

Jo Palmer I Research Information and Data Officer
Royal Cornwall Hospitals NHS Trust
F37 I Knowledge Spa I Truro I Cornwall I TR1 3HD
Tel: 01872 25 5175 I **Internal:** 5175 I **Email:** joanne.palmer15@nhs.net

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Appendix 14 B.

Table 5. Relational Ethics

Relational Ethics of Care (Simon, 2015)
• How can we bring relational awareness to all stages of research planning, process and presenting and in all activities?
• How are we to speak from within research relationships, alongside people rather than about them as if from "outside"?
• How are we to know if are writing with care, respect and concern in presenting people, characters and views?
• How can we listen to our inner dialogue, outer dialogue, texts and performance with reflexive curiosity and with an awareness of prejudicial, dominant and subjugated voices?
• How can we use transparency and reflexive, dialogical writing to show detail inner and outer dialogue, behaviours in research relationships which show dilemmas, prejudice, reactions etc?
• How can we collaborate with people and take their voices into account in our generating and presenting of research?
• How can we be reflexive about the relational consequences of choices and influencing contexts at all stages in the research process?
• Whose lives will this research change/improve and how?
• How can we commit to acting with reflexivity about one's bias, the limits of

one's understanding, and ask "What might I be missing or assuming?"

• How might we act with care and awareness about the impact researchers and research participants can have on each other and on others? How can we write with anticipation of a dialogical and listening reader?

• How can we act with structural and theoretical irreverence to find ways of doing and presenting research which support or challenges the context for the research?

• How can we resist the pull to separate talking, writing and reading from the collaborative processes of meaning-making between conversational participants?

• How can we critically and appreciatively review what researchers and participants have done together, what it means for each of us, for others, for now and what else we might have done?

Appendix 14 c. Reflexivity Tasks and Strategies

Tasks and Strategies Concerning Subjectivity in Psychological Research (Gough, B and Madill, A. (2012) [p.381]

Task Possible strategies

How may research participants be facilitated to elaborate on their responses?

Provide space for open-ended responses on questionnaires; build in opportunities for verbal contributions before, during, and after the study; consider post- or follow-up interviews with participants.

How should “additional” participant responses be incorporated into the research?

An initial, data-led inductive analysis (Braun & Clarke, 2006; Glaser & Strauss, 1967); a second analytic stage linking derived themes to prevailing theory, perhaps leading to conceptual refinements.

How should apparently “irrelevant” participant data be managed?

Do not ignore “off topic” accounts—consider their relevance to literature outside of current research focus and the possibility of new research questions and investigations.

How should participant accounts be incorporated into research reports?

Present verbatim participant extracts accompanied by researcher analysis specifically orienting to the fit with other data and relevant theory; make transparent the methods of eliciting and analyzing the accounts.

What is it like to be a research participant?

Imagine yourself as a research participant and complete some or all of the tasks asked of the participants, recording your thoughts and feelings in the process; contrast your experience as a participant (of sorts) with that of researcher, and use these reflections to inform research design and content.

In what ways can researcher subjectivity be monitored?

Become familiar with the concept and practice of reflexivity (e.g., Finlay, 2002); write a research journal documenting reflections on, reactions to, and adjustments made during the research (e.g., topic choice, theoretical preference, interpersonal dynamics).

How can a reflexive awareness of subjective preferences and their impact on research attitude improve research practice?

Can be mobilized to enhance rapport-building with participants, monitor and control researcher interventions and omissions, and enrich data analyses (see Holloway & Jefferson, 2000).

How would the study change if owned and designed by the relevant population?

Consider adopting elements of participatory action research (e.g., Fine & Sirin, 2007) where participants are involved in conceiving, designing, and developing the study, and think through the benefits and challenges of doing so.

How does the research fit with psychological science?

Reflect on implicit theories that influence research practices (e.g., methodological orientation, preference for pure vs. applied research, attitude to other disciplines/collaboration with non-psychologists, etc.).

Appendix 15. Example of Word Analysis of Nodes and Codes for Themes

Occupational Health	Positive experiences of OH	• Personal service • Accessible • Speed of response • Mainly did not feel a stigma attending • Workplace support/changes • Few concerns with confidentiality and stigma; trust won't be reported to GMC • Personal " face"/ recommendation important	• Most useful- Workplace • Counselling/ signposting • Relationship with OH practitioner • Feel supportive • Comparison with other services e.g. medical school/ GMC, HWB activities; health champs; belonging	
	Medical School experienc	• Sometimes got needs met but after a struggle. • If express a mental health difficulty it might equate		

	es of OH	with a fitness to practice concern so did not report it. • Development of avoiding/ counter-productive coping • Good welfare support • Fear re reporting to GMC; distrust • Issues re confidentiality and stigma • Practice placements in OH helped reduce barriers		
	Is screening F1 doctors useful?	• Positive • Viewed organisation as concerned about their HWB • Welcomed the safety net • Helps redress any previous negative OH experiences		
	How to engage with F1 further	• Screen all F1? • Continue to attend induction/ generic skills teaching • Offer OH as a placement?		
Obstacles and enablers	Improved/ continued Self-care	Earning Money	• Previously gained insight • Attention to HWB needs e.g. Physical health/ good	• Anchors; • Creating support networks • other F1 • Creating shared

