



The specific needs of doctors with mental health problems: qualitative analysis of doctor-patients' experiences with the Practitioner Health Programme

Samantha K. Brooks, Clare Gerada & Trudie Chalder

To cite this article: Samantha K. Brooks, Clare Gerada & Trudie Chalder (2017) The specific needs of doctors with mental health problems: qualitative analysis of doctor-patients' experiences with the Practitioner Health Programme, *Journal of Mental Health*, 26:2, 161-166, DOI: [10.1080/09638237.2016.1244712](https://doi.org/10.1080/09638237.2016.1244712)

To link to this article: <http://dx.doi.org/10.1080/09638237.2016.1244712>



Published online: 12 Nov 2016.



Submit your article to this journal [↗](#)



Article views: 54



View related articles [↗](#)



View Crossmark data [↗](#)

ORIGINAL ARTICLE

The specific needs of doctors with mental health problems: qualitative analysis of doctor-patients' experiences with the Practitioner Health Programme

Samantha K. Brooks¹, Clare Gerada², and Trudie Chalder¹

¹Department of Psychological Medicine, King's College London, Institute of Psychiatry, Weston Education Centre, London, UK, and ²Practitioner Health Programme, Riverside Medical Centre, Vauxhall, London, UK

Abstract

Objectives: The current paper aimed to explore doctor-patients' views about their treatment from the Practitioner Health Programme (PHP), a UK-based service treating health professionals with mental health/addiction problems. Aims were to gain insights into the issues most important to patients and consider whether a service specifically for doctors is important in helping to overcome barriers to accessing mental healthcare.

Methods: Nine doctor-patients attending PHP took part in semi-structured interviews between September 2010 and June 2011. Thematic analysis was used to explore recurring patterns in the data. 134 written comments from PHP patients were also included.

Results: Participants reported difficulties in finding appropriate treatment; problems were often severe by the time PHP was involved. Concerns about confidentiality, judgement and impact on career were obstacles to help-seeking and important issues during treatment. Analysis of written comments provided further support for these findings.

Conclusion: Whilst some of the needs of mentally unwell doctors mirror the needs of patients in general – e.g. a supportive and non-judgemental attitude from clinicians – they do have specific needs related to confidentiality and stigma.

Keywords

UK, health professionals, qualitative research, mental health of doctors

History

Received 17 August 2015

Revised 1 August 2016

Accepted 30 August 2016

Published online 8 November 2016

Introduction

Previous literature have demonstrated that doctors may be at risk of stress (Wall et al., 1997), depression (Firth-Cozens, 2006), anxiety (Kroenke et al., 2007), substance misuse or addiction (Ghodse & Galea, 2006), and high levels of distress (Brooks et al., 2011a). Firth-Cozens (2006) suggests that 10–20% of doctors become depressed, and are at greater risk for suicide than the general population. The mental health of doctors can impact not only the quality of life of doctors themselves, but also the quality of care of their own patients (Firth-Cozens, 2001). Therefore, it appears that fast and efficient treatment for sick doctors is important.

Difficulties accessing healthcare are important for all individuals, not only doctors – avoiding, or having to wait, for treatment can impact on employment, income and relationships. However the issue is particularly pertinent for doctors, who have a responsibility to the public – thus, any delay in accessing care may affect not only the doctors themselves but also their colleagues and patients. Doctors do, however, often delay help-seeking (Kay et al., 2008), perhaps due to their own unrealistic expectations of themselves, together with

minimisation or denial of problems (Stanton & Randal, 2011), or the “shame” involved in having a mental illness in a profession which makes them feel they should be invincible (Henderson et al., 2012). The Department of Health's (2010) “Invisible Patients” report suggests other barriers such as workload and concerns about confidentiality, but emphasises the importance of doctors being healthy in terms of both productivity and safety.

It has been suggested that doctors would find it useful to have a “doctor's doctor” (Forsythe et al., 1999); a literature review of mental ill health in doctors concluded that specialist services for doctor-patients would be beneficial (Brooks et al., 2011b). However, there is a lack of literature on the qualitative experiences of doctor-patients accessing treatment from specialist services.

