



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

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

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[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

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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]

For peer review only

## 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

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4 discussed by McTeivitt (14) who described how some doctors find it difficult to cede control and  
5  
6 thereby cease being the "expert" in a two-person relationship. In contrast Stanton highlighted  
7  
8 how non-medical friends and colleagues can identify that "something is wrong" yet find  
9  
10 themselves disempowered by the doctor-patient's medical knowledge when trying to discuss  
11  
12 this(15).

13  
14 Beyond the issues with access to appropriate services and the complications of regulatory  
15  
16 involvement, relatively little is known about the ability of doctors to be able to return to work  
17  
18 after a period of sick leave. We explored the views of doctors with a range of physical and  
19  
20 psychiatric health problems, with and without GMC involvement, on the obstacles that prevent  
21  
22 them from returning to work.  
23  
24

## 25 26 27 28 **Methods**

29  
30 We carried out a qualitative study to examine the views of doctors with complex needs on the  
31  
32 obstacles they faced in returning to work. Ethical approval was granted by the South East  
33  
34 London Research Ethics Committee. Although the Royal Medical Benevolent Fund funded this  
35  
36 study, they had no role in the study design, data analyses, or data interpretation.  
37  
38

39 For this study we defined doctors with complex needs as those currently away from work more  
40  
41 than six months due to problems with their health, with or without involvement with the GMC,  
42  
43 or who had a similar period of absence within the last year. Doctors from across the UK were  
44  
45 eligible for inclusion. We excluded doctors who had any ongoing health problem, physical or  
46  
47 psychiatric, that would make an in-depth 90 minute interview distressing or uncomfortable.  
48

49 We formed partnership arrangements with the General Medical Council, the Practitioner Health  
50  
51 Programme, and the Royal Medical Benevolent Fund. Recognising the importance of  
52  
53 confidentiality, these organisations agreed to an 'arms-length' arrangement whereby they would  
54  
55 identify potential participants, based on our eligibility criteria, and give them a letter of  
56  
57

1  
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4 introduction from the research team. The letter contained details of how the potential participant  
5  
6 could make contact with the research team if they wished to take part. The research team  
7  
8 therefore had no knowledge of potential participants who did not make contact. Moreover, the  
9  
10 partner organisations did not know which of the doctors they had identified made contact with  
11  
12 the research team. There was no exchange of information about the doctor between the research  
13  
14 team and the partner organisation.

15  
16 A detailed interview guide was prepared initially by MJH and LdB, and then amended  
17  
18 following discussions with the rest of the research team. The content of this guide and its  
19  
20 performance were reviewed by the research team after 3 interviews, though no major changes  
21  
22 were felt necessary. The researchers (LdB and SB) determined eligibility and gained consent  
23  
24 from potential participants. Those interested were invited to take part in an in-depth semi-  
25  
26 structured interview. When the researchers met the participants the nature and purpose of the  
27  
28 study was explained again. Participants had the opportunity to ask questions. All participants  
29  
30 provided full written consent to take part in the study.

31  
32  
33 A total of 19 interviews were completed; the first ten interviews were completed by LdB and  
34  
35 the last nine by SB. Each interview lasted between one and two hours. Interviews were recorded  
36  
37 directly onto an encrypted drive on a laptop computer then transcribed verbatim. Using the  
38  
39 Nvivo software package(16), transcripts were analysed by thematic content analysis using the  
40  
41 constant comparison method(17). The two researchers (LdB and SB) each analysed all the  
42  
43 transcripts using a thematic analysis(17). Initially the researchers each completed the coding  
44  
45 procedure independently. They then compared codes and reached consensus on the emerging  
46  
47 themes by discussion leading to a final set of agreed codes. Emerging themes were discussed  
48  
49 regularly by the research team. In addition both researchers engaged in a process of reflexivity.  
50  
51 They each recorded details of the interviewing interaction, and reflected on their own  
52  
53 experience which may have had an impact on the interpretation of data.  
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## 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*

1  
2  
3  
4 *loved my job. So for all those reasons it was really important to me to go back to*  
5  
6 *work.” [#11]*  
7

8  
9 *“You get to be part of your job, it becomes part of you...” [#17]*

10  
11 Perhaps as a consequence, being away from work then left them feeling lost, isolated and sad.

12  
13 *“..once you try and put that doctor persona aside, I realised there wasn't much left of*  
14  
15 *me” [#9]*  
16

17  
18 *“I can't, emotionally I can't retire. I mean, I gotta be involved. I feel a total emptiness”*  
19  
20 *[#10]*  
21

22  
23 *“..because I have spent all my entire adult life from the first year of my medical school*  
24  
25 *to 2008, I mean its nearly two decades, so and then everything is taken from you. You*  
26  
27 *have been left alone and no one can hear it if you no matter how loudly cry and so it is*  
28  
29 *very, very difficult, and you see hopeless helpless, and nowhere to go and you just*  
30  
31 *simply got lost in a, in a huge sea without any navigator and you don't know what to*  
32  
33 *do” [#12]*  
34

35  
36  
37  
38 *“I almost didn't want to do the normal things like going out, because I almost wanted*  
39  
40 *that to be on hold before I started working again, because work was so important...I*  
41  
42 *also I think with the sense that because I wasn't working I shouldn't be almost allowed*  
43  
44 *to do all the things that, or any fun things like because I wasn't working I shouldn't be*  
45  
46 *going out and having any sort – doing any sort of non-work-related, or non-serious sort*  
47  
48 *of activity” [#18]*  
49

50  
51 *Relationships with family and friends*  
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4 Many, though not all, doctors had absorbed negative responses they had received from family  
5  
6 and friends. The impact of no longer working appeared to be super-imposed on that of the  
7  
8 illness itself. Some even tried to conceal their difficulties from their close family.  
9

10  
11 A number of participants spoke about the change in the nature of their close relationships that  
12  
13 had been brought about by their difficulties.

14  
15 *“My relationship with my children has changed very much and that’s an ongoing thing*  
16  
17 *which I’ll have to face as they get older and learn more about me and what I can and*  
18  
19 *can’t do. And obviously even my wife has completely changed, as you can imagine. But*  
20  
21 *I’ve been fortunate in the fact that they’ve all been very accepting and supportive of*  
22  
23 *me” [#11]*  
24

25  
26 There were several doctors who described very positive experiences of support.

27  
28 *“My friends were very supportive. I think they put up with a lot really in a sense*  
29  
30 *because I was very unwell on and off. In the same way as I got weary of it I’m sure they*  
31  
32 *did and there were crises. As I say, even when I was well I didn’t think I was that great,*  
33  
34 *but no, they were very supportive....They really stuck by me. I think they couldn’t really*  
35  
36 *understand what was happening. They had no background in psychiatry or anything but*  
37  
38 *they could see that none of these tablets were really helping things and I think it must*  
39  
40 *have been very, very frustrating for them. I think I owe them a lot really” [#14]*  
41

42  
43 *“I live with my husband and we have quite a few really good friends who live nearby ..*  
44  
45 *and they were, kind of, the people who got me through really. So, all of them were*  
46  
47 *people I could talk to who would understand, who would, kind of, pray for me, support*  
48  
49 *me, and really see, they saw the effect it was having on me because they knew me and I*  
50  
51 *could be open and honest with them. Yeah, without them I don’t know what, how it*  
52  
53 *would have gone really” [#5]*  
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4 In contrast, several doctors reported receiving less than adequate support from family and  
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6 friends.

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

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12  
13 *“I have gone down in their esteem because of the problems at work...they didn’t think  
14 too highly of me for that”* [#7]

15  
16  
17 *“I am quite an outsider in my family”* [#5]

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19  
20 To avoid negative changes in close relationships, more than one doctor resorted to concealing  
21  
22 their difficulties from their families.