	What helps maintain resilience and HWB?	Having responsibility Learning personal hidden strength e.g. I have definitely seen myself being more bold than I thought I would have necessarily predicted. (Re) Nurses often look out for Junior Drs; The nurses always respect that when you're on lounge and you're on a 12 hour shift and you have to, you're admitting all the patients and you're the only one and there will be people piling up that need to be seen but you haven't had a break….it is very helpful ".., at least they're on my side"(RE) • Support from colleagues • OH relationship with Deanery/Post graduate centre	sleep/ friends • Routine • Peer support. (More collegiate than at medical school (competitive) • Sense of belonging/ connectedness to others; including Educational and clinical supervisors • Support from nurses valuable.	professional identity • Creating inter-professional identities

		• Support from organisation • OH point of contact • Not having medics as friends • Keeping work and personal life separate so not "labelled"/ stigmatised.		
Mental Health	How do they view it ?	• Some openly share it • Some aware of professional identity and require privacy	Especially in early stages of F1 year when don't know colleagues Concerns re professional stigma from colleagues at all levels. Can feel supported if consultants share their mental health challenges	OH can help F1 note triggers and self-care so good parenting internalized. Inter-foundation school transfer

Comparison Themes

Obstacles and	Improved/ continued Self	• Recognising when to call the crash bell • Friends recognising warning signs better; lack of insight	•

enablers	-care Developing medical identity as separate from nursing Feeling like an equal partner in OH.	• Denial of ill health • Anchors; • Creating support networks • other F1 • Creating shared professional identity • Creating inter-professional identities	
OH <u>General</u> <u>Quote</u> Yeah, I think it's good to know that I have a something I can fall back on if I do need it and I haven't had to resort to using occupational	Trusted relationship /therapeutic alliance in OH Safety Net Knowing that it is there is important in its own right/ "....I know that it's there. It's not like a fall-back position, but it's like almost like even when I don't need it, the fact that there's the safety net there, is support enough. Like, just knowing that there is something." Experiental value.OH often underrated until used; Relationship important OH interprets what is required emotionally or physically in the workplace The import / ability to "hold OH in mind " (mentalise)	• Same • Can change even if had poor previous experience • Helps feel supported by organisation • Role of work place adjustments • • Has psychological value/ safety for the F1 • Also has functional value • Trust of client in practitioner • People think OH just takes blood/vaccinates (becca) "take your own blood." • Having same point of contact helpful. Unlike most services e.g GP. A shared understanding with you that then gets translated to them in terms of actually, so therefore these are adjustments that need to be made because this is the impact this situation is having and therefore in the workplace	• Links with H Deanery important. Only shared necessary

health beyond my baseline needs, beyond routine follow up and stuff. But it's good to know it's there, but up till now it's been fine just having … tc (Physical health)			
What is happening in the year? How hospital systems work; Respect for other colleagues;	• Learning How to be a DR • Developing Clinical competence rather than exam competence; Yeah, definitely, in psychiatry, I think. I have definitely learnt things that will be useful in MAU and	Developing stamina Because in their mind they're like "and we need this to be done and this to be done and you're the person that's going to do it and get these people out!", so, yeah. And also, I think because it's a bit of a stamina thing, you can feel like you have got enough energy	

