Trainee doctors' views on mental illness among their peers and access to support services

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Abstract

The mental health of doctors in training raises two major concerns, first that they are reluctant to, and have difficulty accessing, treatment and second that undiagnosed and untreated doctors expose patients to unacceptable risks,

Four one-hour focus groups were held with participants' views explored on; their observations about mental health as an issue amongst doctors, their personal knowledge of, and preferences for, sources of support and other related factors.Transcripts were analysed using a thematic framework approach.

Findings

Doctors in training described working in an environment which is not conducive to good mental health. Trainee doctors are reluctant to speak up or seek help because they think that difficulties in coping will be interpreted as underperformance. They also reported limited knowledge of support services. We propose some policy changes.

Introduction

Becoming a doctor is not easy: it requires early commitment, hard work and a very extended period of training. It is a process which excludes, for the most part, other options, involves high investment financially and emotionally and in that sense is a single bet in which the stakes are high.

On graduating from medical school, new doctors transition into a period of postgraduate training, learning how to deliver medical care in the real world. They are taking their first steps in a professional environment recognised internationally as being associated with higher than average rates of work related stress (Vijendren et al 2015) and mental ill health (Wu, Ireland, Hafekost, & Lawrence 2019), manifesting in some cases as burnout, a work related hazard, characterised by extreme exhaustion, a sense of depersonalisation or cynicism towards people and work, and a sense of professional inefficacy (Lemaire & Wallace, 2017). Mental ill health among doctors raises twofold concerns. Firstly, for the doctors themselves who may be denied, or at least reluctant to seek, help; and secondly for patients, whose safety may be compromised by unreported, untreated doctors who continue to practise when clinically impaired (Udemezue, 2017).

In response, in the UK, NHS England has put concerns about the mental wellbeing of healthcare professionals firmly on the policy agenda, highlighting them both within the Long Term Plan (2019) and through the NHS Staff and Learners' Wellbeing Commission Review of causes, interventions, innovations and good practice in relation to the mental wellbeing of the NHS workforce (Health Education England 2019) .

Problems may be more acute in organizational settings which are hostile to acknowledging mental health problems and which, in any event, may be a contributory cause. The source of mental ill health in doctors can be viewed at the level of both the individual doctor (propensity) and the environment (system wide), and also resulting from the interaction between the two. Risk factors include personality type, challenges of managing emotional involvement, presenteeism, regulation/fear of being investigated, and stigma (Health

Education England 2019), along with high and unpredictable workloads (Vijendren et al 2015) .

Suggested solutions include interventions geared to, for instance, increasing resilience or those which suggest system level changes such as changing shift schedules, which, it has been argued, are more effective (Panagioti et al 2017). In the case of interventions at the level of the individual the debate is between those who see doctors as a special case (Brooks, Gerada, & Chalder, 2011) requiring a service tailored specifically to their needs, and those who would prefer to see wider use of generic services (such as Occupational Health) as a means of 'normalisation' and stigma reduction (Grant, Rix, Mattick, Winter, & Jones, 2013). However, the effectiveness of such services may well be limited by a reluctance to seek help on the part of medical professionals: Cohen et al (2016) surveyed UK doctors and received 1,954 responses about how they would access support for mental ill-health, and found that only 6% would go to Occupational Health, and none would choose their local professional support unit (run by Health Education England or Health Education and Improvement Wales). Most (73%) would prefer to disclose concerns to family or friends rather than a healthcare professional, while 97% would opt to confide in someone outside the workplace, to avoid being labelled.

There is a considerable literature about doctors as patients, which suggests that they create a special case because they are seen as different by other doctors: a view reinforced by the way in which they present themselves and which colours the relationship between co-professionals. Doctors may use 'corridor consultations' or informal means of getting advice from colleagues. Barriers to seeking healthcare include lack of time, embarrassment, and system issues such as the pressure to be healthy. Doctors are aware of that legal requirements to report competence concerns, and the closeness of social networks, can challenge confidentiality (Kay, Mitchell, Clavarino, & Doust, 2008).

