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"If you're crying this much you shouldn't be a consultant": the lived experience of UK doctors in training with mental illness.

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Abstract

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 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 mental 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.

Introduction

There is some uncertainty in the literature whether mental illness is more common among medical students and doctors than in the general population (Mata et al., 2015; Brooks et al, 2011) although maladaptive behaviour in young doctors when ill has been reported for over 20 years (Baldwin, Dodd, & Wrate, 1997). The chosen methods of defining and measuring mental illness for this purpose has some bearing on the variability of these findings (Brooks, 2011). A number of self-report studies do show an increased prevalence of mental illness among doctors compared to the general population (Brooks, 2015) and a systematic review and meta-analysis found the prevalence of depression among doctors to be 28.2%, ranging from 20.9% to 43.2% depending on the instrument used (Mata et al., 2015). There is, however, a consensus that it is imperative for the safety of their patients that mentally ill doctors can access immediate effective medical care (GMC, 2014). Many factors commonly create barriers to medical students accessing this care, which include, unwillingness to accept the patient role, fears around confidentiality and fears around being referred for a fitness-to-practise panel (Grant, Rix, Mattick, Winter, & Jones, 2013). There are specific factors in relation to mental health in young doctors: transition from medical student to trainee doctor and from trainee to full consultant responsibility; having to make life and death decisions and working shifts (Baldwin et al., 1997; Brooks, Gerada, & Chalder, 2011; Dyrbye, Thomas, & Shanafelt, 2005). Peculiar to doctors is the ability to consult colleagues informally about their ailments and easily accessible prescription medications (Baldwin et al., 1997; Roberts, Warner, & Trumpower, 2000(1)).

There is also a divergence of opinion in the literature whether rates of death from suicide are higher among doctors than the general population (Bright & Krahn, 2011; Goldman, Shah, & Bernstein, 2015). Concern has escalated in recent years as the prevalence of mental illness and death by suicide has become more prominent, at least in mainstream media (Clarke & McKee, 2017; Kuhn & Flanagan, 2017). These concerns are troubling both concerning our social responsibility to this group, but also regarding consideration of the healthcare provision for our patients. A study comparing suicide attempts in doctors and nurses showed that suicide attempts among doctors were more likely to be successful (Braquehais et al., 2016)

Concerns over the prevalence of mental illness among medical students and the wide variability in the provision of support by medical schools led the General Medical Council (UK),

to commission the authors to carry out research into the provision of support for medical students with mental illness (Grant et al., 2013). Consequently, guidelines for medical schools were written based on the study findings and disseminated to all UK medical schools (GMC, 2013b). The research revealed the existence of an iceberg of mental health issues, distrust of organisational responses, peer and role model pressures not to admit to ill-health and study patterns not conducive to seeking early help or taking time out (Grant et al., 2013a).

What emerged from that study was that while medical schools fully expected some of their students to need support due to mental illness and perceived that they provided acceptable and approachable help. Students, whether or not they had personal experience of mental illness, were of the opinion that disclosing such an illness would have deleterious consequences for their future career in medicine and may even bring it to a premature end(Grant et al., 2013). The students who had personal experience of more severe mental illness, in fact, had no choice but to disclose their illness to the medical school. None had experienced a negative impact on their career in any way as a result of doing this, and there was no evidence that any student's career had been damaged. This is reflected in findings from a survey of postgraduate trainees in North America (Moutier C et al., 2009).

This view of the potential harm that disclosure might cause was voiced strongly by the focus group participants (who did not have personal experience of mental illness) but none of them could give an example of a medical student whose career had actually been harmed in any way as a result of disclosure. Many students voiced concern about fitness to practise proceedings as the method by which they would be censured or their career ended if they disclosed a mental illness (Grant et al., 2013; Winter, Rix, & Grant, 2017). Several sources indicated that not only did some medical students remain vulnerable as they proceeded into their Foundation years and subsequent specialist training but the same pressures to hide mental illness, to conform to unrealistic role models and to be 'present' even when their health condition would indicate otherwise, applied to an even more strongly as they assumed more significant responsibilities.

