KAROLINA KOSYLA BSc Hons MSc

UNDERSTANDING WELL-BEING AND HELP-SEEKING AMONG DOCTORS OF THE GLOBAL MAJORITY

Section A: What Does the Current Literature Say About the Well-Being, in Particular in Terms of Experiences Of Stress, Anxiety and Depression, of Doctors of The Global Majority? A Systematic Review and Narrative Synthesis
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Summary of Major Research Project

Section A:

The review aimed to examine and critically appraise the literature exploring the relationship between well-being, in particular experiences of stress, anxiety, and depression, and ethnicity. Five databases (PubMed, MedLine, ERIC, PsychInfo, Web of Science) were systematically searched for relevant studies. Ten studies met the inclusion criteria. A mixed-method narrative review of two qualitative and eight quantitative papers was completed. The results show mixed findings, particularly, due to the quality, heterogeneity, and mixed-method nature of the studies. Further research in this area is required to clarify whether a relationship exists between ethnicity and experiences of stress, anxiety, and depression.

Section B:

This study aimed to develop a better understanding of experiences of well-being and help-seeking among a sample of doctors of the Global Majority. A qualitative modified grounded theory methodology was employed using convenience sampling and semi-structured interviews. Thirteen doctors were recruited from NHS Trusts in South-East England. A model of doctor's experiences and perceptions of well-being and help-seeking was devised. Seven main categories and seventeen subcategories were identified. Implications, limitations, and recommendations for future research were discussed. This included consideration of how doctors of the Global Majority can be supported by their organisation and professional body.

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Section A: What Does the Current Literature Say About the Experiences Of Stress, Anxiety and Depression, Among Doctors of The Global Majority? A systematic Review and Narrative Synthesis

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Abstract

Aims and Objectives: It is widely documented that working in healthcare disproportionately affects doctors from underrepresented ethnic groups, which can impact doctors' well-being. This review aimed to identify, evaluate, and synthesise the recent literature on the well-being of doctors of the Global Majority, across settings, specifically about their experiences of stress, depression, and anxiety.

Method: Five databases (PubMed, MedLine, ERIC, PsychInfo, Web of Science) were systematically searched for relevant studies. Ten studies met the inclusion criteria. A mixed-method narrative review of two qualitative and eight quantitative papers was completed.

Results: The identified studies differed in sample, design, methodology, and outcomes measured. There were mixed findings about the variation in experiences of stress, anxiety, and depression, among trainee and qualified doctors of the Global Majority.

Conclusion: The results showed that it is difficult to draw conclusions about the experiences of well-being among doctors of the Global Majority, due to the quality, heterogeneity, and mixed-method nature of the studies. Further research in this area is required to clarify the relationship between ethnicity and experiences of stress, anxiety, and depression among doctors of the Global Majority.

Keywords: Doctors, stress, anxiety, depression, ethnicity

Introduction

Overview

Staff well-being has been a topic of interest for the last 30 years (Loretto et al., 2005). The well-being of staff is an urgent and complex issue subject to numerous factors at the individual, organisational, inter-professional, and broader societal levels. Individual factors may include relocation adjustments, financial stressors, cultural factors, limited leisure time, and availability of coping skills (Memon et al., 2016, Shanafelt et al., 2003). Organisational factors such as high workload, shift patterns, work patterns, poor leadership and team working, can all impact a doctor's well-being at work and outside of work (Cohen & Rhydderch, 2006). For an in-depth review of the impact of organisational factors, such as service architecture; see Taylor et al. (2022). It is also widely documented that working in healthcare disproportionately affects doctors from underrepresented ethnic groups, which can impact their well-being (NHS Race & Health Observatory, 2022).

Definitions

Numerous definitions and models of well-being have been proposed, but a thorough examination of this topic is outside the scope of this review (for more details, see Larson, 1999; Tetrick, 2002). For this review, well-being has been considered from a holistic and systemic perspective, drawing on positive psychology where well-being is regarded as more than merely the absence of ill health, but instead includes aspects of human experiences such as hope, wisdom, courage, spirituality, responsibility, and perseverance (Browne et al., 2023; Seligman, & Csikszentmihalyi, 2000). Based on this, the following definition has been chosen, "well-being encompasses quality of life, as well as the ability of people and societies to contribute to the world in accordance with a sense of meaning and purpose … and supports the tracking of the equitable distribution of resources" (World Health Organisation, 2021, p. 10). However, limited studies have been conducted investigating broader aspects of well-

being, which meant that it was not possible to conduct a review in this area (Douglas et al., 2022; Nguyen et al., 2023; Nituica, et al., 2021). Most of the available research on doctors' experiences of well-being, is predominantly understood through the medical model and includes studies focussing on doctors' self-reports of stress, anxiety and depression (Kinman & Teoh, 2018; Melnyk et al., 2020). Therefore, the focus of this review was to summarise the literature on doctors of the Global majority experiences of stress, anxiety and depression.

Stress has been defined as a physiological and psychological response to a perceived threat or challenge, leading to a state of increased alertness and arousal. It can manifest as various emotional, cognitive, behavioural, and physiological experiences (Selye, 1956). Anxiety can be defined as a natural and adaptive human response to stress or potential threats, often characterised by increased worrying and fear. Whereas, depression can be defined by continued feelings of sadness, hopelessness, and a lack of interest or pleasure in activities. It often involves a range of physical and psychological experiences, including changes in appetite, sleep disturbances, fatigue, and difficulty concentrating (APA, 2013).

While this review does not seek to provide a comprehensive review of the various theories related to well-being, in particular, about levels of stress, anxiety and depression, it is important to mention how these concepts have been understood. Several theories of well-being have been proposed. One model of well-being which seeks to explain anxiety, depression, and stress is the PERMA model proposed by Seligman (2011). This model outlined five core elements which were considered crucial to psychological well-being, which were positive emotion, engagement, relationships, meaning and achievement (Table 1).

Table 1

A summary of the PERMA model (Seligman, 2011)

Aspect of well-being	Definition	Impact on stress, anxiety and depression
Positive Emotion	Being able to experience joy, gratitude, and other positive emotions.	Not being able to experience positive emotions can contribute to higher levels of anxiety and depression. Ongoing experiences of stress can reduce experiences of positive emotions, and can lead negative feelings to subjugate over positive ones.
Engagement	Being able to be involved and present in activities	Not engaging in activities can lead to feelings of anxiety as individuals may feel disconnected from others. Those who experience depression may find it difficult to engage in activities, leading to possible feelings of emptiness and hopelessness.
Relationships	Having supportive and fulfilling social connections.	Difficulties in relationships can exacerbate experiences of anxiety due to a lack of support and social reassurance. Experiences of stress can impact relationships, which can lead to reduced social support and increased feelings of isolation.
Meaning	Finding purpose and meaning in life	A loss of meaning or purpose can make it hard for individuals to find motivation or joy in life, which can increase the risk of feeling depressed
Achievement	Being able to pursue and accomplish goals	Feeling depressed can lead to feelings of worthlessness and a perceived inability to achieve goals. High levels of stress can impact on one's ability to accomplish tasks and meet goals.

Other similar models such as Ryff's Six-Factor Model of Psychological Well-Being (Ryff, 1989) and Self-Determination Theory (Deci & Ryan, 2012) also emphasise the role of autonomy, self-acceptance, and perceived mastery as potentially relating to experiences of stress, anxiety and depression. Furthermore, the Demands-Resources-Individual Effects model suggests that well-being at work is influenced by the balance between job demands and resources (Margrove & Smith, 2022). For example, when job demands exceed an individual's perceived capabilities, it can lead to experiences of anxiety, stress and

depression. Whilst these models provide valuable frameworks for understanding these factors and their relationships in the workplace, they do not explicitly address the role of cultural factors, as well as social inequalities, which have been shown to have a significant impact on well-being (Navarro, 2020; Slavin et al., 1991).

Studies have shown that high levels of stress, anxiety and depression start in medical school, and continue into medical training and qualified positions (Dyrbye et al., 2007). Trainees and qualified doctors may also have different experiences, such that trainee doctors may face stressors related to knowledge transfer, decision-making and uncertainty, and adjusting to the medical hierarchy, whereas qualified doctors may face stressors such as the responsibility of management, supervision and accountability to stakeholders (Allen et al., 1999; Bullock et al., 2013). Furthermore, a decline in doctor's well-being has been identified after the first wave of the pandemic such as increased anxiety, guilt, isolation, poor support, uncertainty, fear, and emotional exhaustion (Couper et al., 2022; Revythis et al., 2021; Tran et al., 2022). Experiences of stress, anxiety, and depression can have both short-term and long-term effects on doctors' well-being, such as reduced quality of life, disability, and suicide (Andrews & Titov, 2007; Hawton & van Heeringen, 2009). It has also been suggested that doctors of the Global Majority are at higher risk of experiencing stress, anxiety, and depression (BMA, 2022; 2023).

Terminology

Please note that when the term Global Majority is used, this refers to "people who identify as Black, Asian, Brown, dual-heritage, indigenous to the Global South, or have been racialised as 'ethnic minorities'" (Campbell-Stevens, 2020, p. 1). Across the world, people of the Global Majority currently represent approximately eighty per cent (80%) of the population. Most of the research and guidance, which will be discussed, has used terms such as 'Black, and Minority Ethnic (BAME)', or 'People of Colour'. These terms have been

appropriately criticised due to maintaining social hierarchies, contributing to “othering”, conflating experiences as synonymous, and centralising whiteness as the norm (Fakim & Macaulay, 2020; Mohdin et al., 2021). In the United States (US), terms such as ‘underrepresented in medicine minority’ (Pololi et al., 2013), and ‘underrepresented in medicine’ have been used to describe doctors of the Global Majority (Association of American Medical Colleges, 2004). However, in other Western contexts, such as the UK, doctors of the Global Majority are well represented, and in some cases make up a greater proportion of doctors (NHS Digital, 2023).

Furthermore, there is an ongoing debate around terminology such as ‘race’ or ‘ethnicity’ within research. It is important to acknowledge that these terms are considered to be social constructs, which have been created and defined by society, rather than being inherent or biological characteristics (Bryant et al., 2022; Gracia et al., 2017). Nonetheless, racial, and ethnic classifications continue to be extensively utilised in medical education, clinical practice, and research. The review draws on existing studies which have grouped data based on self-reported “race/ethnicity”. Therefore, for this review doctors who are normally assigned or self-identify to these groups will be referred to using the term the “Global Majority”. Where possible, specific groups of the Global Majority will be referred to as “ethnic groups”, where ethnicity refers to shared traditions, language, religion, customs, and identity among individuals (Banks, 2015). Terminology has been chosen to comply with published guidance, inclusivity, and audience familiarity. Further exploration of these crucial issues is outside the scope of this present review. The aim of this review is not to conflate the experiences of doctors who identify as the Global Majority but rather to gain an understanding of how factors such as diversity, culture and racism, as well as sources of coping and resilience, may impact experiences of stress, anxiety and depression between ethnic groups.

Stress, Anxiety and Depression Among Doctors of the Global Majority

It has been suggested that doctors of the Global Majority have different experiences in the workplace, and the profession more broadly (Okolo et al., 2022; Sudol et al., 2021). For example, in the US, doctors of the Global Majority, are more likely to provide care for more patients who experience social and economic inequalities compared to their White counterparts (Cantor et al., 1996; Moy & Bartman, 1995). It has been hypothesised that this disparity in patient distribution partially arises from doctors of the Global Majority's decisions to practice in disproportionally affected geographic areas, which are more likely to provide care for patients who face socioeconomic challenges, and are more likely to actively seek healthcare providers from a doctor of the Global Majority (Saha et al., 1999). Furthermore, studies have documented differences between doctors of the Global Majority and White doctors, in terms of their experiences, such as being subject to microaggressions, differences in beliefs and perceptions around well-being and mental health, feeling like they do not fit in during training, and access to different protective factors that improve coping strategies (Sudol et al., 2021; Wong et al., 2013).

It is also well documented that ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in Western contexts, such as the US and the UK, and are rooted in experiences of structural, institutional, and interpersonal discrimination (Feagin & Bennefield, 2014; Memon et al., 2016; NHS Race & Health Observatory, 2022). Systemic racism can impact doctors both as patients themselves, who are considering seeking help for their well-being, as well as more widely impact their well-being, through experiences of racism and inequalities in the workplace. For example, implicit racial bias among healthcare providers disproportionately affects Black Americans and other marginalised patient populations (Chapman et al., 2013; Fitzgerald & Hurst, 2017). Previous research emphasises the need for cultural change within healthcare, including shared

accountability for dismantling systemic racism, and a willingness to understand White privilege and White supremacy (Saad, 2020).

At the organisational level, psychodynamic and social psychology theories provide valuable insight into group dynamics, which can help us understand experiences of diversity, such as formulating how racism functions on a systemic scale (Rasmussen & Garran, 2022). It has been shown that phenomena such as groupthink, conformity, and intergroup dynamics can help hypothesise how institutions and societies perpetuate racial hierarchies (Asch, 1956; Janis, 1972).

Most studies have been conducted in the US and the United Kingdom (UK). In the UK, healthcare staff of the Global Majority make up 25.7% of all NHS staff and 49.9% of all community and hospital doctors (NHS Digital, 2023). Whereas, in the US, it has been shown that 36% of doctors are of the Global Majority, where, 20.6% are Asian, 6.9% are Hispanic, 5.7% are Black or African American, and 2.8% are of other ethnicities (Association of American Medical Colleges, 2022). Both the US and the UK have a high proportion of international factors, for example, approximately 75,000 Indian doctors, of which two-thirds are settled in the US, and approximately 19,000 in the UK (BMJ Careers, 2019; Organisation for Economic Co-operation and Development, 2023).

Rationale and Aims

Further understanding of how well-being, specifically levels of stress, anxiety, and depression, are experienced by doctors of the Global Majority is needed. Several reviews have explored the impact on well-being among medical students, some of which have investigated the role of ethnicity as a factor (Lourenção et al., 2010). However, there is a paucity of reviews, which have focused on the relationship between ethnicity and well-being among trainee and qualified doctors. One review has explored the impact of ethnicity on burnout among medical students, residents, and doctors, where burnout was defined as a

psychological experience characterised by emotional exhaustion, depersonalisation, and reduced personal accomplishment as a result of persistent workplace stressors (Lawrence et al., 2022; Maslach et al., 2001).

The current study aims to provide a review of the current literature exploring ethnicity, in the context of well-being, more specifically in terms of experiences of stress, anxiety and depression among doctors of the Global Majority. The aim is to address the following research questions:

1) Are there differences in well-being, in terms of, experiences of stress, anxiety and depression, among doctors of the Global Majority across hospital and community settings?

2) What are the differences in well-being, in particular, in terms of experiences of stress, anxiety and depression, among doctors of the Global Majority across hospital and community settings?

Method

Design

A systematic review was undertaken to appraise, synthesise and analyse the identified studies on experiences of stress, anxiety, and depression, among doctors of the Global Majority (Cochrane Collaboration, 2011; Grant & Booth, 2009). Due to the small number of qualitative studies (n = 2), a meta-synthesis or thematic analysis of qualitative studies was not possible for this review. Furthermore, the range of methodologies, outcomes, and populations across the quantitative studies (n = 10), and the small number of studies, meant that a meta-analysis was also not possible.