It is important to find out the views of service users, in order to evaluate and improve healthcare services (Edwards & Staniszewska, 2000; Nordin, 2000). Traditionally, the views of service users have been obtained through self-report questionnaires; however, the validity of such measures has been criticised (Avis et al., 1997; Mulcahy & Tritter, 1998). Qualitative research methods are becoming more widespread in healthcare research to provide more detailed understanding (Coyle, 1999; Thomson & Doody, 2010), which is useful in enabling practitioners to evaluate and develop services (Marcinowicz et al., 2009).

Correspondence: Samantha K. Brooks, Department of Psychological Medicine, King's College London Institute of Psychiatry, Weston Education Centre, Cutcombe Road, London, SE5 9RJ, UK. E-mail: samantha.k.brooks@kcl.ac.uk

The present study adds to the growing body of qualitative literature on the unique experience of being a doctor-patient, by exploring the views of patients being treated by the Practitioner Health Programme (PHP). This is a London-based service doctors self-refer to, specifically developed to treat health professionals with mental health problems and addictions and run by clinicians with expertise in treating doctor-patients (Brooks et al., 2011a). The study aimed to explore patients' views about accessing and experiencing treatment, and the issues most important to them regarding treatment.

Method

The study used multiple methods, with data collected from interviews with doctor-patients and analysis supported by written comments from patients on an optional feedback form.

Inclusion and exclusion criteria

PHP uses a risk assessment process to categorise doctor-patients on the basis of risk to self, patients or delivery of services, in order to case-manage all patients appropriately. Patients coded as high-risk were excluded as it was believed they may have health problems of sufficient severity that an interview might be unhelpful to their well-being. A list of patients was generated using PHP's patient database. Twenty potential participants (10% of PHP patients), identified using random sampling using a random number generator, received information letters about the interviews. Twenty were contacted, as it has been suggested that less than 20 participants in a qualitative study is ideal as it enables the researcher to build rapport with each participant allowing for open exchange of information (Crouch & McKenzie, 2006).

Interviews

Interviews were carried out by one researcher, and took place at King's College London, lasting an average of one hour. Prior to interviews, participants were assured that their confidentiality would be respected by removing identifying details from transcripts. All participants signed informed consent forms and were informed that they could stop the interview or request withdrawal of their data at any time. As interviews were semi-structured (Kvale, 1996; Smith, 1995), participants were given the freedom to "guide" the direction of the interviews and therefore not all interviews covered the same specific questions. There was however a general topic guide with central questions raised in each interview to ensure consistency; this interview guide was developed by the researcher, with input from PHP practitioners, and can be seen in Appendix I.

Written feedback

As part of PHP's ongoing service evaluation, doctor-patients complete various measures of mental health and global improvement at regular intervals during their treatment. At the end of the global improvement questionnaire is one open-ended question asking service users if they have any comments or suggestions on how to improve the service.

These feedback forms are anonymised as far as possible (doctor-patients are given an identifying number, which they use on the forms instead of names; one external researcher has access to these forms but they are not read by PHP practitioners). Written comments were analysed alongside the interviews.

Data management

Interviews were audio recorded using a Dictaphone. The interviewer transcribed each interview verbatim, and used NVivo (version 8, NVivo qualitative data analysis software, 2008) to manage and code interviews. Written feedback comments were collated and also entered into NVivo for coding. Data were stored in encrypted files and any identifying details were removed from the recordings. The researcher monitored the research process throughout, keeping detailed notes on interview experiences.

Analysis

Thematic analysis was used as this provides a useful way of organising large amounts of data and summarise findings, and allows comparison across participants (Morse & Field, 1995). Following multiple readings of transcripts, interview notes and feedback comments to allow familiarisation, data were "coded" (i.e. chunks of text were allocated to thematic codes representing meanings in the data). This process was inductive, in that codes were derived from the data itself without any pre-determined ideas about what would be found. Codes were examined and related codes combined to build a set of themes. The themes were reviewed and organised until a master list of thematic codes was produced. We acknowledge that the use of a topic guide meant that participants' responses were often guided by the questions posed; however, the questions were fairly broad, and the semi-structured format of the interview meant that topics other than those in the interview guide were discussed. To ensure reliability of results, a second external researcher read and coded four of the transcripts, which was again an inductive process with no knowledge of the first researcher's coding. The two researchers then compared the codes and reached consensus on the emerging themes through discussion. The same kind of coding was performed on the written comments, and these too were reviewed until a clear list of themes was produced. The research process was scrutinised throughout and the researcher continually reviewed the analysis with awareness of the importance of reflexivity, to avoid potential biases or researcher interests affecting the analysis.