Medical professionals have a responsibility to be mindful of their own wellbeing, and the well-being of colleagues, and to seek support when required (GMC, 2013a). Much has been written about the factors that contribute towards doctors becoming mentally unwell, somewhat less

about the factors that aid their recovery, and the barriers they encounter in seeking support when needed.

We undertook a study which aimed to identify factors and barriers that influence the recovery of doctors in training who experience mental illness, drawing on: a review of the literature, interviews with stakeholders, focus group interviews with trainee doctors, and narrative interviews with trainees who had personally experienced mental illness. Stakeholders included: members of national bodies with an interest in doctors' mental health such as the GMC and the BMA; providers of support including BMA Doctors for Doctors, the Practitioner Health Programme, and the Doctors' Support Network; as well as members of Health Education England (the organisation responsible for the postgraduate training of doctors), including associated support staff and educational supervisors.

This paper is based on those narrative interviews and gives unique insights into what it is like to experience mental illness during a doctor's trainee years. It attempts to understand the factors, specific to their occupation, that may have contributed to their illness, the barriers they faced in seeking help, and the factors that influenced their recovery. In doing so, we draw on lessons from these experiences in order to inform the development of policy relating to how members of the medical profession who experience mental illness are supported.

Methods

Often in biomedical research there is a concentration on objective, reproducible findings. When researching human experience, such as an episode of illness, we cannot capture the lived experience without the patient/sufferer's subjective account of how it affected *them* (Hurwitz, Greenhalgh, & Skultans, 2004). Stories, or narratives, are used by individuals to make sense of experiences which otherwise they would be unable to explain. Where the individual cannot make sense (Monrouxe, 2009).

The study was concerned with developing an understanding of the experience of doctors in training with mental illness. We were asking participants about an episode of illness and wanted to encourage them to tell their story in their own words. We chose the biographical narrative interviewing method (BNIM) because it is designed to give the interviewee maximum encouragement to tell their story in narrative form (Wengraf, 2001, 2008). We used this method in previous work to explore the lived experience of medical students who

had suffered mental illness (Grant et al., 2013). It enables the participant to tell their story (narrative) without the use of an interview guide, and without any interruption by the interviewer (Wengraf, 2008). The interviewer asked the participant a single question to induce narrative (SQIN) then listened in silence, taking notes while the participants told their story (Appendix 1).

Further questions were developed based on information arising from the narrative relating to the participant's recalled: Situation, Happening, Event, Incident, Occasion, or Time ('SHEIOT') (Wengraf, 2013) (Appendix 2). These questions encouraged participants to explore their narrative in more depth. We chose the BNIM two-stage approach as a method as it facilitates the participants to give more detail or to give a personal incident narrative, without interruption or undue guidance. We used this method to good effect in similar interviews in our previous study (Grant et al., 2013)

Recruitment

We were aware when setting up this study that we were asking doctors in training to talk about a painful and challenging time in their lives. We asked the Wales Deanery and Health Education England to cascade a request for doctors in training who had experienced mental illness during their training via email. The decision to participate was left with individual doctors, thus preserving the identity of volunteers. Thirty doctors in training volunteered to be interviewed. We took a purposive sample, aiming to get responses from a wide selection of specialties and grades within the constraints of time and budgets, and selected the 10 participants who gave us the most comprehensive sample. The parameters we used were: level of seniority, specialty and gender.

Analysis

Interviews were digitally recorded and transcribed verbatim, and field notes typed up. Participants were pseudonymised. Two of the researchers (AG and DS) carried out a preliminary analysis of two transcripts following the conventions of BNIM (Wengraff, 2013;). They then, through a process of consensus, developed a thematic framework based on their combined analysis of the data. This thematic framework was then used to analyse all ten transcripts with iterative changes being made to the framework during analysis as agreed by consensus. When the thematic analysis was completed we carried out further analysis using

a matrix in order to confirm the most prominent factors affecting the experience of mental illness of doctors in training, This process made it easy to determine which nodes were most prominent in terms of the number of participants affected and also in the strength of their narrative. Setting up and writing the content for the matrix proved a useful exercise for the researchers to further familiarising them with the data.

The process identified four primary nodes from within the narrative transcripts. These were:

- Doing the job while ill,
- Sick leave (initiating, being on, returning from),
- Interaction with the employer and
- Availability of, and access to, sources of support.