In an earlier study commissioned by the GMC (Grant et al., 2013) we described the socialization of medical students to accept a culture of hard work, long hours and an attitude to their own health needs best summed up by the phrase ''Doctors don't get sick''. We noted that the culture made life difficult for those

who were ill, and that access to treatment was often spasmodic. Two threats caused a great deal of concern to medical students: having to repeat a whole year of the programme because too of time missed through illness; and the fear that disclosure of a mental health condition would call into play the Medical School's, and maybe the GMC's, processes for deciding whether a student was 'fit to practice', effectively ending hopes of a career in medicine. This 'belief' was sufficient to drive several unhelpful behaviours, including hiding mental illness and delaying seeking treatment (Winter, Rix, & Grant, 2017).

In the present study, we take some of the original GMC study questions further into the real work world of qualified doctors. Although it is known that doctors in training are less likely to disclose concerns about mental ill health than are their more senior colleagues (Cohen et al 2016), the particular experience and needs of this group are under-researched (Health Education England 2019). In a companion article in this special edition we examine the experience of doctors in training who have experienced mental ill-health (ref biographical narrative paper, this issue, Grant et al, 2019) and show that mental health carries significant stigma. In this paper we report on trainee doctors' attitudes to mental health issues among their peer group, their beliefs about causes, and explore awareness of support services for mental health and wellbeing and how to access them.

Method

Ethical approval

Ethical approval was obtained from the research ethics committee, College of Human and Health Science, Swansea University.

Recruitment

In England and Wales, postgraduate medical training falls under the aegis of Health Education England (HEE) and Health Education and Improvement Wales (HEIW – previously Wales Deanery) respectively. We adopted a convenience sampling approach. For three of the four focus groups we enlisted, with the help of these organisations,, postgraduate centre and human resource staff who approached junior doctors on our behalf. Trainee doctors who were already

attending meetings and study days were invited to stay and participate in focus groups. A letter of introduction was distributed. Recruitment for the fourth focus group (held nearest to the researchers' base) consisted of a call for participants for the focus group and for narrative interviews (which formed another arm of this study). This call was circulated by Wales Deanery. No potential participants were rejected but some were directed towards the individual narrative interviews (see below). We were looking for doctors at any training stage from F1 through to ST 7, who were prepared to give up approximately an hour of their time to participate in a focus group. We specifically asked for trainee doctors with a personal history of mental health problems not to come forward for this part of the study but, if they felt able, to volunteer for the biographical narrative interviews which formed a separate part of our research study (ref BNIM paper, this issue). After reading the information sheet some potential participants might, therefore, have decided that it would be more appropriate for them to (confidentially) put themselves forward for a narrative interview. Every focus group participant was given an information sheet and were asked to sign a consent form.

Data collection

1. Four, one- hour, focus groups were carried out in four separate locations, involving 34 participants at various stages of training. The groups were audio recorded and transcribed verbatim.

The topic was introduced by a trained facilitator, explicitly seeking views on:-

a) Their observations about mental health as an issue amongst this workgroup e.g. manifestation, impact reaction
b) Their knowledge of, and preferences for, sources of support, including examples of good practice
c) Their beliefs about the consequences of 'coming out' as someone with a mental health issue on subsequent career prospects
d) Mitigating and aggravating factors in causation and their impact on seeking and benefitting from treatment.

To stimulate discussion, each focus group began with a ranking exercise in which participants were presented with a series of statements about mental ill health and asked to rank them according to how they felt they might influence their decision to disclose a mental health problem (see Appendix 1).

Analysis

After an initial read-through of the data and a discussion between members of the research team a thematic coding framework was developed, structured around the following headings: formal support services; informal support; barriers to accessing support; promotors of accessing support; promoters of well-being and resilience; triggers of stress and ill-health; impact of stress; suggestions for improvements; other (coding framework presented in full in Appendix 2).

