Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2012-001776
Article Type:	Research
Date Submitted by the Author:	06-Jul-2012
Complete List of Authors:	HENDERSON, MAX; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON, PSYCHOLOGICAL MEDICINE BROOKS, SAMANTHA; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON, DEL BUSSO, LILLIANA; OSTFOLD UNIVERSITY COLLEGE, Chalder, Trudie; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON, HARVEY, SAMUEL; UNIVERSITY OF NEW SOUTH WALES, HOTOPF, MATTHEW; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON, MADAN, IRA; GUYS AND ST THOMAS NHS FOUNDATION TRUST, HATCH, STEPHANI; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON,
Primary Subject Heading:	Occupational and environmental medicine
Secondary Subject Heading:	Mental health, Qualitative research
Keywords:	MENTAL HEALTH, OCCUPATIONAL & INDUSTRIAL MEDICINE, Adult psychiatry < PSYCHIATRY, QUALITATIVE RESEARCH

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Dr Max Henderson [corresponding author]
Senior Lecturer in Epidemiological & Occupational Psychiatry
Institute of Psychiatry, Kings College London
Department of Psychological Medicine
Weston Education Centre, Cutcombe Road
London SE5 9RJ UK
T: 020 3228 8564
F: 020 7848 5408
E: max.j.henderson@kcl.ac.uk

Dr Samantha Brooks
Research Assistant
Institute of Psychiatry, Kings College London
London UK

Dr Lilliana del Busso
Associate Professor of Social Psychology
Østfold University College
Halden Norway

Professor Trudie Chalder PhD
Professor of Cognitive Behavioural Therapy
Institute of Psychiatry, Kings College London
London UK

Dr Samuel B Harvey PhD
Senior Lecturer in Workplace Mental Health
School of Psychiatry, University of New South Wales
Sydney Australia

Professor Matthew Hotopf PhD
Professor of General Hospital Psychiatry
Institute of Psychiatry, Kings College London
London UK

Dr Ira Madan MD
Consultant Occupational Physician
St Thomas' Hospital
London UK

Dr Stephani Hatch PhD
Lecturer in Social Epidemiology
Institute of Psychiatry, Kings College London
London UK

[4202 words]

ABSTRACT

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 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. We 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.

[240 words]

ARTICLE SUMMARY

Article focus

- Doctors have rates of mental illness, drug and alcohol misuse and suicide at least as high as the general population though many doctors have difficulty accessing appropriate mainstream health care often due to fears about confidentiality.
- A number of studies have examined risk factors for doctors becoming ill but no studies have examined the difficulties faced by sick doctors in returning to work.
- Our qualitative study used in-depth semi-structured interviews to assess the views of doctors who had been away from work for at least six months on the obstacles to them returning to work.

Key Messages

- Illness, surprising to many doctors, forces an entire reappraisal of their view of the world and their place within it.
- Many doctors internalise the perceived negative responses of colleagues and others to their illness
- These factors contribute to the difficulties faced by doctors in returning to work.

Strengths and limitations

- We recruited 19 doctors from all over the UK in partnership with the General Medical Council, the Royal Medical Benevolent Fund and the Practitioner Health Programme.
- Our methodology meant that we have no way of knowing anything about the doctors who were approached by our partner organisations but decided not to take part. Further, we only have the doctors own accounts and no independent way of understanding for example the relationship between their initial reason for stopping work and their current problems.

Background

Daksha Emson, a trainee psychiatrist with bipolar affective disorder, killed herself and her daughter in October 2000. She was terrified that her career would be adversely affected if her illness was disclosed(1). Not long after this Dame Janet Smith who chaired the Shipman Inquiry heavily criticised the General Medical Council (GMC) for being more concerned with the interests of doctors than patients(2). In the last 15 years there has been a growing interest in the health of healthcare professionals(3-7). Whilst doctors have rates of mental illness, drug and alcohol misuse and suicide at least as high, if not higher, than the general population(8), for many reasons they struggle to engage with mainstream healthcare. In 2009 a pilot service, The Practitioner Health Programme, was established for doctors with psychiatric or physical health problems that were interfering with their work(9). In 2010 the Department of Health published *Invisible Patients*(10) which provided a detailed account of the difficulties faced by health professionals with mental health problems accessing appropriate care, and called on the regulator to provide greater consistency in the assessment of the impact of health difficulties on performance.

Notwithstanding this increased interest there have been few qualitative studies of doctors, and none specifically looking at the question of obstacles preventing return to work for doctors with complex needs. Fatholm interviewed 15 doctors who had successfully returned to work after a period of prolonged sick leave (11). Doctors commented on how hard they found it holding the identity of both a doctor and a patient. Several described having resisted sick leave fearing their own clinical competence would be questioned. A number reported 'negotiating' with their own doctor in an attempt to expedite their return to work. Fox spoke to doctors with significant long term illness (12). Further issues around personal identity emerged, as did comments about the culture of "invincibility" within medicine, and how sick doctors need to put on 'facade'. Ingstad (13) identified participants who had been asked by their doctor to make clinical decisions about their own health. The tension between the role of the patient and that of the doctor was also

discussed by McTevitt (14) who described how some doctors find it difficult to cede control and thereby cease being the "expert" in a two-person relationship. In contrast Stanton highlighted how non-medical friends and colleagues can identify that “something is wrong” yet find themselves disempowered by the doctor-patient’s medical knowledge when trying to discuss this(15).

Beyond the issues with access to appropriate services and the complications of regulatory involvement, relatively little is known about the ability of doctors to be able to return to work after a period of sick leave. We explored the views of doctors with a range of physical and psychiatric health problems, with and without GMC involvement, on the obstacles that prevent them from returning to work.

Methods

We carried out a qualitative study to examine the views of doctors with complex needs on the obstacles they faced in returning to work. Ethical approval was granted by the South East London Research Ethics Committee. Although the Royal Medical Benevolent Fund funded this study, they had no role in the study design, data analyses, or data interpretation.

For this study we defined doctors with complex needs as those currently away from work more than six months due to problems with their health, with or without involvement with the GMC, or who had a similar period of absence within the last year. Doctors from across the UK were eligible for inclusion. We excluded doctors who had any ongoing health problem, physical or psychiatric, that would make an in-depth 90 minute interview distressing or uncomfortable.

We formed partnership arrangements with the General Medical Council, the Practitioner Health Programme, and the Royal Medical Benevolent Fund. Recognising the importance of confidentiality, these organisations agreed to an ‘arms-length’ arrangement whereby they would identify potential participants, based on our eligibility criteria, and give them a letter of

introduction from the research team. The letter contained details of how the potential participant could make contact with the research team if they wished to take part. The research team therefore had no knowledge of potential participants who did not make contact. Moreover, the partner organisations did not know which of the doctors they had identified made contact with the research team. There was no exchange of information about the doctor between the research team and the partner organisation.

A detailed interview guide was prepared initially by MJH and LdB, and then amended following discussions with the rest of the research team. The content of this guide and its performance were reviewed by the research team after 3 interviews, though no major changes were felt necessary. The researchers (LdB and SB) determined eligibility and gained consent from potential participants. Those interested were invited to take part in an in-depth semi-structured interview. When the researchers met the participants the nature and purpose of the study was explained again. Participants had the opportunity to ask questions. All participants provided full written consent to take part in the study.

A total of 19 interviews were completed; the first ten interviews were completed by LdB and the last nine by SB. Each interview lasted between one and two hours. Interviews were recorded directly onto an encrypted drive on a laptop computer then transcribed verbatim. Using the Nvivo software package(16), transcripts were analysed by thematic content analysis using the constant comparison method(17). The two researchers (LdB and SB) each analysed all the transcripts using a thematic analysis(17). Initially the researchers each completed the coding procedure independently. They then compared codes and reached consensus on the emerging themes by discussion leading to a final set of agreed codes. Emerging themes were discussed regularly by the research team. In addition both researchers engaged in a process of reflexivity. They each recorded details of the interviewing interaction, and reflected on their own experience which may have had an impact on the interpretation of data.

Results

Recruitment

77 doctors were informed about the study by the partner organisations. No potential participants were believed to meet exclusion criteria. Given our recruitment methodology we do not know which partner organisation introduced each participant. A number of the doctors were known to more than one of the partners, though this does not necessarily mean they were contacted by each. Thirty of those provided with information about the study made contact with the researchers. Nineteen (25% of the 77) doctors took part in the study. At least two doctors who had initially expressed an interest subsequently became too unwell to participate. The reasons given by other potential participants for not taking part included not wishing to be recorded, and ongoing concerns, despite reassurance, regarding confidentiality. All doctors who took part were able to complete the interview.

The participants are described in Table 1. Their ages ranged from 20s to 60s. All but one doctor had a mental health or addiction problem, and 14 had involvement with the GMC.

(Table 1 about here)

Importance of work identity

Participants reported their job as an important part of their identity, and many described being deeply committed to their work and defined themselves in these terms. Often this related to the effort and sacrifice that went into becoming a doctor. For many of the participants going off work sick was associated with a fundamental change in identity. Many appeared to incorporate negative views of themselves into their new identity. While the loss of income was mentioned by some of the doctors, the loss of identity was rarely about the financial aspects alone.

> *"I want to work. I would have liked to have worked, for lots of reasons. I think it's good for anybody to have a structure to their life and purpose. I have always wanted to be a doctor and I trained as a mature student in medicine. So I sacrificed a lot. And I*

loved my job. So for all those reasons it was really important to me to go back to work." [#11]

"You get to be part of your job, it becomes part of you..." [#17]

Perhaps as a consequence, being away from work then left them feeling lost, isolated and sad.

"..once you try and put that doctor persona aside, I realised there wasn't much left of me" [#9]

"I can't, emotionally I can't retire. I mean, I gotta be involved. I feel a total emptiness" [#10]

"..because I have spent all my entire adult life from the first year of my medical school to 2008, I mean its nearly two decades, so and then everything is taken from you. You have been left alone and no one can hear it if you no matter how loudly cry and so it is very, very difficult, and you see hopeless helpless, and nowhere to go and you just simply got lost in a, in a huge sea without any navigator and you don't know what to do" [#12]

"I almost didn't want to do the normal things like going out, because I almost wanted that to be on hold before I started working again, because work was so important...I also I think with the sense that because I wasn't working I shouldn't be almost allowed to do all the things that, or any fun things like because I wasn't working I shouldn't be going out and having any sort – doing any sort of non-work-related, or non-serious sort of activity" [#18]

Relationships with family and friends

Many, though not all, doctors had absorbed negative responses they had received from family and friends. The impact of no longer working appeared to be super-imposed on that of the illness itself. Some even tried to conceal their difficulties from their close family.