Inclusion Criteria

Broad eligibility criteria for studies were initially set due to the limited number of literature in this area (Table 2). All articles investigating experiences of well-being were included for full-text review, except for studies measuring experiences of burnout

exclusively, as a review in this area had already been conducted (Lawrence et al., 2022). To allow for a comparable synthesis of studies, variables of well-being were chosen based on those appearing most frequently in the literature, which were stress, depression, and anxiety respectively. This led to the identification of 17 studies, of which seven were excluded due to being conducted in Eastern countries. This decision was made to allow for a comparison of findings, due to the similar ethnic representation in the populations of Western countries (e.g., USA, UK, Australia; Association of American Medical Colleges, 2022; NHS, 2021). Furthermore, it has also been shown that experiences of well-being, as well as racism and discrimination, differ significantly between Eastern and Western countries, making it difficult to synthesise and compare the findings from across the Globe (Joshanloo & Weijers, 2014; Krendl & Pescosolido, 2020). For example, it has been shown that Western countries may prioritise values of independence and individualism, whereas Eastern countries may prioritise interdependence and collectivism (for more details see Kitayama & Salvador, 2024). Both quantitative and qualitative studies were included in the review.

Table 2

The inclusion and exclusion criteria for the database search

Type of criteria	Criteria
Inclusion criteria	Assessment of at least one of stress, anxiety, or depression Doctors employed in clinical settings (including junior doctors, medical residents, and trainee doctors) Articles written in English Empirical articles Peer-reviewed articles Studies conducted in Western countries
Exclusion criteria	Medical students Mixed samples of doctors and other healthcare professionals No assessment of stress, anxiety, or depression No assessments by ethnicity/race Medical faculty staff Physician assistants Psychiatrists Theoretical articles or books

Search Strategy

Journal articles were identified using the following databases: Pubmed (via the National Library of Medicine), MedLine (via Web of Science), Education Resources Information Centre (ERIC; via Elton B. Stephens CO [company; EBSCO]), Web of Science (via own database) and PsychInfo (via Ovid). A literature search was conducted on the 11th of October 2023 using selected search terms (Table 3).

Table 3

Search terms for each database

Database	Search Terms
PubMed (via the National Library of Medicine)	((Doctor*[Title/Abstract] OR Medic[Title/Abstract] OR "Medical Students"[Title/Abstract] OR "Medical residents"[Title/Abstract] OR Physician*[Title/Abstract] OR Surgeon*[Title/Abstract]) AND (Depression[Title/Abstract] OR Depressive[Title/Abstract] OR Anxiety[Title/Abstract] OR Stress[Title/Abstract])) AND (Ethnic[Title/Abstract] OR Ethnicity[Title/Abstract] OR "Global Majority"[Title/Abstract] OR Race[Title/Abstract] OR BME[Title/Abstract] OR BAME[Title/Abstract] OR "Black and Minority Ethnic"[Title/Abstract] OR Underrepresented[Title/Abstract] OR "People of Colour"[Title/Abstract] OR Indigenous[Title/Abstract] OR Multi-ethnic[Title/Abstract] OR Black [Title/Abstract] or "African"[Title/Abstract] or Hispanic[Title/Abstract] or Latino[Title/Abstract] OR Asian[Title/Abstract])
MedLine (via Web of Science)	((AB=(Doctor* OR Medic OR "Medical Students" OR "Medical Residents" OR Physician* OR Surgeon*)) AND AB=(Depression Or Depressive OR Anxiety OR Stress)) AND AB=(Ethnic OR Ethnicity OR "Global Majority" OR Race OR BME OR BAME OR "Black and Minority Ethnic" OR Underrepresented OR "People of Colour" OR Indigenous OR Multi-ethnic OR Black OR African OR Hispanic OR Latino OR Asian)
Web of Science (own database)	((AB=(Doctor* OR Medic OR "Medical Students" OR "Medical Residents" OR Physician* OR Surgeon*)) AND AB=(Depression Or Depressive OR Anxiety OR Stress)) AND AB=(Ethnic OR Ethnicity OR "Global Majority" OR Race OR BME OR BAME OR "Black and Minority Ethnic" OR Underrepresented OR "People of Colour" OR Indigenous OR Multi-ethnic OR Black OR African OR Hispanic OR Latino OR Asian)
ERIC (via EBSCO)	AB (Doctor* OR Medic OR 'Medical Students' OR 'Medical residents' OR Physician* OR Surgeon*) AND AB (Depression Or Depressive OR Anxiety OR Stress) AND AB (Ethnic OR Ethnicity OR 'Global Majority' OR Race OR BME OR BAME OR 'Black and Minority Ethnic' OR Underrepresented OR 'People of

	Colour' or Indigenous or Multi-ethnic OR Black OR African OR Hispanic OR Latino OR Asian)
PsycInfo (via Ovid)	((Doctor* or Medic or 'Medical students' or 'Medical residents' or Physician* or Surgeon*) and (Depression or depressive or Anxiety or stress) and (Ethnic or Ethnicity or 'Global Majority' or Race or BME or BAME or 'black minority ethnic' or 'underrepresented' or 'people of colour' or indigenous or multi-ethnic or Black or African or Hispanic or Latino or Asian)).ab.

Study Selection

Based on the above search strategy 2228 relevant studies were identified (after duplicates were removed), and underwent title and abstract screening to determine their relevance to the present review.

Quality Assessment

For the quantitative studies, quality was reviewed using the National Institute for Health and Care Excellence (NICE) quality appraisal checklist for quantitative studies reporting correlations and associations checklist (NICE, 2012; Appendix A). This tool was developed based on the appraisal step of the 'graphical appraisal tool for epidemiological studies' by Jackson et al. (2006). The NICE (2012) tool comprised 19 criteria split across five sections: population, method of selection of exposure groups, outcomes, analyses, and summary. Each study was evaluated and rated using the above criteria (Figure 1).

Figure 1

Rating system used to evaluate criteria for the NICE quality appraisal tool

++	Indicates that based on that study design, the study has been designed or conducted in such a way as to minimise the risk of bias.
+	Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design.
−	Should be reserved for those aspects of the study design in which significant sources of bias may persist.
Not reported (NR)	Should be reserved for those aspects in which the study under review fails to report how they have (or might have) been considered.
Not applicable (NA)	Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case–control studies).

For qualitative studies, the Critical Appraisal Skills Program (CASP; 2022) checklist was used as a quality assessment tool (Appendix B). The CASP tool is the most frequently used quality assurance tool in health and social care-related research (Dalton et al., 2017). For each study, a rating of 'yes', 'no' or 'can't tell' was selected for each of the ten criteria from the CASP tool. These ratings were then summed together to create a total quality score ranging from 0-10.

Data Synthesis

Due to the range of methodologies, outcomes, and populations across the quantitative studies (n = 10), and the small number of studies, it was not possible to follow existing guidelines for a narrative synthesis (Popay et al., 2006). Instead, data was extracted and results were summarised using a narrative format with a tabular accompaniment. A summary of the method undertaken has been provided, which was consistent with existing systematic reviews using a narrative synthesis (Table 4; Wining & Beverley, 2003).

Table 4

A description of the analysis undertaken (Winning & Beverley, 2003)

Stage	Description
Step 1	A summary table was used to extract data, summarise each study and tabulate the main findings and methodologies. Patterns were identified based on variable measured (e.g., stress, anxiety or depression), methodologies and findings, and recorded using an Excel spreadsheet
Step 2	Studies were grouped based on variables (e.g. stress) and similarities in findings, methodologies, populations, or contexts. Narrative descriptions were used to explain the relationships and patterns within the data. Each study was considered by its context, including cultural, social, and methodological factors that might influence the findings.
Step 3	Quality assessments were conducted for quantitative and qualitative studies separately. Potential biases, limitations, and the generalisability of the findings were considered. this included consideration of researcher reflexivity.

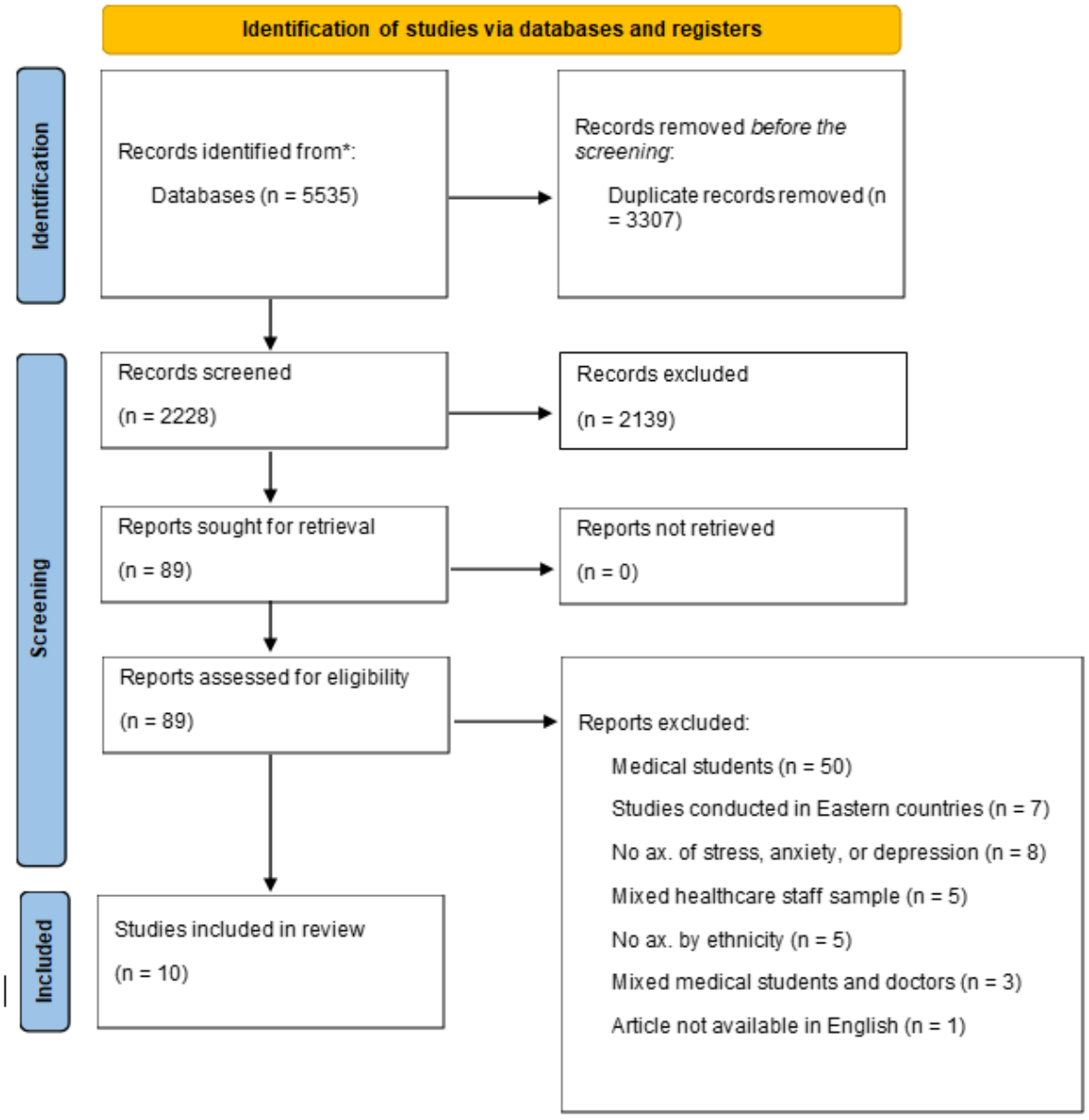
	Findings from the quality assessment were integrated as part of the narrative descriptions, and considered to form conclusions
Researcher Reflexivity	The primary researcher identified as a White, Polish female trainee clinical psychologist employed in the NHS. As a White researcher, this introduced the risk of researcher bias in the choice of research questions, inclusion criteria and data synthesis (e.g., due to the increased familiarity with the Western perspective). The primary researcher had also previously provided psychological support to healthcare staff post-pandemic, which helped facilitate insight, awareness, and ability to bring meaning to the data. However, such background does pose a risk of holding preconceived ideas and previous encounters to influence the analysis of the data.

Results

The initial search identified 5535 journal articles, of which 3307 were excluded as duplicates. The remaining 2228 studies underwent title and abstract screening. A full-text review was completed on 89 studies. Ten studies were considered eligible for inclusion in this review. The study selection process is outlined in Figure 2.

Figure 2

Prisma diagram of systematic search



Overview of Studies

Ten studies were considered eligible for inclusion in this review (Table 5). Eight studies were conducted in the US, one study was conducted in the UK, and one study comprised a mixed sample of doctors from the UK, Australia, and New Zealand.

Table 5

Overview of included studies

Authors	Method	Design	Sample	Setting	Variables	Analysis	Results
Dunning et al. (2022)	Quantitative	Cross-sectional	456 Junior doctors in the UK. White (71.1%), Mixed (4%), Asian (15.8%); Black (2%), Other (5.5%)	Not reported.	21-item Depression, Anxiety and Stress Scale	Kruskal-Wallis Test	***Stress***. No differences were observed for stress (p=0.770) among junior doctors from different ethnic groups. ***Depression.*** They found a significant difference in levels of depression (p=0.016). Post-hoc analyses showed that doctors from mixed ethnic backgrounds (M = 24.80, SD = 9.48) reported lower levels of depression than those from an Asian (M = 31.51, SD = 12.84) or White background (M = 27.74, SD = 27.80). Junior doctors identifying as White (M=27.74) also reported lower levels of depression than those identifying as 'other' (M=34.76) and those identifying as Asian (M=31.55). ***Anxiety.*** Differences were observed between doctors from different ethnicities for anxiety (p=0.020), with Bonferroni comparisons showing that junior doctors identifying as Asian (M=27.88) reported higher levels of anxiety than those identifying as White (M=24.16).

Frank and Dingle (1999)	Quantitative	Cross-sectional	4501 Female doctors in the US. White (73%), Hispanic (5.1%), African American (4.2%), Asian-American (12.6%), Other (2.7%)	Active, part-time, professionally inactive, and retired doctors, aged 30–70 years, who were not in residency training programs	Items "Please mark any known conditions in the columns below that you or your family [children, mother, father, siblings, and current spouse, queried separately] have now or have experienced in the past:…depression…attempted/completed suicide."	Chi-Square	***Depression.*** They found that Asian female doctors were more likely to report a history of depression in comparison to White and all other (African American, Hispanic) female doctors, $\chi 2(4, N = 4501) = 81.08$, $p = <0.0001$.

Garcia et al. (2020)	Quantitative	Cross-sectional	4424 doctors in the US. White (78.7%), Asian (12.3%), Hispanic/Latinx (6.3%), and Black (2.8%).	Primary and secondary care, Private practice, Academic medical center Veterans hospitals, Active military practice Not in practice or retired	2-item validated Primary Care Evaluation of Mental Disorders – (1) "During the past month, have you often been bothered by feeling down, depressed, or hopeless?" and (2) "During the past month, have you often been bothered by little interest or pleasure in doing things?"	Multiple Regression	***Depression.*** They found no statistically significant associations between "race/ethnicity" and symptoms of depression.