Results

The response to our request for participants was surprisingly enthusiastic and we had more offers from people willing to participate than we were able to interview. Subsequently, were able to interview ten doctors in training from England and Wales across a range of specialities, and we were able to include doctors in training across various levels of seniority from F2 (foundation year 2, second-year post-graduation) to ST5 (at least fifth-year post-foundation training). We also interviewed doctors with a range of mental health conditions, including symptoms of anxiety, depression and psychosis. The characteristics of the participants, along with their assigned pseudonym, are summarised in table 1.

Table 1: Characteristics of doctors in training with experience of mental illness, by seniority, gender and a pseudonym used for data reporting.

Speciality	Seniority	Gender	Participant code & pseudonym
Anaesthetics	Post CCT	Female	Cheryl
Anaesthetics	ST3	Male	Brian
General medicine	CT2	Female	Daisy
General Practice	CT2	Female	Felicity

General Practice	ST3	Male	Clive
General Practice	ST1	Female	Grace
Orthopaedics	F2	Female	Helen
Paediatrics	ST5	Female	Imelda
Psychiatry	CT3	Female	Jackie
Radiology	ST3	Female	Karen

Effects of the demographic

All of the participants were doctors in training, most of whom were in their mid to late twenties and, as would be expected with people in this age range, commonly experiencing life events such as meeting a life partner, getting married, buying a home and the arrival of and caring for young children. What being a doctor in training appeared to add to this for the people that we interviewed was the need to do a highly pressurised job where the consequences of error were grave. At times the combination of doing the job while feeling unsupported was overwhelming:

> *'Oh, God. I have to do something to fix this situation, and I don't know what to do and I don't know who I should ask to find out what to do and this person is weight bearing on their hideous fracture and I don't know how bad that is. I don't know if it means they are going to have to have their leg chopped off or something or if it just means it will take a little bit longer to heal. Like I don't know how, I don't know how bad these things are. I don't know if they are life-threatening or if they are just a bit 'oh well'.*
>
> *Helen*

Helen also went on to describe how much easier situations like this were to handle with the benefit of some experience and when she felt able to be assertive:

> *'Yeah I know how to bleep. And if I bleep someone and they don't answer I will bleep and bleep and I will call consultants on their mobiles because I don't care if they shout at me'*
>
> Helen

Doing the job while ill

A number of the participants had knowingly continued working even though they knew they were ill and sometimes after they had been diagnosed and advised to take sick leave. 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 practice. For the most part, they had sufficient insight into the consequences but felt they had no alternative but to continue working.

Having a mental health 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:

I started having some problems, end of 2015, when I was in a GP placement. It was mainly sort of social anxiety. And so I found it very difficult to talk to people. Very, yeah, basically. And then that sort of culminated in me being unable to go to work for a time

And I said this to my supervisor that you know this is what's happened in general practice. I have had problems with it before, I do have social anxiety, I have performance anxiety, you know I haven't given a presentation in a good three years I would say. Just because it terrifies me…

…he sort of documented it all on my e-portfolio because they do those educators notes when they have a conversation with you.'

Grace

Daisy summed up her behaviour and feeling at the time

'I'd kind of be okay if it was like a senior ward round, I could just go and do the jobs. But if I had to have any autonomous thinking and it was you know, I think it was the first time I did my own bit of the ward round. And I just couldn't, I couldn't my thoughts weren't very coherent because I just felt so panicked. I just thought 'well I can't do this anymore' like I just felt so overwhelmed by it and I felt like 'well this is such a responsibility, like what am I doing here?' And I just remember feeling like really, really anxious'

Daisy

Felicity recognised that she was dealing with patients when, in effect, cognitively impaired:

'not really being able to read or comprehend or retain any information which was tricky.'

Felicity

Brian recalls getting through the minimum required in a day's work but was unable to do anything about studying for his postgraduate exams.