This framework was then used to analyse the data from all four focus groups. Iterative changes were made to the framework during the course of the analysis. The results section is presented using headings from the analytical framework.

Results

Support services

Observations about mental health as an issue amongst this workgroup

There was a general consensus that mental health issues are an increasing problem affecting a significant proportion of doctors in training and that the prevailing culture leads to concealment. Knowledge of formal support services was not generally high and there was a perception that support structures based within the medical education system are more about performance management rather than providing help with mental health problems.

> *'I think there is a doctor for doctors.' ' I have heard of it as well, it seems like a myth.' FG002*

'The deanery has got a support unit that you might find yourself being sent to at some point. It's not usually for mental health problems, it's usually for, you know, bad boy.' FG002

Educational supervisors were seen as performance managers first and doctors in training said they were unlikely to approach their designated supervisor about a potential mental health problem because it would be regarded as a performance issue that could affect future judgements about performance and future opportunities within the foundation system which were allocated on the basis of competition.

'I think the educational supervisor would be the last person I would tell. I would seek services from lots of other avenues but not one that they are potentially assessing your performance and ability to be a doctor' FG001 F4p4

' I feel like if you went to your educational supervisor, a lot of them at first sort of reaction would be like "oh really, I didn't realise you were struggling" and just that sort of, that reaction would make me like "oh god they think of me differently now...they thought I was really competent and now they think I am really struggling with work or something".' FG001 F2p3

Where there was knowledge of availability of support services they were regarded with some cynicism, particularly in relation to its impartiality and confidentiality. Focus group participants had a strong aversion to 'in-house' services and expressed the view that if they did need support they would seek it from a source of their own choosing, such as a GP with whom they had a long standing relationship.

As a consequence they were unlikely to access services such as Occupational Health to help them manage periods of non-coping. Occupational Health, particularly if it was nurse-led, was not something they saw as part of their employment package. Rather they saw themselves as isolated, with support coming from colleagues (often cohort peers). There were exceptions to this

where trainees saw themselves as being supported by 'the team' and some teams were clearly well led and had strong cultural norms about 'time-out' and mutual responsibility, when things went wrong. Mentorship was highly regarded but provision was dependent on the good will of individual consultants.

Serious neurotic or psychotic conditions among peers tended to manifest themselves either by unacceptable behaviour or prolonged non-attendance and so quickly came to the attention of supervisors or colleagues as potential patient risks or sources of organizational disruption. More difficult for Foundation 1 (F1) and foundation 2 (F2) doctors (these are the most junior participants who are within their first (F1 or second (F2) postgraduate year) was how to react to colleagues who were 'not coping' or who had insufficient self-awareness to recognize that they needed to seek help. As periods of not coping affected almost everyone at some time, there was a tendency to see such problems as a reaction to a set of external organizational issues, such as poor supervision, a particularly challenging role, or life events common to this age group e.g. managing work/life balance, arrival of children etc. Young doctors found themselves providing support for colleagues and faced a dilemma about where to draw the line between giving personal support and escalating concerns to senior staff.

Barriers and facilitators to accessing support

There was considerable discussion about stigma being attached to mental health problems, making people reluctant to share their experience. Anxieties about what supervisors would think, and also about what peers would think.

> *'There is a bit of stigma around not being able to cope' FG004*

> *'It's almost like you are not allowed to moan about it because everybody does it even though you might be really struggling' FG001 F3p10*

> *'Doctors are expected to be sort of demi gods who live every hour in work, have no human failings whatsoever, their lives are in complete order and they haven't got any health problems. And if you reveal any sort of weakness at all, there is still that relic from the past' FG001 F1p4*

As well as being unaware of available services participants were worried about the confidentiality with which their disclosure about their mental health would be treated. These concerns were associated with the stigma attached to mental health issues.