A number of participants spoke about the change in the nature of their close relationships that had been brought about by their difficulties.

> *"My relationship with my children has changed very much and that's an ongoing thing which I'll have to face as they get older and learn more about me and what I can and can't do. And obviously even my wife has completely changed, as you can imagine. But I've been fortunate in the fact that they've all been very accepting and supportive of me"* [#11]

There were several doctors who described very positive experiences of support.

> *"My friends were very supportive. I think they put up with a lot really in a sense because I was very unwell on and off. In the same way as I got weary of it I'm sure they did and there were crises. As I say, even when I was well I didn't think I was that great, but no, they were very supportive....They really stuck by me. I think they couldn't really understand what was happening. They had no background in psychiatry or anything but they could see that none of these tablets were really helping things and I think it must have been very, very frustrating for them. I think I owe them a lot really"* [#14]

> *"I live with my husband and we have quite a few really good friends who live nearby .. and they were, kind of, the people who got me through really. So, all of them were people I could talk to who would understand, who would, kind of, pray for me, support me, and really see, they saw the effect it was having on me because they knew me and I could be open and honest with them. Yeah, without them I don't know what, how it would have gone really"* [#5]

In contrast, several doctors reported receiving less than adequate support from family and friends.

> *"Mostly he [partner] detached himself, carried on working and regarded me as a nuisance...my family have really put me into the sort of bad category"* [#19]

> *"I have gone down in their esteem because of the problems at work...they didn't think too highly of me for that"* [#7]

> *"I am quite an outsider in my family"* [#5]

To avoid negative changes in close relationships, more than one doctor resorted to concealing their difficulties from their families.

> *"I heard that most doctors, they don't actually want to involve anyone else, because it's just a stigma and a shame on themselves, that something happened, so even my close family did not know what happened"* [#12]

> *"Sometimes there's a situation where I'm going to rush off to a [Alcoholic Anonymous] meeting and they're still in our house having a cup of tea and it's like 'Oh, I'm just off to go and meet a friend'. I am kind of; I'm just not telling them the whole truth but I don't feel I'm lying. I'm just protecting them, protecting our relationship, protecting our family"* [#9]

Professional relationships

Many participants reported a negative response to their situation from colleagues. Such responses were more internalised than challenged and doctors used terms such as "failure", "uncomfortable", "shame" and "guilt" when describing themselves.

Several doctors recalled the support they had received from colleagues – both doctors and other healthcare professionals.

"They came to visit me in the hospital. I remember one of the nurses commented she'd never seen so many doctors on the ward before at once. I was surrounded by about eight [specialty] registrars. They'd all come en masse to visit me. And my consultant direct educational supervisor boss at the time was being very nice. He'd occasionally ring to find out how things were going and so on. So they were very good" [# 11]

"The nursing staff, ancillary staff, other medical staff outside of the department were extremely supportive. They would come over and open the car door and shake my hand. Some of them sent me emails and phoned me and I really felt welcomed back. Less so with my own colleagues but having said that, they've been through the wars with me and they supported me big time before [year] and then I had a relapse and then I think they probably felt "That's it, he'll not be back." Then I come back, it's difficult for them and maybe that's passing in time though" [#16]

"I was actually quite pleasantly surprised that a lot of my friends from work were very supportive. When asked for testimonials for GMC for me and wrote a lot of very nice things about me including those who turned up and actually spoke on my behalf" [#17]

However, doctors not caring about other doctors were mentioned by several participants. Doctors described their experiences of support or the lack thereof, in contrast to the care doctors provide for their patients. Moreover the lack of caring was described as a cultural and attitudinal issue rather than purely situational. Many doctors observed and experienced this culture of support, both when others have gone off sick, and whilst they themselves have been ill.

"*I mean we're meant to be caring people [laughs] but we don't, don't seem to care about each other at all in my experience"* [#3]

"Most of the consultants (...) were not bothered at all, and I don't think they would really care unless you drop dead and they were only bothered about the work being done, regardless of what happened to you. And I think the only time they would get concerned is if the work wasn't being done (...) if I was just talking to a friend, I would just say, "They do not care about junior doctors, consultants, and they don't care about their welfare" [#18]

> *"It was a bit unfortunate that at the time I went off sick one of my [specialty] training colleagues went off sick as well and she went the week before me and she was absolutely slammed, it was just, 'Oh it's disgusting, she shouldn't be going off sick, there's nothing the matter with her,' and I was going, 'Well she's really stressed, she's not sleeping,' all the things, she shouldn't be at work. 'Oh but you know…' and then of course the next week it was me. But I just think unless you can change how doctors as a generic body, nationally, perceive mental illness you are never going to change it"* [#2]

> *"You're seen as being weak, and one comment I had from this... from the Head of Department in my last job was when she found out I was going for psychotherapy and she said, "I suppose if you need it," was her attitude, as if I were some inferior person because I was having psychotherapy."* [#7]

It is therefore no surprise that the anticipation of their colleagues' response is an important factor as a doctor gets ready to start the return to work system.

> *"I've still got to get over the hurdle of meeting my colleagues, knowing what they've said about me...knowing that is going to be difficult"* [#2]

> *"I don't like it when I feel...that people know and that I am being judged...I find that quite uncomfortable"* [#3]

> *"I think there's a perception that doctors who experience medical conditions should not be doc-, or at least there was a perception amongst the people, who I've... some of the people of my experience, that they shouldn't be in the profession."* [#18]

Overall, feelings of being "a failure" became a generalised self-perception rather than specific to the loss of the work role. For most participants, the experience of being a doctor away from work culminated in an internalised, altered sense of self.

> *"There was guilt, there was shame, there was fear...there was low self-esteem...there was the uncertainty of medicine. Self-confidence – that plummeted"* [#9]

> *"But my confidence has totally gone....I've felt a total failure and I still sometimes do"* [#5]

> *"I think I felt like a bit of a failure....if you even said to me that I would not be working, about 2 years before this...I'd have said "What a loser!"* [#18]

Finally, for some doctors the impact of their experience with colleagues and in the work place was exacerbated by stigmatisation based on existing disabilities.

> *Er, I think, I always felt that there was, erm, so much wrong with me already, that I didn't want to be seen as someone who, kind of, exaggerated or had loads of things wrong with them, and always, kind of, moaned and, I just didn't want people to think I was looking for sympathy or, I don't know, I just, I just thought, I just didn't want to be treated any more differently and I thought if I tell somebody…they might not involve me in certain conversations, or they might talk about me with each other, and I just didn't want any of that, so… [#6]*

> *Erm developing [physical disability] and erm … and just a total dearth of information about how you practice as a healthcare professional with [physical disability] …Nobody I could find knew anything about that. …but the huge thing was just erm living…it was erm adapting to a new disability both socially and erm er professionally. Erm there's a high rate of depression in [people with physical disability], much higher than the general population, higher than [physical disability]. [#5]*

Discussion

We carried out in-depth interviews on 19 doctors who had been off work for six months or more. These doctors had various combinations of physical and psychiatric disorders. The majority, though not all, had had some dealings with the General Medical Council. Commitment to, and identifying with, the role of a doctor was a common theme that emerged. It is likely that medicine with its long training and long hours of work preferentially attracts individuals likely to make a commitment to their work. The flip-side of such an approach is the relative absence of an alternative structure or purpose if, for whatever reason, an individual is unable to work.

The centrality of this role also seemed to be strengthened by the perception amongst doctors that they are "invincible", and that "illness is only for patients", alluded to in both Cohen's review for the Royal Medical Benevolent Fund (Cohen D – personal communication) and Harvey's

review for the National Clinical Assessment Service(8). It is understandable therefore that for some doctors the recognition of illness presents a challenge over and above that of just the disorder – it forces an entire reappraisal of their view of the world and their place within it. The accounts given by several doctors convey a sense of great surprise, often only implicitly, that they had suffered a health problem. Whilst these issues have been recognised as factors in delaying or preventing a doctor seeking medical attention(8, 18), they have not previously been considered as reasons for a doctor having difficulty in returning to work.

One of the most striking findings was the negative view the doctors had of themselves since ill health became a part of their identity. This was clearly exacerbated by the views and behaviours they perceived or encountered from family members and colleagues. The participants in our study described having experienced negative interactions with their families and colleagues during their illness, but also seemed to anticipate this as part of any return to work process(19). It has been suggested that doctors stigmatise mental illness more than the public(20) , but the self-stigmatisation seemed to extend to physical illness as well. As is common with stigma, the doctors' accounts are likely, in part, to represent negative internalised self-perceptions and their views about how others perceive them(21, 22).

Profound and potentially destructive negative self-images were shared by several participants. Whilst low self esteem can be part of a depressive disorder, not all doctors had experienced a depressive episode or were currently suffering from depression; a number had made a clinical recovery from their health condition. Our findings went beyond low self esteem into the realm of self-stigma. Self-stigma describes the phenomenon whereby people adopt and internalize external social stigma and experience loss of self-esteem and self-efficacy(23, 24). As a result, they refrain from taking an active role in various areas of life. Many of the doctors we interviewed appeared to have absorbed negative views of themselves. Moreover, at least two doctors described difficulties in dealing with having a disabling physical health problem, only to

then have to cope with yet more perceived criticism regarding a mental health problem. It is possible that in absorbing them, doctors perpetuate and reinforce the negative views of others.

Any understanding of the difficulties faced by doctors in returning to work needs to be able to incorporate both the omnipotent "doctors are invincible" view and the negative self-stigmatising views elicited in our study. Although these may seem to be mutually exclusive, an alternative hypothesis would be that the self-stigmatising views are a direct consequence of the unhealthy "doctors are invincible" view. The competitive medical environment reinforces the need for toughness and self-reliance which has become more of a wider cultural phenomenon rather than a trait identified in a few. It is possible that, for some, this has a selective advantage – that is, for some students and trainees this outlook assists in being able to manage the suffering of the patients and families they are learning to treat. Its success in the short-term means it often remains unchallenged. The incorporation of the "illness is for patients" view however reduces the chances of alternative "healthier" narratives about the interchangeability of the patient and doctor roles being generated. Thus when a doctor does become ill they are challenged on a range of levels, dealing not only with the illness but also for some the loss of their self-image as invincible.