'it got to the point where I was almost catatonic in my room all the time. I was making it to work, just doing what is required and then coming back but I wasn't making any advancements in anything else in work I was just doing my on calls, turning up doing the list'

Brian

Having a mental illness reduced some doctors' capacity for work and increased their need for rest. Helen's physical and mental health suffered in relation to work-related fatigue. While the social pressures of the job pushed them to say that they loved it, their own needs, such as to get sufficient rest to remain well and to carry out the job safely, were not met. Indeed, their request that these needs be met were responded to as them wanting a 'special thing' to be set up just for them an apparently requests were met were treated as unreasonable. unreasonable request:

*'But I love ****** and everyone is like 'but you love it so much' but I am like 'I know but I am dying'. I just get worn out and then like the migraines get really really bad and then I start to get depressed and then that's when I am like 'shit' and it will take me like three weeks to just build up to a level where I can start going to work again. And but I just cannot get anyone to see it or understand it which is just like 'why would they make a special thing for you' and I am like 'I am telling you that I am ill'. It is such a nightmare.'*

Karen

Leaving the Job

For some having a mental illness resulted in them leaving medicine temporarily. Some of those who took a long break from their career were required to take further exams before they were allowed to restart practising as a doctor:

*'Yes so I had to resit some exams because I never finished my PRHO year so you need ten months minimum out of the twelve and I had only done eight. So, I redid some exams. Worked as a supernumerary F1 in ****** after doing the exams and before I could restart foundation training.'*

Clive

Sick leave

Sick leave, and the decisions it forced the participants to make when they were unwell caused a great deal of distress. The need to take sick leave was a source of major conflict. One participant was even told at induction not to take sick leave.

Most participants took a period of sick leave. Almost all had resisted this and, in several cases, a third person, a friend or relative had intervened and persuaded them that they must take sick leave

'So, she made me phone in sick on Monday. I told them I had a temperature and that I was unwell and that I couldn't come to work and she made an appointment for me. So my mum took me to the GP and she took one look at me, gave me a sick note for six weeks that said stress and I think started me on an antidepressant there and then.'

Helen

For some participants it was their own perception of taking sick leave and it being associated with failure that kept them at work:

'Yeah of course, so I managed not to make any major mistakes that I know of but just I couldn't think. I thought it would be a complete failure to have to have time off work'

Felicity

However, negative views of mental illness among doctors were aired freely in the workplace by senior colleagues:

'Like the department I was in before there was about five trainees off sick around the time that I was with mental health problems and there was so much public chat amongst the consultants about how these days trainees just can't cope with the stress and they go off sick and as soon as they go off sick we should half their pay, that would stop them going off. And lots of public talking about trainees in general like criticising different people and so it was quite a difficult environment to be in, even more so when you were a trainee with a mental health problem.'

Grace

In some cases, it was the GP or psychiatrist that convinced the doctor to take sick leave:

'I couldn't think straight, I couldn't remember anything, my memory was absolutely shot and they were going up on my doses loads. So I kept going until she said 'you really have to take some time off' at which point I took some time off and I had eight weeks off.'

Grace

Indeed, several participants only went onto sick leave when the clinician looking after them said they would inform their employer that they were not well enough to be at work:

> *…he said that you either don't, you either go on sick leave now or I am calling the hospital and telling them that you are not going to be allowed to go to work'*

Clive

And even when they did take leave it still took second place to the needs of their unit. For example, having been taken to their GP by a friend who was a psychiatrist, and having been given a medical certificate for 2 weeks Brian still did not start the sick leave for another 2 days because there was nobody else to do his shifts:

> *'So I had the, I was signed off for two weeks as well but I still had two more on calls to do like the following day so I still went and did those, at one point locking myself in a cupboard because I thought I was going to have a panic attack. So probably not the most sensible thing to do but I thought well we won't get anyone'*

Brian

Felicity described their time away from work, when she was ill, as being so unpleasant that she did not want to be spending more time like this by being on sick leave:

> *'Well yeah I did not want time off work. I didn't want to you know admit that I didn't want to be in the house, sat on the floor in the dark all day.'*

Felicity

Another participant said that doing the routine jobs required of a doctor in training had a therapeutic effect but that they were devastated when they overheard the nursing staff being critical of them.