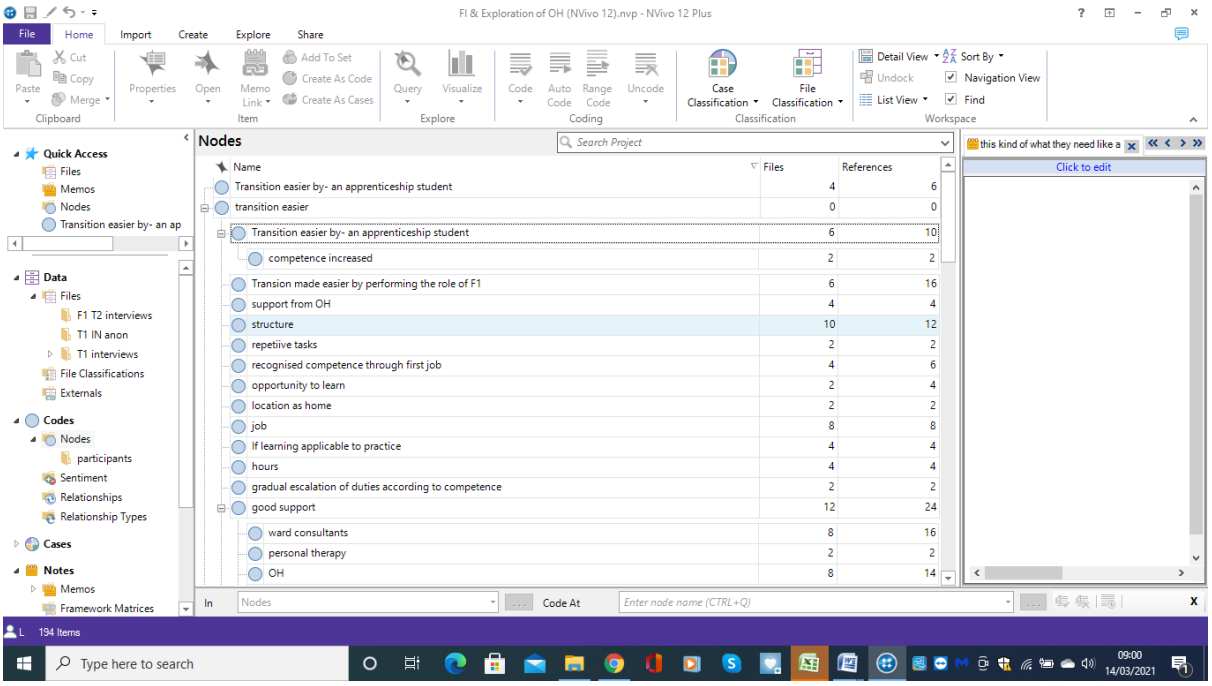
<u>General Quote</u> I think it definitely can be broader than that yeah, definitely. In psychiatry it's very easy for it to be multi-disciplinary because you all do the same thing, so you haven't got a difference in your roles, the nurses are extremely competent, and they do the risk assessments and take	useful if I do general practice. Just learning, and lots around risk, a more clear idea of how they categorise patients in terms of risk and the decisions they are likely to make with follow up patients coming in with overdoses or suicide attempts. Um, and then I've just seen lots of skilful communication which is also good to see and definitely a skill that kind of comes with practice. And experience. So those things I will definitely take forward(RE) • Beginning to consider career choices; • Understanding role cause it's such a specialist. I think if you'd have asked me when I was in MAU I probably	to, a few times I've had 12 hour shifts on lounge and I barely haven't got a break and you can sometime be quite full of energy and you feel like you can carry on, but then you'll feel it in a few days' time. So, it's learning how to pace yourself and not, actually no even though I'm feeling fine I still need to, because this is not just today, this is a year. (RE) So, it's something about how organisation, your systems work and how you manage that system in order to meet one of your needs.	

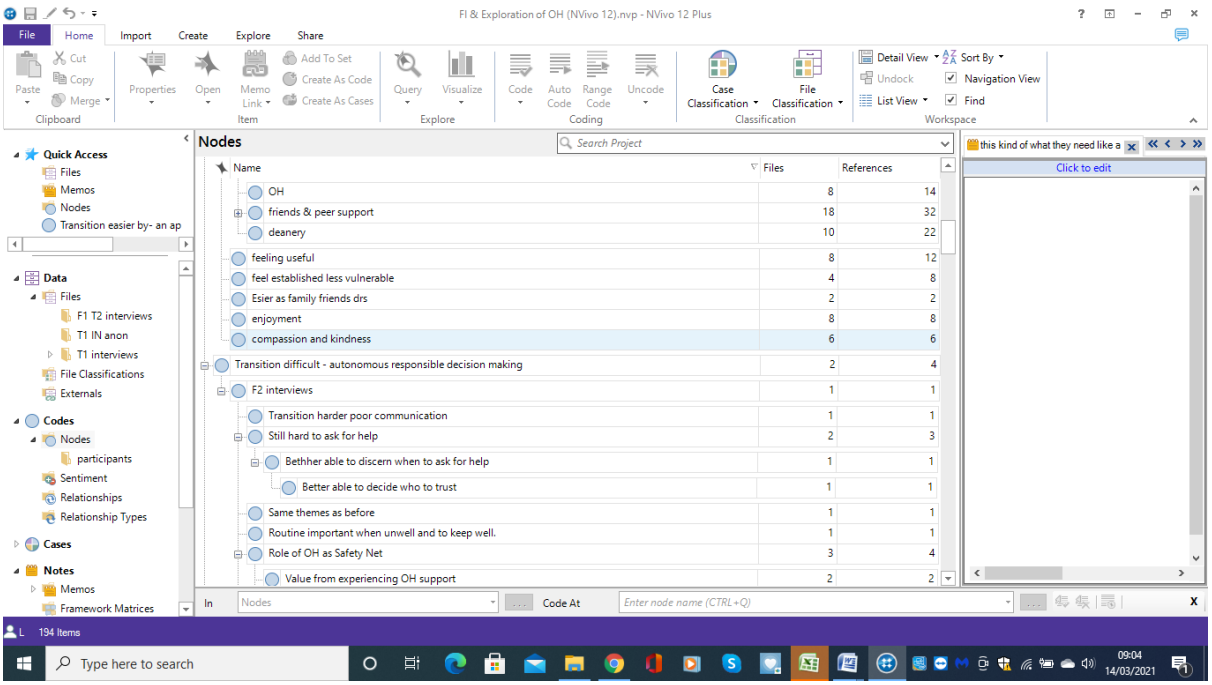
histories and form the plans and they work independently. SO everyone is working for the same goal all the time which makes it easier.	would have said yes because I have done four months of acute stuff and surgery and more in the swing of it. I know my role, and I do have a sense of what is expected of me, what my role is and so I think in medicine and surgery but not specialist stuff. • Developing sense of purpose; I'm essential enough to feel like it's a worthwhile job		
How to engage with F1 further	• Awareness this is challenging and that Medical professional persona (defence) might prevent many acknowledging they needed help • Sense that F1 have to take responsibility and be aware when		