> *'feeling safe to disclose because I think you don't know what's going to like go with that information as soon as you get it out, where does it stop?' FG003p5*

Respondents also described feeling reluctant to take time out of work to seek help because of not wanting to let down colleagues, in a pressured work environment. Most reported that they had continued to work when they we unfit to do so. Taking sick leave was not just seen as letting their colleagues and the organisation down but also as behaviour that might be interpreted a showing lack of commitment or inability to fulfil the requirements of being a doctor.

> *'I feel that there is more pressure on us to come to work if you are slightly ill than there is for other people'. FG004*

Good practice in provision of support

A mentorship scheme in one of the localities provided by consultants who did not have direct supervisory responsibility was given as an example of formal provision which might be able support doctors in training to address stressful issues before they led to serious problems

'*We had a mentor which was, nothing to do with your assessment. He or she was a consultant either within or outside of your discipline. You could choose...And it just gave the opportunity once a fortnight, once a month, to talk through anything difficult that you had in the canteen with someone that was a consultant that has kind of been there, been through it, done it all, seen it all before then they just kind of patted you on the head and say 'it's fine'.' FG002*

Structural promoters of stress

Respondents described various aspects of their job which were likely to promote stress: these included shortage of staff, leading to doctors working beyond agreed hours and being unable to take breaks or holidays.

'*I have come from a job that was very well supported, very well staffed, enjoyable place to work, knew that I would be finishing on time and having a, and it would be like a good day most days and now I have gone to a job where I feel it is understaffed, disorganised and I won't be finishing on time most days and that makes me stressed to go to work before I even start the day whereas I used to enjoy and look forward to going to work every day in my last rotation.' FG001 F2p11*

'*things are much more stressful when you are tired aren't they? You can cope with pretty much anything if you have had a good night's sleep. But when you haven't and it accumulates then you know your threshold falls doesn't it, not coping' FG001 F4p9*

Participants also singled out the issue of frequent rotation between jobs during the foundation years (which is 4 months including some annual leave), caused disruption and made it hard to forge positive relationships with supervisors

'*There is a fair amount of switching of jobs like after six months then you move, and so you get shifted around a lot. I suppose that is quite destabilising.' FG002*

Working alone/isolation

Participants talked about the negative effects of isolation with this being worst when they were on the night shift.

'*But night shift on you're own when you don't know anyone else, thoroughly miserable isn't it? There is no other word to describe it.' FG002*

Pressure of work could combine with anxieties about patient safety to create additional stress

'*am I safe to do this? Can I do this? This is what I want, this is the only career that I want but other people are making me feel that I am unsafe from a problem that I cannot help or avoid having. And it's devastating. It's destroying.' FG003p11*

'You are so stressed with the situation and your name is in the notes as having refused, you can't write, it's unprofessional to write anything in there, other than just do your job, yet you know that this can then come up in coroners court and you won't be able to remember what the other three hundred things you had to do were because you are individually responsible, vicariously responsible for one thing, but you are in a system that it failing.' FG002

'*I think it's very very stressful, feeling bad at your job. Feeling that you are not doing your job very well. You want to help all these people and satisfy all these nurses and you just can't do it and it makes you feel rubbish. It makes you feel resourceless.' FG002*

Protective factors

Informal support provided by peers helped to reduce stress and prevent problems escalating

> *'[In] DGHs (District General Hospitals) you have got all your juniors with you in exactly the same stage in their experience who can sort of chat to someone.' FG002*

Supportive consultants, who designate allocated time for one to one contact, were highly valued

> *'I have been working in psychiatry, the biggest advantage I have found completely different to medicine is that we get one-hour supervision time with our consultant every week and that is something that is mandatory, something that's recorded. And I find it really beneficial. It's the time when you can talk about anything.' FG002*

Respondents were aware of the importance of self-care strategies, but did not always find these easy to achieve

> *'I think we have a responsibility to, we all know about the things that can help our mental health as someone said, exercising, getting a good night's sleep and things…*

Discussion

In this study we aimed to find out the attitudes and beliefs about mental ill-health among doctors in training, and to examine their awareness of support services and the barriers or facilitators to accessing support.