A number of doctors though do not have access to strategies which will allow them to come to terms with these issues whilst maintaining their personal integrity. A greater willingness to accept the possibility that one might at some stage become a patient, together with greater input from trainers and senior colleagues as to how this might be managed, could reduce the sense of shock and bewilderment should illness strike.

As with all stigma, reducing social distance can help change minds(25). It is possible that recent improvements in the quality of NHS occupational health services(26) and the services provided to treat sick doctors, such as the Practitioner Health Programme, might mean that more doctors who have had complex difficulties are able to return to active practice more rapidly. The presence of these doctors in the workforce will therefore increase over time, improving the

chance that students and trainees will come into contact with such doctors, and this will act as a counter-weight to the notion that "doctors are invincible". But if we are to create an environment which facilitates the return to work of doctors with complex needs, attention must be paid to how the "invincible" culture in medicine is generated. The regulator, which now has responsibility for UK medical undergraduates, the Deaneries and the medical schools must work together to enable students and trainees to recognise their own vulnerabilities and facilitate the generation of strategies should they become ill. Further, aspects of personal and colleague health, especially mental health, should be part of the curriculum for all medical students. Doctors must learn to provide themselves and their colleagues with the same level of excellent care that they provide for their patients.

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Table 1. Participant characteristics

Participant number	Gender	Physical health problem?	Mental health problem/addiction?	GMC involvement?
1	M	Yes	Yes	Yes
2	F	Yes	Yes	Yes
3	F	No	Yes	Yes
4	M	No	Yes	Yes
5	F	Yes	Yes	No
6	F	Yes	Yes	No
7	F	No	Yes	Yes
8	F	No	Yes	Yes
9	M	No	Yes	Yes
10	M	No	Yes	No
11	M	Yes	No	No
12	M	No	Yes	Yes
13	F	No	Yes	Yes
14	F	No	Yes	Yes
15	M	Yes	Yes	Yes
16	M	No	Yes	Yes
17	M	No	Yes	Yes
18	F	No	Yes	No
19	F	Yes	Yes	Yes

STATEMENTS

Competing Interests

"All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: Dr Brooks and Dr del Busso had financial support from Royal Medical Benevolent Fund for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous 3 years; no other relationships or activities that could appear to have influenced the submitted work."

Ethics Approval

Approval for this study was granted by the South East London Research Ethics Committee [10/H0807/33].

Authors Contributions

Henderson, Hotopf, and Harvey had the initial idea for the study. Henderson, Hotopf, Harvey, Madan, Hatch, and Chalder refined the study methodology. Del Busso and Brooks carried out the initial analyses. Henderson, del Busso, and Brooks wrote the initial draft. Hotopf, Harvey, Madan, Hatch and Chalder revised the draft critically for important intellectual content.

Acknowledgements

We gratefully acknowledge the funding provided by the Royal Medical Benevolent Fund. We are grateful for the support of the General Medical Council, the Practitioner Health Programme and all the study participants who gave their time so generously.

This study was funded by a grant from the Royal Medical Benevolent Fund. The funder had no input into the design, analysis and interpretation of the data, the writing of the report or the decision to submit the article for publication. The funder contributed to the identification of

potential participants as described in the Methods section. All the researchers are independent of the funders.

Data

No additional data are available

BMJ open

Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2012-001776.R1
Article Type:	Research
Date Submitted by the Author:	19-Aug-2012
Complete List of Authors:	HENDERSON, MAX; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON, PSYCHOLOGICAL MEDICINE BROOKS, SAMANTHA; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON, DEL BUSSO, LILLIANA; OSTFOLD UNIVERSITY COLLEGE, Chalder, Trudie; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON, HARVEY, SAMUEL; UNIVERSITY OF NEW SOUTH WALES, HOTOPF, MATTHEW; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON, MADAN, IRA; GUYS AND ST THOMAS NHS FOUNDATION TRUST, HATCH, STEPHANI; INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON,
Primary Subject Heading:	Occupational and environmental medicine
Secondary Subject Heading:	Mental health, Qualitative research
Keywords:	MENTAL HEALTH, OCCUPATIONAL & INDUSTRIAL MEDICINE, Adult psychiatry < PSYCHIATRY, QUALITATIVE RESEARCH

Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study

Dr Max Henderson [corresponding author]
Senior Lecturer in Epidemiological & Occupational Psychiatry
Institute of Psychiatry, Kings College London
Department of Psychological Medicine
Weston Education Centre, Cutcombe Road
London SE5 9RJ UK
T: 020 3228 8564
F: 020 7848 5408
E: max.j.henderson@kcl.ac.uk

Dr Samantha K. Brooks
Research Assistant
Institute of Psychiatry, Kings College London
London UK

Dr Lilliana del Busso
Associate Professor of Social Psychology
Østfold University College
Halden Norway

Professor Trudie Chalder PhD
Professor of Cognitive Behavioural Therapy
Institute of Psychiatry, Kings College London
London UK

Dr Samuel B Harvey PhD
Senior Lecturer in Workplace Mental Health
School of Psychiatry, University of New South Wales
Sydney Australia

Professor Matthew Hotopf PhD
Professor of General Hospital Psychiatry
Institute of Psychiatry, Kings College London
London UK

Dr Ira Madan MD
Consultant Occupational Physician
St Thomas' Hospital
London UK

Dr Stephani Hatch PhD
Lecturer in Social Epidemiology
Institute of Psychiatry, Kings College London
London UK

[5071 words]

ABSTRACT

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 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. We 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.

[240 words]

ARTICLE SUMMARY

Article focus

- Doctors have rates of mental illness, drug and alcohol misuse and suicide at least as high as the general population though many doctors have difficulty accessing appropriate mainstream health care often due to fears about confidentiality.
- A number of studies have examined risk factors for doctors becoming ill but no studies have examined the difficulties faced by sick doctors in returning to work.
- Our qualitative study used in-depth semi-structured interviews to assess the views of doctors who had been away from work for at least six months on the obstacles to them returning to work.

Key Messages

- Illness, surprising to many doctors, forces an entire reappraisal of their view of the world and their place within it.
- Many doctors internalise the perceived negative responses of colleagues and others to their illness
- These factors contribute to the difficulties faced by doctors in returning to work.

Strengths and limitations

- We recruited 19 doctors from all over the UK in partnership with the General Medical Council, the Royal Medical Benevolent Fund and the Practitioner Health Programme.
- Our methodology meant that we have no way of knowing anything about the doctors who were approached by our partner organisations but decided not to take part. Further, we only have the doctors own accounts and no independent way of understanding for example the relationship between their initial reason for stopping work and their current problems.

Background

Daksha Emson, a trainee psychiatrist with bipolar affective disorder, killed herself and her daughter in October 2000. She was terrified that her career would be adversely affected if her illness was disclosed(1). Not long after this Dame Janet Smith who chaired the Shipman Inquiry heavily criticised the General Medical Council (GMC) for being more concerned with the interests of doctors than patients(2). In the last 15 years there has been a growing interest in the health of healthcare professionals(3-7). Whilst doctors have rates of mental illness, drug and alcohol misuse and suicide at least as high, if not higher, than the general population(8), for many reasons they struggle to engage with mainstream healthcare. In 2009 a pilot service, The Practitioner Health Programme, was established for doctors with psychiatric or physical health problems that were interfering with their work(9). In 2010 the Department of Health published *Invisible Patients*(10) which provided a detailed account of the difficulties faced by health professionals with mental health problems accessing appropriate care, and called on the regulator to provide greater consistency in the assessment of the impact of health difficulties on performance.

Notwithstanding this increased interest there have been few qualitative studies of doctors, and none specifically looking at the question of obstacles preventing return to work for doctors with long term difficulties. There is a small literature on obstacles to a successful return to work for the general population. Dekkers-Sanchez (11) used focus group methodology to uncover four broad areas – personal factors, health-related factors, social obstacles and work-related obstacles. A range of perceptual issues were described in the context of personal factors, including self-efficacy and illness representations. Individual perceptions of self, work, and the ability to cope with returning to work emerged from Marhold's study of Obstacles to Return-to-Work Questionnaire (12). These were further influenced by pain and mood. The study identified concerns that returning to work might lead to a worsening of symptoms as particularly relevant. Andersen recently published a meta-synthesis of qualitative studies examining return to work

for people with common mental disorders (13). Emerging themes were grouped as personal factors, support in the workplace, and wider economic and societal issues. This important paper emphasised that returning to work is a process into which past experience, current perception and anticipation of the future all input.

Although to our knowledge no papers on doctors have had obstacles to returning to work as their main focus, several studies exploring the general experience of being a sick doctor have found that doctors emphasise the difficulty of being off work and the barriers faced in returning to work after sickness absence. Fatholm interviewed 15 doctors who had successfully returned to work after a period of prolonged sick leave (14). Doctors commented on how hard they found it holding the identity of both a doctor and a patient. Several described having resisted sick leave fearing their own clinical competence would be questioned. A number reported 'negotiating' with their own doctor in an attempt to expedite their return to work. Fox spoke to doctors with significant long term illness (15). Further issues around personal identity emerged, as did comments about the culture of "invincibility" within medicine, and how sick doctors need to put on 'facade'. Ingstad (16) identified participants who had been asked by their doctor to make clinical decisions about their own health. The tension between the role of the patient and that of the doctor was also discussed by McTevitt (17) who described how some doctors find it difficult to cede control and thereby cease being the "expert" in a two-person relationship. In contrast Stanton highlighted how non-medical friends and colleagues can identify that "something is wrong" yet find themselves disempowered by the doctor-patient's medical knowledge when trying to discuss this(18).

Beyond the issues with access to appropriate services and the complications of regulatory involvement, relatively little is known about the ability of doctors to be able to return to work after a period of sick leave. We explored the views of doctors with a range of physical and psychiatric health problems, with and without GMC involvement, on the obstacles that prevent them from returning to work.