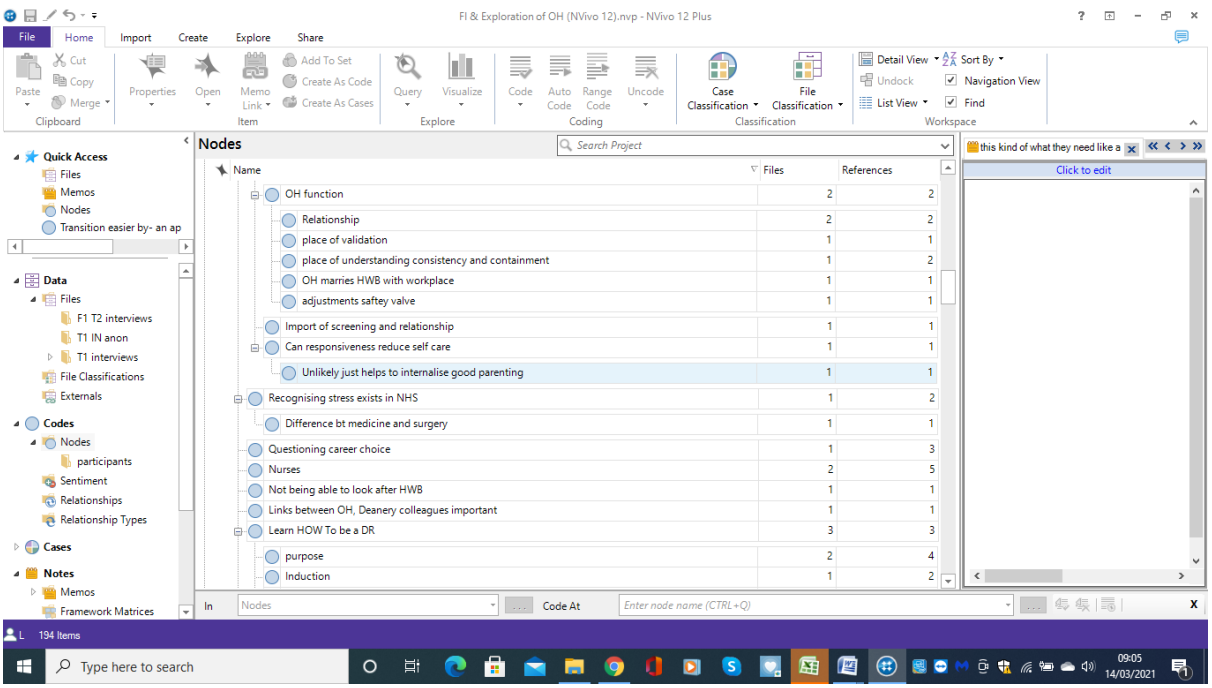
	they need help and this may only come when it is "time to call the crash bell"		
Cathartic role of the interview	• Shared narrative of experiences, hitherto untold • Safe space • Opportunity to share career thoughts safely	Used it as opportunity to explore alternatives to medicine in the future Signposting to other support Access to other resources e.g. assertiveness training. • Utilised it to indicate another need related to insight e.g. "injunctions" to self-care / getting portfolio signed off.	
Transition year	Obstacles	• Personality • Isolation • Mood • Reduced Sleep • Unexpected events	•
	Enablers	• Support from colleagues • OH relationship with Deanery/Post graduate centre • Support from organisation • OH point of contact • Not having medics as friend • Keeping work and personal life separate so	•

		not “labelled”/ stigmatised • Support from multiple sources and types including OH and GP	
		•	•