Being on sick leave

Being on sick leave meant being away from the career path and the professional identity that most participants had been working towards for many years and which formed a central part of their sense of identity:

> *'…my identity was extremely bound up in my you know my profession and like it had been ever since I started medical school you know immediately*

once you start university you are one of the medics… It's not just a job is it. You are stepping off the whole training treadmill and everything. Like you are really cutting your ties. It's not just 'oh I am going to be stop being a doctor for a bit and I will probably come back in a year or so' like I felt'

Helen

For some, the barrier to returning to medicine seemed impossibly high, and they took other jobs that included working in pubs, bars and cafes and working in schools:

'so like after about like after fourteen or sixteen months or something, after I had first gone off sick I started working at a pub just a couple of nights a week. And then I started working in a café for a few days a week as well. And that went on for a couple of years'

Helen

As well as identity, doctors in training stand to lose their income if they are on sick leave for a certain period, the exact time being determined by their years of service for the NHS:

Participants talked about feeling like a fraud when they were on sick leave and pushed the doctors caring for them to permit them to return to work before they were ready.

Returning from Sick Leave

Returning from sick leave was difficult for a number of respondents. The length of the period of sickness made a difference to the most likely concerns on returning to work. Where the participant had been on leave for a short period of time there was uncertainty how much their superiors at work knew or wanted to know about the nature of the illness. In a number of cases formal back to work interviews with line managers were not held:

'I went back, nothing was said of it. There was no back to work meeting, there was nothing. Even though I had had to send the sick form up to the department, you know nothing more was said about it. All I got was an exchange in the changing room from the guy who did the rota, the consultant who did the rota just saying 'oh you are back now, do you need more time off or are you okay?' and I said 'well you know I am okay', probably wasn't but often the problem with mental illness is your lack of insight.'

Brian

There was a need for the employer to ascertain whether a period of working in a supernumerary capacity or a phased return to work was required when a doctor returned from a period of sick leave. Occupational health advice was not always available to liaise between the employer and the doctor's psychiatrist or GP. In the absence of any contact with their employer one participant took the initiative and made contact with the occupational health unit only to be sent an appointment for six months' time:

'I self-referred to occupational health at ((******)), and on the referral form, I detailed that…

I had suffered from low mood and was having a lot of confidence and anxiety issues. And I basically got sort of a generic letter back giving me an appointment for May. And I was due to go back in February.'

Daisy

For doctors on a training rotation taking time off usually meant that on return they would not return to the job they had been doing when they started sick leave and, in many cases, that they would join a different cohort. In some cases, causing awkwardness with the doctor and their former contemporaries.

Disclosure

Fear of disclosure manifested itself in a number of ways. Felicity was sufficiently afraid of the effects of disclosure on her career that she consulted a psychiatrist privately:

'By that time I knew I was really poorly. With records and now I don't, I've not consented for any record, any GP record sharing, so I didn't want my notes potentially accessible. I didn't want my notes, I didn't want my notes there, I didn't want them recorded for time indefinite. I knew I was really poorly. I was worried about fitness to practice issues. I didn't want to stop work. I didn't want long-term consequences. I didn't really want anybody to know what was going on. Yeah I felt very strongly about it. The psychiatrist I see sees lots of doctors.'

Felicity

Clive, who had physical and mental health problems, was quite happy to discuss their physical problems with his educational supervisor but might have been reticent about to discussing problems relating to mental health especially when he was unwell:

'I am happy to talk about the [my] back. Because you can't avoid the back. I have been absent from this workplace for four months because of the back. I don't have a problem saying I have had mental health issues but I am saying that from the point of view where I feel relatively well.'

Clive

Participants were unsure and very reticent about any disclosure to people who might have some say in their future career progression and these included discussions with their educational supervisor and in annual reviews of competence progression (ARCP's). The ongoing effects of this lack of disclosure meant that at times some participants were treated as either being lazy or ineffective at their work when in fact they were mentally ill.