Methods

We carried out a qualitative study to examine the views of doctors with long term difficulties on the obstacles they faced in returning to work. Ethical approval was granted by the South East London Research Ethics Committee. Although the Royal Medical Benevolent Fund funded this study, they had no role in the study design, data analyses, or data interpretation.

For this study we defined doctors with long term difficulties as those currently away from work more than six months due to problems with their health, with or without involvement with the GMC, or who had a similar period of absence within the last year. Doctors from across the UK were eligible for inclusion. We excluded doctors who had any ongoing health problem, physical or psychiatric, that would make an in-depth 90 minute interview distressing or uncomfortable.

We formed partnership arrangements with the General Medical Council, the Practitioner Health Programme, and the Royal Medical Benevolent Fund. Recognising the importance of confidentiality, these organisations agreed to an 'arms-length' arrangement whereby they would identify potential participants, based on our eligibility criteria, and give them a letter of introduction from the research team. The letter contained details of how the potential participant could make contact with the research team if they wished to take part. The research team therefore had no knowledge of potential participants who did not make contact. Moreover, the partner organisations did not know which of the doctors they had identified made contact with the research team. There was no exchange of information about the doctor between the research team and the partner organisation.

A detailed interview guide was prepared initially by MJH and LdB, and then amended following discussions with the rest of the research team. The content of this guide and its performance were reviewed by the research team after 3 interviews, though no major changes were felt necessary. The researchers (LdB and SB) determined eligibility and gained consent

from potential participants. Those interested were invited to take part in an in-depth semi-structured interview. When the researchers met the participants the nature and purpose of the study was explained again. Participants had the opportunity to ask questions. All participants provided full written consent to take part in the study.

A total of 19 interviews were completed; the first ten interviews were completed by LdB and the last nine by SB. Each interview lasted between one and two hours. Interviews were recorded directly onto an encrypted drive on a laptop computer then transcribed verbatim. Using the Nvivo software package(19), transcripts were analysed by thematic content analysis using the constant comparison method(20). The two researchers (LdB and SB) each analysed all the transcripts using an inductive approach to thematic analysis(20), using NVivo to 'code' data in order to build a set of 'themes' i.e. ideas or topics occurring at several points in the data corpus. Initially the researchers each completed the coding procedure independently. They then compared codes and reached consensus on the emerging themes by discussion leading to a final agreed master list of themes and sub-themes. Emerging themes were discussed regularly by the research team. This type of thematic analysis is inductive, i.e. the themes emerged from the data itself and were not imposed by the researchers. In addition both researchers engaged in a process of reflexivity. They each recorded details of the interviewing interaction, and reflected on their own experience which may have had an impact on the interpretation of data.

Results

Recruitment

77 doctors were informed about the study by the partner organisations. No potential participants were believed to meet exclusion criteria. Given our recruitment methodology we do not know which partner organisation introduced each participant. A number of the doctors were known to more than one of the partners, though this does not necessarily mean they were contacted by

each. Thirty of those provided with information about the study made contact with the researchers. Nineteen (25% of the 77) doctors took part in the study. At least two doctors who had initially expressed an interest subsequently became too unwell to participate. The reasons given by other potential participants for not taking part included not wishing to be recorded, and ongoing concerns, despite reassurance, regarding confidentiality. All doctors who took part were able to complete the interview.

The participants are described in Table 1. Their ages ranged from 27 – 67 years and the median age was 46. Diagnoses included depression, anxiety, bipolar affective disorder and alcohol dependence. All but one doctor had a mental health or addiction problem, seven had a physical health problem and 14 had involvement with the GMC.

(Table 1 about here)

Four main themes and a number of sub-themes were identified. The main themes which emerged from the data were: work identity; relationships with family and friends; professional relationships; and self perception. Sub-themes relating to work identity included identity being bound up with career, and feelings of emptiness when not at work. Sub-themes relating to relationships with family and friends included changes in relationships due to their difficulties; positive support; feeling unsupported; and concealing difficulties from others. Sub-themes relating to professional relationships included support; lack of caring; anticipating feeling judged on return to work; and stigmatisation. Sub-themes relating to self perception included sense of failure becoming generalised rather than specific to loss of work, and an altered sense of self due to being away from work.

Work identity

Participants reported their job as an important part of their identity, and many described being deeply committed to their work and defined themselves in these terms. Often this related to the effort and sacrifice that went into becoming a doctor. For many of the participants going off

work sick was associated with a fundamental change in identity. Many appeared to incorporate negative views of themselves into their new identity. While the loss of income was mentioned by some of the doctors, the loss of identity was rarely about the financial aspects alone.

> *"I want to work. I would have liked to have worked, for lots of reasons. I think it's good for anybody to have a structure to their life and purpose. I have always wanted to be a doctor and I trained as a mature student in medicine. So I sacrificed a lot. And I loved my job. So for all those reasons it was really important to me to go back to work." [#11]*

> *"You get to be part of your job, it becomes part of you..."* [#17]

Perhaps as a consequence, being away from work then left them feeling lost, isolated and sad.

> *"..once you try and put that doctor persona aside, I realised there wasn't much left of me"* [#9]

> *"I can't, emotionally I can't retire. I mean, I gotta be involved. I feel a total emptiness"* [#10]

> *"..because I have spent all my entire adult life from the first year of my medical school to 2008, I mean its nearly two decades, so and then everything is taken from you. You have been left alone and no one can hear it if you no matter how loudly cry and so it is very, very difficult (...) you just simply got lost in a, in a huge sea without any navigator and you don't know what to do" [#12]*

> *"I almost didn't want to do the normal things like going out, because I almost wanted that to be on hold before I started working again, because work was so important...I also I think with the sense that because I wasn't working I shouldn't be almost allowed ... I shouldn't be going out and having any sort – doing any sort of non-work-related, or non-serious sort of activity" [#18]*

Relationships with family and friends

Many, though not all, doctors had absorbed negative responses they had received from family and friends. The impact of no longer working appeared to be super-imposed on that of the illness itself. Some even tried to conceal their difficulties from their close family.

A number of participants spoke about the change in the nature of their close relationships that had been brought about by their difficulties.

> *"My relationship with my children has changed very much and that's an ongoing thing which I'll have to face as they get older and learn more about me and what I can and can't do. And obviously even my wife has completely changed, as you can imagine. But I've been fortunate in the fact that they've all been very accepting and supportive of me"* [#11]

There were several doctors who described very positive experiences of support.

> *"My friends were very supportive. I think they put up with a lot really in a sense because I was very unwell on and off. They really stuck by me. I think they couldn't really understand what was happening. They had no background in psychiatry or anything but they could see that none of these tablets were really helping things and I think it must have been very, very frustrating for them. I think I owe them a lot really"* [#14]

> *"I live with my husband and we have quite a few really good friends who live nearby .. and they were, kind of, the people who got me through really. So, all of them were people I could talk to who would understand, who would, kind of, pray for me, support me, and really see, they saw the effect it was having on me because they knew me and I could be open and honest with them"* [#5]

In contrast, several doctors reported receiving less than adequate support from family and friends.

"Mostly he [partner] detached himself, carried on working and regarded me as a nuisance...my family have really put me into the sort of bad category" [#19]

"I have gone down in their esteem because of the problems at work...they didn't think too highly of me for that" [#7]

"I am quite an outsider in my family" [#5]

To avoid negative changes in close relationships, more than one doctor resorted to concealing their difficulties from their families.

"I heard that most doctors, they don't actually want to involve anyone else, because it's just a stigma and a shame on themselves, that something happened, so even my close family did not know what happened" [#12]

"Sometimes there's a situation where I'm going to rush off to a [Alcoholic Anonymous] meeting and they're still in our house having a cup of tea and it's like 'Oh, I'm just off to go and meet a friend'. I am kind of; I'm just not telling them the whole truth but I don't feel I'm lying. I'm just protecting them, protecting our relationship, protecting our family" [#9]

Professional relationships

Many participants reported a negative response to their situation from colleagues. Such responses were more internalised than challenged and doctors used terms such as "failure", "uncomfortable", "shame" and "guilt" when describing themselves.

Several doctors recalled the support they had received from colleagues – both doctors and other healthcare professionals.

"They came to visit me in the hospital. I remember one of the nurses commented she'd never seen so many doctors on the ward before at once. (...) They'd all come en masse to visit me. And my consultant direct educational supervisor boss at the time was being

very nice. He'd occasionally ring to find out how things were going and so on. So they were very good" [# 11]

"The nursing staff, ancillary staff, other medical staff outside of the department were extremely supportive. Some of them sent me emails and phoned me and I really felt welcomed back. Less so with my own colleagues but having said that, they've been through the wars with me and they supported me big time before [year] and then I had a relapse and then I think they probably felt "That's it, he'll not be back." Then I come back, it's difficult for them and maybe that's passing in time though" [#16]

"I was actually quite pleasantly surprised that a lot of my friends from work were very supportive. When asked for testimonials for GMC for me and wrote a lot of very nice things about me including those who turned up and actually spoke on my behalf" [#17]

Some doctors felt less supported. In several cases, this was attributed to other medical professionals lacking the knowledge and experience in dealing with sick doctors.

"Certainly within the medical profession I don't think the culture's there to accept somebody who's severely disabled. They're not geared up towards it at all. (...) it's going to be a big battle because the culture isn't there, the knowledge isn't there, the experience isn't there to deal with somebody who is severely disabled." [#11]

However, doctors not caring about other doctors were mentioned by several participants. Doctors described their experiences of support or the lack thereof, in contrast to the care doctors provide for their patients. Moreover the lack of caring was described as a cultural and attitudinal issue rather than purely situational. Many doctors observed and experienced this culture of support, both when others have gone off sick, and whilst they themselves have been ill.