The respondents to our focus groups paint an unhappy picture in which anxiety and self-doubt are widespread. At one level, given the complexity of the task and

the environment in which it takes place, this is not surprising as the consequences are of concern. Reluctance to disclose a lack of coping or a mental health issue to their educational supervisor for fear of being seen as weak and not fulfilling the high expectations of the profession is a systemic problem. Not taking appropriate action when ill, recognised in previous studies (Editorial, 2016) represents a worrying threat to patient safety.

What we report here confirms what has been reported previously (Fox et al., 2011) as a belief culture relating to the effects of having, or, more specifically being known to have a mental illness while working as a junior doctor.

The time has come, we believe, to move on from describing these shared beliefs and the effects they have on trainee doctors and, potentially, on the clinical safety of their patients. What we propose is an active and explicit campaign from within the medical profession including regulatory bodies. The trainee doctors themselves have a special part to play.

We propose an ambitious plan which challenges attitudes and beliefs towards mental illness among medical students and doctors from within the medical profession, the employers, medical schools and the bodies responsible for postgraduate training. We need a campaign of myth-busting. One of the most potent ways of doing this is to encourage very senior members of the medical establishment who have, themselves, experienced mental illness to 'come out', to make public their experience and to demonstrate that a very successful career after mental illness is possible and, indeed, to be expected. The testimonies of doctors who have survived mental illness and gone on to career success can be disseminated to doctors in training in a number of ways.

It is also clear that being a doctor in training can interfere with access to medical care both because of work and shift patterns making access to medical care difficult but also because of fears around confidentiality. This may combine to cause a delay in a doctor in training accessing medical help. While the argument continues about whether doctors should have a dedicated medical service such is their concern for confidentiality and the effects that the lack of it may have on their future career that the separation between their place of work and their employer and any source of health care has to be sufficient to make them feel

comfortable that accessing help for a mental illness cannot or will not be disclosed to their employer or their seniors.

The HEE (2019) Report, published after our fieldwork was conducted, has five recommendations specifically in relation to doctors in training, among an extensive list of recommendations relevant to a range of healthcare professionals:

- Each staff member to have a personal wellbeing tutor – separate from their clinical and educational supervisors, with protected time in their role.
- Educational and clinical supervisors should give clear guidance to trainees on the support available to allay fears associated with disclosure.
- Staff working on-call should have dedicated rest spaces.
- Confidential, rapid access referral pathways for support, based on a request from a primary care clinician or occupational health specialist
- Review the current allocation system for trainee placements to make it more just and more humane.

It is important to recognise that different countries and healthcare systems have different sets of pressures on trainee doctors and therefore it is important that we share findings and examples of good practice.

Policy implications

- A high-profile campaign across medical establishment should encourage any doctor who is ill to seek help and to make clear that how this can be achieved without any cause for anxiety about breaches in confidentiality and resultant damage to their career.
- A myth-busting campaign to demonstrate that disclosure of a mental illness will not damage the career of a doctor in training.
- Cultural issues which encourage presenteeism and working beyond contracted hours need to be addressed as problems of workforce welfare and patient safet*y*
- Help needs to be signposted not just at the beginning of placements but throughout making information available when it's needed

- Peers provide essential support but need to recognize that the point at which they need to encourage their fellow trainee doctor that they need the professional help.
- All support on offer should be independent, easily and confidentially accessed and well-publicised as an employment right
- Trainees learn best when they are properly supervised, lone working should be the exception rather than the rule. Access to supervision should be 24/7, with clear lines of responsibility
- Mentoring and support from group sessions in stressful situations should be the norm as should instruction in how to support a colleague with mental health concerns (mental health first aid)

A

Limitations of this study

The data presented here comes from just 34 participants across four focus groups. This is, clearly, not sufficient to give a representative sample. However, there was consistency across the four focus groups.