Glymour et al. (2004)	Quantitative	Cross-sectional	2217 doctors in the US. White (73%), Asian or Pacific Islander (18%), Hispanic (6%), Black (3%).	Family Practice, Internal Medicine, Internal Medicine Specialty, Pediatrics, Pediatric Specialty	4-Item Perceived Stress Scale	ANOVA; Regression	***Stress***. They found that Asian or Pacific Islander doctors reported higher levels of stress ($p<0.01$) in comparison to White doctors, after controlling for age, sex, marital status, and job income. ***Other***. Overall, they found that doctors of the Global Majority appeared to care for a more challenging patient base than White doctors. Hispanic doctors reported significantly higher job ($p=0.05$) and career ($p=0.03$) satisfaction than White doctors.

Greenberg et al. (2022)	Quantitative	Case-Control	300 General Surgery residents in the US. White (57%), Asian (21.3%), Mixed Asian (2%), Latinx (5.3%), Latinx mixed (4%), African American (3%), Mixed African American (0.7%), Other (3.7%), American Indian/Alaska Native (0.3%), Mixed AI/IN (0.7%), Declined to state (2%). Comparison groups are stated throughout.	Clinical and Research Settings	Cohen's Perceived Stress Scale; Spielberger's State-Trait Anxiety Index; Patient Health Questionnaire-8; Maslach Burnout Inventory	ANOVA	***Stress.*** They found no significant differences when comparing White trainees to "Residents of Colour" ($p = 0.92$). ***Depression.*** They found no significant differences in experiences of depression among "Residents of Colour". ***Anxiety***. They found that doctors of the "Residents of Colour" reported significantly higher levels of anxiety, which remained significant after adjusting for gender, year of study and number of gap years.

Hainer and Palesch (1998)	Quantitative	Cross-sectional (Longtidinal)	350 Family Practise Medical Residents in the US. Caucasian (88.6%, African American (5.1%), Hispanic (0.01%), Asian (3.1%), Other (0.02%).	Family Practise Residents	Beck Depression Inventory, Profile of Mood Scale	ANOVA; Chi-Square	***Depression.*** The findings from the study were that family medicine residents reported lower levels of depression compared to the general population. However, both studies reported no overall significant differences in experiences of depression, relating to ethnicity. They found a significant difference relating specifically to the total mood disturbance scale on the second test date, however, no consistent pattern of association was found.
Kovoor et al. (2022)	Quantitative	Cross-sectional	205 surgical trainees from Australia (71.2%, New Zealand (16.6%), and the UK (12.2%). White (74.1%) and Minority ethnic background (25.9%)	Surgery residents enrolled in a formal surgical training program. All years of training and surgical sub-specialties were included.	Four-Item Screening Tool Perceived Stress Scale (PSS-4); Patient Health Questionnaire-2	Multiple regression	***Stress.*** They found that higher levels of stress were associated with being from a “minority race”, in comparison to White trainees ($p = 0.0012$).

Michels et al. (2003)	Quantitative	Cross-sectional (Longtidinal)	350 Family Practise Medical Residents in the US. Caucasian (88.6%, African American (5.1%), Hispanic (0.01%), Asian (3.1%), Other (0.02%).	Family medicine residents	Beck Depression Inventory, the State-Trait Anxiety Inventory, the Profile of Mood States, the Hassles Scale, the Maslach Burnout Inventory	Chi-square; ANOVA	***Anxiety.*** They found that residents reported lower levels of anxiety across most dimensions when compared with the adult populations on which the tests were standardised and with other resident and practising doctors. Regarding ethnicity, they found that the MBI depersonalisation scale was the only anxiety measure significantly influenced by ethnicity. They found that Caucasians reported significantly higher depersonalisation scores vs. residents of other ethnicities ($p = < .0001$).
Post and Weddington (1997)	Qualitative	Qualitative	10 Doctors in the US. 2 African American doctors. The ethnicity of the remaining 8 doctors is not clearly stated,, but implied to be White.	Community-based practising family physicians	Stress	Qualitative analysis by Miles and Huberman	***Stress.*** They found that among African American doctors, common stressors included work overload and a sense of responsibility. One doctor mentioned experiencing stress due to the nature of the medical environment and the emotional impact of losing patients, whilst another doctor spoke about challenges related to managing interpersonal interactions with patients and staff. Participants also discussed coping strategies to manage stress, such as awareness, a positive perspective, an action-oriented approach, family support, and time for self, which could mediate the relationship between stress and ethnicity.

Post and Weddington (2000)	Qualitative	Qualitative	10 African American doctors in the US	Community-based practising family physicians	Stress	Specific analysis method not stated. Patterns and themes common to the interviews were identified.	***Stress.*** They found that doctors reported encountering stressors such as facing racism within the field of medicine, grappling with self-doubt, and feeling a need to prove themselves. African American doctors described qualities of perseverance and fortitude as necessities to survive the stressful experiences associated with racism in the workplace.

Quality Assessment

Quantitative studies were reviewed using the National Institute of Care and Excellence (NICE) quality appraisal checklist for quantitative studies reporting correlations and associations checklist (NICE, 2012; Table 6). All studies provided clear information about their sample and population, for example, and recruited participants representative of the source population. The studies were of mixed quality in terms of measures utilised. None of the studies conducted follow-ups. None of the studies reported whether they completed a power analysis. Most studies used appropriate analyses for the methodology and research questions. Most studies had good internal validity indicating that their findings could be generalised. All assessed studies were included in the review.

Table 6

Quality assessment of quantitative studies

	Frank and Dingle (1999)	Kovoor et al. (2022)	Michels et al. (2003)	Dunning et al. (2022)	Hainer & Palesch (1998)	Glymour et al. (2004)	Greenberg et al. (2022)	Garcia et al. (2020)
Section 1: Population								
1.1 Is the source population or source area well described?	++	++	++	++	++	++	++	++
1.2 Is the eligible population or area representative of the source population or area?	+	+	+	+	+	++	++	+
1.3 Do the selected participants or areas represent the eligible population or area?	++	++	++	+	++	+	++	++
Section 2: Method of selection of exposure (or comparison) group								
2.1 How was selection bias minimised?	++	+	+	+	+	++	+	++
2.2 Was the selection of explanatory variables based on a sound theoretical basis?	++	++	++	++	++	++	++	+
2.3 Was the contamination acceptably low?	N/A	+	+	+	+	+	+	+
2.4 How well were likely confounding factors identified and controlled?	+	+	−	+	−	++	++	+
2.5 Is the setting applicable to the UK?	++	++	+	++	+	+	+	+
Section 3: Outcomes								
3.1 Were the outcome measures and procedures reliable?	−	−	++	++	++	+	++	−

3.2 Were the outcome measurements complete?	+	+	−	+	−	+	−	+
3.3 Were all the important outcomes assessed?	+	+	++	+	++	+	++	−
3.4 Was there a similar follow-up time in exposure and comparison groups?	NA	NA	NA	NA	NA	NA	NA	NA
3.5 Was follow-up time meaningful?	NA	NA	NA	NA	NA	NA	NA	NA
Section 4: Analyses								
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)?	NR	NR	NR	NR	NR	NR	NR	NR
4.2 Were multiple explanatory variables considered in the analyses?	+	-	++	+	++	++	++	+
4.3 Were the analytical methods appropriate?	+	++	++	++	++	++	++	++
4.6 Was the precision of association given or calculable? Is association meaningful?	++	++	+	+	++	++	++	++
Section 5: Summary								
5.1 Are the study results internally valid (i.e. unbiased)?	+	−	+	+	+	+	+	+
5.2 Are the findings generalisable to the source population (i.e. externally valid)?	++	+	+	+	+	+	++	+

For qualitative studies, the Critical Appraisal Skills Program (CASP; 2002) checklist was used as a quality assessment tool (Table 7). All studies demonstrated appropriate methodology, design, data collection methods, and clear aims. Both qualitative studies clearly stated their findings and were of value in terms of contribution to the literature. There was mixed quality relating to consideration of the researcher's reflexivity. Both studies were included in the review.

Table 7

Quality assessment of qualitative studies

Reference	Post and Weddington (1997)	Post and Weddington (2000)
1. Clear Aim	Yes	Yes
2. Appropriate methodology	Yes	Yes
3. Appropriate design	Yes	Yes
4. Appropriate sampling & recruitment	Can't tell	Yes
5. Appropriate data collection	Yes	Yes
6. Consideration of researcher-participant relationship	No	Yes
7. Consideration of ethical issues	Yes	Can't tell
8. Rigorous analysis	Yes	No
9. Findings clearly stated	No	Yes
10. Value of research	Yes	Yes
Criteria Met	7/10	8/10
Include?	Yes	Yes

Stress

Six studies investigated stress levels among doctors. Three studies were conducted among trainees (i.e., junior doctors or medical residents; Dunning et al., 2022; Greenberg et al., 2022; Kovoor et al., 2022) and three studies were conducted among qualified doctors (Glymour et al., 2004; Post & Weddington, 1997, 2000). Three studies were conducted before the COVID-19 pandemic, and three were conducted during the COVID-19 pandemic.

Trainee Doctors

Three studies explored whether stress levels differed among ethnic groups. Greenberg et al. (2022) conducted an observational cross-sectional study of experiences of stress, anxiety, and depression by ethnicity among junior doctors. They collected data from 300 general surgery junior doctors across the US in January 2021. Experiences of stress were measured using the Perceived Stress Scale (PSS; Cohen et al., 1994), and were compared with a normative sample of 433 young adults (aged 25-34) in the general population (Cohen & Janicki-Deverts, 2012). They found no significant differences (n = 300) when comparing White residents versus "Residents of Colour" (p = 0.92) after adjusting for gender, training level, and number of gap years, but found significant differences when compared levels of stress by ethnicity in a sample of 433 US adults age 25–34 in the general population (p = <.05). These findings indicate that stress levels may be experienced similarly by doctors regardless of ethnicity, but that there could be a disparity among stress levels by ethnicity in the general population. This study also had a high response rate (34%) minimising the risk of self-selection bias (Elston, 2021). However, the study measured stress levels on a mixed group of trainee doctors across clinical and research specialities, where

stress levels are likely to vary across clinical and research settings, which could have skewed the responses (Goldacre et al., 2012).

Similarly, a cross-sectional study by Dunning et al (2022) of 456 junior doctors in the UK, during the COVID-19 pandemic, investigated doctors's well-being, including experiences of stress, anxiety, and depression. Dunning et al (2022) measured stress using the 21-item Depression, Anxiety and Stress scale. They found no differences in stress levels between participants from different ethnic groups ($p = 0.77$). The absence of more pronounced disparities could be due to a lack of meaningful differences in stress levels between ethnic groups. In contrast to the study by Greenberg et al. (2022), differences in stress levels were compared between self-reported ethnicities (White, Mixed, Asian, Black, and Other), as opposed to a comparison of White junior doctors versus doctors of the Global Majority. A strength of this study was the sample of participants which showed diverse representation across ethnicity, specialities, and years of experience.

Kovoor et al. (2022) conducted a cross-sectional study of 205 trainee surgeons from the UK, Australia, and New Zealand. Similarly to the study by Greenberg et al. (2022), they analysed ethnicity by comparing White versus "minority ethnic background". They found that higher levels of stress were associated with being from a "minority ethnic background", in comparison to White trainees ($p = 0.0012$), whilst controlling for all other covariates such as year of surgical training, and number of COVID-19 patients treated. They also found that poor working conditions were significantly associated with "minority ethnic background" ($P = 0.0267$), however, this relationship was not explored in the context of experiences of stress, which means that it is not possible to ascertain whether poor working conditions experienced by those from "minority ethnic backgrounds" could

be related to their experiences of increased stress levels. Furthermore, the authors did not report effect sizes which means that it is not possible to state the potential magnitude of the difference in stress levels between White and "minority ethnic background" surgical trainees (Clark-Carter, 2007). It is important to note that the study by Kovoor et al. (2022) measured stress using a four-item screening tool PSS-4, indicating the need for replication using full outcome measures with good reliability and validity. Furthermore, the response rate was not reported, which could indicate a risk of self-selection bias, for example, it could be that those doctors who might be more stressed may have been unable to take part in the study (Elston, 2021).

Doctors

Three studies investigated the relationship between ethnicity and stress among doctors of the Global Majority in the US. Two of the studies were qualitative in design (Post & Weddington, 1997, 2000), and one study was of quantitative design (Glymour et al., 2004). One study explored the experiences of African American doctors only (Post & Weddington, 2000).

Glymour et al. (2004) conducted a cross-sectional study of 2217 doctors based on data from the national physician survey in the US. They utilised stratified sampling to disproportionally sample certain groups allowing for a more representative sample of US doctors, achieving a response rate of 52%. Self-selection bias was also minimised by measuring any potentially significant difference between early and late responders, which did not discover any notable differences (Elston, 2021). They found that Asian or Pacific Islander doctors reported higher levels of stress ($p<0.01$) in comparison to White doctors, after controlling for age, sex, marital status, and job income. They also found significant differences in career satisfaction, such as autonomy, patient care matters, interactions with colleagues, community engagement,

compensation, and available resources, related to ethnicity, however, this relationship was not explored in the context of experiences of stress. They also measured potential confounding factors and found that Asian or Pacific Islander doctors were more likely to report practising internal medicine, more likely to work in small group settings and solo practice, and reported working with the greatest percentage of uninsured patients, however, these were not assessed specifically by stress levels, which means that it is not possible to ascertain whether differences in these factors experienced by Asian or Pacific Islander doctors could be related to their experiences of increased stress levels.

Furthermore, no noteworthy differences in stress levels were found among doctors identifying as Black or Hispanic, despite Black doctors reporting working with the most demanding patient base, such as caring for the highest number of patients with complex psychosocial needs, and Medicaid patients, which are those receiving treatment from a public insurance program that provides health coverage to low-income families and individuals. The lack of differences in stress levels between Black doctors could indicate high levels of resilience among Black doctors. Alternatively, the lack of significant differences in stress levels could be because working with more demanding patients is not considered more stressful by Black doctors, or that working with more demanding is considered more rewarding such that the positive aspects outweigh the stressors (Kane, 2019).

Two qualitative studies exploring the relationship between stress and ethnicity were conducted. Post and Weddington (1997) conducted a qualitative study of US doctors as participants (n = 10), which included African American doctors (n = 2). However, a major limitation of this study was that the ethnicity of the remaining participants was not clearly stated, even though this data was reported to be collected as part of the interview questionnaire. However, the authors referred to White

participant doctors in the discussion of their report. The omission of ethnicity in the participant demographics indicates racial bias, where whiteness has been centralised or assumed as the norm (Fakim & Macaulay, 2020). Consequently, no conclusions can be drawn about the remaining participants from this study. The remaining findings should be interpreted cautiously due to the potential risk of researcher allegiance effects, which could have influenced how the researchers analysed and interpreted the data (Munder et al., 2013).