Appendix 16. Examples of Nvivo Nodes and Codes for Themes



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place of understanding consistency and containment 1 2
OH marries HWB with workplace 1 1
adjustments saftey valve 1 1
Import of screening and relationship 1 1
Can responsiveness reduce self care 1 1
Unlikely just helps to internalise good parenting 1 1
Recognising stress exists in NHS 1 2
Difference bt medicine and surgery 1 1
Questioning career choice 1 3
Nurses 2 5
Not being able to look after HWB 1 1
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Induction 1 2
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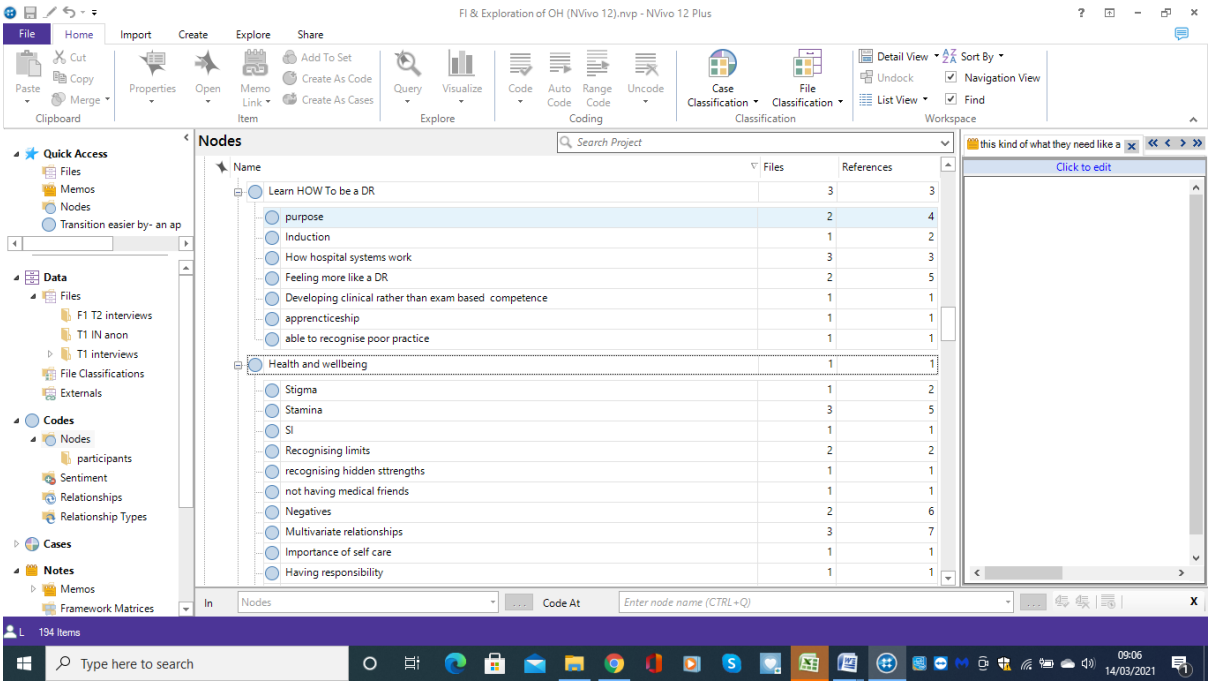
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Feeling more like a DR 2 5
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apprencticeship 1 1
able to recognise poor practice 1 1
Health and wellbeing 1 1
Stigma 1 2