Interface with the employer

Most participants, if they could avoid it, did not disclose to their educational supervisor or anybody else who might have any influence over their career progression (and this included sources of potential support within the deanery). One outcome of this was that some participants' poor performance or poor engagement with evaluations of progress such as ARCPs was perceived as poor performance, lack of engagement or rudeness when, in fact, it related to mental illness:

I came home after that appraisal the first one where I was in the jeans and t shirt and you know I said to my wife 'I don't think it went very well' and she said 'well what did you say to them' and I said 'well I didn't really say anything. I just got a dressing down from everyone including someone who I had never met before'. I had one of the panel ask me 'how's your revision going' and I said 'well I am doing what I can' and she said 'oh it doesn't sound like you are doing enough' and I sort of had to bite my tongue and just say 'I am doing as much as I can with the time that I have'

Brian

When this doctor explained the combination of events in their life concerning recent poor performance this was met with little sympathy:

'At the same time, I get confronted by the college tutor in the middle of the corridor of main theatres because my ARCP outcome at the time was a five [1] …this was around January time and he was asking me 'oh how is your

[1] Outcomes for ARCPs are a numerical score. (1 = satisfactory progress, 5 = insufficient evidence submitted, further training may be necessary).

revision going?' because I was having the written resit in March and I said '…I am doing what I can but you know I have got lots of work on and you know my children don't sleep through the night, they are up four or five times a night every night'. I said 'my wife is doing shifts and she often has to work opposite shifts to me … all he said to me 'yeah but if you don't pass this exam you will just look back on it and see all those excuses' which I didn't think was very fair.'

Brian

Sources of support

Access to appropriate support was impeded for the interviewees in a number of ways. In more rural areas doctors in training were more likely to be known to local practitioners such as psychiatrists. Understandably they did not wish to consult current or former colleagues about their mental illness:

Discussion

The data presented here form part of a larger study examined the need for and provision of support for doctors in training with mental illness. The purpose of exploring the subset of data here is to gain an understanding of the lived experience of doctors in training who have experienced mental illness themselves. Each of the ten interviews presented here tells the story of one doctor in training dealing with mental illness in their own way and in their own voice.

What our data say

The thematic analysis reveals not just strong themes but clear linkages between them, sometimes leading to negative consequences for doctor, patient and the system. For instance, in most cases the doctor was unable or unwilling to disclose their illness to their line manager or supervisor. The implicit assumption being that disclosure of their illness may result in them being seen as failing. The consequence of non-disclosure in several cases was that the doctor was seen as rude or uncooperative with the assessment process or making excuses for their lack of success in their career or in postgraduate exams. Reluctance to disclose their illness was reinforced by negative attitudes being expressed by the doctors' peers and senior colleagues. The hidden presence of the illness had repercussions for patients who found themselves not being listened to or communicated with effectively. Once illness had been recognised, barriers to accessing appropriate support and treatment were created, including the overt expression of negative attitudes towards illness; purposefully preventing opportunities to access appropriate clinical care, and creating difficulties in negotiating time away from work for appointments. For those who chose private psychiatric help, there were significant financial implications. It is reasonable to assume that both the mental illness itself and the side effects of treatment had some impact on the quality of patient treatment decisions. Such barriers may contribute to the temptation peculiar to members of the medical profession to treat themselves when they become ill (George, Hanson, & Jackson, 2014), a behaviour which of itself raises questions of efficiency if not risk.

Concealment was closely linked to presenteeism. A 2015 survey found that doctors took one-third of the amount of sick leave that other healthcare workers took (Workforce and Facilities Team, 2015). This is at odds with data illustrating the prevalence of mental illness amongst this group (Mata et al, 2015). Factors that were identified as contributing to presenteeism in participant narratives included: Attitudes in the workplace; a strong work ethic; a sense that

to take sick leave would add to colleagues' burden, because; locums would not be available. In some cases, this meant that trainees were at work when they were not fit to be. Some described working clinically when, due to their illness, they struggled with the challenging workload of a doctor in training. In particular participants struggled to communicate with patients and described difficulty in working as a doctor either because their cognitive processes were slowed or because they felt panicky or anxious. Reticence in disclosing their mental illness also meant that some doctors fell foul of the career progression mechanisms. Two respondents were admonished for their poor performance and were perceived as arrogant or rude due to their lack of engagement which was, in fact, due to their being mentally ill at the time of assessment.

Most of the participants took sick leave at some time during their illness, many only with persuasion from family or friends, or their GP or psychiatrist had threatened to contact their employer if they did not take a leave of absence voluntarily. Being on sick leave was a shock. People who had put all their efforts for many years into getting into medical school, then following a chosen career path lost a large part of their identity when this suddenly was suspended. Once they had taken leave, mechanisms of support for trainees while they were absent and to assist their return to work were inconsistent. In many cases no return to work interview took place and not all of the participants were offered an occupational health assessment.