Further research

We propose the introduction of systemic changes that will address current prevailing attitudes towards mental health within the medical profession. Further research, therefore, will involve designing these changes and evaluating their impact.

Conclusion

Sufficient evidence, provided here and cited from other authors' work demonstrates that there is a problem, partly of culture, that prevents doctors in training from accessing medical care when they have a mental health problem, at least in part, because of their fears of the consequences of disclosing their illness. We have proposed, in this paper, that policy changes should be implemented that will address the most fundamental problem, that of attitudes towards mental illness in doctors and the effects of these attitudes on doctors behaviour when they experience mental illness'. In the last 40 years workplace culture in relation

to racism, misogyny and homophobia have changed dramatically and for the better. It must, therefore, be possible to change expressed attitudes towards mental illness within medicine. We do believe that this needs to come from the Profession itself.

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Appendix 1. Focus group topic guide

Introduction (5 minutes)

We need to state the aims of the study and their role in it

We need signatures to consent

Focus on:

The role of self-disclosure

Messages about mental health

Their knowledge of what is available by way of support

Barriers and enablers to access and usage

Task 1 – individual (10 minutes)

Consider the following statements

It’s a doctor thing; you are not supposed to get ill (medical student)

Mental illness is a weakness, a sign that you can’t cope with the pressures (junior doctor)

Mental illness is behind many performance issues; we are here to support junior doctors (clinical supervisor)

We encourage trainee doctors to develop insights into their mental health and to seek early help if they need it (professional support unit)

Mental ill health, of itself, is not a barrier to a career in medicine (GMC interviewee)

Rank the statements:

1 = most likely to influence your decision to disclose a mental health problem

5 = least likely to influence your decision to disclose a mental health problem

(needs a data capture form/pre prepared flip chart)

Task 2 - Group (10 Minutes)

What mental health services are available to trainees locally?

(use post its/flip chart to list)

Task 3 - Group (15 minutes)

What features encourage/discourage potential users to access and use these services?

Task 4 – Group (10 minutes)

How can we encourage a more positive view of mental health to support the aims of early disclosure and access?

(using results from the ranking exercise as a starting point)

Appendix 2 Analytical framework

MIMS coding frame for focus groups		
Code	Sub-code	Example
1. Formal support services	1.1 Clinical supervisor	*'I have been working in psychiatry, the biggest advantage I have found completely different to medicine is that we get one-hour supervision time with our consultant eery week and that is something that is mandatory, something that's recorded. And I find it really beneficial. It's the time when you can talk about anything.' FG002*
	1.2 Deanery/professional support unit	*'The deanery has got a support unit that you might find yourself being sent to at some point. It's not usually for mental health problems, it's usually for, you know, bad boy.' FG002*
	1.3 Mentor	*'We had a mentor which was a , nothing to do with your assessment. He or she was a consultant either within or outside of your discipline. You could choose......And it just gave the the opportunity once a fortnight, once a month, to talk through anything difficult that you had in the canteen with someone that was a consultant that has kind of been there,*

		been through it, done itall, seen it all before then they just kind of patted you on the head and say 'it's fine'.' FG002
	1.4 Educational supervisor	'*I might tell my educational supervisor because I have known them throughout the whole time but the clinical supervisor ....I have literally met them in the last week or so.' FG004* *'I think the educational supervisor would be the last person I would tell. I would seek services form lots of other avenues but not one that they are potentially assessing your performance and ability to be a doctor' FG001 F4p4*
	1.5 Royal Colleges	
	1.6 Occupational health in NHS Trust or hospital	'*I think occupational health offers something, they are quite good but then it's feeding into that' FG003p7*
	1.7 GP	*'I try and avoid my GP at all costs' FG002*
	1.8 Counselling services	*'I think there is a doctor for doctors.' ' I have heard of it as well, it seems like a myth.' FG002*
	1.9 GMC	
	1.10 BMA	
	1.11 Third sector organisations	