Stamina 3 5
SI 1 1
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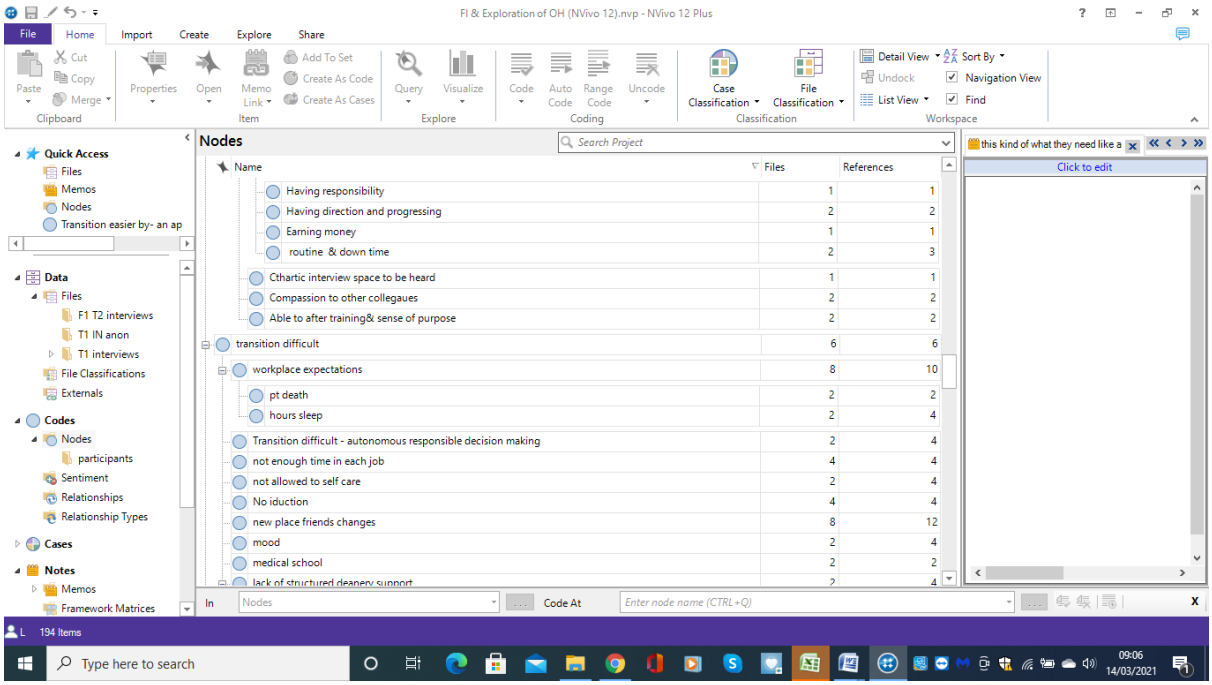
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Earning money 1 1
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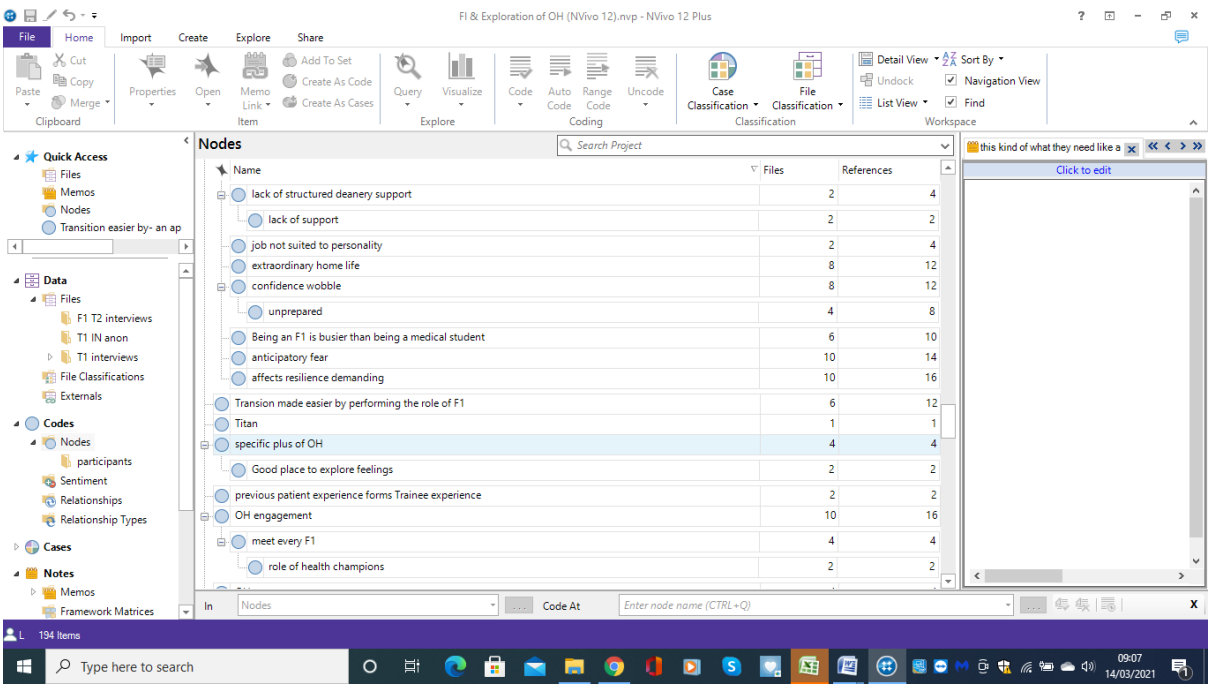
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extraordinary home life 8 12
confidence wobble 8 12
unprepared 4 8
Being an F1 is busier than being a medical student 6 10
anticipatory fear 10 14
affects resilience demanding 10 16
Transion made easier by performing the role of F1 6 12
Titan 1 1
specific plus of OH 4 4
Good place to explore feelings 2 2
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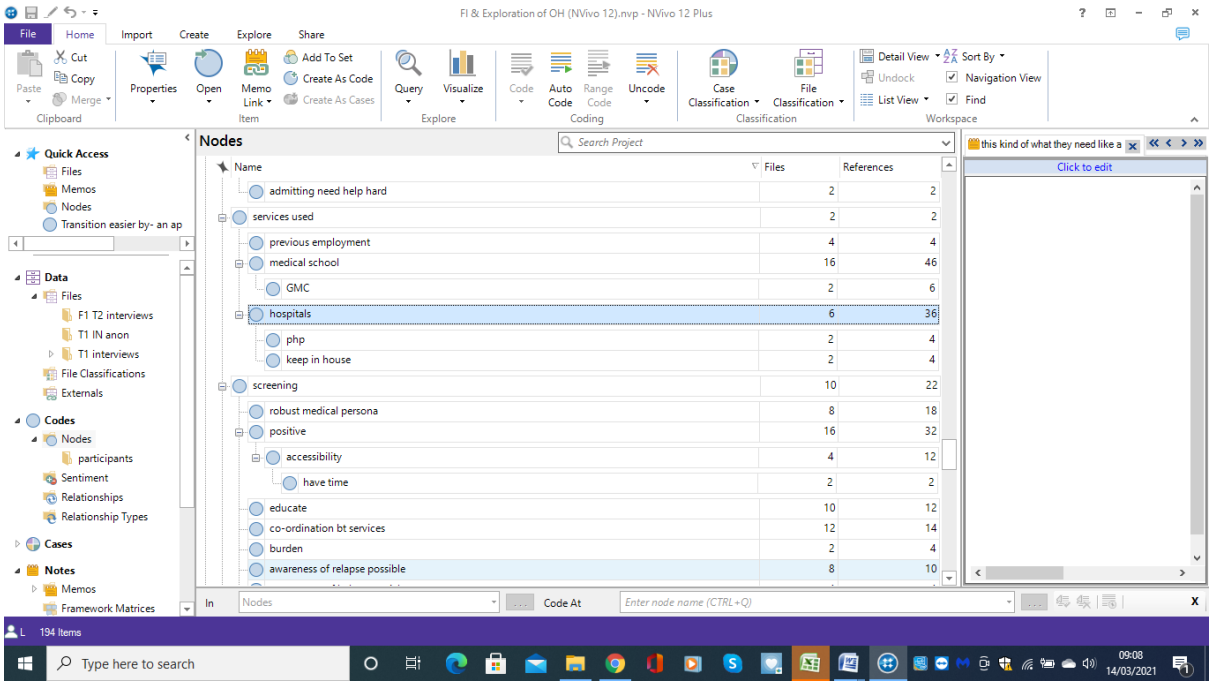
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positive 16 32
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educate 10 12
co-ordination bt services 12 14