Despite the trainees' reluctance to disclose their illness several educational supervisors were very helpful and supportive, once they became aware of the trainee's difficulties. Doctors' concerns about the consequences of disclosure went beyond revealing their illness to their line manager. The title of this paper is taken from a doctor who, having told a colleague that they did not feel confident to do a job where they would have had to act up at a more senior level that they should, in that case, take sick leave.

Recommendations

On the basis of our findings, the moving testimony of ten doctors in training who have had a mental illness, special provision should be made for doctors in training with mental illness. We see this as imperative because, as our data show, doctors with mental illness, at best, are unavailable due to sick leave and, at worst are practising when their ability to function and to carry out their job is impaired. This study reinforces that these doctors are currently working

in a culture that supports negative messages about mental illness among doctors leading to commonly held views that mental illness is equal to weakness, echoing the findings of others (e.g. Wallace, 2012). Mental health provision for doctors with mental health problems needs to be far enough away from their workplace to enable them to get the medical care they need without having any concerns about their illness being disclosed to anyone associated with their work unless they choose to make that disclosure.

Most respondents did not have access to a senior colleague, tutor or mentor to whom they felt they could turn if they needed support. This was in stark contrast to our findings in a previous study examining support for medical students with mental illness all of whom had access to a personal tutor (Grant et al., 2013).

As well as good clinical care, doctors with any health problems need access to an occupational health unit where they can get advice on any aspect of their health in relation to work. An occupational physician can advise a doctor on when to return to work and whether this should happen gradually over a period of time. The occupational health unit can also act as a conduit of information between the doctor's own GP and/or psychiatrist. We strongly recommend that occupational health advice is one strand of a rigorous return to work process which is led by the doctor's line manager or supervisor.

It is disappointing that the recommendations we make are repetitious of those found in the 2010 report 'invisible patients' (Health, 2010). For the interviewees from most parts of the UK it was clear that no medical service tailored to the needs of medical practitioners with mental illness has been created. Patterson calls for 'Invisible patients' to be reinvigorated and delivered, he goes on to call for a binding covenant between the NHS and its doctors (Patterson, 2016). He does this because, although a national bespoke medical service for doctors would be expensive, to not do it would cost more.

How this compares to previously published work

In a previous study we examined the support available to medical students with mental illness (Grant et al., 2013). Fear of the effects of disclosure was a major issue for this group also but those students who did disclose to their medical school, without exception, received good support. For doctors in training, there does not seem to be any organisation that replaces the role taken by the medical school. In most cases, the relationship with the educational supervisor was expected to be formal and work-oriented. The postgraduate training bodies

have support units which are in place to support trainees with a wide spectrum of problems, including mental illness. However, these support units were perceived to be too close to the employment/disciplinary provision and referral to them was seen as punitive by some.

Limitations

This study has produced and analysed ten biographical narrative interviews with doctors in training. The respondents' testimonies are clear, and in places harrowing. It is also true that after ten interviews there was a familiarity with themes in the data, particularly referring to disclosure and sick leave. However, these findings are based on just ten interviews and despite our having used a purposive sampling framework these data cannot be said to be representative of all doctors with mental illness.

Further research

It would be very useful to triangulate the findings presented here. Having received a very positive response to requests for participants for this study it would be possible to access the experience of a much larger and more representative sample of doctors with experience of mental illness by administering a survey with a combination of numerical and free-text items.

Implications for practice

These data clearly describe doctors in training suffering from mental illness. It appears that their profession, in some cases, can purposefully hinder access to the support that they need. In another component of this study we interviewed staff from the Practitioner Health Programme which provides support and medical care for medical students and doctors in the Greater London Area. Because this service is geographically separate from the organisation they work for, doctors appear willing to access it. While we realise that it will not be possible to provide an identical service to this in all parts of the UK, we propose that a confidential clinical service be provided for doctors in all parts of the UK which is sufficiently separated physically and in terms of governance from the NHS organisation for which they work to ensure that they get appropriate medical care for all health problems. It is in the remote parts of the UK that it may be hardest to provide confidential care. In rural areas, the area covered by one community mental health team may be vast making care by a neighbouring team difficult but not impossible.