2. Informal support	2.1 Peers	*'[In] DGHs you have got all your juniors with you in exactly the same stage in their experience who can sort of chat to someone.' FG002*
	2.2 Doctors' mess/shared meals	
	2.3 Supportive consultants	*'Having moved from a big hospital to a very very small DGH now, I have never been happier actually. I relish coming into work. And now that I can approach any single one of my consultants with any problem whatsoever in a department of twenty-four consultants and I know that they will always lend me a sympathetic ear. Now I know that most of my happiness has been coming from that relationship which I never had in any larger hospitals.' FG002* *'I had one consultant who just said to me "ring me any time about patient stuff, but touchy feely stuff don't bring that to me".' FG003p11*
	2.4 Leaflets/written information	
	2.5 Family	

3 Barriers to accessing support	3.1 Stigma and shame	*'There is a bit of stigma around not being able to cope' FG004* *'I don't know if it's so much with the confidentiality buy maybe more of a stigma. I feel like if you went to your educational supervisor, a lot of them at first sort of reaction would be like "oh really, I didn't realise you were struggling" and just that sort of, that reaction would make me like "oh god they think of me differently now...they thought I was really competent and now they think I am really struggling with work or something".' FG001 F2p3*
	3.2 Fear of damage to career and prospects	*'If I tell, if I fess up to the fact that I am struggling is that going to create more pressure on me? Because suddenly the whole of the system is watching me to make sure I am coping…and I think the GMC is maybe the kind of the top of that ladder of things you don't want to be looking at you. Because at the end of the day they can tell you not to work.' FG004* *'am I safe to do this? Can I do this? This is what I want, this is the only career that I want but other people are making me feel that I am unsafe from a problem that I cannot help or avoid having. And it's devastating. It's destroying.' FG003p11*

	3.3 Not wanting to let colleagues down/pressure not to take time off	*'I feel that there is more pressure on us to come to work if you are slightly ill than there is for other people'. FG004*
	3.4 Lack of awareness of what is available	*'I don't think a lot of people are aware that your supervisors don't actually need to be aware if you seek support. It's kind of a private counselling thing' FG003p4*
	3.5 Insufficiently developed relationship with senior colleagues	*'I think it takes time to build up that relationship with people that you want to have that kind of conversation with and after four months we move on and have a new person to build a relationship with and maybe by the time you have done that you have decided you are not going to do it or when you need to do it you don't have the relationship there that you feel you can do it.' FG004*
	3.6 Anxieties about confidentiality	*'Having worked amongst health professionals I have seen it even if it's unintentional. I have seen other people break confidentiality frequently I would say' FG001 F1p3* *'feeling safe to disclose because I think you don't know what's going to like go with that information as soon as you get it out, where does it stop?' FG003p5*
	3.7 Culture	*'It's almost like you are not allowed to moan about it because everybody does it even though you might be really struggling' FG001 F3p10*

		'a neurosis, I find that people are just like, every time they talk to you they are just talking about work…it's so ingrained into their behaviour you can't get away from it. And it can cause stress and mental illness just by the very behaviour and the culture that's kind of, like, growing in the scenario.' FG003p2/3
	3.8 Unapproachable senior staff	'*If you felt the staff were approachable or not. I suppose if you had an educational supervisor that you didn't get on with maybe or was the cause of your mental health issues' FG001 M1p3*
	3.9 Structural problems	'*that's the viewpoint that some consultants and some of the older registrars used to do very long hour weeks but now I think it's kind of merging and understanding that now we don't get as much support. We don't have a firm structure, we work with different people every day and there is much more kind of financial pressures on the NHS which are making our lives harder. And I think that is slowly emerging in some of the older staff members now.' FG003p10*