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24  
25 *“I heard that most doctors, they don’t actually want to involve anyone else, because it’s  
26 just a stigma and a shame on themselves, that something happened, so even my close  
27 family did not know what happened”* [#12]

28  
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30  
31 *“Sometimes there’s a situation where I’m going to rush off to a [Alcoholic Anonymous]  
32 meeting and they’re still in our house having a cup of tea and it’s like ‘Oh, I’m just off  
33 to go and meet a friend’. I am kind of; I’m just not telling them the whole truth but I  
34 don’t feel I’m lying. I’m just protecting them, protecting our relationship, protecting  
35 our family”* [#9]

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41  
42 Professional relationships

43  
44 Many participants reported a negative response to their situation from colleagues. Such  
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46 responses were more internalised than challenged and doctors used terms such as “failure”,  
47  
48 “uncomfortable”, “shame” and “guilt” when describing themselves.

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

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4 “They came to visit me in the hospital. I remember one of the nurses commented she’d  
5 never seen so many doctors on the ward before at once. I was surrounded by about  
6 eight [specialty] registrars. They’d all come en masse to visit me. And my consultant  
7 direct educational supervisor boss at the time was being very nice. He’d occasionally  
8 ring to find out how things were going and so on. So they were very good” [# 11]  
9

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12  
13 “The nursing staff, ancillary staff, other medical staff outside of the department were  
14 extremely supportive. They would come over and open the car door and shake my  
15 hand. Some of them sent me emails and phoned me and I really felt welcomed back.  
16 Less so with my own colleagues but having said that, they’ve been through the wars  
17 with me and they supported me big time before [year] and then I had a relapse and then  
18 I think they probably felt “That’s it, he’ll not be back.” Then I come back, it’s difficult  
19 for them and maybe that’s passing in time though” [#16]  
20  
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24  
25 “I was actually quite pleasantly surprised that a lot of my friends from work were very  
26 supportive. When asked for testimonials for GMC for me and wrote a lot of very nice  
27 things about me including those who turned up and actually spoke on my behalf” [#17]  
28  
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30  
31 However, doctors not caring about other doctors were mentioned by several participants.

32  
33 Doctors described their experiences of support or the lack thereof, in contrast to the care doctors  
34 provide for their patients. Moreover the lack of caring was described as a cultural and attitudinal  
35 issue rather than purely situational. Many doctors observed and experienced this culture of  
36 support, both when others have gone off sick, and whilst they themselves have been ill.  
37  
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39

40  
41 “I mean we’re meant to be caring people [laughs] but we don’t, don’t seem to care  
42 about each other at all in my experience” [#3]  
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44  
45

46  
47 “Most of the consultants (...) were not bothered at all, and I don’t think they would  
48 really care unless you drop dead and they were only bothered about the work being  
49 done, regardless of what happened to you. And I think the only time they would get  
50 concerned is if the work wasn’t being done (...) if I was just talking to a friend, I would  
51 just say, “They do not care about junior doctors, consultants, and they don’t care about  
52 their welfare” [#18]  
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4 *"It was a bit unfortunate that at the time I went off sick one of my [specialty] training*  
5 *colleagues went off sick as well and she went the week before me and she was*  
6 *absolutely slammed, it was just, 'Oh it's disgusting, she shouldn't be going off sick,*  
7 *there's nothing the matter with her,' and I was going, 'Well she's really stressed, she's*  
8 *not sleeping,' all the things, she shouldn't be at work. 'Oh but you know...' and then of*  
9 *course the next week it was me. But I just think unless you can change how doctors as a*  
10 *generic body, nationally, perceive mental illness you are never going to change it"* [#2]  
11  
12  
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14

15  
16 *"You're seen as being weak, and one comment I had from this... from the Head of*  
17 *Department in my last job was when she found out I was going for psychotherapy and*  
18 *she said, "I suppose if you need it," was her attitude, as if I were some inferior person*  
19 *because I was having psychotherapy."* [#7]  
20  
21  
22

23 It is therefore no surprise that the anticipation of their colleagues' response is an important  
24 factor as a doctor gets ready to start the return to work system.  
25

26 *"I've still got to get over the hurdle of meeting my colleagues, knowing what they've*  
27 *said about me...knowing that is going to be difficult"* [#2]  
28

29  
30 *"I don't like it when I feel...that people know and that I am being judged...I find that*  
31 *quite uncomfortable"* [#3]  
32

33 *"I think there's a perception that doctors who experience medical conditions should not*  
34 *be doc-, or at least there was a perception amongst the people, who I've... some of the*  
35 *people of my experience, that they shouldn't be in the profession."* [#18]  
36  
37

38 Overall, feelings of being "a failure" became a generalised self-perception rather than specific to  
39 the loss of the work role. For most participants, the experience of being a doctor away from  
40 work culminated in an internalised, altered sense of self.  
41  
42  
43

44  
45 *"There was guilt, there was shame, there was fear...there was low self-esteem...there*  
46 *was the uncertainty of medicine. Self-confidence – that plummeted"* [#9]  
47

48 *"But my confidence has totally gone....I've felt a total failure and I still sometimes do"*  
49 *[#5]*  
50

51  
52 *"I think I felt like a bit of a failure....if you even said to me that I would not be working,*  
53 *about 2 years before this...I'd have said "What a loser!"* [#18]  
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4 Finally, for some doctors the impact of their experience with colleagues and in the work place  
5  
6 was exacerbated by stigmatisation based on existing disabilities.  
7

8  
9 *Er, I think, I always felt that there was, erm, so much wrong with me already, that I*  
10 *didn't want to be seen as someone who, kind of, exaggerated or had loads of things*  
11 *wrong with them, and always, kind of, moaned and, I just didn't want people to think I*  
12 *was looking for sympathy or, I don't know, I just, I just thought, I just didn't want to be*  
13 *treated any more differently and I thought if I tell somebody...they might not involve me*  
14 *in certain conversations, or they might talk about me with each other, and I just didn't*  
15 *want any of that, so... [#6]*  
16  
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19

20  
21 *Erm developing [physical disability] and erm ... and just a total dearth of information*  
22 *about how you practice as a healthcare professional with [physical disability]*  
23 *...Nobody I could find knew anything about that. ...but the huge thing was just erm*  
24 *living...it was erm adapting to a new disability both socially and erm er professionally.*  
25 *Erm there's a high rate of depression in [people with physical disability], much higher*  
26 *than the general population, higher than [physical disability]. [#5]*  
27  
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## 32 Discussion

33  
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35 We carried out in-depth interviews on 19 doctors who had been off work for six months or  
36  
37 more. These doctors had various combinations of physical and psychiatric disorders. The  
38  
39 majority, though not all, had had some dealings with the General Medical Council.  
40  
41 Commitment to, and identifying with, the role of a doctor was a common theme that emerged. It  
42  
43 is likely that medicine with its long training and long hours of work preferentially attracts  
44  
45 individuals likely to make a commitment to their work. The flip-side of such an approach is the  
46  
47 relative absence of an alternative structure or purpose if, for whatever reason, an individual is  
48  
49 unable to work.  
50

51  
52 The centrality of this role also seemed to be strengthened by the perception amongst doctors that  
53  
54 they are “invincible”, and that “illness is only for patients”, alluded to in both Cohen's review  
55  
56 for the Royal Medical Benevolent Fund (Cohen D – personal communication) and Harvey's  
57  
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3  
4 review for the National Clinical Assessment Service(8). It is understandable therefore that for  
5  
6 some doctors the recognition of illness presents a challenge over and above that of just the  
7  
8 disorder – it forces an entire reappraisal of their view of the world and their place within it. The  
9  
10 accounts given by several doctors convey a sense of great surprise, often only implicitly, that  
11  
12 they had suffered a health problem. Whilst these issues have been recognised as factors in  
13  
14 delaying or preventing a doctor seeking medical attention(8, 18), they have not previously been  
15  
16 considered as reasons for a doctor having difficulty in returning to work.  
17