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awareness of relapse possible 8 10
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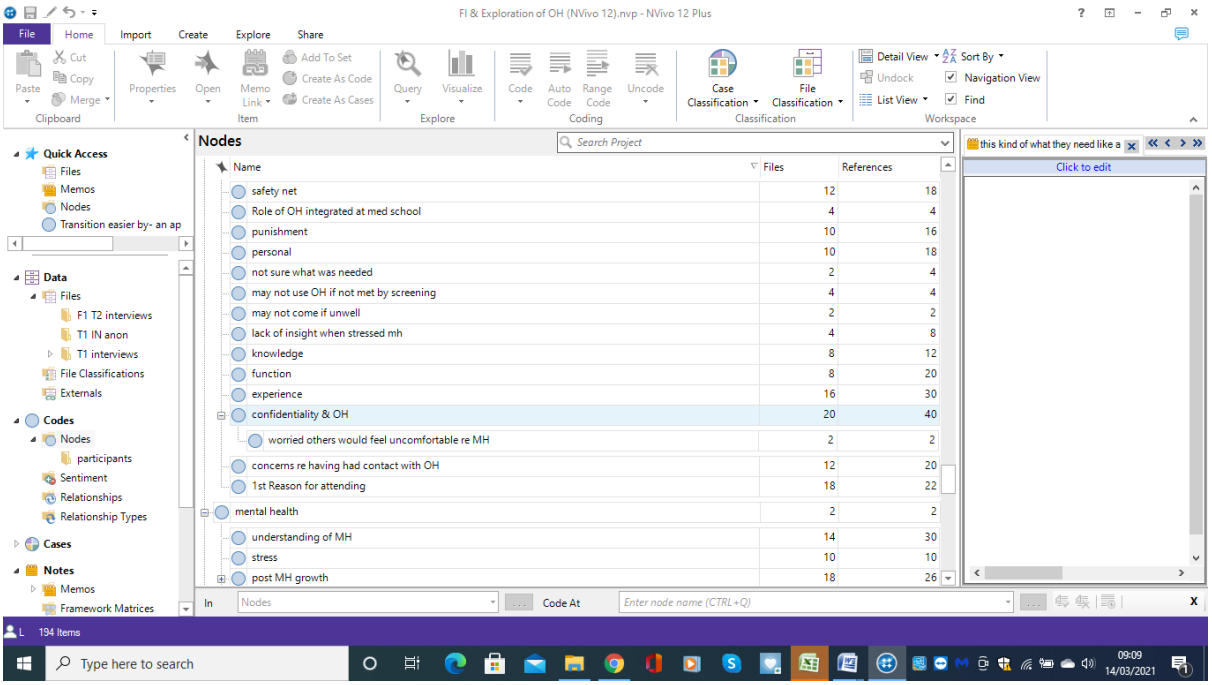
FI & Exploration of OH (NVivo 12).nvp - NVivo 12 Plus
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Name
Files
References
safety net 12 18
Role of OH integrated at med school 4 4
punishment 10 16
personal 10 18
not sure what was needed 2 4
may not use OH if not met by screening 4 4
may not come if unwell 2 2
lack of insight when stressed mh 4 8
knowledge 8 12
function 8 20
experience 16 30
confidentiality & OH 20 40
worried others would feel uncomfortable re MH 2 2
concerns re having had contact with OH 12 20
1st Reason for attending 18 22
mental health 2 2
understanding of MH 14 30
stress 10 10
post MH growth 18 26
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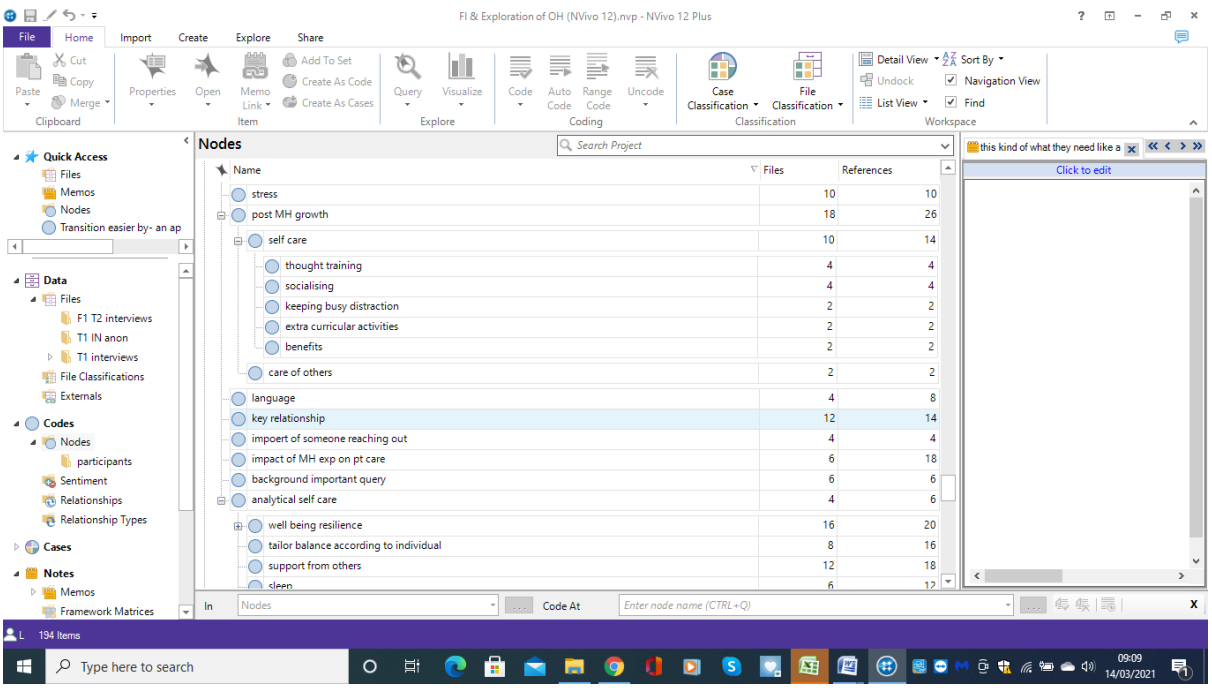