Ethics

The research was approved by the Brent NHS Research Ethics Committee (ref 09/H0717/77) and followed the British Psychological Society's (2006) ethical guidelines. It should be noted that two of the current authors have treated patients at PHP, though the researcher who conducted and analysed the interviews had not treated patients and was therefore at less risk of bias.

Results

Twelve doctor-patients contacted through by phone or email to discuss the study further. Nine of these participants agreed to take part in interviews.

Five men and four women participated in interviews, with an average age of 51 years (range 27–65). All were doctors. Two had been diagnosed with mental health problems, five with addiction or substance misuse and two with a combination of physical health and addiction issues.

At the time of analysis for this study, 134 feedback forms had been submitted; feedback was submitted at two time-points so several participants submitted feedback twice, although we have ensured that comments used in this paper are from different individuals. In total, 87 individuals (43.5% of PHP patients) submitted comments.

Thematic analysis yielded five main themes: help-seeking/accessing treatment; confidentiality; compassion/support; specific needs of doctors; and overall impact of PHP on the doctor-patients' lives. These themes are discussed below and illustrated by quotes from both interviews and written feedback. References to specific individuals or places have been changed to "[name]" for confidentiality. "(...)" within an extract shows that some text has been omitted. Quotes followed by "(written)" are from written feedback; all other extracts are from interviews.

Help-seeking and accessing treatment

Many participants delayed help-seeking, mostly due to shame or worries about confidentiality. Several felt that they would be seen as wasting the time of healthcare providers; many felt that doctors were not "supposed" to become ill themselves and were concerned that this may impact their professional reputation. For many, finding appropriate help had taken so long that illness had become severe.

By the time I made the first contact with PHP I'd actually booked myself into a local treatment centre, funded myself into it, and so it's just desperation really. All else had failed (...) I was at death's door. [Participant 3]

Even after deciding to seek help, participants experienced difficulties accessing treatment. They were often unsure which services to approach and many had been through a lengthy process of referrals before they heard of PHP. Several commented that they did not know where to go for help as they had never been advised about the help-seeking process.

It's that connection, that network of finding appropriate advice which I think is very missing (...) you're not taught about it at medical school, there's no mention of what happens if your life goes wrong. [Participant 7]

Many participants had sought help from other services prior to approaching PHP, but had not found them helpful. In particular, it was suggested that other services were not understanding of addictions.

It's very difficult for doctors to get help which is why people end up with so many problems. Most GPs have got very little experience of addiction. [Participant 9]

In my experience, addiction treatment in the NHS is sort of you know – not very impressed with it. If you came along and said I want to be admitted for detox then it just

wouldn't happen (...) PHP can refer people for inpatient detoxification quickly and they can get ongoing help for those who need it. [Participant 4]

Several participants remarked that local Primary Care Trusts, Occupational Health services and Community Mental Health Teams (CMHTs) were unable to offer the appropriate support with issues unique to being a doctor, such as General Medical Council investigations and "fitness to practice" concerns. In contrast, it was felt that PHP was understanding of the specific needs of doctors.

Without PHP I could not have sorted out my difficulties. CMHT does not have the expertise to deal with me, especially throughout my investigation. (written)

Several participants remarked that they had been wary of seeking help via their GPs or Occupational Health services, as they were unsure about boundary issues and concerned that they would not be getting expert advice due to lack of understanding of doctors' specific needs.

My experience of occupational health, they're not that effective, plus they're working for your employer (...) you feel that there's a conflict of interest, and you don't feel that conflict of interest in PHP. (...) It's, I think, appropriate [to] have another space to go into, where they specialise in problems with doctors. They can handle all the – they know almost the fears (...) and all the interaction between doctors and the GMC. [Participant 8]

Confidentiality

As well as being an obstacle to help-seeking, confidentiality remained an issue for participants during treatment. For many, this was due to feelings of shame or the fear of being judged.