The study by Post and Weddington (1997) found that among African American doctors, common stressors included work overload and a sense of responsibility. One doctor mentioned experiencing stress due to the nature of the medical environment and the emotional impact of losing patients, whilst another doctor spoke about challenges related to managing interpersonal interactions with patients and staff. Participants also discussed coping strategies to manage stress, such as awareness, a positive perspective, an action-oriented approach, family support, and time for self, which could mediate the relationship between stress and ethnicity. For example, one of the African-American doctors shared a strong spiritual aspect to his coping with the stress of racism. The authors proposed that African American doctors' experiences were considered to be influenced by an Afrocentric perspective, which prioritises group needs and family values, however, this appeared to be more relevant to doctors' choice of speciality, as opposed to their experiences of stress and coping. Furthermore, despite culture being the factor under investigation, it was not clear how the authors and participants defined culture, making it difficult to compare experiences across studies.

Post and Weddington (2000) conducted another study of experiences of stress and coping among African American doctors. However, it is important to note that the

analysis strategy was not explicitly stated, but referred to the identification of "themes and patterns" raising the issue of rigour in the methodology. The authors conducted semi-interviews with 10 African American doctors, where doctors identified numerous stressors such as racism in medicine, experiences of self-doubt, and feeling the need to prove themselves. Furthermore, experiences of doubt were reported by African American doctors, such as that others were doubting their capacity for success, and uncertainty around indirect experiences of racism, both of which led doctors to feel the need to prove themselves, consequently contributing to experiences of stress. African American doctors also described qualities of perseverance and fortitude, which were considered necessities to survive the stressful experiences associated with racism in the workplace. This study tentatively suggested that African American doctors may face additional stressors in the workplace such as racism, which can increase their experiences of stress and coping. Furthermore, due to the qualitative nature of both studies by Post and Weddington (1997, 2000), it is not possible to generalise these findings to the wider population of African American doctors working in state hospitals in Western countries, indicating the need for quantitative studies investigating the relationship between stress and ethnicity. For example, factors such as experiences of racism and self-doubt were not addressed in the quantitative study investigating levels of stress among qualified doctors conducted by Glymour et al. (2004).

It is important to note that both studies by Post and Weddington (1997; 2000) were conducted by the same authors and published in the same journal, increasing the risk of researcher allegiance effects (Munder et al., 2013). Furthermore, it was reported that due to the principal investigator not being African American it was felt by the rest of the research team certain topics were not explored, indicating a potential

risk of “code-switching”, which refers to when a person might alter their speech, behaviour, or communication style to adapt to different social or cultural situations (Morton, 2014). This can occur for various reasons such as conformity, fear of discrimination, or to navigate different cultural or social norms (Young & Barrett, 2018).

Depression

Six studies investigated experiences of depression by ethnicity among doctors. Four were conducted among trainee doctors (i.e., junior doctors or medical residents; Dunning et al., 2022; Greenberg et al., 2022; Hainer & Palesch, 1998; Michels et al., 2003) and two were conducted among qualified doctors (Frank & Dingle, 1999; Garcia et al., 2020). Five studies were conducted before the COVID-19 pandemic, and one was completed during the pandemic (Dunning et al., 2022).

Trainee Doctors

Four studies investigated the relationship between ethnicity and depression among trainee doctors. Two studies were conducted based on the same set of data, which was collected from family practice junior doctors in the US between July 1993, and January 1996 (Hainer & Palesch, 1998; Michels et al., 2003). Data was collected bi-annually for three years. These studies were both case-control studies which compared the experiences of depression among family practice residents with a sample of non-medical students. Depression was measured using the Profile of Mood States (POMS) subscales: Depression-Dejection and the Total Mood Disturbance scale (McNair et al., 1971). Both studies found that family medicine residents reported lower levels of depression compared to the general population, which was consistent with previous findings in this research area (Kirsling et al., 1989). However, both studies reported no overall significant differences in experiences of

depression, by ethnicity. The only exception was that Hainer and Palesch (1998) reported one significant finding relating to “race” for the total mood disturbance scale on the second test date, however, no consistent pattern of association was found, indicating a potentially false positive significant effect (Wilson et al., 2022).

The lack of significant findings from the studies by Hainer and Palesch (1998) and Michel et al. (2003) could suggest that experiences of stress are similar across ethnic groups. However, it is important to note that the sample consisted of predominantly White junior doctors (88.6%), and was not representative, in terms of ethnicity, of the wider population in South Carolina (69%). Furthermore, the authors did not report whether they completed a power analysis, which meant that it was not possible to ascertain whether the study was sufficiently powered to detect significant effects, in terms of experiences of depression by ethnicity, should they exist. Overall, these findings indicate that further investigation of experiences of depression among doctors between ethnic groups is required with a representative and adequate sample size.

Similarly, a cross-sectional study by Greenberg et al (2022) of a diverse sample of 300 general surgery trainees across the US, compared experiences of depression among “Residents of Colour” versus White trainees. They measured depression using the Patient Health Questionnaire and compared the data to a sample of parents of school-age children aged 31- 40 years old (Sequeira et al., 2021). They found no significant differences in experiences of depression between “Residents of Colour” and White residents. These findings indicate that trainee doctors, regardless of ethnicity, may have similar experiences of depression. However, it is important to note the limitations of this study, such as the risk of conflating the experiences of trainee doctors into two categories of White versus “Residents of Colour”.

In contrast, a cross-sectional study by Dunning et al. (2022) of 456 junior doctors in the UK, found a significant difference) in levels of depression, when comparing ethnic groups during the COVID-19 pandemic ($p = 0.016$). Post-hoc analyses showed that doctors from "mixed ethnic backgrounds" ($M = 24.80$, $SD = 9.48$) reported lower levels of depression than those from an Asian ($M = 31.51$, $SD = 12.84$) or White background ($M = 27.74$, $SD = 27.80$). They also found that junior doctors identifying as White ($M = 27.74$, $SD = 27.80$) also reported lower levels of depression than those identifying as 'other' ($M=34.76$, $SD = 12.70$) and those identifying as Asian ($M = 31.55$, $SD = 12.84$). However, effect sizes were not reported which meant that it was not possible to determine the size of the reported effects (Clark-Carter, 2007). Furthermore, the authors did not report whether they completed a power analysis, although they stated that the study was underpowered to explore the comparison of ethnic groups. Therefore, although these findings tentatively suggest that trainees identifying as Mixed Race may experience lower levels of depression, followed by those identifying as White, they should be interpreted with caution. Furthermore, Dunning et al. (2022) also did not investigate mediating factors making it difficult to ascertain why certain ethnic groups may report lower levels of depression.

Doctors

Two studies investigated the relationship between ethnicity and depression among trainee doctors. Both studies were conducted in the US, before the COVID-19 pandemic (Frank & Dingle, 1999; Garcia et al. 2020).

The study conducted by Garcia et al. (2020) was a cross-sectional study of US doctors ($n = 4424$), where experiences of depression were measured using the 2-item validated Primary Care Evaluation of Mental Disorders (Spitzer et al., 1994), where

depression was measured by (1) “During the past month, have you often been bothered by feeling down, depressed, or hopeless?” and (2) “During the past month, have you often been bothered by little interest or pleasure in doing things?” (Henkel et al., 2004, p. 217). Similarly to some of the studies conducted on trainee doctors, Garcia et al. (2020) found no statistically significant differences between “race/ethnicity” and symptoms of depression. This finding could be due to a lack of meaningful differences among these groups. Alternatively, the lack of significant differences could also be due to using a 2-item scale to measure levels of depression, which could have limited the capacity to capture the spectrum of experiences related to levels of depression.

Another cross-sectional study by Frank and Dingle (1999) investigated experiences of depression among only female doctors in the US. This was a cross-sectional study based on data from the Women Physicians’ Health Study (n = 4,501), which is a nationally distributed questionnaire to all doctors including those that are active, part-time, professionally inactive, and retired doctors, aged 30–70 years, and those who were not in residency training programs. The study utilised a health questionnaire where additional items measuring levels of depression were added, and data was compared by ethnicity (Table 3). The authors were able to compare the respondents with non-respondents and found that they did not differ significantly, based on age and ethnicity. They found that Asian female doctors were less likely to report having experienced depression in comparison to African American, Hispanic, and White female doctors, $\chi 2(4, N = 4501) = 81.08$, $p = <0.0001$ (Frank and Dingle, 1999). They also found that experiences of depression were more common among those who reported working too much, career dissatisfaction, less control at work, and high job stress, however, these factors were not examined by ethnicity. However, it is

important to note that the study did not utilise a validated and reliable measure of depression, therefore, these findings should be interpreted with caution. Furthermore, due to the large sample size, there is an increased risk of publication and sampling bias where a finding is more likely to be significant, but less likely to be clinically meaningful (Kühberger et al., 2014). Another limitation was limited response options to questions about experiences of depression, which may have caused participants to hyperbolise their experiences (Simms et al., 2019).

Anxiety

Three studies investigated the experiences of anxiety among doctors by ethnicity. All three studies examined these relationships among trainee doctors (Dunning et al., 2022; Greenberg et al., 2022; Michels et al., 2003). Two studies were conducted before the COVID-19 pandemic, and one was conducted during the COVID-19 pandemic.

Trainee Doctors

A cross-sectional study by Dunning et al (2022) of 456 junior doctors in the UK, during the COVID-19 pandemic, found that ethnicity was a significant factor relating to experiences of anxiety ($p = 0.020$), for example, post hoc analyses revealed that residents identifying as Asian ($M = 27.88$, $SD = 11.42$) reported higher levels of anxiety than those as identifying as White ($M = 24.16$, $SD = 9.77$). The authors hypothesised that this finding could be attributed to the poorer working conditions faced by healthcare staff among certain ethnic groups, and the higher probability of experiencing workplace harassment, however, these factors were not addressed in this study (NHS, 2022; Riley et al., 2021).

Michels et al. (2003) conducted a study of family practice residents ($n = 350$, as described previously). They conducted a cross-sectional study of residents' well-

being, where they used the State-Trait Anxiety Inventory and the tension-Anxiety subscale of the POMS scale (McNair et al., 1971), which have demonstrated mixed findings in terms of reliability due its focus on measuring transitory states of anxiety, and validity with studies suggesting that the scale is not able to discriminate between experiences of depression and anxiety (Kennedy et al., 2001; Spielberger, 1970). They also administered a measure of burnout (e.g., Maslach Burnout Inventory [MBI], Maslach et al., 2011), and found that the MBI depersonalisation scale was the only anxiety measure significantly influenced by ethnicity. Michels et al. (2003) found that "Caucasians" reported significantly higher depersonalisation scores versus residents of other ethnicities ($p = < .0001$). It is also important to note that the MBI measure is not validated to measure anxiety, however, experiences of depersonalisation can be considered as part of the conceptualisation of anxiety (Baker et al., 2003). However, the authors reported that given the number of analyses undertaken, it is likely that the findings have arisen by chance.

Furthermore, Michels et al. (2003) also conducted further analyses of levels of anxiety across time (year of training) and found that Caucasian residents later reported significantly higher levels of depersonalisation, than African American residents ($p <.0001$) when compared with their initial test scores. The authors hypothesised that African American residents may report lesser experiences of depersonalisation due to greater ethnic identification and emotional investment in patient-doctor relationships.

A study by Greenberg et al (2022) of a diverse sample of 300 general surgery trainees across the US, also examined experiences of anxiety among "Residents of Colour" (as described above). Greenberg et al. (2002) conducted analyses based on two comparisons of ethnicity, 1) a comparison of "Residents of Colour" and White residents, 2) a comparison of trainees who were overrepresented in medicine (those

who identify as White, and those who identify as Asian), and those who were underrepresented in medicine (those who identified as Black/African American, Latinx, American Indian/Alaska Native, and Native Hawaiian/other Pacific Islander, and biracial).

When comparing “Residents of Colour” and White trainee doctors, they found that "Residents of Colour” reported significantly higher levels of anxiety which remained significant after adjusting for gender, year of study and number of gap years. This study provides preliminary findings suggesting that trainees “Residents of Colour” may be at higher risk of experiencing work-related anxiety. However, the study did not measure potential mediating factors, which means that it is not possible to understand how ethnicity plays a role in understanding experiences of anxiety between various ethnic groups. Furthermore, it is important to note that effect sizes were not reported making it difficult to ascertain the potential magnitude of the effect (Clark-Carter, 2007).

However, when comparing those who were overrepresented versus underrepresented trainee doctors, there were no significant differences in levels of anxiety. This tentatively suggests that for Asian-identifying trainee doctors experiences of anxiety are more similar to those of doctors underrepresented in medicine (e.g., Black/African American) than White trainee doctors, however, the differences are likely to be related to complex, nonhomogeneous, and nuanced experiences of doctors identifying as different races/ethnicities. Furthermore, the authors did not report whether they completed a power analysis, however, they stated that the study was underpowered to explore the comparison of ethnic groups, which means that these findings should be interpreted with caution.

Discussion

Summary and Discussion of Findings

The studies included in this analysis were systematically selected from five databases and utilised various methodologies, measures and analyses to explore stress, anxiety, and depression, across different populations such as trainees and qualified doctors, and specialities. The results suggested that it is difficult to make conclusions about the experiences of well-being among doctors of the Global Majority, due to the quality, heterogeneity, and mixed-method nature of the studies.

Two studies found significant differences in levels of depression and anxiety among trainee doctors when compared by ethnicity, however, these should be interpreted with caution due to the quality of the studies, for example, lack of validated measures for depression (Dunning et al., 2022; Frank & Dingle; 1999). For example, one study found that trainees of the Global Majority reported higher levels of anxiety than White trainees (Dunning et al., 2022).

However, three further studies found no significant differences in experiences of depression and anxiety, concerning ethnicity (Greenberg et al., 2022, Hainer & Palesch, 1997; Michels et al., 2003). One possible explanation for this could be due to similar rates of depression and anxiety between ethnic groups.

In terms of experiences of stress, studies indicated mixed findings, such that two studies found no significant differences by ethnicity (Dunning et al., 2022; Greenberg et al., 2022), and two studies found higher levels of stress among trainee surgeons of the Global Majority when compared with White trainees (Glymour et al., 2004; Kovoor et al., 2022). For example, Glymour et al. (2004) found that Asian or Pacific Islander doctors reported higher levels of stress ($p<0.01$) in comparison to White doctors, after controlling for age, sex, marital status, and job income, however,

no significant differences were found for any other self-reported ethnicities. Two studies found potential differences in stress levels among trainee doctors when compared by ethnicity (Dunning et al., 2022; Garcia et al., 2020). One study found lower stress levels among “Residents of Colour” could reflect higher levels of “racial/ethnic minority resilience”, which has been proposed to correlate with highly adaptive coping strategies in the context of adversity (Lipson et al., 2018; Masten & Coatsworth, 1998).

Two qualitative studies explored the experiences of stress relating to ethnicity, but neither looked at experiences of anxiety and depression. The findings revealed that the following factors were related to stress: overload and a sense of responsibility, racism, doubt, and feeling the need to prove themselves (Post & Weddington, 1997; 2000). Themes of perseverance and fortitude were also identified among African American doctors as the necessities of surviving the stressful experiences associated with racism in the workplace. Within the African American community, some suggested factors contributing to resilience include racial socialisation and group identification, both of which rely on strong social connections and are thought to enhance the ability to navigate discrimination and challenge stereotypes (Branscombe et al., 1999; Fischer & Shaw, 1999).