18  
19 One of the most striking findings was the negative view the doctors had of themselves since ill  
20  
21 health became a part of their identity. This was clearly exacerbated by the views and  
22  
23 behaviours they perceived or encountered from family members and colleagues. The  
24  
25 participants in our study described having experienced negative interactions with their families  
26  
27 and colleagues during their illness, but also seemed to anticipate this as part of any return to  
28  
29 work process(19). It has been suggested that doctors stigmatise mental illness more than the  
30  
31 public(20) , but the self-stigmatisation seemed to extend to physical illness as well. As is  
32  
33 common with stigma, the doctors' accounts are likely, in part, to represent negative internalised  
34  
35 self-perceptions and their views about how others perceive them(21, 22).  
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37  
38 Profound and potentially destructive negative self-images were shared by several participants.  
39  
40 Whilst low self esteem can be part of a depressive disorder, not all doctors had experienced a  
41  
42 depressive episode or were currently suffering from depression; a number had made a clinical  
43  
44 recovery from their health condition. Our findings went beyond low self esteem into the realm  
45  
46 of self-stigma. Self-stigma describes the phenomenon whereby people adopt and internalize  
47  
48 external social stigma and experience loss of self-esteem and self-efficacy(23, 24). As a result,  
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50 they refrain from taking an active role in various areas of life. Many of the doctors we  
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52 interviewed appeared to have absorbed negative views of themselves. Moreover, at least two  
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54 doctors described difficulties in dealing with having a disabling physical health problem, only to  
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4 then have to cope with yet more perceived criticism regarding a mental health problem. It is  
5 possible that in absorbing them, doctors perpetuate and reinforce the negative views of others.  
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9 Any understanding of the difficulties faced by doctors in returning to work needs to be able to  
10 incorporate both the omnipotent “doctors are invincible” view and the negative self-stigmatising  
11 views elicited in our study. Although these may seem to be mutually exclusive, an alternative  
12 hypothesis would be that the self-stigmatising views are a direct consequence of the unhealthy  
13 “doctors are invincible” view. The competitive medical environment reinforces the need for  
14 toughness and self-reliance which has become more of a wider cultural phenomenon rather than  
15 a trait identified in a few. It is possible that, for some, this has a selective advantage – that is, for  
16 some students and trainees this outlook assists in being able to manage the suffering of the  
17 patients and families they are learning to treat. Its success in the short-term means it often  
18 remains unchallenged. The incorporation of the “illness is for patients” view however reduces  
19 the chances of alternative “healthier” narratives about the interchangeability of the patient and  
20 doctor roles being generated. Thus when a doctor does become ill they are challenged on a  
21 range of levels, dealing not only with the illness but also for some the loss of their self-image as  
22 invincible.  
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37 A number of doctors though do not have access to strategies which will allow them to come to  
38 terms with these issues whilst maintaining their personal integrity. A greater willingness to  
39 accept the possibility that one might at some stage become a patient, together with greater input  
40 from trainers and senior colleagues as to how this might be managed, could reduce the sense of  
41 shock and bewilderment should illness strike.  
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48 As with all stigma, reducing social distance can help change minds(25). It is possible that recent  
49 improvements in the quality of NHS occupational health services(26) and the services provided  
50 to treat sick doctors, such as the Practitioner Health Programme, might mean that more doctors  
51 who have had complex difficulties are able to return to active practice more rapidly. The  
52 presence of these doctors in the workforce will therefore increase over time, improving the  
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4 chance that students and trainees will come into contact with such doctors, and this will act as a  
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6 counter-weight to the notion that “doctors are invincible”. But if we are to create an  
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8 environment which facilitates the return to work of doctors with complex needs, attention must  
9  
10 be paid to how the “invincible” culture in medicine is generated. The regulator, which now has  
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12 responsibility for UK medical undergraduates, the Deaneries and the medical schools must work  
13  
14 together to enable students and trainees to recognise their own vulnerabilities and facilitate the  
15  
16 generation of strategies should they become ill. Further, aspects of personal and colleague  
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18 health, especially mental health, should be part of the curriculum for all medical students.  
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20 Doctors must learn to provide themselves and their colleagues with the same level of excellent  
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22 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](http://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.

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

**Data**

No additional data are available

For peer review only





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

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Manuscripts

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

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[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

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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]

For peer review only

## 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

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4 for people with common mental disorders (13). Emerging themes were grouped as personal  
5 factors, support in the workplace, and wider economic and societal issues. This important paper  
6 emphasised that returning to work is a process into which past experience, current perception  
7 and anticipation of the future all input.  
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12 Although to our knowledge no papers on doctors have had obstacles to returning to work as  
13 their main focus, several studies exploring the general experience of being a sick doctor have  
14 found that doctors emphasise the difficulty of being off work and the barriers faced in returning  
15 to work after sickness absence. Fatholm interviewed 15 doctors who had successfully returned  
16 to work after a period of prolonged sick leave (14). Doctors commented on how hard they found  
17 it holding the identity of both a doctor and a patient. Several described having resisted sick  
18 leave fearing their own clinical competence would be questioned. A number reported  
19 'negotiating' with their own doctor in an attempt to expedite their return to work. Fox spoke to  
20 doctors with significant long term illness (15). Further issues around personal identity emerged,  
21 as did comments about the culture of "invincibility" within medicine, and how sick doctors need  
22 to put on 'facade'. Ingstad (16) identified participants who had been asked by their doctor to  
23 make clinical decisions about their own health. The tension between the role of the patient and  
24 that of the doctor was also discussed by McTevitt (17) who described how some doctors find it  
25 difficult to cede control and thereby cease being the "expert" in a two-person relationship. In  
26 contrast Stanton highlighted how non-medical friends and colleagues can identify that  
27 "something is wrong" yet find themselves disempowered by the doctor-patient's medical  
28 knowledge when trying to discuss this(18).  
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47 Beyond the issues with access to appropriate services and the complications of regulatory  
48 involvement, relatively little is known about the ability of doctors to be able to return to work  
49 after a period of sick leave. We explored the views of doctors with a range of physical and  
50 psychiatric health problems, with and without GMC involvement, on the obstacles that prevent  
51 them from returning to work.  
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## 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



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

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

### 45 46 Recruitment

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48 77 doctors were informed about the study by the partner organisations. No potential participants  
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50 were believed to meet exclusion criteria. Given our recruitment methodology we do not know  
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52 which partner organisation introduced each participant. A number of the doctors were known to  
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54 more than one of the partners, though this does not necessarily mean they were contacted by  
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4 each. Thirty of those provided with information about the study made contact with the  
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6 researchers. Nineteen (25% of the 77) doctors took part in the study. At least two doctors who  
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8 had initially expressed an interest subsequently became too unwell to participate. The reasons  
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10 given by other potential participants for not taking part included not wishing to be recorded, and  
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12 ongoing concerns, despite reassurance, regarding confidentiality. All doctors who took part  
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14 were able to complete the interview.