However, participants believed that PHP respected confidentiality and gave them a safe environment in which to talk freely about their problems. They appreciated being able to visit PHP without the fear of encountering people they knew.

It was very difficult (...) getting help in the same hospital I worked at. Just kind of embarrassment. [Participant 5]

The problem is I live in a – although it's not a small town or village everybody knows each other and it was very difficult to approach my GP for various reasons (...) PHP were very good I have to say and it was all confidential what I told them. [Participant 6]

Compassion and support

"Compassion" encompasses care for well-being, sensitivity, sympathy, distress tolerance, empathy and non-judgement (Gilbert, 2009). This appeared to be important to participants who emphasised the need to feel supported and understood and the importance of non-judgemental attitudes in being able to be open and honest with treatment providers. Being trusted was also important, and several participants commented that it had been helpful for them to know that the personal accounts they shared with their clinicians were believed.

They [PHP] always trusted me, that the story I am telling them is right. [Participant 2]

Participants appreciated being involved in their treatment process and related decision-making. Having individual, personalised treatment was beneficial and participants appreciated having their specific needs listened to.

You treat patients as professionals and take into account patients' ideas, concerns and expectations, involving us in decision-making for treatment options. (written)

The PHP also offers support groups, which a small number of their doctor-patients attend. A supportive atmosphere in these groups was also important. Participants often felt lonely and isolated, and found it helpful to meet the other doctor-patients in similar situations.

PHP has given us you know a platform sort of thing to discuss our problems together. So that we are open to each other and (...) what other people have gone through. [Participant 2]

Specific needs of doctors

Participants felt it was important to have clinicians particularly understanding of the specific needs of a doctor-patient and the experiences unique to the health profession which they may need to support with. Written feedback suggested they wanted a service that was flexible and understanding with regard to the working timetable of a doctor and the difficulty of fitting in appointments around working hours. Several interviewees highlighted the importance of understanding the specific experiences of doctors, including not only the demanding workload but also the sense of shame involved and the fears about potentially facing fitness to practice hearings.

I'm just very grateful to have been helped by people who understand the NHS system, and so therefore already know so much, without having to explain it to them. (written)

I suppose at PHP, because they see lots of doctors (...) they have knowledge of what sick doctors go through and if you go to an ordinary sort of hospital they wouldn't know that. [Participant 8]

We might infer from these comments that a different service, not specialising in doctor-patients, would be more troublesome as they would not have the same depth of knowledge about "what sick doctors go through".

Impact of PHP

Participants were overall positive about their experiences with PHP and most reported that their life had improved after starting treatment. Many reported feeling happier, more relaxed, more self-confident or emotionally stronger; several felt they had rebuilt their self-respect, and many had improved their relationships with family members and colleagues.

Previously I'd get very very you know excited about things or nervous about things. (...) I still get worked up but just sorta internally. (...) before where I'd turn to drink to relax, I can just sort of relax, naturally. [Participant 1]

An unexpectedly large number of participants credited PHP with not only changing their lives but with saving them. Several participants believed they would not be alive had they not found the service. One participant called PHP "the best thing that ever happened to me"; another said that finding PHP had led them to "[discard] the idea of committing suicide". PHP was also credited for saving careers; several participants believed they would no longer be working in medicine had they not accessed the service.

[Without PHP] I think I would have either hung my stethoscope or would not be in this world. [Participant 2]

I think the service provided by PHP has probably saved my life and my career. I am eternally grateful for that. (written)

The following two extracts illustrate how PHP turned two participants' lives around:

Four months ago, I was depressed, suicidal and felt my life had fallen apart. Now, I am back at work full-time, enjoying life again and feel I have a very sturdy support network. PHP (...) are first class, and have likely saved my life. (written)

My life has changed in its entirety. I am now healthy, happy and working as a safe, successful doctor. I cannot thank [clinician name] and PHP enough for their help which has transformed my life. (written)

These extracts show how extreme the positive effects of treatment from PHP could be, having a dramatic impact on life, health and career. While earlier themes illustrated the difficulties involved in initial help-seeking and in adapting to the role of patient, this theme highlights the importance of overcoming these barriers, showing that even those with severe problems could turn their lives around with the help of the service.