We recommend that the policy and procedures relating to return to work interviews following a period of sick leave from any cause should be followed. It is essential to determine whether

a phased return with or without a period of working in a supernumerary capacity is necessary. This is contingent on access to expert occupational health advice.

At induction to their jobs, we believe that doctors in training should be advised that illness, including mental illness is a frequent occurrence within the medical profession. Without trivialising the experience of mental illness, awareness should be raised about the signs that could alert trainees to the common experience of mental illness in themselves and their peers. It is worth acknowledging that many doctors who do experience mental health problems are very concerned that this may have an adverse effect on their future career. They can be encouraged, should they become unwell, to seek medical help early from a doctor in whom they trust and who is distanced from their place of work. They are then able to discuss, in confidence, their illness and their fitness to practise.

Professional support services exist for medical students and doctors, although provision is variable across the UK and has been criticised for being un-systematic and reactive (Firth-Cozens, 2003). More recently there has been a lot of interest in interventions which look at prevention of mental health problems among doctors with a great deal of attention on cognitive behaviour therapy and mindfulness meditation, as well as more general self-care measures such as exercise, adequate sleep and a healthy diet (Fox et al., 2017). The aim of such programmes is frequently referred to as helping the doctor in training to become more resilient. One possible benefit of such initiatives is the provision of a forum in which doctors can talk to others openly about the stresses of the job and can explore sources of help (Harry, 2014; Kuhn & Flanagan, 2017). A meta-analysis showed that behavioural, cognitive and mindfulness-based initiatives were effective in reducing stress in doctors and medical students (Regehr, Glancy, Pitts, & LeBlanc, 2014). Burnout is used widely in the literature as a marker of impaired mental health (low mood, poor sleep, etc) without the person concerned suffering from an overt mental illness (Kuhn & Flanagan, 2017).

Initiatives in a number of countries have set out to provide mental health support specifically for doctors (Braquehais, Tresidder, & DuPont, 2015; McClafferty & Brown, 2014; Platman, Allen, Bailey, Kwak, & Johnson, 2013). While recognising that doctors may be reticent about disclosing a mental illness or seeking help, they set out to offer confidential help thereby encouraging doctors to access a service that is systematic and safe. Adoption of a model of dedicated, well-networked provision of specialised help for doctors in training who

experience mental illness is long overdue. This study reinforces earlier recommendations and further highlights the needs that inform them.

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Appendix 1:

The SQIN for this study was:

> *'As you are aware I am interested in the experience of doctors in training who have personal experience in mental health problems. In particular I am interested in whether you being a doctor contributed to your illness or whether being a doctor made a difference to accessing health care or support once you began to experience problems. I will listen without interrupting but will take some notes'*

Appendix 2: SHEOIT notepad

Wengraf…

blank page of BNIM SHEIOT notepad – please use in your pilot and other interviews

1. Emotional recognition (if necessary); working through / time out (if necessary)
2. Push towards narrative, push for PINs, then on each PIN more in-PIN detail
(if necessary via left-hand bundles **back towards the right-hand one)**

Use this magic formula + choice of magic word from one of three bundles
If possible from ***right***, *usually from middle, occasionally from the left*
Then move back as fast as possible **to the red-bundle on the right!**

You said
XX- below
their words

"Do you remember
any **particular**
[any more detail]
[any image-feeling thought?]

…time – situation
phase – example
period

occasion - incident
event – moment –
happening, day
*[***How it all happened?]**

Scenic Reconstruction – where it all happened – "the café"

ROUND 2 MAGICWORDS ***ROUND 3 MAGICWORDS*** **ROUND N MAGICWORDS**

Not a Generalising-**GIN** – "what always/typically/often happens"
But a **Unique** Particular **IN-PIN**, partly re-living of one single original emotional experiencing !
PIN = Particular Incident Narrative
"We were there, a Saturday evening…he said…she said…What I do is…I'm thinking …Then what happens is… Afterwards I remember feeling (I'm still feeling it a bit) feeling…. Now I feel a bit different, I feel… … Looking back I think it was quite a critical moment, because…."