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

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25 (Table 1 about here)

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

#### 47 48 *Work identity*

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51 Participants reported their job as an important part of their identity, and many described being  
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53 deeply committed to their work and defined themselves in these terms. Often this related to the  
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55 effort and sacrifice that went into becoming a doctor. For many of the participants going off  
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4 work sick was associated with a fundamental change in identity. Many appeared to incorporate  
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6 negative views of themselves into their new identity. While the loss of income was mentioned  
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8 by some of the doctors, the loss of identity was rarely about the financial aspects alone.  
9

10  
11 *“I want to work. I would have liked to have worked, for lots of reasons. I think it’s*  
12  
13 *good for anybody to have a structure to their life and purpose. I have always wanted to*  
14  
15 *be a doctor and I trained as a mature student in medicine. So I sacrificed a lot. And I*  
16  
17 *loved my job. So for all those reasons it was really important to me to go back to*  
18  
19 *work.” [#11]*

20  
21 *“You get to be part of your job, it becomes part of you...” [#17]*  
22

23  
24 Perhaps as a consequence, being away from work then left them feeling lost, isolated and sad.

25  
26 *“..once you try and put that doctor persona aside, I realised there wasn’t much left of*  
27  
28 *me” [#9]*

29  
30  
31 *“I can’t, emotionally I can’t retire. I mean, I gotta be involved. I feel a total emptiness”*  
32  
33 *[#10]*

34  
35  
36 *“..because I have spent all my entire adult life from the first year of my medical school*  
37  
38 *to 2008, I mean its nearly two decades, so and then everything is taken from you. You*  
39  
40 *have been left alone and no one can hear it if you no matter how loudly cry and so it is*  
41  
42 *very, very difficult (...) you just simply got lost in a, in a huge sea without any navigator*  
43  
44 *and you don’t know what to do” [#12]*

45  
46  
47 *“I almost didn’t want to do the normal things like going out, because I almost wanted*  
48  
49 *that to be on hold before I started working again, because work was so important...I*  
50  
51 *also I think with the sense that because I wasn’t working I shouldn’t be almost allowed*  
52  
53 *... I shouldn’t be going out and having any sort – doing any sort of non-work-related,*  
54  
55 *or non-serious sort of activity” [#18]*  
56  
57

1  
2  
3  
4 *Relationships with family and friends*

5  
6 Many, though not all, doctors had absorbed negative responses they had received from family  
7 and friends. The impact of no longer working appeared to be super-imposed on that of the  
8 illness itself. Some even tried to conceal their difficulties from their close family.  
9

10  
11 A number of participants spoke about the change in the nature of their close relationships that  
12 had been brought about by their difficulties.  
13

14  
15 *“My relationship with my children has changed very much and that’s an ongoing thing*  
16 *which I’ll have to face as they get older and learn more about me and what I can and*  
17 *can’t do. And obviously even my wife has completely changed, as you can imagine. But*  
18 *I’ve been fortunate in the fact that they’ve all been very accepting and supportive of*  
19 *me” [#11]*  
20  
21  
22  
23  
24  
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27

28 There were several doctors who described very positive experiences of support.  
29

30  
31 *“My friends were very supportive. I think they put up with a lot really in a sense*  
32 *because I was very unwell on and off. They really stuck by me. I think they couldn’t*  
33 *really understand what was happening. They had no background in psychiatry or*  
34 *anything but they could see that none of these tablets were really helping things and I*  
35 *think it must have been very, very frustrating for them. I think I owe them a lot really”*  
36  
37  
38  
39  
40  
41  *[#14]*  
42

43  
44 *“I live with my husband and we have quite a few really good friends who live nearby ..*  
45 *and they were, kind of, the people who got me through really. So, all of them were*  
46 *people I could talk to who would understand, who would, kind of, pray for me, support*  
47 *me, and really see, they saw the effect it was having on me because they knew me and I*  
48 *could be open and honest with them” [#5]*  
49  
50  
51  
52  
53

54 In contrast, several doctors reported receiving less than adequate support from family and  
55 friends.  
56  
57

1  
2  
3  
4 “Mostly he [partner] detached himself, carried on working and regarded me as a  
5 nuisance...my family have really put me into the sort of bad category” [#19]  
6  
7

8 “I have gone down in their esteem because of the problems at work...they didn't think  
9 too highly of me for that” [#7]  
10  
11

12 “I am quite an outsider in my family” [#5]  
13  
14

15 To avoid negative changes in close relationships, more than one doctor resorted to concealing  
16 their difficulties from their families.  
17  
18

19  
20 “I heard that most doctors, they don't actually want to involve anyone else, because it's  
21 just a stigma and a shame on themselves, that something happened, so even my close  
22 family did not know what happened” [#12]  
23  
24

25  
26 “Sometimes there's a situation where I'm going to rush off to a [Alcoholic Anonymous]  
27 meeting and they're still in our house having a cup of tea and it's like 'Oh, I'm just off  
28 to go and meet a friend'. I am kind of; I'm just not telling them the whole truth but I  
29 don't feel I'm lying. I'm just protecting them, protecting our relationship, protecting  
30 our family” [#9]  
31  
32  
33  
34  
35  
36

### 37 Professional relationships

38 Many participants reported a negative response to their situation from colleagues. Such  
39 responses were more internalised than challenged and doctors used terms such as “failure”,  
40 “uncomfortable”, “shame” and “guilt” when describing themselves.  
41  
42  
43  
44  
45

46 Several doctors recalled the support they had received from colleagues – both doctors and other  
47 healthcare professionals.  
48  
49

50  
51 “They came to visit me in the hospital. I remember one of the nurses commented she'd  
52 never seen so many doctors on the ward before at once. (...) They'd all come en masse  
53 to visit me. And my consultant direct educational supervisor boss at the time was being  
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1  
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4 very nice. He'd occasionally ring to find out how things were going and so on. So they  
5 were very good" [# 11]

6  
7 "The nursing staff, ancillary staff, other medical staff outside of the department were  
8 extremely supportive. Some of them sent me emails and phoned me and I really felt  
9 welcomed back. Less so with my own colleagues but having said that, they've been  
10 through the wars with me and they supported me big time before [year] and then I had  
11 a relapse and then I think they probably felt "That's it, he'll not be back." Then I come  
12 back, it's difficult for them and maybe that's passing in time though" [#16]

13  
14  
15 "I was actually quite pleasantly surprised that a lot of my friends from work were very  
16 supportive. When asked for testimonials for GMC for me and wrote a lot of very nice  
17 things about me including those who turned up and actually spoke on my behalf" [#17]

18  
19  
20  
21  
22  
23 Some doctors felt less supported. In several cases, this was attributed to other medical  
24 professionals lacking the knowledge and experience in dealing with sick doctors.

25  
26  
27  
28 "Certainly within the medical profession I don't think the culture's there to accept  
29 somebody who's severely disabled. They're not geared up towards it at all. (...) it's  
30 going to be a big battle because the culture isn't there, the knowledge isn't there, the  
31 experience isn't there to deal with somebody who is severely disabled." [#11]

32  
33  
34  
35  
36 However, doctors not caring about other doctors were mentioned by several participants.

37  
38 Doctors described their experiences of support or the lack thereof, in contrast to the care doctors  
39 provide for their patients. Moreover the lack of caring was described as a cultural and attitudinal  
40 issue rather than purely situational. Many doctors observed and experienced this culture of  
41 support, both when others have gone off sick, and whilst they themselves have been ill.