Discussion

Early clinical engagement for mentally ill doctors is important for the personal health of the doctors and to protect the care of their patients. However, doctors in this study frequently delayed help-seeking; similar findings have previously been reported (Davidson & Schattner, 2003) which have suggested that many doctors feel ashamed to seek help from fellow doctors, particularly for psychiatric problems.

Participants in this study identified confidentiality and shame as barriers to help-seeking. Many worried about the stigma attached to being a mentally unwell doctor and feared breaches of confidentiality or jeopardy to their employment or professional reputation; similar findings have been reported elsewhere (Henderson et al., 2012; Stanton & Randal, 2011; Strang et al., 1998). There are specific expectations of the roles of both doctor and patient in medical consultations (Parsons, 1951) and it is understandable that doctors may feel disempowered by illness and find it difficult to accept the role

of patient when these roles are blurred. Even after deciding to seek help participants were often unsure of where to go or found that treatment providers did not have the expertise or understanding necessary. Assurance of confidentiality, a supportive atmosphere and a non-judgemental treatment team who understood the specific needs of doctors were important. Support from other patients in groups was also beneficial. This supports previous qualitative research suggesting it is helpful for service users to meet others with similar experiences (Hodge et al., 2010). Data supported the notion that healthcare services should put more emphasis on compassion (Gilbert, 2009), which participants felt was sometimes lacking from other providers. Compassion-based therapies are a recent concept and yet have not been tested with randomised controlled trials; however, the current paper suggests the therapeutic relationship should ensure that patients feel supported and "safe". Healthcare professionals should therefore be trained to emphasise kindness and care from an early stage of their career. Medical education can be unsupportive, critical and patriarchal and if doctors report a lack of compassion from providers it is highly likely that other patients seen in the health service will feel this too.

The results of this study can also be considered in relation to "social ranking", a means of deciding social control (Gilbert, 1992). Doctors' position in society means that they have a high rank and social power, associated with "dominance, status, respect, prestige and authority" (Gilbert, 1992, p.150). The medical profession itself is also hierarchical. Doctors who are used to being in a powerful position may find this hierarchy changes when they become ill and it seems reasonable to suggest that it may be difficult for them to adjust to this. Gilbert (1990, 1992) suggests that there are important consequences to gaining and losing rank, influenced by the roles an individual can perform and their functional utility to others. Gilbert (1992) suggests that depression is about not being able to control one's social place – and is associated with changes in one's relative social place or feeling that one is occupying a low social place. Role competence is an important aspect of this and if the self is construed as being inferior, this can lead to shame and depression. This study suggested that doctors with mental health problems or addictions are worried about others thinking they are not capable of doing their jobs properly – this may mean that they see their role competence as poor and feel ashamed.

Some of the needs of doctor-patients appear to mirror the needs of patients in general – e.g. the need for compassion, understanding and kindness from practitioners. However, doctor-patients also have specific needs such as an emphasis on confidentiality.

The results of this study might be useful in providing suggestions for improving the mental healthcare of doctors. For example, it would be useful to raise awareness of mental ill health, making it easier for academic and clinical staff to recognise problems in medical students and colleagues. This has also been suggested by Firth-Cozens (2001) and a Department of Health report (2008), with both papers emphasising the importance of healthcare organisations being aware of problems and knowing where to direct doctors for appropriate help. It is clear from this study that doctors were wary of seeking help due to fear of stigma and

embarrassment, and so promoting a culture of respect and sensitivity in medical schools and health services may help in this respect by diminishing the potential shame that mentally ill doctors may feel. The Department of Health (2008) also suggested that medical schools might benefit from using mental health service users as trainers and teachers, as this direct contact with individuals with mental health problems may help to reduce negative views of them. This study supports that notion, as the reduction of pejorative views may help to reduce the shame reported by sufferers. Finally this study, as well as previous research (Brooks et al., 2011b), suggests that specialist mental health services for doctors may be beneficial.

Limitations

Though several transcripts were coded by two researchers and consensus was high, it would be useful to have all nine transcripts double-coded. Another shortcoming of this study was the small sample size. Recruiting doctor-patients was challenging, and the sample size is not necessarily broadly representative. It should be noted that the majority of doctor-patients interviewed had addictions, which may have impacted on their perceptions of accessing support and feeling judged.