"*I mean we're meant to be caring people [laughs] but we don't, don't seem to care about each other at all in my experience"* [#3]

"Most of the consultants (...) were not bothered at all, and I don't think they would really care unless you drop dead and they were only bothered about the work being done, regardless of what happened to you. And I think the only time they would get concerned is if the work wasn't being done (...) if I was just talking to a friend, I would

just say, "They do not care about junior doctors, consultants, and they don't care about their welfare" [#18]

"It was a bit unfortunate that at the time I went off sick one of my [specialty] training colleagues went off sick as well and she went the week before me and she was absolutely slammed, it was just, 'Oh it's disgusting, she shouldn't be going off sick, there's nothing the matter with her,' (…) and then of course the next week it was me. But I just think unless you can change how doctors as a generic body, nationally, perceive mental illness you are never going to change it" [#2]

"You're seen as being weak, and one comment I had from this... from the Head of Department in my last job was when she found out I was going for psychotherapy and she said, "I suppose if you need it," was her attitude, as if I were some inferior person because I was having psychotherapy." [#7]

It is therefore no surprise that the anticipation of their colleagues' response is an important factor as a doctor gets ready to start the return to work system.

"I've still got to get over the hurdle of meeting my colleagues, knowing what they've said about me...knowing that is going to be difficult" [#2]

"I don't like it when I feel...that people know and that I am being judged...I find that quite uncomfortable" [#3]

"I think there's a perception that doctors who experience medical conditions should not be doc-, or at least there was a perception amongst the people, who I've... some of the people of my experience, that they shouldn't be in the profession." [#18]

For some doctors the impact of their experience with colleagues and in the work place was exacerbated by stigmatisation based on existing disabilities.

"I always felt that there was, erm, so much wrong with me already, that I didn't want to be seen as someone who, kind of, exaggerated or had loads of things wrong with them, and always, kind of, moaned and, I just didn't want people to think I was looking for sympathy or, I don't know, I just, I just thought, I just didn't want to be treated any more differently and I thought if I tell somebody…they might not involve me in certain conversations, or they might talk about me with each other, and I just didn't want any of that, so…" [#6]

> *"Developing [physical disability] and erm … and just a total dearth of information about how you practice as a healthcare professional with [physical disability] …Nobody I could find knew anything about that. …but the huge thing was just erm living…it was erm adapting to a new disability both socially and erm er professionally. Erm there's a high rate of depression in [people with physical disability], much higher than the general population, higher than [physical disability]. [#5]*

Self perception

Overall, feelings of being "a failure" became a generalised self-perception rather than specific to the loss of the work role.

> *"There was guilt, there was shame, there was fear...there was low self-esteem...there was the uncertainty of medicine. Self-confidence – that plummeted"* [#9]
>
> *"But my confidence has totally gone....I've felt a total failure and I still sometimes do"* [#5]

For most participants, the experience of being a doctor away from work culminated in an internalised, altered sense of self.

> *"But once you try and put that doctor persona aside, I realised there wasn't much left of me. I realised I was kind of a doctor, but what else do I do?"*
>
> *"I think I felt like a bit of a failure....if you even said to me that I would not be working, about 2 years before this...I'd have said "What a loser!"* [#18]
>
> Feelings of emptiness, guilt, shame and of being a 'failure' were prominent in many doctors' accounts. Self esteem appeared to be worsened by illness and loss of work. Doctors tended to blame themselves for their situations and felt like failures when experiencing difficulties with work and encountering obstacles to returning to work, often resulting in a loss of confidence. This, in turn, further worsened self esteem and created a vicious circle where the doctor needs work to improve their self esteem but cannot work due to their self esteem being so low.*"If I tried to get a job in [specialty], I don't know if I'd remain as well. I probably wouldn't, and so I would get into that vicious circle again of health affecting my performance and my performance, lower performance affecting my mood and everything spiralling down again." [#7]*

Discussion

We carried out in-depth interviews on 19 doctors who had been off work for six months or more. These doctors had various combinations of physical and psychiatric disorders. The majority, though not all, had had some dealings with the General Medical Council. A number of potential participants declined to participate in the study, with many suggesting they were concerned about confidentiality and anonymity. This is interesting in itself and shows a distrust of how the findings might be used, despite reassurance about the purpose of the study and how confidentiality would be maintained.

Many of our participants had a mixture of physical and mental health difficulties. The interviews which were semi structured and therefore to some degree led by the interviewee. They tended to focus on the mental health issues, which is why these appear more prominent in the analysis.

Commitment to, and identifying with, the role of a doctor was a common theme that emerged. It is likely that medicine with its long training and long hours of work preferentially attracts individuals likely to make a commitment to their work. The flip-side of such an approach is the relative absence of an alternative structure or purpose if, for whatever reason, an individual is unable to work.

The centrality of this role also seemed to be strengthened by the perception amongst doctors that they are "invincible", and that "illness is only for patients", alluded to in both Cohen's review for the Royal Medical Benevolent Fund (Cohen D – personal communication) and Harvey's review for the National Clinical Assessment Service(8). It is understandable therefore that for some doctors the recognition of illness presents a challenge over and above that of just the disorder – it forces an entire reappraisal of their view of the world and their place within it. The accounts given by several doctors convey a sense of great surprise, often only implicitly, that they had suffered a health problem. Whilst these issues have been recognised as factors in

delaying or preventing a doctor seeking medical attention(8, 21), they have not previously been considered as reasons for a doctor having difficulty in returning to work.

One of the most striking findings was the negative view the doctors had of themselves since ill health became a part of their identity. This may have been exacerbated by the views and behaviours they perceived from family members and colleagues: many felt unsupported or judged. It is important to note that these feelings are the perceptions of the participants; as no significant others were interviewed, we do not have information about their views. The participants in our study described having experienced negative interactions with their families and colleagues during their illness, but also seemed to anticipate this as part of any return to work process(22). It has been suggested that doctors stigmatise mental illness more than the public(23) , but the self-stigmatisation seemed to extend to physical illness as well. As is common with stigma, the doctors' accounts are likely, in part, to represent negative internalised self-perceptions and their views about how others perceive them(24, 25).

Profound and potentially destructive negative self-images were shared by several participants. Whilst low self esteem can be part of a depressive disorder, not all doctors had experienced a depressive episode or were currently suffering from depression; a number had made a clinical recovery from their health condition. Our findings went beyond low self esteem into the realm of self-stigma. Self-stigma describes the phenomenon whereby people adopt and internalize external social stigma and experience loss of self-esteem and self-efficacy (26-28). As a result, they refrain from taking an active role in various areas of life. Many of the doctors we interviewed appeared to have absorbed negative views of themselves. Moreover, at least two doctors described difficulties in dealing with having a disabling physical health problem, only to then have to cope with yet more perceived criticism regarding a mental health problem. It is possible that in absorbing them, doctors perpetuate and reinforce the negative views of others. An alternative suggestion may be that the doctors have internalised the view of themselves as invincible to the extent that they view themselves as failures, and cannot conceive that anyone

else might view their illness differently. So rather than absorbing negative views of others, they may in fact be externalising their own negative views. A future study would benefit from assessing the views held by those close to doctors.

We are not aware of a literature describing why doctors may be more prone to self-stigmatise and are therefore restricted to hypothesising. It is possible that it reflects a general tendency to stigmatise – doctors have been shown to stigmatise others with mental health problems (23). It may in part be connected to the issue of "invincibility" which is constructed in binary fashion – you are either invincible, or you are completely useless. It may also reflect a more widespread aspect of medical culture where doctors develop a sensitivity to the views of others. Normally this is the positive views of colleagues and patients which can be quite intoxicating. Doctors may also be predisposed to internalise negative views of others.

Any understanding of the difficulties faced by doctors in returning to work needs to be able to incorporate both the omnipotent "doctors are invincible" view and the negative self-stigmatising views elicited in our study. Although these may seem to be mutually exclusive, an alternative hypothesis would be that the self-stigmatising views are a direct consequence of the unhealthy "doctors are invincible" view. The competitive medical environment reinforces the need for toughness and self-reliance which has become more of a wider cultural phenomenon rather than a trait identified in a few. It is possible that, for some, this has a selective advantage – that is, for some students and trainees this outlook assists in being able to manage the suffering of the patients and families they are learning to treat. Its success in the short-term means it often remains unchallenged. The incorporation of the "illness is for patients" view however reduces the chances of alternative "healthier" narratives about the interchangeability of the patient and doctor roles being generated. Thus when a doctor does become ill they are challenged on a range of levels, dealing not only with the illness but also for some the loss of their self-image as invincible.

A number of doctors though do not have access to strategies which will allow them to come to terms with these issues whilst maintaining their personal integrity. A greater willingness to accept the possibility that one might at some stage become a patient, together with greater input from trainers and senior colleagues as to how this might be managed, could reduce the sense of shock and bewilderment should illness strike.

As with all stigma, reducing social distance can help change minds(29). It is possible that recent improvements in the quality of NHS occupational health services(30) and the services provided to treat sick doctors, such as the Practitioner Health Programme, might mean that more doctors who have had complex difficulties are able to return to active practice more rapidly. The presence of these doctors in the workforce will therefore increase over time, improving the chance that students and trainees will come into contact with such doctors, and this will act as a counter-weight to the notion that "doctors are invincible". But if we are to create an environment which facilitates the return to work of doctors with long term difficulties, attention must be paid to how the "invincible" culture in medicine is generated. The regulator, which now has responsibility for UK medical undergraduates, the Deaneries and the medical schools must work together to enable students and trainees to recognise their own vulnerabilities and facilitate the generation of strategies should they become ill. Further, aspects of personal and colleague health, especially mental health, should be part of the curriculum for all medical students. Doctors must learn to provide themselves and their colleagues with the same level of excellent care that they provide for their patients.

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Table 1. Participant characteristics

Participant number	Gender	Physical health problem?	Mental health problem/addiction?	GMC involvement?
1	M	Yes	Yes	Yes
2	F	Yes	Yes	Yes
3	F	No	Yes	Yes
4	M	No	Yes	Yes
5	F	Yes	Yes	No
6	F	Yes	Yes	No
7	F	No	Yes	Yes
8	F	No	Yes	Yes
9	M	No	Yes	Yes
10	M	No	Yes	No
11	M	Yes	No	No
12	M	No	Yes	Yes
13	F	No	Yes	Yes
14	F	No	Yes	Yes
15	M	Yes	Yes	Yes
16	M	No	Yes	Yes
17	M	No	Yes	Yes
18	F	No	Yes	No
19	F	Yes	Yes	Yes

STATEMENTS

Competing Interests

"All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: Dr Brooks and Dr del Busso had financial support from Royal Medical Benevolent Fund for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous 3 years; no other relationships or activities that could appear to have influenced the submitted work."