42  
43  
44  
45  
46  
47 "I mean we're meant to be caring people [laughs] but we don't, don't seem to care  
48 about each other at all in my experience" [#3]

49  
50  
51  
52 "Most of the consultants (...) were not bothered at all, and I don't think they would  
53 really care unless you drop dead and they were only bothered about the work being  
54 done, regardless of what happened to you. And I think the only time they would get  
55 concerned is if the work wasn't being done (...) if I was just talking to a friend, I would  
56  
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1  
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4 just say, "They do not care about junior doctors, consultants, and they don't care about  
5 their welfare" [#18]  
6

7  
8 "It was a bit unfortunate that at the time I went off sick one of my [specialty] training  
9 colleagues went off sick as well and she went the week before me and she was  
10 absolutely slammed, it was just, 'Oh it's disgusting, she shouldn't be going off sick,  
11 there's nothing the matter with her,' (...) and then of course the next week it was me.  
12 But I just think unless you can change how doctors as a generic body, nationally,  
13 perceive mental illness you are never going to change it" [#2]  
14  
15  
16

17  
18 "You're seen as being weak, and one comment I had from this... from the Head of  
19 Department in my last job was when she found out I was going for psychotherapy and  
20 she said, "I suppose if you need it," was her attitude, as if I were some inferior person  
21 because I was having psychotherapy." [#7]  
22  
23  
24

25  
26 It is therefore no surprise that the anticipation of their colleagues' response is an important  
27 factor as a doctor gets ready to start the return to work system.

28  
29 "I've still got to get over the hurdle of meeting my colleagues, knowing what they've  
30 said about me...knowing that is going to be difficult" [#2]  
31

32  
33 "I don't like it when I feel...that people know and that I am being judged...I find that  
34 quite uncomfortable" [#3]  
35

36  
37 "I think there's a perception that doctors who experience medical conditions should not  
38 be doc-, or at least there was a perception amongst the people, who I've... some of the  
39 people of my experience, that they shouldn't be in the profession." [#18]  
40

41  
42 For some doctors the impact of their experience with colleagues and in the work place was  
43 exacerbated by stigmatisation based on existing disabilities.  
44

45  
46 "I always felt that there was, erm, so much wrong with me already, that I didn't want to  
47 be seen as someone who, kind of, exaggerated or had loads of things wrong with them,  
48 and always, kind of, moaned and, I just didn't want people to think I was looking for  
49 sympathy or, I don't know, I just, I just thought, I just didn't want to be treated any  
50 more differently and I thought if I tell somebody...they might not involve me in certain  
51 conversations, or they might talk about me with each other, and I just didn't want any  
52 of that, so..." [#6]  
53  
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1  
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4 *"Developing [physical disability] and erm ... and just a total dearth of information*  
5 *about how you practice as a healthcare professional with [physical disability]*  
6 *...Nobody I could find knew anything about that. ...but the huge thing was just erm*  
7 *living...it was erm adapting to a new disability both socially and erm er professionally.*  
8 *Erm there's a high rate of depression in [people with physical disability], much higher*  
9 *than the general population, higher than [physical disability]. [#5]*

### 14 15 *Self perception*

16  
17 Overall, feelings of being "a failure" became a generalised self-perception rather than specific to  
18 the loss of the work role.

19  
20  
21 *"There was guilt, there was shame, there was fear...there was low self-esteem...there*  
22 *was the uncertainty of medicine. Self-confidence – that plummeted" [#9]*

23  
24  
25 *"But my confidence has totally gone....I've felt a total failure and I still sometimes do"*  
26 *[#5]*

27  
28  
29 For most participants, the experience of being a doctor away from work culminated in an  
30 internalised, altered sense of self.

31  
32 *"But once you try and put that doctor persona aside, I realised there wasn't much left of*  
33 *me. I realised I was kind of a doctor, but what else do I do?"*

34  
35  
36 *"I think I felt like a bit of a failure....if you even said to me that I would not be working,*  
37 *about 2 years before this...I'd have said "What a loser!" [#18]*

38  
39 Feelings of emptiness, guilt, shame and of being a 'failure' were prominent in many  
40 doctors' accounts. Self esteem appeared to be worsened by illness and loss of work.  
41 Doctors tended to blame themselves for their situations and felt like failures when  
42 experiencing difficulties with work and encountering obstacles to returning to work,  
43 often resulting in a loss of confidence. This, in turn, further worsened self esteem and  
44 created a vicious circle where the doctor needs work to improve their self esteem but  
45 cannot work due to their self esteem being so low. *"If I tried to get a job in [specialty], I*  
46 *don't know if I'd remain as well. I probably wouldn't, and so I would get into that*  
47 *vicious circle again of health affecting my performance and my performance, lower*  
48 *performance affecting my mood and everything spiralling down again." [#7]*  
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## 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

1  
2  
3  
4 delaying or preventing a doctor seeking medical attention(8, 21), they have not previously been  
5  
6 considered as reasons for a doctor having difficulty in returning to work.  
7

8  
9 One of the most striking findings was the negative view the doctors had of themselves since ill  
10  
11 health became a part of their identity. This may have been exacerbated by the views and  
12  
13 behaviours they perceived from family members and colleagues: many felt unsupported or  
14  
15 judged. It is important to note that these feelings are the perceptions of the participants; as no  
16  
17 significant others were interviewed, we do not have information about their views. The  
18  
19 participants in our study described having experienced negative interactions with their families  
20  
21 and colleagues during their illness, but also seemed to anticipate this as part of any return to  
22  
23 work process(22). It has been suggested that doctors stigmatise mental illness more than the  
24  
25 public(23) , but the self-stigmatisation seemed to extend to physical illness as well. As is  
26  
27 common with stigma, the doctors' accounts are likely, in part, to represent negative internalised  
28  
29 self-perceptions and their views about how others perceive them(24, 25).  
30

31  
32 Profound and potentially destructive negative self-images were shared by several participants.  
33  
34 Whilst low self esteem can be part of a depressive disorder, not all doctors had experienced a  
35  
36 depressive episode or were currently suffering from depression; a number had made a clinical  
37  
38 recovery from their health condition. Our findings went beyond low self esteem into the realm  
39  
40 of self-stigma. Self-stigma describes the phenomenon whereby people adopt and internalize  
41  
42 external social stigma and experience loss of self-esteem and self-efficacy (26-28). As a result,  
43  
44 they refrain from taking an active role in various areas of life. Many of the doctors we  
45  
46 interviewed appeared to have absorbed negative views of themselves. Moreover, at least two  
47  
48 doctors described difficulties in dealing with having a disabling physical health problem, only to  
49  
50 then have to cope with yet more perceived criticism regarding a mental health problem. It is  
51  
52 possible that in absorbing them, doctors perpetuate and reinforce the negative views of others.  
53  
54 An alternative suggestion may be that the doctors have internalised the view of themselves as  
55  
56 invincible to the extent that they view themselves as failures, and cannot conceive that anyone  
57  
58  
59  
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1  
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3  
4 else might view their illness differently. So rather than absorbing negative views of others, they  
5  
6 may in fact be externalising their own negative views. A future study would benefit from  
7  
8 assessing the views held by those close to doctors.  
9

10  
11 We are not aware of a literature describing why doctors may be more prone to self-stigmatise  
12  
13 and are therefore restricted to hypothesising. It is possible that it reflects a general tendency to  
14  
15 stigmatise – doctors have been shown to stigmatise others with mental health problems (23). It  
16  
17 may in part be connected to the issue of “invincibility” which is constructed in binary fashion –  
18  
19 you are either invincible, or you are completely useless. It may also reflect a more widespread  
20  
21 aspect of medical culture where doctors develop a sensitivity to the views of others. Normally  
22  
23 this is the positive views of colleagues and patients which can be quite intoxicating. Doctors  
24  
25 may also be predisposed to internalise negative views of others.  
26

27  
28 Any understanding of the difficulties faced by doctors in returning to work needs to be able to  
29  
30 incorporate both the omnipotent “doctors are invincible” view and the negative self-stigmatising  
31  
32 views elicited in our study. Although these may seem to be mutually exclusive, an alternative  
33  
34 hypothesis would be that the self-stigmatising views are a direct consequence of the unhealthy  
35  
36 “doctors are invincible” view. The competitive medical environment reinforces the need for  
37  
38 toughness and self-reliance which has become more of a wider cultural phenomenon rather than  
39  
40 a trait identified in a few. It is possible that, for some, this has a selective advantage – that is, for  
41  
42 some students and trainees this outlook assists in being able to manage the suffering of the  
43  
44 patients and families they are learning to treat. Its success in the short-term means it often  
45  
46 remains unchallenged. The incorporation of the “illness is for patients” view however reduces  
47  
48 the chances of alternative “healthier” narratives about the interchangeability of the patient and  
49  
50 doctor roles being generated. Thus when a doctor does become ill they are challenged on a  
51  
52 range of levels, dealing not only with the illness but also for some the loss of their self-image as  
53  
54 invincible.  
55  
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4 A number of doctors though do not have access to strategies which will allow them to come to  
5  
6 terms with these issues whilst maintaining their personal integrity. A greater willingness to  
7  
8 accept the possibility that one might at some stage become a patient, together with greater input  
9  
10 from trainers and senior colleagues as to how this might be managed, could reduce the sense of  
11  
12 shock and bewilderment should illness strike.