None of the studies explored the role of mediating factors between experiences of stress, anxiety and depression and the doctor’s self-identified ethnicity. One study found that poor working conditions were related to being a doctor of the Global Majority, however, this relationship was not explored in the context of experiences of stress, which means that it is not possible to ascertain whether poor working conditions mediate the relationship between stress and ethnicity (Kovoor et al., 2022).

Overall, these studies show mixed findings and warrant further investigation into the experiences of stress, anxiety and depression between ethnic groups.

Strengths and Limitations

The key strength of this review was the focus on ethnicity, in the context of well-being among trainee and qualified doctors, which has only previously been conducted based on burnout (Lawrence et al., 2021). This review explored a gap in the literature, which outlined the available evidence regarding the experiences of stress, anxiety and depression, which included consideration of factors such as culture, discrimination, resilience, and coping.

However, there are several limitations to this review. The main limitation of this review was the broad research area, caused by the small number of studies available, making it difficult to compare the experiences of stress, anxiety and depression by ethnicity among trainees and qualified doctors. Moreover, there was significant variation in how ethnic groups were conceptualised, and how comparisons were made across ethnic groups, making it difficult to generalise findings from the studies (e.g., Greenberg et al., 2022).

There was further variation in where the studies were conducted, as eight were undertaken in the US, one in the UK and one in a mixed sample, making it difficult to draw comparisons and conclusions about the experiences of doctors of the Global Majority across Western healthcare clinical settings. Furthermore, the studies were conducted across a wide timeframe, during which significant changes in healthcare systems in Western countries have occurred, such as the increasing number of patients, staffing shortages, and evolving healthcare policies, which have been further exacerbated by the Covid-19 pandemic (Teoh et al., 2023).

Furthermore, one of the studies examined the experiences of female doctors only (Frank et al., 1997), whereas the remaining studies measured experiences of stress among male and female doctors, and did not investigate gender differences. For example, there is the potential for underreporting or overreporting depending on participant characteristics, including gender, where it is more acceptable for women to disclose being stressed than men (Mayor, 2015).

Some studies found no significant differences relating to stress, anxiety and depression by ethnicity. One possible explanation for the lack of significant findings could be due to the lack of high-quality studies such as use of brief screening or unvalidated measures of stress and depression (Frank & Dingle, 1999; Greenberg et al., 2022). Furthermore, all measures were developed in Western populations, which, may not have the same validity in populations from Eastern communities (Uysal-Bozki et al., 2013). Furthermore, studies were conducted at different times, including before and during the COVID-19 pandemic, and may have captured varying peak times during this health crisis, as it has been shown that varying peak times can impact well-being (Iserson, 2008).

Furthermore, six of the studies were cross-sectional and all studies relied on self-report data which can lead to a response bias (Elston, 2021). For example, it has been shown that doctors are likely to deny and minimise mental well-being concerns (Stanton & Randall, 2011). Furthermore, another limitation of using self-reported data was the risk of bias due to cultural stigma, which may discourage doctors from openly discussing mental health concerns, particularly within certain racial/ethnic communities (Ran et al., 2021).

None of the studies reported details about power analysis and effect size, making it difficult to compare an actual effect with the real population effects

(Schäfer & Schwarz, 2019). Only two studies had a qualitative design, and both were conducted by the same authors, indicating that further qualitative research is needed for doctors of various ethnic groups, including experiences of depression and anxiety (Post & Weddington, 1997, 2000).

Furthermore, even though the US and the UK have a high proportion of international doctors, none of the studies included in the review reported the number of international doctors in their sample (BMJ Careers, 2019; Organisation for Economic Co-operation and Development, 2023). It is well known that the conditions in which migrants live and work are shaped by diverse factors and social structures such as economic and educational inequalities, which can impact mental and physical well-being (Kapilashrami & Hankivsky, 2018).

Research Implications

The results suggest that it is difficult to make conclusions about the experiences of well-being among doctors of the Global Majority, due to the quality, heterogeneity, and mixed-method nature of the studies, which indicates that further research is needed to improve the understanding of the relationship between these factors. For example, there is a need for further investigation of experiences of depression among doctors of the Global Majority using quantitative studies using culturally validated measures and stratified sampling, as well as a requirement for calculating, reporting, and discussing effect sizes and power analyses, (Brandt et al., 2014; Cumming, 2014).

Current research tends to rely on medical models which are based mainly on physical “symptoms” and mental health diagnoses and do not allow for a deeper understanding of individual experiences and perceptions, as well as consideration of the influence of culture, and environment, which could be explored using further

qualitative studies (Dunning et al., 2022). Previous studies found that doctors of the Global Majority may feel like they do not fit in during training, and access to different protective factors that improve coping strategies, which have been shown to be related to experiences of well-being (Sudol et al., 2021; Wong et al., 2013).

Future studies should investigate whether factors such as poor working conditions, caring for a more disadvantaged patient base, coping strategies and experiences of racism and discrimination, mediate the relationship between stress levels and ethnicity, whilst considering the cultural relevance and heterogeneity amongst doctors of the Global Majority of various ethnic groups (Hennein et al., 2022). Further research should also investigate positive manifestations of well-being (e.g., values, work satisfaction, sense of accomplishment), which may act as mediating factors for experiences of stress, anxiety and depression (Couper et al., 2022). For example, it has been shown during the COVID-19 pandemic, that age, education, and ethnicity may influence factors that mitigate distress cultivating measures that support resilience among medical residents (Guran et al., 2022).

Clinical Implications

This review provided mixed findings about the experiences of stress, anxiety and depression among doctors of the Global Majority. Some studies indicated preliminary findings that doctors are at higher risk, in terms of their well-being, when compared to the general population (e.g., Kovoor et al., 2022). Potential implications could include systemic changes or interventions that prioritise enhancing the working conditions of doctors, rather than solely focusing on building resilience at the individual level (Dunning et al., 2022). At the organisational level, the role of practitioner psychologists can include changing workplace culture to be more supportive, by normalising distress and encouraging doctors to speak up in the

workplace, as well as increasing awareness and understanding about well-being needs through staff training, supervision and reflective practice (BPS, 2021).

Further attention to staff well-being interventions could be considered to help support systemic initiatives in managing doctors' well-being. At the individual level, further understanding of the experiences of well-being among doctors of the Global Majority can be utilised by clinical psychologists to provide support in well-being services. Previous research has also found various interventions helpful for medical students of the Global Majority, for example, mindfulness, yoga, and peer mentoring (Jackson, 2023; Youmans et al., 2020).

Conclusions

The review aimed to examine and critically appraise the literature exploring the relationship between well-being, in particular experiences of stress, anxiety, and depression, relating to ethnicity. The results show that it is difficult to draw definite conclusions about the experiences of well-being among doctors of the Global Majority, due to the quality, heterogeneity, and mixed-method nature of the studies. Further research in this area is required to clarify whether a relationship exists between ethnicity and experiences of stress, anxiety, and depression among doctors of the Global Majority.

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KAROLINA KOSYLA BSc Hons MSc

UNDERSTANDING WELL-BEING AND HELP-SEEKING AMONG DOCTORS OF THE GLOBAL MAJORITY

Section B: A Modified Grounded Theory Study About the Experiences and Perceptions of Well-Being and Help-Seeking Among NHS Doctors of the Global Majority

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Abstract

Aims and Objectives: Research shows that doctors of the Global Majority are at higher risk regarding their well-being, whilst at the same time less likely to seek help. The project aimed to develop a theory about well-being and help-seeking experiences and perceptions among a group of NHS doctors of the Global Majority.

Methods: A qualitative modified grounded theory methodology was employed using convenience sampling and semi-structured interviews. Thirteen doctors employed in acute hospital NHS Trusts were interviewed between October and March 2024. A draft model was shared with participants for respondent validation and feedback was incorporated into the finalised model.

Results: Seven main categories were identified from the data, including associated subcategories, and additional lower-level categories within subcategories. A tentative model of doctor's experiences and perceptions of well-being and help-seeking was devised.

Conclusions: Implications, limitations, and recommendations for future research were discussed. Consideration of how doctors of the Global Majority can be supported by their organisation and professional body was proposed.

Keywords: Doctors, Well-being, Help-seeking, Ethnicity, Grounded Theory

Introduction

Overview

Doctor's well-being has been impacted recently by particular stressors, including the COVID-19 pandemic, industrial strike action, and the cost of living crises (British Medical Association [BMA], 2023). Factors such as high workload, shift patterns, poor leadership and teamwork, impact doctor's well-being at work and outside of work (Cohen & Rhydderch, 2006). Positive factors have also been identified in the context of adversity such as community trust and cooperation, adapting to new pressures, and improved finances (Couper et al., 2022; Revythis et al., 2021). Research shows that doctors of the Global Majority were at higher risk of impact on their well-being, whilst at the same time less likely to seek help for well-being (BMA, 2022, 2024; Hinsby et al., 2022).

Terminology

Healthcare staff of the Global Majority make up 25.7% of all NHS staff and 49.9% of all community and hospital doctors in the UK (NHS Digital, 2023). The term Global Majority refers to "people who identify as Black, Asian, Brown, dual-heritage, indigenous to the Global South or have been racialised as 'ethnic minorities'" (Campbell-Stevens, 2020, p. 1). Most of the current research and guidance has used terms such as "Black, and Minority Ethnic (BAME)". These terms have been appropriately criticised due to maintaining social hierarchies, contributing to "othering", conflating experiences as synonymous, and centralising whiteness as the norm (Fakim & Macaulay, 2020; Mohdin et al., 2021). For this study, the terminology has been chosen based on consultation with doctors who participated in the study.

Doctor's Well-Being

"Well-being encompasses quality of life, as well as the ability of people and societies to contribute to the world in accordance with a sense of meaning and purpose. Focusing on wellbeing supports the tracking of the equitable distribution of resources" (World Health Organisation, 2021, p. 10). As per the biopsychosocial approach, the impact on doctors' well-being in the workplace can be influenced by an intersection of biological, psychological and social factors (Engel, 1977; Karunamuni et al., 2021).

Individuals who enter caring professions, such as medicine, have been described as "wounded healers", suggesting that their drive to enter the profession was related to their own experiences of distress and a desire to relieve the suffering of others (Gerada, 2015). Consequently, doctors who have experienced suffering may have a deeper understanding of their patients' difficulties (Duune, 2015). On the other hand, witnessing patients' distress may simultaneously trigger doctors' emotional distress, known as "secondary trauma" (Figley, 2013). These experiences can impact a doctor's well-being, where doctors may cope through self-reflection and gaining new insights, leading to resilience, or instead, some doctors may repress, avoid, or adopt unhealthy responses, which may perpetuate their distress (Thangathurai, 2015).

Studies have documented differences among doctors of the Global Majority, in terms of their experiences of well-being, such as being subject to microaggressions, cultural differences in perceptions around well-being, feeling like they do not fit in during training, and access to different protective factors that improve coping strategies (Sudol et al., 2021; Wong et al., 2013). It has also been documented that doctors of the Global Majority experience bias, discrimination, and racism throughout their career progression (Okolo et al., 2022). Consequently, it has been suggested that

doctors of the Global Majority are at higher risk of experiencing stress, anxiety, and depression (BMA, 2022; 2024). Psychodynamic and social psychology theories provide valuable insight into organisational dynamics, which can help us understand experiences related to diversity, for example, such as formulating how organisations may conceptualise, and experience the diversity of culture, ethnicity, and "race", including how racism functions on a systemic scale (Rasmussen & Garran, 2022).

Help-Seeking

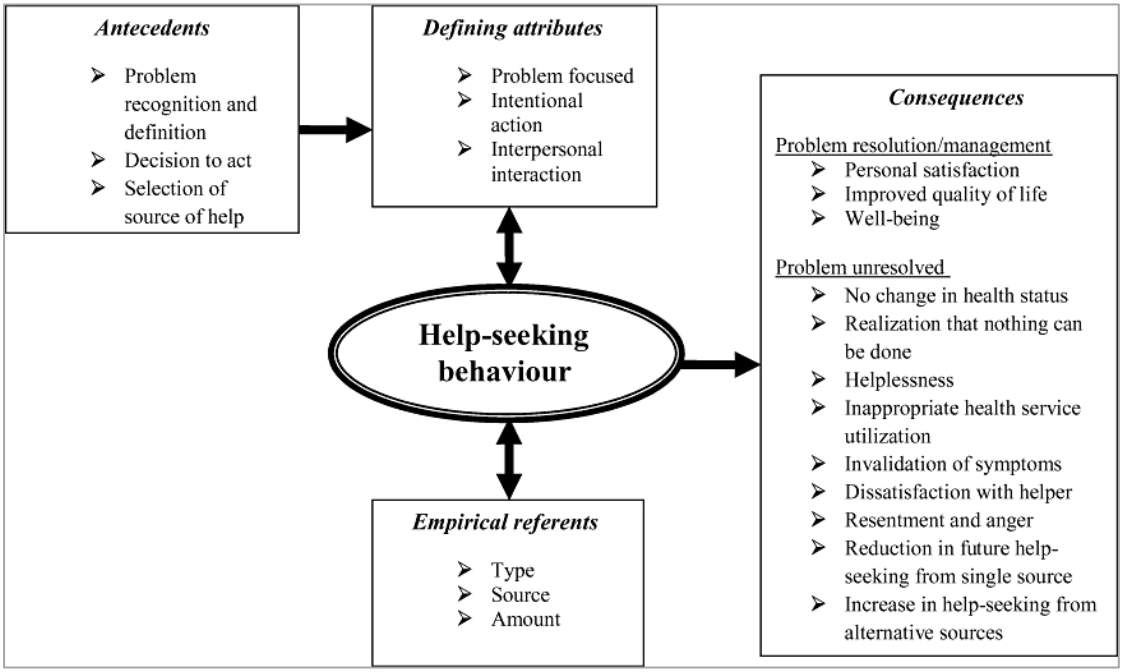
As a response to the COVID-19 pandemic, NHS England set up 40 national wellbeing hubs to provide access to psychological support for NHS healthcare staff, including doctors, in the workplace (NHS England, 2022). The British Psychological Society (2020) supported the well-being hubs and published guidance, which recommended that psychological interventions be offered to healthcare staff with psychological needs. However, it has been shown that doctors are unlikely to seek help for their well-being, for example, a grounded theory study conducted by Stanton and Randall (2011) found that doctors in psychiatry specialities were likely to deny and minimise mental well-being concerns, and only sought help as a last resort, usually when a point of crisis was reached.

Help-seeking is a complex phenomenon, which has been conceptualised through several frameworks. Cornally and McCarthy (2011) conducted a concept analysis of help-seeking behaviour in response to health concerns among the general population, where help-seeking was defined as "intentional action to solve a problem that challenges personal abilities" (p. 286; Figure 1). The complex decision-making process began with the recognition and definition of a problem, which led to the decision being made to act, which tended to be influenced predominantly by social-cognitive factors. Once an intention was formed, the person moved to select a source

of help, made contact, and disclosed the problem to initiate seeking help. However, this model of help-seeking does not capture the complex interaction between social-cognitive factors to help-seeing, such as attitudes towards help-seeking, which are influenced by wider sociopolitical and cultural factors (Pasupuleti, 2013; Spahlholz et al., 2023).