Ethics Approval

Approval for this study was granted by the South East London Research Ethics Committee [10/H0807/33].

Authors Contributions

Henderson, Hotopf, and Harvey had the initial idea for the study. Henderson, Hotopf, Harvey, Madan, Hatch, and Chalder refined the study methodology. Del Busso and Brooks carried out the initial analyses. Henderson, del Busso, and Brooks wrote the initial draft. Hotopf, Harvey, Madan, Hatch and Chalder revised the draft critically for important intellectual content.

Acknowledgements

We gratefully acknowledge the funding provided by the Royal Medical Benevolent Fund. We are grateful for the support of the General Medical Council, the Practitioner Health Programme and all the study participants who gave their time so generously.

This study was funded by a grant from the Royal Medical Benevolent Fund. The funder had no input into the design, analysis and interpretation of the data, the writing of the report or the decision to submit the article for publication. The funder contributed to the identification of

potential participants as described in the Methods section. All the researchers are independent of the funders.

Data

No additional data are available

Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study

Dr Max Henderson [corresponding author]
Senior Lecturer in Epidemiological & Occupational Psychiatry
Institute of Psychiatry, Kings College London
Department of Psychological Medicine
Weston Education Centre, Cutcombe Road
London SE5 9RJ UK
T: 020 3228 8564
F: 020 7848 5408
E: max.j.henderson@kcl.ac.uk

Dr Samantha K. Brooks
Research Assistant
Institute of Psychiatry, Kings College London
London UK

Dr Lilliana del Busso
Associate Professor of Social Psychology
Østfold University College
Halden Norway

Professor Trudie Chalder PhD
Professor of Cognitive Behavioural Therapy
Institute of Psychiatry, Kings College London
London UK

Dr Samuel B Harvey PhD
Senior Lecturer in Workplace Mental Health
School of Psychiatry, University of New South Wales
Sydney Australia

Professor Matthew Hotopf PhD
Professor of General Hospital Psychiatry
Institute of Psychiatry, Kings College London
London UK

Dr Ira Madan MD
Consultant Occupational Physician
St Thomas' Hospital
London UK

Dr Stephani Hatch PhD
Lecturer in Social Epidemiology
Institute of Psychiatry, Kings College London
London UK

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ABSTRACT

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 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. We 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.

[240 words]

ARTICLE SUMMARY

Article focus

- Doctors have rates of mental illness, drug and alcohol misuse and suicide at least as high as the general population though many doctors have difficulty accessing appropriate mainstream health care often due to fears about confidentiality.
- A number of studies have examined risk factors for doctors becoming ill but no studies have examined the difficulties faced by sick doctors in returning to work.
- Our qualitative study used in-depth semi-structured interviews to assess the views of doctors who had been away from work for at least six months on the obstacles to them returning to work.

Key Messages

- Illness, surprising to many doctors, forces an entire reappraisal of their view of the world and their place within it.
- Many doctors internalise the perceived negative responses of colleagues and others to their illness
- These factors contribute to the difficulties faced by doctors in returning to work.

Strengths and limitations

- We recruited 19 doctors from all over the UK in partnership with the General Medical Council, the Royal Medical Benevolent Fund and the Practitioner Health Programme.
- Our methodology meant that we have no way of knowing anything about the doctors who were approached by our partner organisations but decided not to take part. Further, we only have the doctors own accounts and no independent way of understanding for example the relationship between their initial reason for stopping work and their current problems.

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Background

Daksha Emson, a trainee psychiatrist with bipolar affective disorder, killed herself and her daughter in October 2000. She was terrified that her career would be adversely affected if her illness was disclosed(1). Not long after this Dame Janet Smith who chaired the Shipman Inquiry heavily criticised the General Medical Council (GMC) for being more concerned with the interests of doctors than patients(2). In the last 15 years there has been a growing interest in the health of healthcare professionals(3-7). Whilst doctors have rates of mental illness, drug and alcohol misuse and suicide at least as high, if not higher, than the general population(8), for many reasons they struggle to engage with mainstream healthcare. In 2009 a pilot service, The Practitioner Health Programme, was established for doctors with psychiatric or physical health problems that were interfering with their work(9). In 2010 the Department of Health published *Invisible Patients*(10) which provided a detailed account of the difficulties faced by health professionals with mental health problems accessing appropriate care, and called on the regulator to provide greater consistency in the assessment of the impact of health difficulties on performance.

Notwithstanding this increased interest there have been few qualitative studies of doctors, and none specifically looking at the question of obstacles preventing return to work for doctors with ~~complex needs~~long term difficulties. There is a small literature on obstacles to a successful return to work for the general population. Dekkers-Sanchez (11) used focus group methodology to uncover four broad areas – personal factors, health-related factors, social obstacles and work-related obstacles. A range of perceptual issues were described in the context of personal factors, including self-efficacy and illness representations. Individual perceptions of self, work, and the ability to cope with returning to work emerged from Marhold's study of Obstacles to Return-to-Work Questionnaire (12). These were further influenced by pain and mood. The study identified concerns that returning to work might lead to a worsening of symptoms as particularly relevant. Andersen recently published a meta-synthesis of qualitative studies examining return to work

for people with common mental disorders (13). Emerging themes were grouped as personal factors, support in the workplace, and wider economic and societal issues. This important paper emphasised that returning to work is a process into which past experience, current perception and anticipation of the future all input.

Although to our knowledge no papers on doctors have had obstacles to returning to work as their main focus, several studies exploring the general experience of being a sick doctor have found that doctors emphasise the difficulty of being off work and the barriers faced in returning to work after sickness absence. Fatholm interviewed 15 doctors who had successfully returned to work after a period of prolonged sick leave (14). Doctors commented on how hard they found it holding the identity of both a doctor and a patient. Several described having resisted sick leave fearing their own clinical competence would be questioned. A number reported 'negotiating' with their own doctor in an attempt to expedite their return to work. Fox spoke to doctors with significant long term illness (15). Further issues around personal identity emerged, as did comments about the culture of "invincibility" within medicine, and how sick doctors need to put on 'facade'. Ingstad (16) identified participants who had been asked by their doctor to make clinical decisions about their own health. The tension between the role of the patient and that of the doctor was also discussed by McTevitt (17) who described how some doctors find it difficult to cede control and thereby cease being the "expert" in a two-person relationship. In contrast Stanton highlighted how non-medical friends and colleagues can identify that "something is wrong" yet find themselves disempowered by the doctor-patient's medical knowledge when trying to discuss this(18).

Beyond the issues with access to appropriate services and the complications of regulatory involvement, relatively little is known about the ability of doctors to be able to return to work after a period of sick leave. We explored the views of doctors with a range of physical and psychiatric health problems, with and without GMC involvement, on the obstacles that prevent them from returning to work.

Methods

We carried out a qualitative study to examine the views of doctors with ~~complex needs~~long term difficulties on the obstacles they faced in returning to work. Ethical approval was granted by the South East London Research Ethics Committee. Although the Royal Medical Benevolent Fund funded this study, they had no role in the study design, data analyses, or data interpretation.

For this study we defined doctors with ~~complex needs~~long term difficulties as those currently away from work more than six months due to problems with their health, with or without involvement with the GMC, or who had a similar period of absence within the last year. Doctors from across the UK were eligible for inclusion. We excluded doctors who had any ongoing health problem, physical or psychiatric, that would make an in-depth 90 minute interview distressing or uncomfortable.

We formed partnership arrangements with the General Medical Council, the Practitioner Health Programme, and the Royal Medical Benevolent Fund. Recognising the importance of confidentiality, these organisations agreed to an 'arms-length' arrangement whereby they would identify potential participants, based on our eligibility criteria, and give them a letter of introduction from the research team. The letter contained details of how the potential participant could make contact with the research team if they wished to take part. The research team therefore had no knowledge of potential participants who did not make contact. Moreover, the partner organisations did not know which of the doctors they had identified made contact with the research team. There was no exchange of information about the doctor between the research team and the partner organisation.

A detailed interview guide was prepared initially by MJH and LdB, and then amended following discussions with the rest of the research team. The content of this guide and its performance were reviewed by the research team after 3 interviews, though no major changes

were felt necessary. The researchers (LdB and SB) determined eligibility and gained consent from potential participants. Those interested were invited to take part in an in-depth semi-structured interview. When the researchers met the participants the nature and purpose of the study was explained again. Participants had the opportunity to ask questions. All participants provided full written consent to take part in the study.

A total of 19 interviews were completed; the first ten interviews were completed by LdB and the last nine by SB. Each interview lasted between one and two hours. Interviews were recorded directly onto an encrypted drive on a laptop computer then transcribed verbatim. Using the Nvivo software package(19), transcripts were analysed by thematic content analysis using the constant comparison method(20). The two researchers (LdB and SB) each analysed all the transcripts using an inductive approach to thematic analysis(20), using NVivo to 'code' data in order to build a set of 'themes' i.e. ideas or topics occurring at several points in the data corpus. Initially the researchers each completed the coding procedure independently. They then compared codes and reached consensus on the emerging themes by discussion leading to a final ~~set of agreed codes~~agreed master list of themes and sub-themes. Emerging themes were discussed regularly by the research team. This type of thematic analysis is inductive, i.e. the themes emerged from the data itself and were not imposed by the researchers. In addition both researchers engaged in a process of reflexivity. They each recorded details of the interviewing interaction, and reflected on their own experience which may have had an impact on the interpretation of data.

Results

Recruitment

77 doctors were informed about the study by the partner organisations. No potential participants were believed to meet exclusion criteria. Given our recruitment methodology we do not know

which partner organisation introduced each participant. A number of the doctors were known to more than one of the partners, though this does not necessarily mean they were contacted by each. Thirty of those provided with information about the study made contact with the researchers. Nineteen (25% of the 77) doctors took part in the study. At least two doctors who had initially expressed an interest subsequently became too unwell to participate. The reasons given by other potential participants for not taking part included not wishing to be recorded, and ongoing concerns, despite reassurance, regarding confidentiality. All doctors who took part were able to complete the interview.