13  
14 As with all stigma, reducing social distance can help change minds(29). It is possible that recent  
15  
16 improvements in the quality of NHS occupational health services(30) and the services provided  
17  
18 to treat sick doctors, such as the Practitioner Health Programme, might mean that more doctors  
19  
20 who have had complex difficulties are able to return to active practice more rapidly. The  
21  
22 presence of these doctors in the workforce will therefore increase over time, improving the  
23  
24 chance that students and trainees will come into contact with such doctors, and this will act as a  
25  
26 counter-weight to the notion that “doctors are invincible”. But if we are to create an  
27  
28 environment which facilitates the return to work of doctors with long term difficulties, attention  
29  
30 must be paid to how the “invincible” culture in medicine is generated. The regulator, which now  
31  
32 has responsibility for UK medical undergraduates, the Deaneries and the medical schools must  
33  
34 work together to enable students and trainees to recognise their own vulnerabilities and facilitate  
35  
36 the generation of strategies should they become ill. Further, aspects of personal and colleague  
37  
38 health, especially mental health, should be part of the curriculum for all medical students.  
39  
40 Doctors must learn to provide themselves and their colleagues with the same level of excellent  
41  
42 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
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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](http://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.

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1  
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3  
4 potential participants as described in the Methods section. All the researchers are independent  
5  
6 of the funders.  
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8 **Data**  
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10 No additional data are available  
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For peer review only

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

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[50714202 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

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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]

For peer review only

## ARTICLE SUMMARY

### Article focus

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- 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/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

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

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14 [Although to our knowledge no papers on doctors have had obstacles to returning to work as](#)  
15 [their main focus, several studies exploring the general experience of being a sick doctor have](#)  
16 [found that doctors emphasise the difficulty of being off work and the barriers faced in returning](#)  
17 [to work after sickness absence.](#) Fatholm interviewed 15 doctors who had successfully returned  
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22 to work after a period of prolonged sick leave (14). Doctors commented on how hard they found  
23  
24 it holding the identity of both a doctor and a patient. Several described having resisted sick  
25  
26 leave fearing their own clinical competence would be questioned. A number reported  
27  
28 'negotiating' with their own doctor in an attempt to expedite their return to work. Fox spoke to  
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30 doctors with significant long term illness (15). Further issues around personal identity emerged,  
31  
32 as did comments about the culture of "invincibility" within medicine, and how sick doctors need  
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34 to put on 'facade'. Ingstad (16) identified participants who had been asked by their doctor to  
35  
36 make clinical decisions about their own health. The tension between the role of the patient and  
37  
38 that of the doctor was also discussed by McTevitt (17) who described how some doctors find it  
39  
40 difficult to cede control and thereby cease being the "expert" in a two-person relationship. In  
41  
42 contrast Stanton highlighted how non-medical friends and colleagues can identify that  
43  
44 "something is wrong" yet find themselves disempowered by the doctor-patient's medical  
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46 knowledge when trying to discuss this(18).

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48 Beyond the issues with access to appropriate services and the complications of regulatory  
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50 involvement, relatively little is known about the ability of doctors to be able to return to work  
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52 after a period of sick leave. We explored the views of doctors with a range of physical and  
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54 psychiatric health problems, with and without GMC involvement, on the obstacles that prevent  
55  
56 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



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7 were felt necessary. The researchers (LdB and SB) determined eligibility and gained consent  
8 from potential participants. Those interested were invited to take part in an in-depth semi-  
9 structured interview. When the researchers met the participants the nature and purpose of the  
10 study was explained again. Participants had the opportunity to ask questions. All participants  
11 provided full written consent to take part in the study.  
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16 A total of 19 interviews were completed; the first ten interviews were completed by LdB and  
17 the last nine by SB. Each interview lasted between one and two hours. Interviews were recorded  
18 directly onto an encrypted drive on a laptop computer then transcribed verbatim. Using the  
19 Nvivo software package(19), transcripts were analysed by thematic content analysis using the  
20 constant comparison method(20). The two researchers (LdB and SB) each analysed all the  
21 transcripts using [an inductive approach to thematic analysis\(20\), using NVivo to 'code' data in](#)  
22 [order to build a set of 'themes' i.e. ideas or topics occurring at several points in the data corpus.-](#)  
23  
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25  
26 Initially the researchers each completed the coding procedure independently. They then  
27 compared codes and reached consensus on the emerging themes by discussion leading to a final  
28 [set of agreed codes agreed master list of themes and sub-themes](#). Emerging themes were  
29 discussed regularly by the research team. [This type of thematic analysis is inductive, i.e. the](#)  
30 [themes emerged from the data itself and were not imposed by the researchers](#). In addition both  
31 researchers engaged in a process of reflexivity. They each recorded details of the interviewing  
32 interaction, and reflected on their own experience which may have had an impact on the  
33 interpretation of data.  
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## 45 46 **Results**

### 47 48 Recruitment

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50 77 doctors were informed about the study by the partner organisations. No potential participants  
51 were believed to meet exclusion criteria. Given our recruitment methodology we do not know  
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7 which partner organisation introduced each participant. A number of the doctors were known to  
8 more than one of the partners, though this does not necessarily mean they were contacted by  
9 each. Thirty of those provided with information about the study made contact with the  
10 researchers. Nineteen (25% of the 77) doctors took part in the study. At least two doctors who  
11 had initially expressed an interest subsequently became too unwell to participate. The reasons  
12 given by other potential participants for not taking part included not wishing to be recorded, and  
13 ongoing concerns, despite reassurance, regarding confidentiality. All doctors who took part  
14 were able to complete the interview.

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22 The participants are described in Table 1. Their ages ranged from ~~20s to 60s~~ 27 – 67 years and  
23 the median age was 46. Diagnoses included depression, anxiety, bipolar affective disorder and  
24 alcohol dependence~~addiction~~. All but one doctor had a mental health or addiction problem,  
25  
26  
27 seven had a physical health problem and 14 had involvement with the GMC.

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29  
30 (Table 1 about here)

31  
32 Four main themes and a number of sub-themes were identified. The main themes which  
33 emerged from the data were: work identity; relationships with family and friends; professional  
34 relationships; and self perception. Sub-themes relating to work identity included identity being  
35 bound up with career, and feelings of emptiness when not at work. Sub-themes relating to  
36 relationships with family and friends included changes in relationships due to their difficulties;  
37 positive support; feeling unsupported; and concealing difficulties from others. Sub-themes  
38 relating to professional relationships included support; lack of caring; anticipating feeling  
39 judged on return to work; and stigmatisation. Sub-themes relating to self perception included  
40 sense of failure becoming generalised rather than specific to loss of work, and an altered sense  
41 of self due to being away from work.