Figure 1

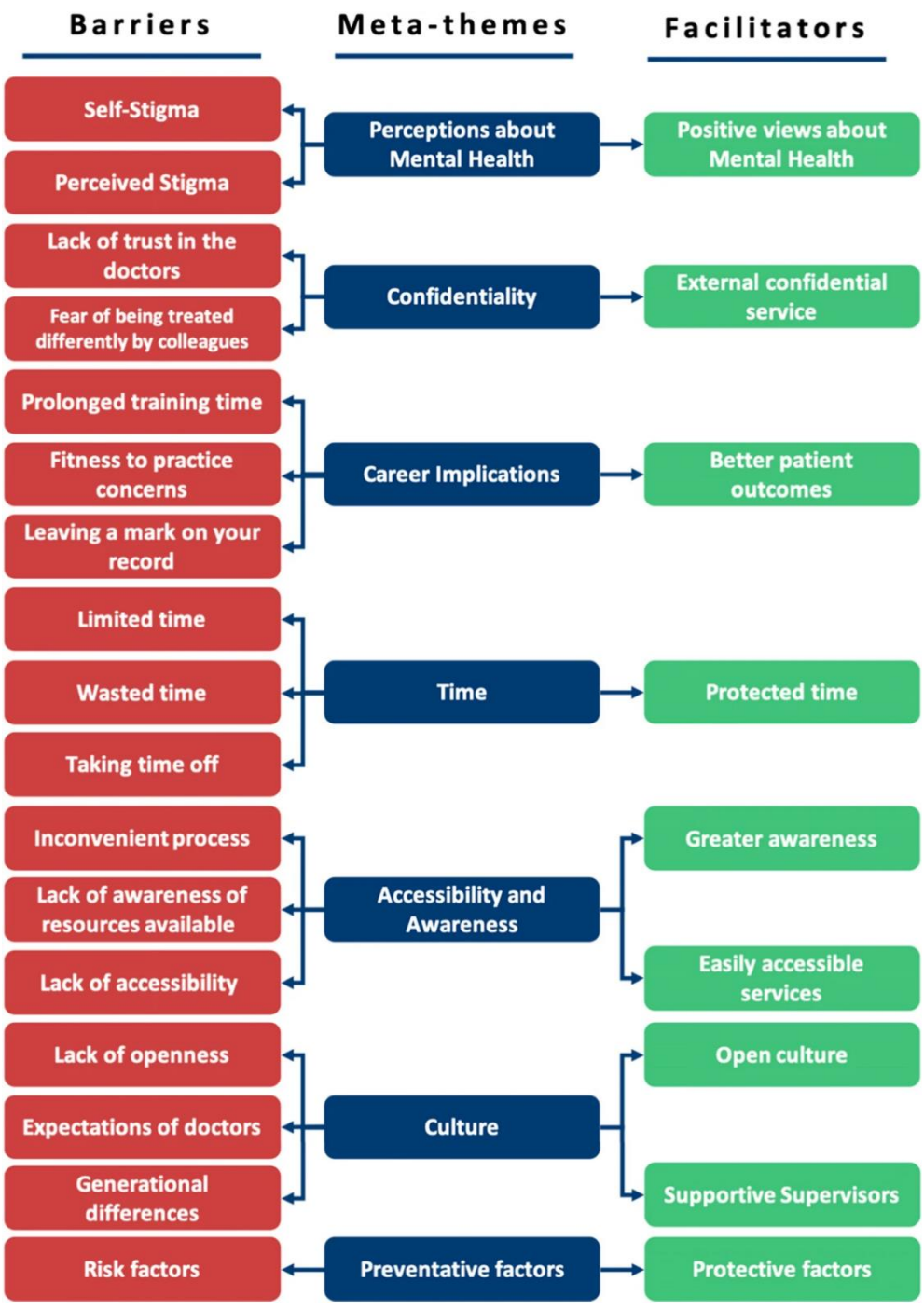
A concept analysis of help-seeking behaviour



There is a lack of research investigating the experiences of help-seeking doctors of the Global Majority, although some research has been conducted among doctors more widely. For example, studies have investigated the barriers and facilitators of seeking help for mental well-being among NHS doctors (Morishita et al., 2020; Zaman et al., 2022, Figure 2). However, this review did not explore the experiences of doctors of the Global Majority.

Figure 2

Barriers and facilitators of help-seeking among NHS doctors



There is also a lack of research investigating the experiences of help-seeking among doctors of the Global Majority, but some research has been conducted among

the general population. A qualitative study by Memon et al. (2016) identified perceived barriers to accessing mental health services among people of the Global Majority which included cultural identity, cultural naivety, insensitivity, discrimination and issues around power and authority. Additional cited factors include acculturation collectivism and individualism, religion and spirituality, and variability in the interpretation of distress, which were key cultural variables in understanding the underutilisation of support services among those of the Global Majority (Goldston et al., 2008). However, there is a lack of understanding regarding the impact of these factors on the well-being of doctors of the Global Majority (Lawrence et al., 2022).

Rationale and Aims

Research shows that doctors of the Global Majority were at higher risk of impact on their well-being, whilst at the same time less likely to seek help for well-being (BMA, 2022, 2024; Hinsby et al., 2022). Additionally, significant disparities have been highlighted in the treatment and career progression of doctors of the Global Majority (Okolo et al., 2022; Sudol et al., 2021). However, there is a lack of understanding of the impact of these factors on the well-being and help-seeking of doctors of the Global Majority which warrants further attention (General Medical Council, 2022). This study aims to address the gap in the literature by gaining a rich understanding of a sample of doctors of the Global Majority's experiences of well-being and help-seeking using a grounded theory methodology (Corbin & Strauss, 2015). Prior research has relied on medical models which are based mainly on physical manifestations and mental health diagnoses and do not allow for a deeper understanding of individual experiences and perceptions, as well as consideration of the influence of culture, and the environment (Dunning et al., 2022; Greenberg et al., 2022). The aim is to address the following research questions:

1. What are the experiences and perceptions of the impact on the well-being of a group of NHS hospital doctors of the Global Majority?
2. What are the experiences and perceptions of coping and help-seeking among a group of NHS hospital doctors of the Global Majority?

Method

Participants

Thirteen doctors participated in the study between October 2023 and March 2024 (Table 1). Nine further people expressed interest in the study, however, they did not respond to invitations to take part. Participants were recruited from four Kent Trusts East Kent (n = 8), Maidstone and Tunbridge Wells (n = 2), Dartford and Gravesham (n = 2), and Medway (n = 1). All participants identified as Asian or British Asian, and the most reported ethnicity was Indian. Most participants were doctors who trained overseas (n = 10).

Table 1

Anonymised participant demographics

Pseudonym	Gender	Age	Job Role	Specialty	Length of time in current role	Length of time in the NHS	Religion
Jaspreet	Male	35-44	Clinical Research Fellow	General Medicine	0 - 3 years	10 - 15 years	Sikh
Zyra	Female	35-44	Specialty Doctor	General Medicine	0 - 3 years	0 - 3 years	Muslim
Sumithra	Female	35-44	Foundation Doctor	Surgery	0 - 3 years	0 - 3 years	Hindu
Nisha	Female	35-44	Consultant	Surgery	0 - 3 years	10 - 15 years	Hindu
Naveen	Male	45-54	Consultant	General Medicine	10 - 15 years	15 - 20 years	Jainism
Reena	Female	45-54	Consultant	Emergency Medicine	10 - 15 years	20+ years	Hindu
Jim	Male	55-64	Consultant	Emergency Medicine	10 - 15 years	20+ years	Christian
Pratibha	Female	35-44	Consultant	Radiology	0 - 3 years	0 - 3 years	Hindu
Ayesha	Female	45-54	Consultant	General Medicine	10 - 15 years	15 - 20 years	Muslim
Tribhuvan	Male	45-54	Specialty Doctor	Surgery	0 - 3 years	0 - 3 years	Hindu
Ashwini	Female	45-54	Consultant	General Medicine	5 - 10 years	15 - 20 years	Hindu
Evelyn	Female	45-54	Consultant	Surgery	5 - 10 years	20+ years	Christian
Amrit	Female	18-24	Foundation Doctor	General Medicine	0 - 3 years	0 - 3 years	Sikh

Note. All names have been changed to ensure confidentiality

Design

A modified grounded theory was employed using semi-structured interviews based on the methodology by Corbin and Strauss (2015). The study was modified based on Willig's (2013) guidelines, which allow for grounded theory to be amended to be more flexible and adaptable to various epistemological positions and research questions. The philosophical underpinning for this study was Critical Realism, where it was recognised that participant responses may not offer perfect representations but instead offer valuable insights into individuals' realities, whilst shedding light on the broader "real world" context (Bhaskar & Hardwig, 2010).

Ethics

The study received ethical approval from the Salomons Research Ethics Committee approval (Appendix C), HRA Research Governance Approval (Appendix D) and capacity and capability approval from each NHS Kent Trust (Appendix E). A summary of the results from the study was sent to the ethics panel following study completion (Appendix S).

All participants were sent the information sheet and consent form before taking part in the study and were made aware of study details, data handling (as per General Data Protection Regulation, 2016), confidentiality, and the right to withdraw (Appendix G & H).

Materials

Semi-structured interviews were chosen to allow participants to talk freely about the topics they felt were most important, whilst ensuring that perspectives were explored in-depth. The interview schedule was developed based on a literature review of existing studies in this field to allow for theoretical sensitivity (Corbin & Strauss, 2015, Appendix I). The interview schedule was piloted with an expert by experience, and subsequent changes were made to promote accuracy, flow, and depth of responses.

Procedure

Participants were recruited from NHS Trusts, which included eight acute hospitals. To be eligible for the study, participants had to be employed as doctors in an acute hospital and identified as doctors of the Global Majority. Recruitment was undertaken through study advertisement by the primary researcher and the local collaborators in each NHS Trust. Study advertisement was conducted via e-bulletins and mailing lists (Appendix F). The study was also advertised on social media (e.g., Facebook, and LinkedIn), but all participants were recruited through the NHS Trusts.

All interested participants were sent the information sheet and consent form to read before agreeing to participate in the study. Following consent acquisition, an online interview was arranged and recorded via Microsoft Teams. Interviews lasted between 31 and 73 minutes in length. Participants also completed a short demographic survey (Appendix H). Participants underwent verbal and written debriefing and were offered a follow-up verbal debrief with one of the named supervisors (Appendix J).

Data Collection, and Data Analysis

Data collection and analysis were completed by the primary researcher, with assistance from two supervisors to ensure quality assurance (as indicated below). Corbin and Strauss (2015) highlighted the importance of theoretical sampling in grounded theory but also noted that practical constraints may sometimes necessitate using convenience sampling. As this was a hard-to-reach population, theoretical sampling was not possible. Instead, convenience sampling was used to recruit participants, which relied on the availability and willingness of participants rather than selecting them based on their relevance to the emerging theory (Chiovitti & Piran, 2003).

Data collection, coding, and analysis were conducted simultaneously wherever feasible. Adjustments were made to the interview schedule based on identified gaps in the emerging data from participant's experiences (Corbin & Strauss, 2015). The data analysis

process was recorded using theoretical memos, and diagrams (Corbin and Strauss, 2015; Appendix N).

Interview transcripts one to five were coded using line-by-line coding by the primary researcher using NVivo, where constant comparison was employed to identify similarities and differences within and between interviews (Appendix K). Data was coded using primarily in-vivo codes to minimise the risk of imposing interpretations onto the data. Those concepts represented early and tentative categories (e.g., “coping and help-seeking”) with properties (e.g., “coping strategies”) and dimensions (e.g., “letting out your emotions” to “detaching yourself from your emotions”). After the initial five interviews were completed, two interviews were selected at random and coded independently by another researcher. This initiated largely comparable concepts, which were only varied in semantics. Where disagreements were found, researchers discussed those and sought a consensus code.

The Matrix for the Explanatory Paradigm was used to develop interactions between categories throughout the analysis and commenced after line-by-line coding (Corbin & Strauss, 2015; Table 2).

Table 2

Examples of codes describing links between categories

The Matrix for the Explanatory Paradigm step	Explanation	Example
a) Conditions	Situations and meanings of events	“how complex everything is in the NHS, in the system, to get a small change”
b) Action-Interactions and emotions	Responses made by individuals to situations or events	“pushing for change”, “say things if they're wrong”
c) Consequences	What happened because of action interactions, which can lead to the next set of actions and interactions taken	“Feeling frustrated, disappointed and angry”

Throughout this phase of theory integration, the researchers regularly convened to provide feedback on coding, emerging categories, and their connections, ensuring alignment between the evolving grounded theory and the raw data. The number of participants was not predetermined. Based on Willig's (2013) guidelines for modified grounded theory, the data collection and analysis process continued until sufficient data was acquired to describe each category in terms of its properties and dimensions and accounting for variation (Dey, 1999). Finalised categories were agreed by the researchers before a model summary was sent to participants for feedback (Appendix P). Two participants provided feedback via email on the proposed theory which was integrated into the final model (Appendix Q).

Reflexivity and Quality Assurance

To help minimise the risk of bias appropriate guidance was used throughout the study and write-up (Table 3). Further quality monitoring was employed using the Critical Appraisal Skills Program (CASP; 2018) qualitative checklist.

Table 3

Guidance used to ensure the rigorousness of the methodology

Reference	Purpose	Quality assessment technique
Cohen and Crabtree (2008)	Researcher reflexivity	The primary researcher identified as a White, Polish female trainee clinical psychologist employed in the NHS. As a White researcher, this increased the risk of some experiences being overlooked (e.g., due to the possibility of internalised ethnocentric views; Keith, 2019). The primary researcher also had experiences of migration, which overlapped with the participant's experiences. However, these experiences were likely to be different for a White immigrant compared to those of the Global Majority. The primary researcher had also previously provided psychological support to healthcare staff post-pandemic, which helped facilitate insight, awareness, and ability to bring meaning to the data. However, such background does pose a risk of holding preconceived ideas and previous encounters to influence the construction of the grounded theory.
Creswell and Miller (2000)	Credibility and truthfulness	Prolonged engagement and persistent observation Clarification of researcher bias Member-checking Rich, thick descriptions

		External audits
Chiovitti and Piran (2003)	Credibility	(2) Respondent validation (3) Use of in-vivo coding (4) Use of research diary and theoretical memo writing
	Auditability	(5) Use of Matrix for Explanatory Paradigm (Corbin & Strauss, 2015) (6) Convenience sampling and use of data sufficiency
	Fittingness (or transferability)	(7) Demographic information was collected from participants (Table 1) (8) Consideration of how the literature relates to each category which emerged in the theory in the discussion section of this report

Results

Overview

During the analysis, seven main categories were identified from the data, including associated subcategories, and additional lower-level categories within subcategories (where relevant). These lower-level categories were developed inductively from the data and captured the properties and dimensions within sub-categories (Table 4).