The participants are described in Table 1. Their ages ranged from ~~20s to 60s~~27 – 67 years and the median age was 46. Diagnoses included depression, anxiety, bipolar affective disorder and alcohol dependence~~addiction~~. All but one doctor had a mental health or addiction problem, seven had a physical health problem and 14 had involvement with the GMC.

(Table 1 about here)

Four main themes and a number of sub-themes were identified. The main themes which emerged from the data were: work identity; relationships with family and friends; professional relationships; and self perception. Sub-themes relating to work identity included identity being bound up with career, and feelings of emptiness when not at work. Sub-themes relating to relationships with family and friends included changes in relationships due to their difficulties; positive support; feeling unsupported; and concealing difficulties from others. Sub-themes relating to professional relationships included support; lack of caring; anticipating feeling judged on return to work; and stigmatisation. Sub-themes relating to self perception included sense of failure becoming generalised rather than specific to loss of work, and an altered sense of self due to being away from work.

~~*Importance of work identity*~~ *Work identity*

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Participants reported their job as an important part of their identity, and many described being deeply committed to their work and defined themselves in these terms. Often this related to the effort and sacrifice that went into becoming a doctor. For many of the participants going off work sick was associated with a fundamental change in identity. Many appeared to incorporate negative views of themselves into their new identity. While the loss of income was mentioned by some of the doctors, the loss of identity was rarely about the financial aspects alone.

> *"I want to work. I would have liked to have worked, for lots of reasons. I think it's good for anybody to have a structure to their life and purpose. I have always wanted to be a doctor and I trained as a mature student in medicine. So I sacrificed a lot. And I loved my job. So for all those reasons it was really important to me to go back to work." [#11]*

> *"You get to be part of your job, it becomes part of you..."* [#17]

Perhaps as a consequence, being away from work then left them feeling lost, isolated and sad.

> *"..once you try and put that doctor persona aside, I realised there wasn't much left of me"* [#9]

> *"I can't, emotionally I can't retire. I mean, I gotta be involved. I feel a total emptiness"* [#10]

> *"..because I have spent all my entire adult life from the first year of my medical school to 2008, I mean its nearly two decades, so and then everything is taken from you. You have been left alone and no one can hear it if you no matter how loudly cry and so it is very, very difficult~~, and you see hopeless helpless, and nowhere to go and~~ (...) you just simply got lost in a, in a huge sea without any navigator and you don't know what to do" [#12]*

> *"I almost didn't want to do the normal things like going out, because I almost wanted that to be on hold before I started working again, because work was so important...I*

also I think with the sense that because I wasn't working I shouldn't be almost allowed ... I shouldn't be going out and having any sort – doing any sort of non-work-related, or non-serious sort of activity" [#18]

~~*"I almost didn't want to do the normal things like going out, because I almost wanted that to be on hold before I started working again, because work was so important...I also I think with the sense that because I wasn't working I shouldn't be almost allowed to do all the things that, or any fun things like because I wasn't working I shouldn't be going out and having any sort – doing any sort of non-work-related, or non-serious sort of activity" [#18]*~~

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Relationships with family and friends

Many, though not all, doctors had absorbed negative responses they had received from family and friends. The impact of no longer working appeared to be super-imposed on that of the illness itself. Some even tried to conceal their difficulties from their close family.

~~*Relationships with family and friends*~~

~~Many, though not all, doctors had absorbed negative responses they had received from family and friends. The impact of no longer working appeared to be super-imposed on that of the illness itself. Some even tried to conceal their difficulties from their close family.~~

A number of participants spoke about the change in the nature of their close relationships that had been brought about by their difficulties.

"My relationship with my children has changed very much and that's an ongoing thing which I'll have to face as they get older and learn more about me and what I can and

can't do. And obviously even my wife has completely changed, as you can imagine. But I've been fortunate in the fact that they've all been very accepting and supportive of me" [#11]

There were several doctors who described very positive experiences of support.

"My friends were very supportive. I think they put up with a lot really in a sense because I was very unwell on and off. ~~In the same way as I got weary of it I'm sure they did and there were crises. As I say, even when I was well I didn't think I was that great, but no, they were very supportive....~~They really stuck by me. I think they couldn't really understand what was happening. They had no background in psychiatry or anything but they could see that none of these tablets were really helping things and I think it must have been very, very frustrating for them. I think I owe them a lot really" [#14]

"I live with my husband and we have quite a few really good friends who live nearby .. and they were, kind of, the people who got me through really. So, all of them were people I could talk to who would understand, who would, kind of, pray for me, support me, and really see, they saw the effect it was having on me because they knew me and I could be open and honest with them" ~~. Yeah, without them I don't know what, how it would have gone really"~~ [#5]

In contrast, several doctors reported receiving less than adequate support from family and friends.

"Mostly he [partner] detached himself, carried on working and regarded me as a nuisance...my family have really put me into the sort of bad category" [#19]

"I have gone down in their esteem because of the problems at work...they didn't think too highly of me for that" [#7]

"I am quite an outsider in my family" [#5]

To avoid negative changes in close relationships, more than one doctor resorted to concealing their difficulties from their families.

> *"I heard that most doctors, they don't actually want to involve anyone else, because it's just a stigma and a shame on themselves, that something happened, so even my close family did not know what happened"* [#12]

> *"Sometimes there's a situation where I'm going to rush off to a [Alcoholic Anonymous] meeting and they're still in our house having a cup of tea and it's like 'Oh, I'm just off to go and meet a friend'. I am kind of; I'm just not telling them the whole truth but I don't feel I'm lying. I'm just protecting them, protecting our relationship, protecting our family"* [#9]

Professional relationships

Many participants reported a negative response to their situation from colleagues. Such responses were more internalised than challenged and doctors used terms such as "failure", "uncomfortable", "shame" and "guilt" when describing themselves.

Several doctors recalled the support they had received from colleagues – both doctors and other healthcare professionals.

> *"They came to visit me in the hospital. I remember one of the nurses commented she'd never seen so many doctors on the ward before at once. ~~I was surrounded by about eight [specialty] registrars.~~(…) They'd all come en masse to visit me. And my consultant direct educational supervisor boss at the time was being very nice. He'd occasionally ring to find out how things were going and so on. So they were very good"* [# 11]

> *"The nursing staff, ancillary staff, other medical staff outside of the department were extremely supportive. ~~They would come over and open the car door and shake my hand.~~ Some of them sent me emails and phoned me and I really felt welcomed back. Less so with my own colleagues but having said that, they've been through the wars with me and they supported me big time before [year] and then I had a relapse and then*

I think they probably felt "That's it, he'll not be back." Then I come back, it's difficult for them and maybe that's passing in time though" [#16]

"I was actually quite pleasantly surprised that a lot of my friends from work were very supportive. When asked for testimonials for GMC for me and wrote a lot of very nice things about me including those who turned up and actually spoke on my behalf" [#17]

Some doctors felt less supported. In several cases, this was attributed to other medical professionals lacking the knowledge and experience in dealing with sick doctors.

"Certainly within the medical profession I don't think the culture's there to accept somebody who's severely disabled. They're not geared up towards it at all. (...) it's going to be a big battle because the culture isn't there, the knowledge isn't there, the experience isn't there to deal with somebody who is severely disabled." [#11]

However, doctors not caring about other doctors were mentioned by several participants. Doctors described their experiences of support or the lack thereof, in contrast to the care doctors provide for their patients. Moreover the lack of caring was described as a cultural and attitudinal issue rather than purely situational. Many doctors observed and experienced this culture of support, both when others have gone off sick, and whilst they themselves have been ill.

"*I mean we're meant to be caring people [laughs] but we don't, don't seem to care about each other at all in my experience"* [#3]

"Most of the consultants (...) were not bothered at all, and I don't think they would really care unless you drop dead and they were only bothered about the work being done, regardless of what happened to you. And I think the only time they would get concerned is if the work wasn't being done (...) if I was just talking to a friend, I would just say, "They do not care about junior doctors, consultants, and they don't care about their welfare" [#18]

"It was a bit unfortunate that at the time I went off sick one of my [specialty] training colleagues went off sick as well and she went the week before me and she was absolutely slammed, it was just, 'Oh it's disgusting, she shouldn't be going off sick,

there's nothing the matter with her,' ~~and I was going, 'Well she's really stressed, she's not sleeping,' all the things, she shouldn't be at work. 'Oh but you know…'~~ (…) and then of course the next week it was me. But I just think unless you can change how doctors as a generic body, nationally, perceive mental illness you are never going to change it" [#2]

"You're seen as being weak, and one comment I had from this... from the Head of Department in my last job was when she found out I was going for psychotherapy and she said, "I suppose if you need it," was her attitude, as if I were some inferior person because I was having psychotherapy." [#7]

It is therefore no surprise that the anticipation of their colleagues' response is an important factor as a doctor gets ready to start the return to work system.

"I've still got to get over the hurdle of meeting my colleagues, knowing what they've said about me...knowing that is going to be difficult" [#2]

"I don't like it when I feel...that people know and that I am being judged...I find that quite uncomfortable" [#3]

"I think there's a perception that doctors who experience medical conditions should not be doc-, or at least there was a perception amongst the people, who I've... some of the people of my experience, that they shouldn't be in the profession." [#18]

For some doctors the impact of their experience with colleagues and in the work place was exacerbated by stigmatisation based on existing disabilities.

"I always felt that there was, erm, so much wrong with me already, that I didn't want to be seen as someone who, kind of, exaggerated or had loads of things wrong with them, and always, kind of, moaned and, I just didn't want people to think I was looking for sympathy or, I don't know, I just, I just thought, I just didn't want to be treated any more differently and I thought if I tell somebody…they might not involve me in certain conversations, or they might talk about me with each other, and I just didn't want any of that, so…" [#6]

"Developing [physical disability] and erm … and just a total dearth of information about how you practice as a healthcare professional with [physical disability] …Nobody I could find knew anything about that. …but the huge thing was just erm living…it was erm adapting to a new disability both socially and erm er professionally.