4 Promoters of accessing support		
5 Promoters of well-being and resilience	5.1 Positive relationships with colleagues	*'we in a fairly stressful department set up like a biscuit rota and things which generally made the job a bit better' FG001 M1p12*
	5.2 Reflective practice	
	5.3 Yoga, mindfulness etc	
	5.4 Positive arrangements in departments	*'I have come from a job that was very well supported, very well staffed, enjoyable place to work, knew that I would be finishing on time and having a, and it wold be like a good day most days and now I have gone to a job where I feel it is understaffed, disorganised and I won't be finising on tme most days and that makes me stressed to go to work before I even start the day whereas I used to enjoy and look forward to going to work every day in my last rotation.' FG001 F2p11*
	5.5 Self-care and self-help	*'I think we have a responsibility to, we all know about the things that can help our mental health as someone said, exercising, getting a good night's sleep and things and think we are pretty bad at doing that' FG001 F3p12*

		'Bury it deep down inside' FG001 M1p2
6 Triggers of stress and mental ill-health	6.1 Loneliness/working alone	*'But night shift on you're own when you don't know anyone else, thoroughly miserable isn't it? There is no other word to describe it.' FG002*
	6.2 Rapid turnover between placements	*'There is a fair amount of switching of jobs like after six months then you move, and so you get shifted around a lot. I suppose that is quite destabilising.' FG002*
	6.3 Bullying	*'I think bullying certainly exists. I have seen it frequently.' FG002*
	6.4 Paperwork	
	6.5 Anxiety about medical error	*'You are so stressed with the situation and your name is in the notes as having refused, you can't write, it's unprofessional to write anything in there, other than just do your job, yet you know that this can then come up in coroners court and you won't be able to remember what the other three hundred things you had to do were because you are individually responsible, vicariously responsible for one thing, but you are in a system that it failing.' FG002*

	6.6 Excessive hours	*'things are much more stressful when you are tired aren't they. You can cope with pretty much anything if you have had a good night's sleep. But when you haven't and it accumulates then you know your threshold falls doesn't it, not coping' FG001 F4p9*
	6.7 Problems with taking leave	*'MAU and A&E, it's not even time off for compassionate leave, you don't even get time to talk about compassionate leave. It's just horrible.' FG003p9*
	6.8 Pressure of work/not enough staff	*'I think it's very very stressful, feeling bad at your job. Feeling that you are not doing your job very well. You want to help all these people and satisfy all these nurses and you just can't do it and it makes you feel rubbish. It makes you feel resourceless.' FG002*
	6.9 Attitudes of senior staff	*' I think juniors are seen as expendable' FG002*
7 Impact of stress	7.1 Loss of compassion	*'You go to medical school and then you get put through this grinder that makes, that churns out somebody who can do the job very well, you mustn't get sick, you work hard, and you don't care how many hours you do but you lose that human side. And the longer you are in it the more you lose.' FG002*
	7.2 Suicide or suicidal ideation	
	7.3 Burn-out	

	7.4 Using alcohol or drugs	
8 Suggestions for improvements	8.1 peer support groups	
	8.2 Buddy system	
	8.3 non NHS services	
	8.4 train supervisors	
9 Other	9.1 Ambiguity about when stress becomes mental ill health	
	9.2 Ambiguity about when complaining becomes asking for help	
	9.3 Ambiguity about when underperformance	*'in those days there was more clinical pressure but actually a lot less pressure because there was less scrutiny…If you have a mental health problem and you are being supported, that support will take the form of scrutiny' FG003p3*

	becomes mental ill health	
	9.4 Differences between different specialties	In primary care ' *I am starting to realise that I am actually responsible for the patient completely.... it just seems quite overwhelming really, especially at the beginning. Yeah and sitting in your own little room, that is quite isolating, having been used to being in a team all day on the ward' FG002* *'specialities where it would be useful, things like A&E, it's just really blanked out and they need you to work hard and keep working hard and there is just no time for anything else.' FG003p9*
	9.5 Doctors should be superhuman	'*Doctors are expected to be sort of demi gods who live every hour in work, have no human failings whatsoever, their lives are in complete order and they haven't got any health problems. And if you reveal any sort of weakness at all, there is still that relic from the past' FG001 F1p4*