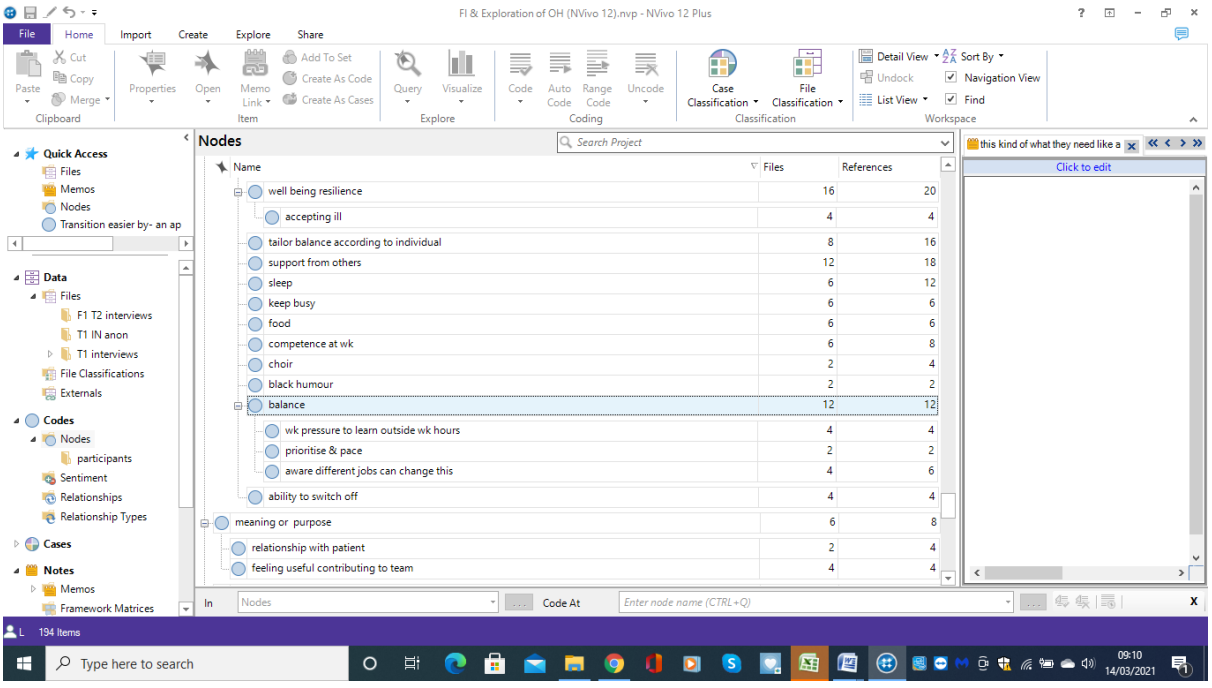

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