Finally, the results may have suffered from a selection bias – it is possible that only those who were mostly satisfied with the service decided to take part in the study. However, the quantitative evaluation of PHP (Brooks et al., 2012) shows equally positive results, with the majority of patients very satisfied with their treatment.

Conclusions

Confidentiality is an important factor in the treatment process, and concerns about confidentiality often prevent help-seeking. The fundamental human qualities of compassion and caring are important though sometimes lacking or under-estimated in routine healthcare services. Specialist services for treating doctors are useful as doctors feel more understood and supported than they might in routine care. Any such services set up in the future should consider the factors highly valued by doctors, such as confidentiality, non-judgmental attitudes and an understanding of doctors' needs. Providing a service which can improve the mental health of doctors will also impact on patient safety and practice, and thus it is important to the field of healthcare in general that doctors are treated quickly and efficiently. Routine services could learn from specialist services and the effort they put into making patients feel cared for. Services could be transformed by more emphasis on kindness and compassion, and this could benefit the NHS in general.

Acknowledgements

We gratefully thank the patients who participated in the study, as well as doctors and staff at the participating general practice. Thanks are also given to Jane Haywood and Martin Black, the PHP staff who helped to recruit participants.

Declaration of interest

Trudie Chalder receives salary support from the National Institute for Health Research (NIHR) [Mental Health

Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London]. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health. The authors also gratefully acknowledge the NHS for funding the research into the Practitioner Health Programme and its evaluation.