Table 4

Summary of categories, subcategories and lower-level categories

Main Category Name	Sub-Category	Lower-Level Categories
A: Wider Context (Social, Political)	The "Country's Infrastructure and Priorities" "Funding and Resources" Racism in England COVID-19	
B: Culture in the Profession	Lack of "Emphasis on Mental Health and Well-being" Doctors as "Superheroes"	
C. Culture in the Organisation	Well-Being is not Prioritised	
D: Variables "Affecting Well-Being"	"Stressors"	"Patient Work Can be Traumatic" "Working with Difficult People" Not Feeling "Looked After" "Have to Work Harder (If Didn't Train Here)" "Racism and Discrimination" Pressures from "Management" Difficult Events
	Protectors	"Working with wonderful people" "Opportunities to grow and learn" Feeling "Supported" Sense of Accomplishment
E: "Understanding and Impact on Well-Being"	"Emotional Well-being" "Mental Well-being" "Physical Well-being" "Relationships"	
E: Factors that Influence on "Coping and Help-Seeking"	"Internal" Factors "External" Factors	
F: "Coping and Help-Seeking"	"Looking After Yourself" "Coping Strategies" "Speaking Up" "Asking for Help"	

The analysis was synthesised into a diagrammatic model (Appendix O; Figure 3). The model depicts a recursive process of the experiences of well-being and help-seeking among a group of NHS doctors of the Global Majority.

Model Summary

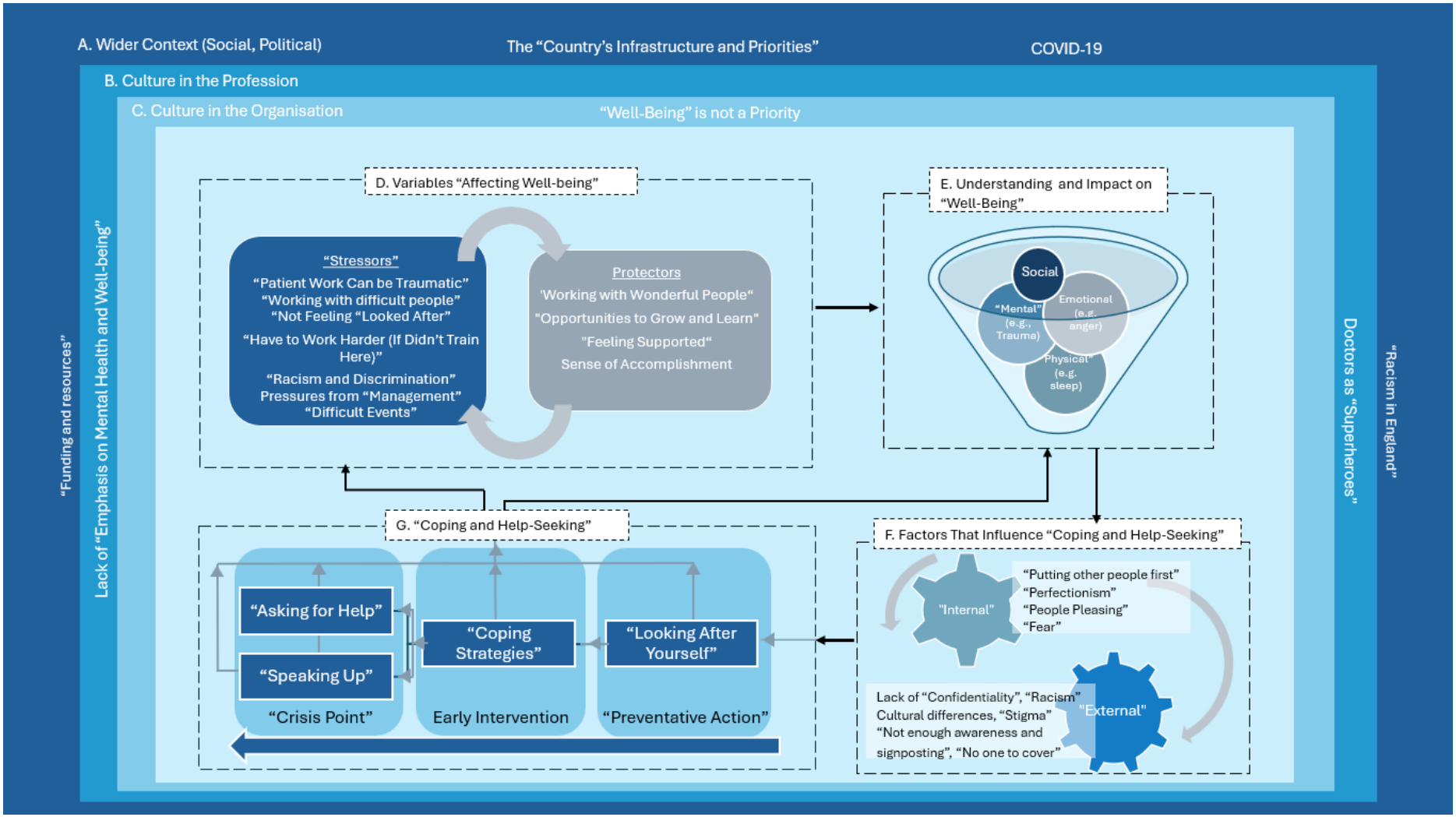
Participants identified that their understanding and experiences of well-being and help-seeking were shaped significantly by the wider social and political context, the role of culture in the organisation and the profession, as well as their upbringing, which included cultural and religious influences.

The impact on participant's well-being was determined by whether the "stressors" identified by participants were balanced by the number and availability of identified "protectors", and was shaped by their understanding of well-being. Participants identified that the perceived impact on their well-being was related to different aspects of their well-being such as mental, physical, emotional and social.

Participants identified that when their well-being was impacted they reported the need to search for and employ various coping and help-seeking strategies. Whether participants engaged in coping and help-seeking behaviours were influenced by "internal" and "external" influences and determined which (if any) strategies they sought out or employed to look after their well-being. Participants identified a hierarchy of "coping and help-seeking" which included preventative, early intervention and "crisis" measures that they have undertaken or would undertake to cope with their well-being at work. Depending on whether participants coping and help-seeking strategies were effective, this in turn influenced the impact on their experiences at work and their well-being.

Figure 3

A diagram summary of the model



Findings

The findings will now be presented as they relate to each category, sub-category and lower-level categories (if relevant). Please note that all in-vivo codes have been presented in quotation marks, and all duplicate words in quotations have been removed for ease of reading.

A. Wider Context (Social, Political)

Participants identified that their understanding and experiences of well-being and help-seeking were significantly shaped by the wider social and political context.

"Country's Infrastructure and Priorities". Two participants spoke about how "every country has its priorities, its way of functioning" (Tribhuvan). Participants compared working in the healthcare system in the UK to working in "lower-middle-income countries" (Tribhuvan). They described how "working in a Western country probably gives you (:) uhh (:) an overview and a different perspective of the same care … And it's probably more protocol based" and "it's got a patient safety at its highest and upmost importance" (Tribhuvan).

"Funding and Resources". Eight participants discussed the impact of "the lack of resources, the financial issues" (Ayesha) on their well-being, such as "putting stress on me" (Ayesha). For example, they discussed how "because people are living longer ... there are more co-morbidities" (Jim), which meant that the "expectation is rising … and that all is putting extra pressure on NHS and to people who are working in it" (Naveen). Participants also spoke about the impact of this on accessing healthcare from the NHS such as "I would have to feel a critical disorder to get to see a physician, and I know that system works this way" (Tribhuvan).

Participants identified the need for "a radical change in the behaviour of the system and organisation" (Naveen), to prevent the "negative impact, including on productivity and

efficiency. If your staff is not happy, I don't think you will get … good amount in return (Naveen).

"COVID-19". Five participants spoke about the impact of the COVID-19 pandemic, for example, participants shared how "I was at the point where I was just going to walk away from the career, because it wasn't worth it anymore" (Jaspreet). One participant shared her experience of joining the NHS as an overseas doctor such as "being in isolation away from the family and being at work which is completely new ... even the medicine and everything" (Pratibha). Participants also acknowledged that "you saw an increase in the amount of support, especially during initial well COVID recovery times. I think a lot of that has fallen away recently" (Jaspreet). Participants also discussed the ongoing impact of COVID-19, for example, "we've seen a lot since COVID. It hasn't made us better human beings. It had to made us worst human beings" (Reena).

"Racism in England". Two participants spoke about "racism in England in the NHS is ... sometimes subtle, sometimes very obvious" (Evelyn), and its role in shaping the "culture in the profession" and the "organisation". For example, "I don't think it will be very easy to manage … at a hospital level or Trust level … It has to come with a societal change" (Nisha).

B. Culture in the Profession

All participants discussed the role of culture in the profession, in the context of their understanding and experiences of well-being, coping and help-seeking. All participants discussed the role of culture in the organisation, for example, how "it is influenced by the workplace culture as well" (Pratibha).

Lack of "Emphasis on Mental Health and Well-Being". Nine participants felt that "well-being and support" were not emphasised in the profession, for example, "I think very early on in my career, if there was more of a focus on that, I think it would have been something that I would have found it easier to carry on throughout my career" (Jaspreet).

Four participants spoke about how “there isn't any (support)”, and “how there is less support available for “senior doctors”, for example, “when you're a junior doctor, speak to a consultant or a colleague who is senior to you and get debriefed. Whereas, consultants you don't” (Evelyn).

Doctors as “Superheroes”. Four participants spoke about “there is a a culture of like thinking about doctors as someone … who can actually manage their own well-being … I think that's the general expectation that doctors will just get on with things and they don't really need support**”** (Nisha). Participants also discussed how “it is still treated as mental health issues are suffered by patients, not by us” (Reena).

C. Culture in the Organisation

All participants discussed the role of culture in the organisation, in the context of their understanding and experiences of well-being, coping and help-seeking. For example, well-being at work “depends significantly on the environment … [which] is created by system and people who work for the organisation” (Naveen).

Well-being is not a Priority. Five participants spoke about how well-being is not prioritised in the NHS, for example, they discussed how “NHS can do better as well, in terms of looking after the employee, which I find astonishing in Western world, 21st-century healthcare, big organisation, but the things what they do for staff is very little” (Naveen). Two participants also discussed how it is not easy to take sick leave, for example, “when I used to fall sick (:) I really had to give so much of an explanation” (Pratibha).

D. Factors Affecting Well-Being

Participants identified a range of factors which posed a risk to their well-being, (i.e. “stressors”), and a range of variables which acted as “protectors” in minimising the impact on their well-being.

"Stressors". This subcategory referred to the "stressors", which participants identified as impacting their well-being.

"Patient Work can be Traumatic". Seven participants discussed the emotional aspect of working with "sick patients". They spoke about how "being a doctor … has an emotional impact … and especially breaking bad news, those are difficult conversations to have" (Pratibha). Participants discussed "deal [ing] with life and death as well. I mean it really takes a toll on the mental health" (Zyra).

"Working With Difficult People". Seven participants spoke about their experiences of "difficult situations with patients, difficult situations with colleagues" (Tribhuvan). For example, "you have to live … with different kinds of personalities" (Jim), which meant that the "stressful aspects of team" work were "when your thoughts don't align and when there are arguments and disagreements" (Tribhuvan).

Not Feeling "Looked After". Seven participants spoke about not feeling "looked after", "supported" or "valued". For example, "I would expect somebody to look after me and those may be very small things, giving me provision for working environment, comfort, time, somebody to ask if there is increasing pressure, resources, parking" (Naveen). Five participants shared how they did not feel valued by others, such as patients, relatives, and managers, for example, they discussed how "we got criticised a lot, blamed a lot, but never thanked" (Evelyn). Two participants spoke about being "where … I've not felt well supported. It's been difficult and challenging" (Jaspreet). Two participants also reported experiences of "bullying", for example, "even in the NHS there are ... people who will talk their way out of bullying and mismanagement of staff" (Evelyn), as well as different forms of "bullying", for example, "it's ethnic minorities in positions of power that are troubling ethnic minorities as well" (Reena).

"Have to Work Harder (If Didn't Train Here)". Four participants spoke about having to "start from another scratch" (Tribhuvan), which led to having to "to work harder " (Sumithra), and "feeling the need to prove yourself" (Nisha). Four participants also spoke about "being away from family" (Pratibha), and having to navigate cultural differences in their places of work, such as "English is not my first language ... when we speak English, we speak very differently from native English people. So, expressing myself can sometimes appear very harsh" (Aysha).

"Racism and Discrimination". Most participants felt like they were treated differently due to their ethnicity, for example, they reported experiences of discrimination (e.g., due to religion), and racism, including racism from patients and systemic racism. Participants explained how "there is an unconscious bias in everyone and the way they view a White doctor is … never the same as they view a different ethnic origin doctor", for example, "whose opinions are going to be taken seriously" (Nisha). Participants also spoke about experiences of racism from patients.

> If you look at the complaints… what GMC comes across for ethnic minority as compared to White people, there is a huge difference, and … if we are all working in the same environment … why there should be a disproportionate complaints against ethnic minority when they all have gone through the same rigorous process of getting degree and experience (Naveen).

Some participants also shared that they did not feel like their ethnicity was not related to the way that they were treated by the organisation, for example,"I do constantly get asked (:) whether you face things like racism and all those things (:) back in England and I've always had to tell them (:) Fortunately, I haven't (:) Okay (:) because it's the way I've-- (:) view the world" (Jim).

Participants also spoke about experiencing and witnessing discrimination, based on religion, gender and national origin. For example, "at work, you can't say that … you're religious … It's it's funny how it gets frowned upon because they think you're into black magic and stuff" (Reena).

Pressures From "Management". Participants who were "senior doctors" spoke about their experiences of "management", whilst at the same time being a manager, "if you're a consultant …, leadership is thrust upon you" (Jim). Participants shared how "we are consultants, but we get dictated to just as much as another person … I don't know how that will ever change, but that would really improve well-being" (Reena). For example, "so, I'm doing a list (for a clinic) … at the beginning of the list I say this list is unrealistic and this is going to overrun and already everybody's put off" (Ayesha). Participants reflected on how clinical work was the "best part" part of their job, and how "the managerial part of my job is the one that is very challenging" (Ayesha).

Difficult Events. Four participants also spoke about difficult events, particularly experiences of loss, both at work, as well as in their personal lives. For example, they shared that "we did have ... two tragedies in our department. Two of our colleagues passed away ... over (the) years" (Ashwini). Participants also shared personal life events, such as bereavement (Reena; Jim).

Protectors. This subcategory addressed factors which served a protective function for the well-being of participants.

"Working With Wonderful People". Ten participants spoke about "the relationships that I've built", and how " that is very good for my well-being" (Ayesha). Participants shared how "it matters if you have colleagues that you can ask for advice, you can ask for help" (Evelyn). Participants valued working in "supportive" and "diverse" teams, for example,

“you would think you're isolated or you don't have any friends at all, but because you see that it's not just you, there's a lot of people who are, as you say, Global Majority” (Zyra).

“Opportunities to Grow and Learn”. Four participants spoke about how “the NHS has given me like an opportunity to train and grow … For example, go to trainings or to study or to mentor” (Zyra). For example, one participant spoke about “being an immigrant in this country, you're getting the first job … was ... a dream” (Jim). Participants discussed “opportunities to grow” concerning “patient work”, such as “you come across lots of … interesting cases, … they stimulate you on a different front” (Jim).