Erm there's a high rate of depression in [people with physical disability], much higher than the general population, higher than [physical disability]. [#5]

Self perception

Overall, feelings of being "a failure" became a generalised self-perception rather than specific to the loss of the work role. ~~For most participants, the experience of being a doctor away from work culminated in an internalised, altered sense of self.~~

"There was guilt, there was shame, there was fear...there was low self-esteem...there was the uncertainty of medicine. Self-confidence – that plummeted" [#9]

"But my confidence has totally gone....I've felt a total failure and I still sometimes do" [#5]

For most participants, the experience of being a doctor away from work culminated in an internalised, altered sense of self.

"But once you try and put that doctor persona aside, I realised there wasn't much left of me. I realised I was kind of a doctor, but what else do I do?"

"I think I felt like a bit of a failure....if you even said to me that I would not be working, about 2 years before this...I'd have said "What a loser!" [#18]

Feelings of emptiness, guilt, shame and of being a 'failure' were prominent in many doctors' accounts. Self esteem appeared to be worsened by illness and loss of work. Doctors tended to blame themselves for their situations and felt like failures when experiencing difficulties with work and encountering obstacles to returning to work, often resulting in a loss of confidence. This, in turn, further worsened self esteem and created a vicious circle where the doctor needs work to improve their self esteem but cannot work due to their self esteem being so low.

"If I tried to get a job in [specialty], I don't know if I'd remain as well. I probably wouldn't, and so I would get into that vicious circle again of health affecting my performance and my performance, lower performance affecting my mood and everything spiralling down again." [#7]

~~Finally, for some doctors the impact of their experience with colleagues and in the work place was exacerbated by stigmatisation based on existing disabilities.~~

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Er, I think, I always felt that there was, erm, so much wrong with me already, that I didn't want to be seen as someone who, kind of, exaggerated or had loads of things wrong with them, and always, kind of, moaned and, I just didn't want people to think I was looking for sympathy or, I don't know, I just, I just thought, I just didn't want to be treated any more differently and I thought if I tell somebody…they might not involve me in certain conversations, or they might talk about me with each other, and I just didn't want any of that, so… [#6]

Erm developing [physical disability] and erm … and just a total dearth of information about how you practice as a healthcare professional with [physical disability] …Nobody I could find knew anything about that. …but the huge thing was just erm living…it was erm adapting to a new disability both socially and erm or professionally. Erm there's a high rate of depression in [people with physical disability], much higher than the general population, higher than [physical disability]. [#5]

Discussion

We carried out in-depth interviews on 19 doctors who had been off work for six months or more. These doctors had various combinations of physical and psychiatric disorders. The majority, though not all, had had some dealings with the General Medical Council. A number of potential participants declined to participate in the study, with many suggesting they were concerned about confidentiality and anonymity. This is interesting in itself and shows a distrust of how the findings might be used, despite reassurance about the purpose of the study and how confidentiality would be maintained.

Many of our participants had a mixture of physical and mental health difficulties. The interviews which were semi structured and therefore to some degree led by the interviewee. They tended to focus on the mental health issues, which is why these appear more prominent in the analysis.

Commitment to, and identifying with, the role of a doctor was a common theme that emerged. It is likely that medicine with its long training and long hours of work preferentially attracts

individuals likely to make a commitment to their work. The flip-side of such an approach is the relative absence of an alternative structure or purpose if, for whatever reason, an individual is unable to work.

The centrality of this role also seemed to be strengthened by the perception amongst doctors that they are "invincible", and that "illness is only for patients", alluded to in both Cohen's review for the Royal Medical Benevolent Fund (Cohen D – personal communication) and Harvey's review for the National Clinical Assessment Service(8). It is understandable therefore that for some doctors the recognition of illness presents a challenge over and above that of just the disorder – it forces an entire reappraisal of their view of the world and their place within it. The accounts given by several doctors convey a sense of great surprise, often only implicitly, that they had suffered a health problem. Whilst these issues have been recognised as factors in delaying or preventing a doctor seeking medical attention(8, 21), they have not previously been considered as reasons for a doctor having difficulty in returning to work.

One of the most striking findings was the negative view the doctors had of themselves since ill health became a part of their identity. This ~~was clearly~~ may have been exacerbated by the views and behaviours they perceived ~~or encountered~~ from family members and colleagues: many felt unsupported or judged. It is important to note that these feelings are the perceptions of the participants; as no significant others were interviewed, we do not have information about~~sight into~~ their views. The participants in our study described having experienced negative interactions with their families and colleagues during their illness, but also seemed to anticipate this as part of any return to work process(22). It has been suggested that doctors stigmatise mental illness more than the public(23) , but the self-stigmatisation seemed to extend to physical illness as well. As is common with stigma, the doctors' accounts are likely, in part, to represent negative internalised self-perceptions and their views about how others perceive them(24, 25).

Profound and potentially destructive negative self-images were shared by several participants. Whilst low self esteem can be part of a depressive disorder, not all doctors had experienced a

depressive episode or were currently suffering from depression; a number had made a clinical recovery from their health condition. Our findings went beyond low self esteem into the realm of self-stigma. Self-stigma describes the phenomenon whereby people adopt and internalize external social stigma and experience loss of self-esteem and self-efficacy (26-28). As a result, they refrain from taking an active role in various areas of life. Many of the doctors we interviewed appeared to have absorbed negative views of themselves. Moreover, at least two doctors described difficulties in dealing with having a disabling physical health problem, only to then have to cope with yet more perceived criticism regarding a mental health problem. It is possible that in absorbing them, doctors perpetuate and reinforce the negative views of others. An alternative suggestion may be that the doctors have internalised the view of themselves as invincible to the extent that they view themselves as failures, and cannot conceive that anyone else might view their illness differently. So rather than absorbing negative views of others, they may in fact be externalising their own negative views. A future study would benefit from assessing the views held by those close to doctors.

We are not aware of a literature describing why doctors may be more prone to self-stigmatise and are therefore restricted to hypothesising. It is possible that it reflects a general tendency to stigmatise – doctors have been shown to stigmatise others with mental health problems (23). It may in part be connected to the issue of "invincibility" which is constructed in binary fashion – you are either invincible, or you are completely useless. It may also reflect a more widespread aspect of medical culture where doctors develop a sensitivity to the views of others. Normally this is the positive views of colleagues and patients which can be quite intoxicating. Doctors may also be predisposed to internalise negative views of others.

Any understanding of the difficulties faced by doctors in returning to work needs to be able to incorporate both the omnipotent "doctors are invincible" view and the negative self-stigmatising views elicited in our study. Although these may seem to be mutually exclusive, an alternative hypothesis would be that the self-stigmatising views are a direct consequence of the unhealthy

"doctors are invincible" view. The competitive medical environment reinforces the need for toughness and self-reliance which has become more of a wider cultural phenomenon rather than a trait identified in a few. It is possible that, for some, this has a selective advantage – that is, for some students and trainees this outlook assists in being able to manage the suffering of the patients and families they are learning to treat. Its success in the short-term means it often remains unchallenged. The incorporation of the "illness is for patients" view however reduces the chances of alternative "healthier" narratives about the interchangeability of the patient and doctor roles being generated. Thus when a doctor does become ill they are challenged on a range of levels, dealing not only with the illness but also for some the loss of their self-image as invincible.

A number of doctors though do not have access to strategies which will allow them to come to terms with these issues whilst maintaining their personal integrity. A greater willingness to accept the possibility that one might at some stage become a patient, together with greater input from trainers and senior colleagues as to how this might be managed, could reduce the sense of shock and bewilderment should illness strike.

As with all stigma, reducing social distance can help change minds(29). It is possible that recent improvements in the quality of NHS occupational health services(30) and the services provided to treat sick doctors, such as the Practitioner Health Programme, might mean that more doctors who have had complex difficulties are able to return to active practice more rapidly. The presence of these doctors in the workforce will therefore increase over time, improving the chance that students and trainees will come into contact with such doctors, and this will act as a counter-weight to the notion that "doctors are invincible". But if we are to create an environment which facilitates the return to work of doctors with ~~complex needs~~long term difficulties, attention must be paid to how the "invincible" culture in medicine is generated. The regulator, which now has responsibility for UK medical undergraduates, the Deaneries and the medical schools must work together to enable students and trainees to recognise their own

vulnerabilities and facilitate the generation of strategies should they become ill. Further, aspects of personal and colleague health, especially mental health, should be part of the curriculum for all medical students. Doctors must learn to provide themselves and their colleagues with the same level of excellent care that they provide for their patients.

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Table 1. Participant characteristics

Participant number	Gender	Physical health problem?	Mental health problem/addiction?	GMC involvement?
1	M	Yes	Yes	Yes
2	F	Yes	Yes	Yes
3	F	No	Yes	Yes
4	M	No	Yes	Yes
5	F	Yes	Yes	No
6	F	Yes	Yes	No
7	F	No	Yes	Yes
8	F	No	Yes	Yes
9	M	No	Yes	Yes
10	M	No	Yes	No
11	M	Yes	No	No
12	M	No	Yes	Yes
13	F	No	Yes	Yes
14	F	No	Yes	Yes
15	M	Yes	Yes	Yes
16	M	No	Yes	Yes
17	M	No	Yes	Yes
18	F	No	Yes	No
19	F	Yes	Yes	Yes

STATEMENTS

Competing Interests

"All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: Dr Brooks and Dr del Busso had financial support from Royal Medical Benevolent Fund for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous 3 years; no other relationships or activities that could appear to have influenced the submitted work."

Ethics Approval

Approval for this study was granted by the South East London Research Ethics Committee [10/H0807/33].

Authors Contributions

Henderson, Hotopf, and Harvey had the initial idea for the study. Henderson, Hotopf, Harvey, Madan, Hatch, and Chalder refined the study methodology. Del Busso and Brooks carried out the initial analyses. Henderson, del Busso, and Brooks wrote the initial draft. Hotopf, Harvey, Madan, Hatch and Chalder revised the draft critically for important intellectual content.

Acknowledgements

We gratefully acknowledge the funding provided by the Royal Medical Benevolent Fund. We are grateful for the support of the General Medical Council, the Practitioner Health Programme and all the study participants who gave their time so generously.

This study was funded by a grant from the Royal Medical Benevolent Fund. The funder had no input into the design, analysis and interpretation of the data, the writing of the report or the decision to submit the article for publication. The funder contributed to the identification of

potential participants as described in the Methods section. All the researchers are independent of the funders.

Data

No additional data are available