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50 ~~Importance of work identity~~ Work identity

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7 Participants reported their job as an important part of their identity, and many described being  
8 deeply committed to their work and defined themselves in these terms. Often this related to the  
9 effort and sacrifice that went into becoming a doctor. For many of the participants going off  
10 work sick was associated with a fundamental change in identity. Many appeared to incorporate  
11 negative views of themselves into their new identity. While the loss of income was mentioned  
12 by some of the doctors, the loss of identity was rarely about the financial aspects alone.  
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18 *"I want to work. I would have liked to have worked, for lots of reasons. I think it's*  
19 *good for anybody to have a structure to their life and purpose. I have always wanted to*  
20 *be a doctor and I trained as a mature student in medicine. So I sacrificed a lot. And I*  
21 *loved my job. So for all those reasons it was really important to me to go back to*  
22 *work."* [#11]  
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27 *"You get to be part of your job, it becomes part of you..."* [#17]  
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30 Perhaps as a consequence, being away from work then left them feeling lost, isolated and sad.  
31

32 *"..once you try and put that doctor persona aside, I realised there wasn't much left of*  
33 *me"* [#9]  
34  
35

36 *"I can't, emotionally I can't retire. I mean, I gotta be involved. I feel a total emptiness"*  
37 [#10]  
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39

40 *"..because I have spent all my entire adult life from the first year of my medical school*  
41 *to 2008, I mean its nearly two decades, so and then everything is taken from you. You*  
42 *have been left alone and no one can hear it if you no matter how loudly cry and so it is*  
43 *very, very difficult, and you see hopeless helpless, and nowhere to go and (...) you just*  
44 *simply got lost in a, in a huge sea without any navigator and you don't know what to*  
45 *do"* [#12]  
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51 *"I almost didn't want to do the normal things like going out, because I almost wanted*  
52 *that to be on hold before I started working again, because work was so important...I*  
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7 *also I think with the sense that because I wasn't working I shouldn't be almost allowed*  
8 *... I shouldn't be going out and having any sort – doing any sort of non-work-related,*  
9 *or non-serious sort of activity” [#18]*  
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17 *“I almost didn't want to do the normal things like going out, because I almost wanted*  
18 *that to be on hold before I started working again, because work was so important...I*  
19 *also I think with the sense that because I wasn't working I shouldn't be almost allowed*  
20 *to do all the things that, or any fun things like because I wasn't working I shouldn't be*  
21 *going out and having any sort – doing any sort of non-work-related, or non-serious sort*  
22 *of activity” [#18]*  
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#### 28 Relationships with family and friends

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

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41 Many, though not all, doctors had absorbed negative responses they had received from family  
42 and friends. The impact of no longer working appeared to be super-imposed on that of the  
43 illness itself. Some even tried to conceal their difficulties from their close family.  
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46  
47 A number of participants spoke about the change in the nature of their close relationships that  
48 had been brought about by their difficulties.  
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51 *“My relationship with my children has changed very much and that's an ongoing thing*  
52 *which I'll have to face as they get older and learn more about me and what I can and*  
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7 can't do. And obviously even my wife has completely changed, as you can imagine. But  
8 I've been fortunate in the fact that they've all been very accepting and supportive of  
9 me" [#11]  
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12 There were several doctors who described very positive experiences of support.

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15 "My friends were very supportive. I think they put up with a lot really in a sense  
16 because I was very unwell on and off. ~~In the same way as I got weary of it I'm sure they~~  
17 ~~did and there were crises. As I say, even when I was well I didn't think I was that great,~~  
18 ~~but no, they were very supportive....~~ They really stuck by me. I think they couldn't really  
19 understand what was happening. They had no background in psychiatry or anything but  
20 they could see that none of these tablets were really helping things and I think it must  
21 have been very, very frustrating for them. I think I owe them a lot really" [#14]  
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28 "I live with my husband and we have quite a few really good friends who live nearby ..  
29 and they were, kind of, the people who got me through really. So, all of them were  
30 people I could talk to who would understand, who would, kind of, pray for me, support  
31 me, and really see, they saw the effect it was having on me because they knew me and I  
32 could be open and honest with them" ~~Yeah, without them I don't know what, how it~~  
33 ~~would have gone really" [#5]~~  
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39 In contrast, several doctors reported receiving less than adequate support from family and  
40 friends.  
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43 "Mostly he [partner] detached himself, carried on working and regarded me as a  
44 nuisance...my family have really put me into the sort of bad category" [#19]  
45  
46

47 "I have gone down in their esteem because of the problems at work...they didn't think  
48 too highly of me for that" [#7]  
49  
50

51 "I am quite an outsider in my family" [#5]  
52  
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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*

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7 *I think they probably felt “That’s it, he’ll not be back.” Then I come back, it’s difficult*  
8 *for them and maybe that’s passing in time though” [#16]*  
9

10 *“I was actually quite pleasantly surprised that a lot of my friends from work were very*  
11 *supportive. When asked for testimonials for GMC for me and wrote a lot of very nice*  
12 *things about me including those who turned up and actually spoke on my behalf” [#17]*  
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15  
16 [Some doctors felt less supported. In several cases, this was attributed to other medical](#)  
17 [professionals lacking the knowledge and experience in dealing with sick doctors.](#)  
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19  
20 [“Certainly within the medical profession I don’t think the culture’s there to accept](#)  
21 [somebody who’s severely disabled. They’re not geared up towards it at all. \(...\) it’s](#)  
22 [going to be a big battle because the culture isn’t there, the knowledge isn’t there, the](#)  
23 [experience isn’t there to deal with somebody who is severely disabled.” \[#11\]](#)  
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27 However, doctors not caring about other doctors were mentioned by several participants.

28  
29 Doctors described their experiences of support or the lack thereof, in contrast to the care doctors  
30 provide for their patients. Moreover the lack of caring was described as a cultural and attitudinal  
31 issue rather than purely situational. Many doctors observed and experienced this culture of  
32 support, both when others have gone off sick, and whilst they themselves have been ill.  
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36  
37 *“I mean we’re meant to be caring people [laughs] but we don’t, don’t seem to care*  
38 *about each other at all in my experience” [#3]*  
39

40  
41 *“Most of the consultants (...) were not bothered at all, and I don’t think they would*  
42 *really care unless you drop dead and they were only bothered about the work being*  
43 *done, regardless of what happened to you. And I think the only time they would get*  
44 *concerned is if the work wasn’t being done (...) if I was just talking to a friend, I would*  
45 *just say, “They do not care about junior doctors, consultants, and they don’t care about*  
46 *their welfare” [#18]*  
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48

49  
50 *“It was a bit unfortunate that at the time I went off sick one of my [specialty] training*  
51 *colleagues went off sick as well and she went the week before me and she was*  
52 *absolutely slammed, it was just, ‘Oh it’s disgusting, she shouldn’t be going off sick,*  
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7 there's nothing the matter with her,' ~~and I was going, 'Well she's really stressed, she's~~  
8 ~~not sleeping, ' all the things, she shouldn't be at work. 'Oh but you know...'~~(...) and  
9  
10 then of course the next week it was me. But I just think unless you can change how  
11 doctors as a generic body, nationally, perceive mental illness you are never going to  
12 change it" [#2]  
13

14  
15 "You're seen as being weak, and one comment I had from this... from the Head of  
16 Department in my last job was when she found out I was going for psychotherapy and  
17 she said, "I suppose if you need it," was her attitude, as if I were some inferior person  
18 because I was having psychotherapy." [#7]  
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20

21 It is therefore no surprise that the anticipation of their colleagues' response is an important  
22 factor as a doctor gets ready to start the return to work system.  
23