C. Gerada directs the service and secured the funding for it. T. Chalder has treated some of the patients.

References

- Avis M, Bond M, Arthur A. (1997). Questioning patient satisfaction, an empirical investigation in two outpatient clinics. *Soc Sci Med*, 44, 85–92.
- British Psychological Society. (2006). Code of ethics and conduct. Available from: http://www.bps.org.uk/the-society/code-of-conduct/code-of-conduct_home.cfm [last accessed 7 Jul 2009].
- Brooks SK, Chalder T, Gerada C. (2011a). Doctors vulnerable to psychological distress and addictions: Treatment from the Practitioner Health Programme. *J Mental Health*, 20, 157–64.
- Brooks SK, Gerada C, Chalder T. (2011b). Review of literature on the mental health of doctors: Are specialist services needed? *J Mental Health*, 20, 146–56.
- Brooks SK, Gerada C, Chalder T. (2012). Doctors and dentists with mental ill health and addictions: Outcomes of treatment from the Practitioner Health Programme. *J Mental Health*, 22, 237–45.
- Coyle J. (1999). Exploring the meaning of 'dissatisfaction' with health care: The importance of 'personal identity threat'. *Soc Health Illn*, 21, 95–124.
- Crouch M, McKenzie H. (2006). The logic of small samples in interview-based qualitative research. *Soc Sc Inf*, 45, 483–99.
- Davidson SK, Schattner PL. (2003). Doctors' health-seeking behaviour: A questionnaire survey. *Med J Aust*, 179, 302–5.
- Department of Health. (2008). Mental health and ill health in doctors. London: Department of Health.
- Department of Health. (2010). Invisible patients. Report of the working group on the health of health professionals. London: Department of Health.
- Edwards C, Staniszevska S. (2000). Accessing the user's perspective. *Health Soc Care Community*, 8, 417–24.
- Firth-Cozens J. (2001). Interventions to improve physicians' well-being and patient care. *Soc Sci Med*, 52, 215–22.
- Firth-Cozens J. (2006). A perspective on stress and depression. In: Cox J, King J, Hutchinson A, McAvoy P, eds, *Understanding doctors' performance*. Oxford: Radcliffe Publishing, 22–25.
- Forsythe M, Calnan M, Wall B. (1999). Doctors as patients: Postal survey examining consultants and general practitioners adherence to guidelines. *Br Med J*, 319, 605–8.
- Ghosh H, Galea S. (2006). Misuse of drugs and alcohol. In: Cox J, King J, Hutchinson A, McAvoy P, eds, *Understanding doctors' performance*. Oxford: Radcliffe Publishing, 38–45.
- Gilbert P. (1990). Changes: Rank, status and mood. In: Fisher S, Cooper C, eds. *On the move: The psychology of change and transition*. Chichester: Wiley, 33–52.
- Gilbert P. (1992). Depression: The evolution of powerlessness. East Sussex, UK: Lawrence Erlbaum Associates Ltd.
- Gilbert P. (2009). Introducing compassion-focused therapy. *Adv Psychiatr Treat*, 15, 199–208.
- Henderson M, Brooks SK, del Busso L, et al. (2012). Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: A qualitative study. *BMJ Open*, 2, e001776. doi:10.1136/bmjopen-2012-001776.
- Hodge S, Barr W, Gopfert M, et al. (2010). Qualitative findings from a mixed methods evaluation of once-weekly therapeutic community day services for people with personality disorder. *J Mental Health*, 19, 43–51.
- Kay M, Mitchell G, Clavarino A, Doust J. (2008). Doctors as patients: A systematic review of doctors' health access and the barriers they experience. *Br J Gen Pract*, 58, 501–8.
- Kroenke K, Spitzer RL, Williams JBW, et al. (2007). Anxiety disorders in primary care: Prevalence, impairment, comorbidity and detection. *Ann Intern Med*, 146, 317–25.
- Kvale S. (1996). *InterViews: An introduction to qualitative research interviewing*. London: Sage.
- Marcinowicz L, Chlabicz S, Grebowski R. (2009). Patient satisfaction with healthcare provided by family doctors: Primary dimensions and an attempt at typology. *BMC Health Serv Res*, 9, Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2678111> [June 2009].
- Morse JM, Field PA. (1995). *Qualitative research methods for health professionals*. Thousand Oaks, CA: Sage.
- Mulcahy L, Tritter J. (1998). Pathways, pyramids and icebergs? Mapping the links between dissatisfaction and complaints. *Soc Health Illn*, 20, 825–47.
- Nordin I. (2000). Expert and non-expert knowledge in medical practice. *Med Health Care Philos*, 3, 297–304.
- NVivo qualitative data analysis software (2008); QSR International Pty Ltd. Version 8. Available from: <http://www.qsrinternational.com/> [last accessed 13 Oct 2016].
- Parsons T. (1951). *The social system*. London: Routledge & Kegan Paul.
- Smith J. (1995). Semi-structured interviewing and qualitative analysis. In: Smith JA, Harre R, Van Langenhove L, eds. *Rethinking methods in psychology*. London: Sage, 9–26.
- Stanton J, Randal P. (2011). Doctors accessing mental-health services: An exploratory study. *BMJ Open*, 1, e000017.
- Strang J, Wilks M, Wells B, Marshall J. (1998). Missed problems and missed opportunities for addicted doctors. *Br Med J*, 316, 405–6.
- Thomson S, Doody G. (2010). Parallel paths? Patient and doctor priorities in psychiatric outpatient consultations. *J Mental Health*, 19, 461–9.
- Wall TD, Bolden RI, Borrill CS, et al. (1997). Minor psychiatric disorder in NHS trust staff: Occupational and gender differences. *Br J Psychiatry*, 171, 519–23.

Appendix I. interview topic guide

- Introduction – gain demographic details etc.
- How long have you been involved with PHP?
- How did you find out about PHP?
- Were there any difficulties in approaching them for help?
- Had you sought help elsewhere? [Probe – if so, what was this process like? If not – why not?]
- What was your first appointment with PHP like?
- How did you feel before you attended – did you think PHP could help?
- What did you expect from sessions at PHP – was it different to what you expected [if so, how?]
- Did you feel understood?
- Did you feel able to share all you wanted to share with your clinician?
- After your assessment did you feel that your situation could improve?
- What is your average PHP session like?
- How are you feeling now compared to how you felt before treatment?
- Is there anything you are especially satisfied with, regarding your treatment with PHP? [Probe – why, how has it helped?]
- Is there anything you are especially dissatisfied with? [Probe: how could this be improved?]
- Are there any aspects of your treatment you wish had gone differently? [Probe: what/how?]
- If you were unhappy with any aspect of your treatment, would you have you raise(d) that with your clinician?
- How would you describe your experience with PHP overall? [Probe: why? If negative: how could this be changed?]
- Ask if the participant would like to talk about anything else they may feel is important which has not been covered by these questions.