24 "I've still got to get over the hurdle of meeting my colleagues, knowing what they've  
25 said about me...knowing that is going to be difficult" [#2]  
26

27 "I don't like it when I feel...that people know and that I am being judged...I find that  
28 quite uncomfortable" [#3]  
29

30 "I think there's a perception that doctors who experience medical conditions should not  
31 be doc-, or at least there was a perception amongst the people, who I've... some of the  
32 people of my experience, that they shouldn't be in the profession." [#18]  
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35 For some doctors the impact of their experience with colleagues and in the work place was  
36 exacerbated by stigmatisation based on existing disabilities.  
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38 "I always felt that there was, erm, so much wrong with me already, that I didn't want to  
39 be seen as someone who, kind of, exaggerated or had loads of things wrong with them,  
40 and always, kind of, moaned and, I just didn't want people to think I was looking for  
41 sympathy or, I don't know, I just, I just thought, I just didn't want to be treated any  
42 more differently and I thought if I tell somebody...they might not involve me in certain  
43 conversations, or they might talk about me with each other, and I just didn't want any  
44 of that, so..." [#6]  
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49 "Developing [physical disability] and erm ... and just a total dearth of information  
50 about how you practice as a healthcare professional with [physical disability]  
51 ...Nobody I could find knew anything about that. ...but the huge thing was just erm  
52 living...it was erm adapting to a new disability both socially and erm er professionally.  
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*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.~~

*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. [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

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7 individuals likely to make a commitment to their work. The flip-side of such an approach is the  
8 relative absence of an alternative structure or purpose if, for whatever reason, an individual is  
9 unable to work.  
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12 The centrality of this role also seemed to be strengthened by the perception amongst doctors that  
13 they are “invincible”, and that “illness is only for patients”, alluded to in both Cohen’s review  
14 for the Royal Medical Benevolent Fund (Cohen D – personal communication) and Harvey’s  
15 review for the National Clinical Assessment Service(8). It is understandable therefore that for  
16 some doctors the recognition of illness presents a challenge over and above that of just the  
17 disorder – it forces an entire reappraisal of their view of the world and their place within it. The  
18 accounts given by several doctors convey a sense of great surprise, often only implicitly, that  
19 they had suffered a health problem. Whilst these issues have been recognised as factors in  
20 delaying or preventing a doctor seeking medical attention(8, 21), they have not previously been  
21 considered as reasons for a doctor having difficulty in returning to work.  
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31 One of the most striking findings was the negative view the doctors had of themselves since ill  
32 health became a part of their identity. This ~~was clearly may have been~~ exacerbated by the views  
33 and behaviours they perceived ~~or encountered~~ from family members and colleagues: many felt  
34 unsupported or judged. It is important to note that these feelings are the perceptions of the  
35 participants; as no significant others were interviewed, we do not have information about  
36 sight ~~into their views~~. The participants in our study described having experienced negative  
37 interactions with their families and colleagues during their illness, but also seemed to anticipate  
38 this as part of any return to work process(22). It has been suggested that doctors stigmatise  
39 mental illness more than the public(23) , but the self-stigmatisation seemed to extend to physical  
40 illness as well. As is common with stigma, the doctors’ accounts are likely, in part, to represent  
41 negative internalised self-perceptions and their views about how others perceive them(24, 25).  
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51 Profound and potentially destructive negative self-images were shared by several participants.

52 Whilst low self esteem can be part of a depressive disorder, not all doctors had experienced a  
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7 depressive episode or were currently suffering from depression; a number had made a clinical  
8 recovery from their health condition. Our findings went beyond low self esteem into the realm  
9 of self-stigma. Self-stigma describes the phenomenon whereby people adopt and internalize  
10 external social stigma and experience loss of self-esteem and self-efficacy (26-28). As a result,  
11 they refrain from taking an active role in various areas of life. Many of the doctors we  
12 interviewed appeared to have absorbed negative views of themselves. Moreover, at least two  
13 doctors described difficulties in dealing with having a disabling physical health problem, only to  
14 then have to cope with yet more perceived criticism regarding a mental health problem. It is  
15 possible that in absorbing them, doctors perpetuate and reinforce the negative views of others.

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23 An alternative suggestion may be that the doctors have internalised the view of themselves as  
24 invincible to the extent that they view themselves as failures, and cannot conceive that anyone  
25 else might view their illness differently. So rather than absorbing negative views of others, they  
26 may in fact be externalising their own negative views. A future study would benefit from  
27 assessing the views held by those close to doctors.

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

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47 Any understanding of the difficulties faced by doctors in returning to work needs to be able to  
48 incorporate both the omnipotent “doctors are invincible” view and the negative self-stigmatising  
49 views elicited in our study. Although these may seem to be mutually exclusive, an alternative  
50 hypothesis would be that the self-stigmatising views are a direct consequence of the unhealthy  
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7 “doctors are invincible” view. The competitive medical environment reinforces the need for  
8 toughness and self-reliance which has become more of a wider cultural phenomenon rather than  
9 a trait identified in a few. It is possible that, for some, this has a selective advantage – that is, for  
10 some students and trainees this outlook assists in being able to manage the suffering of the  
11 patients and families they are learning to treat. Its success in the short-term means it often  
12 remains unchallenged. The incorporation of the “illness is for patients” view however reduces  
13 the chances of alternative “healthier” narratives about the interchangeability of the patient and  
14 doctor roles being generated. Thus when a doctor does become ill they are challenged on a  
15 range of levels, dealing not only with the illness but also for some the loss of their self-image as  
16 invincible.  
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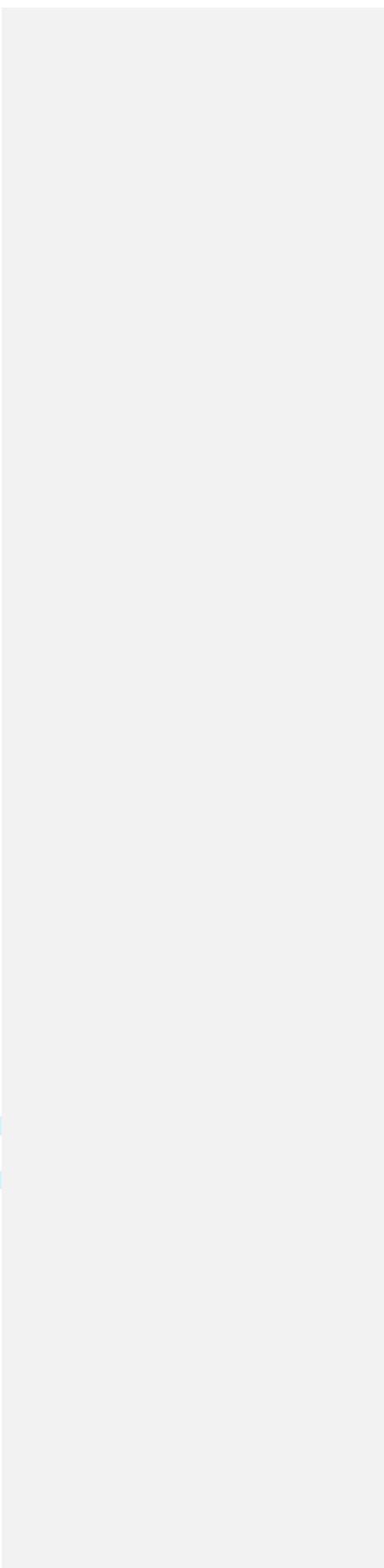
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A number of doctors though do not have access to strategies which will allow them to come to terms with these issues whilst maintaining their personal integrity. A greater willingness to accept the possibility that one might at some stage become a 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 needslong 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

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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.

For peer review only



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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](http://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.

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

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11 **Data**

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13 No additional data are available  
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