Sense of Accomplishment. Several participants spoke about the sense of achievement, both in the context of “starting from scratch in a new country” (Tribhuvan), as well as being a “team leader” (Evelyn). For example, one participant discussed his experiences of being a mentor, “I do manage to uh, take credit in my own mind for myself” (Tribhuvan).

Feeling “Supported” by the Organisation. Nine participants spoke about how feeling “supported”, for example, “one of the best parts of my unit is we have a well-being team” (Tribhuvan). Participants also identified available support such as “mentorship”, “speaking with seniors”, and “occupational health”. Seven participants discussed how they felt there were “equal opportunities”, in terms of the support that was available for all doctors, including doctors of the Global Majority. For example, “I think it's more of a uniform policy that can be good, because you should treat us all the same” (Jaspreet).

E. Understanding and Impact on Well-Being

The impact on participant’s well-being was determined by whether the “stressors” identified by participants were balanced by the number and availability of identified “protectors”, and was shaped by their understanding of well-being. Participants identified that the perceived impact on their well-being was related to different aspects of their well-being such as mental, physical, emotional and social.

Most participants spoke about how their understanding of well-being was shaped by their "upbringing", which included cultural and religious influences, for example, "we all grow up in a cultural environment … and everything that we do is shaped around that" (Reena). On the other hand, some participants also shared how they did not feel like their ethnicity was fundamental to their understanding of well-being, for example, "I don't think my belief or any other sort of cultural influences has got anything to do with it" (Ashwini), and how they "attach more importance as a person, as a human being, rather than what language I speak" (Jim).

"Mental Well-being". Eleven participants spoke about the role of "mental factors" in their understanding of well-being such as "having your own space and time" (Zyra), and being "not too stressed out or not under stressed (:) no apathy, but still excited about life (Ayesha). Nine participants identified signs that their mental health was being impacted at work such as feeling "anxious" about their work, for example, "catching myself constantly overthinking" (Amrit), and feeling "stressed", for example, "I've gone through work-related stress, and I know the impact it can have on people" (Evelyn)". Several participants spoke about the impact of experiencing racism at work, for example, "when you have the urge to prove yourself because you are ethnic minority … my imposter syndrome was shooting up a lot" (Pratibha). Three participants also spoke about the long-term consequences of impact on "mental well-being" that they have witnessed on the profession, such as "burnout" and in some cases, "suicide".

"Physical Well-being". Ten participants spoke about how their understanding of well-being was shaped by "physical factors", for example, "whether I can look after my body and health, whether I get enough breaks, able to manage something to drink, access to food" is integral to their physical well-being (Naveen). Participants also shared about having time for "working out, exercising, being out in nature" (Jaspreet). Seven participants reflected on

the impact on their health such as “we're all getting exhausted (:) and ... to keep the keep the fire burning … to get things done right. And that that is sort of not there anymore” (Ayesha). Participants identified experiencing “disrupted sleep”, impact on “eating”, “falling ill”, and developing physical health conditions in the long term. For example, participants spoke about how they “have got values, then you end up thinking about it a lot and then … lose sleep over it” (Sumithra).

“Emotional Well-being”. Two participants spoke about how their understanding of well-being was shaped by emotional factors such as “being happy and satisfied with life” (Zyra). Six participants discussed the impact of work “stressors” on their emotional well-being, such as feeling “angry”, “frustrated”, “guilty” or “disheartened”. Three participants also spoke about the impact of their values being at odds with work demands. For example, participants discussed how their work “has to be high quality there. It has to be very safe … So, yes, I get frustrated. I get disappointed and then I get angry” (Ayesha).

Social Well-being. Five participants spoke about how “relationships with other people” (Zyra) were important to their understanding of well-being. For example, participants discussed how “it can be the way your … colleagues, seniors, the juniors, how they treat you and how they interact with you as well … how people respect you” (Zyra). Six participants spoke about how “it's hard not to bring those stresses home” (Jaspreet), and how “family can get the brunt of it” (Evelyn). Participants also discussed how “it just got to a stage where you're snappy and had a couple of complaints. And, then you realise we just keep going until eventually people send you home” (Evelyn). Several participants also discussed the impact of “having to stay extra hours”, such as not having time for your family, for example, “you're just doing one thing after another … and then by the evening and you get home and your children are asleep” (Evelyn). Participants also spoke about the long-term impact, for

example, “I have heard from lots of my seniors that at the time when you retire, people will forget who you are and the people who will remember is your friends and families” (Naveen).

F. Factors That Influence “Coping and Help-Seeking”

Participants identified that when their well-being was impacted (e.g., mental, and physical), they reported the need to search for and employ various coping and help-seeking strategies. Whether participants engaged in coping and help-seeking behaviours were influenced by "internal" and "external” influences and determined which (if any) strategies they sought out or employed to look after their well-being. Some participants felt that their “internal” influences acted as more of a barrier to seeking help, whereas other participants felt that “external” influences were more significant in preventing coping and help-seeking. “Internal” influences were considered to be the individual thoughts, emotions, behaviours, and overall mental processes, which originate from within the person and are contrasted with “external” influences, which were considered to be related to the environment and external experiences.

“Internal” Influences. The most commonly discussed **“**internal influences” were perceptions of “coping and help-seeking”, for example, most participants shared that they “would be very sympathetic if I know that they [other doctors] are undergoing any mental or physical well-being problem and … I will do my best to help them” (Naveen). Participants spoke about how “doctors are human beings too”, and that they “are allowed to feel frustrated and sad, very sad and helpless. And that should be accepted” (Ayesha). Participants also highlighted the need for doctors to “look after” themselves as “the NHS, in the grand scheme of things, is not going to care (:) about you. So, you have to take care of yourself” (Evelyn). Some participants identified how they may have previously held judgemental views of others seeking help, but over time realised that it was a normal reaction to “the lack of resources, the

financial issues", for example, "once you get more experience, I think your understanding about the problem becomes more holistic" (Naveen).

Participants also identified "internal" influences such as how doctors were more likely to "put other people first" (Jaspreet), due to their "own values and beliefs", which were shaped by their "upbringing". For example, participants said, "When I was growing up, I didn't really think about mental well-being … or not even spoken about or discussed among friends or family" (Pratibha). Participants identified how "there will be doctors from the Global Majority who have a different background and maybe a different understanding of what counselling entails and they may view it negatively because of their upbringing" (Jaspreet). Participants shared their own "internal" factors, such as "finding it hard to say no", "people pleasing" (Tribhuvan), and "high productive perfectionism" (Pratibha), which impacted on how they "looked after" their well-being. Four participants also reflected about how doctors may not always have "insight", which can act as a barrier to looking after themselves or seeking help.

Participants also spoke about "fear whether it's real or not", which was the most described barrier to seeking help, for example, fear that "you're going to be labelled as someone who can't cope or deal with things" (Jaspreet), fear that "we will lose our job" and fear "they won't take our problem as serious as (:) because our ethnicity" (Sumithra). Experiences of "fear" were also related to "stigma associated with seeking help", as well as experiences of "racism and discrimination".

"External" Influences. This subcategory was related to the influence of culture in the profession, the organisation, and the NHS context as outlined above. The most recognised "external" influence was the "stigma associated with seeking help". Several participants discussed how "people should understand that they shouldn't be discussing sickness of any kind in the open" (Ayesha), which made it more difficult for doctors to take sick leave when

needed, particularly for mental well-being. Participants also spoke about how “senior doctors” were more likely to hold stigmatising views, for example, “they tell you like you know just get on with it, they don't necessarily understand” (Nisha).

Participants also spoke about additional external influences such as lack of “confidentiality”, impact on salary, inequalities in accessing help, “not enough awareness and signposting” of available support, and lack of understanding from others (e.g., cultural differences, Jaspreet) as well as the impact of issues with “funding and resources” (e.g., “no one to cover”, Naveen). Participants also spoke about how taking sick leave off work increased the pressure on the rest of the team, which then perpetuated the “stigma associated with seeking help”. For example, “that is not often considered with any sort of empathy (:) when they come back, … because the other person's work has been done by the remaining” (Naveen).

All participants emphasised how “there should be really good support system available (:) yeah (:) for doctors from ethnic minority” (Pratibha), and that there should be more signposting to “easily available resources to access” (Reena).

G. “Coping and Help-Seeking”

The “internal” and “external” influences determined which coping and help-seeking strategies were utilised by participants. Participants identified a hierarchy of “coping and help-seeking” which included preventative, early intervention and “crisis” measures that they have undertaken or would undertake to cope with their well-being at work.

“Looking After Yourself”. This subcategory referred to how participants “looked after” themselves daily regardless of the presence of “stressors”. Several participants shared how "doctors are necessarily the best people at looking after themselves (:) just given the nature of the profession" (Jaspreet). Participants who have worked in the NHS for several years were less likely to look after themselves, “if you had a scale of pass and fail, I would

probably fail on all this aspect completely" (Tribhuvan). However, participants reported that well-being became more of a priority over time, for example, "I think I'm more conscious of trying to keep … the well-being" (Nisha). Participants who were new to the NHS reported greater attempts to "look after" their well-being, by "balancing" work and personal lives, through hobbies, leisure, spending time with family, and "connecting with others of the same background". Participants also identified religious practises as a way of looking after their well-being, for example, "praying and scriptures that really play a big part in helping me to … stay happy and contribute to my well-being" (Amrit).

"Coping Strategies". Participants spoke about how they found "healthy ways of navigating" work "stressors" such as "letting out their emotions", and "talking" to colleagues. Some participants discussed coping strategies that they have developed over time such as "you slowly detach yourself from those kind of feelings … and, you do develop some resilience which you need for your work" (Nisha).

"Speaking Up". Participants also shared about how they "spoke up" to raise concerns, for example, "I also say things if they're wrong" (Ayesha), and ask for help at work, for example, "speak with my seniors" (Sumithra). For example, two participants shared that they chose to participate in the study as they wanted to speak up and take action to help support doctors of the Global Majority.

"Asking for Help". Participants shared that when faced with work "stressors", they would "take a break" and "reduce their working hours" in the first instance, for example, "I would consider things like (:) changing shift patterns or reducing the number of hours" (Jim). Several participants also discussed how they would be more likely to "ask for help" from family, for example, "I will try and find solution at my own level or within my circle to see how I deal" (Naveen). Four participants reported that they sought "formal" support, for example through the healthcare system, organisation, or professional body, which included

"therapy" and taking "medication". Most participants reported positive experiences of "asking for help", for example, "I recently started with therapy as well … I think that has hugely impacted on the way I see things and approach in my work" (Pratibha).

Coping and Help-seeking and Well-being

Depending on whether participants coping and help-seeking strategies were effective, this in turn influenced the impact on their experiences at work and their well-being. For example, depending on whether participants felt "supported" and "listened to" when raising concerns, this would lead to improving or harming their well-being, "I've I had some counselling during the COVID period … but that you were limited to six sessions … Which is difficult because if you've started to unpick some issues or anything else you suddenly left to it by yourself" (Jaspreet). Participants also spoke about the impact of their coping strategies on their well-being, "I like balance like I do yoga … I come home and with the family, so it's not affected me yet but I know it can be like " (Sumithra).

Discussion

Model Summary

This study investigated experiences of well-being and help-seeking perspectives among NHS doctors of the Global Majority in Southeast England using a modified grounded theory methodology (Corbin, & Strauss, 2015). A tentative model was developed, which addressed doctors' understanding and experiences of well-being, including stressors and protective factors, as well as coping and help-seeking.

Theoretical Implications

The proposed model suggests that the experiences of doctors of the Global Majority may be similar to those across professions and ethnic groups, as well as highlighting and providing a deeper understanding of insights and relationships which may be unique to those of doctors of the Global Majority.

The proposed model suggests the integration of nuanced and complex experiences faced by doctors of the Global Majority, particularly those who were international doctors, such as being subject to racism and discrimination, feeling the need to prove themselves, being away from support networks, internalised racism and experiencing cultural stigma, whilst managing the stressors faced by doctors such as increased responsibility and expectations to have the answers, the lack of support offered to senior doctors, as well as the wider workplace culture, and social and political context, of lack of funding and resources, and racism in England. Some of the factors have been explored across a range of studies and may be applicable across staff and ethnic groups, and will be highlighted below.

The findings were that experiences of well-being and help-seeking were shaped by the culture in the profession and the culture in the organisation, but this has also been found to be applicable across a range of professions and ethnic groups within the NHS. For example, participants reported that experiences of bullying, and discrimination were a key factor contributing to stress levels, which is consistent with previous findings (West, 2016). The 2023 NHS staff survey showed that 25.78% of staff reported experiences of bullying, harassment, and abuse, and 51.38% reported experiences of discrimination based on their ethnic background (NHS, 2023).

Furthermore, participants also reported experiences of internalised racism, which has been shown to impact access to interpersonal support following incidents, due to impaired cognitive functioning, planning and decision-making in the general population, but has not been found in doctors of the Global Majority, and may apply to healthcare staff of the Global Majority as well (Okolo et al., 2022).

The findings from this study showed that the impact of stressors faced by doctors of the Global Majority were consistent with those identified in prior literature, including across professions and ethnic groups (e.g. stress, and anxiety; Johnson et al., 2022).

Participants reported that doctors who trained overseas found it harder to seek help, and “needed more guidance”, which is consistent with previous findings that the less acculturated an individual is to the dominant culture they live in, the less likely they are to access psychological services, and may be applicable across healthcare staff of the Global Majority (Crawford, 2011). It has also been shown that social and psychological support can act as protective factors for well-being in the context of migration, which was consistent with the findings from this study, and may also apply to other healthcare staff of the Global Majority (Brunnet et al., 2020).

Participants shared that feeling supported and looked after by their organisation was integral to their well-being and likelihood of seeking help, which was consistent with general research on the well-being of doctors, and may be applicable across a range of professions and ethnic groups (Grafton-Clarke et al., 2021). However, the findings showed that doctors of the Global Majority required more support than White doctors, such as through coaching, mentorship and support from management.

Participants identified several barriers to seeking help such as perceived stigma, inaccessibility, cultural differences, and a culture of unrealistic expectations towards doctors, consistent with previous studies (Prajapari & Liebling, 2021; Zaman et al., 2022). The findings also showed that doctors of the Global Majority faced additional barriers to coping and seeking help, with fear being the most commonly cited barrier which was related to workplace culture, as well as racism and discrimination, which has been previously identified in the general population, but not among doctors, including those of the Global Majority (Keating & Robertson, 2004).

Regarding coping and help-seeking, participants identified that they were most likely to act by problem-solving (e.g., reducing working hours), followed by reaching out to support networks, and if none of those strategies resulted in desirable outcomes, then doctors chose to

seek formal help (e.g., counselling), which was consistent with previous findings indicating that doctors only sought help as a last resort, and may apply to doctors from across ethnic groups (Hinsby et al., 2022).

Clinical Implications

The study aimed to get a rich understanding of a small sample of doctors' of the Global Majority experiences using a modified grounded theory methodology (Corbin & Strauss, 2015). This meant that the sample was not representative, but instead offered a tentative model for understanding well-being and help-seeking among doctors of the Global Majority. The understanding that came from the analysis was checked with participants and its utility rested on the value it has had in terms of generating ideas to inform practice and further research.

One critical finding concerned the impact on the well-being of doctors of the Global Majority in the NHS. It has been shown that persistent experiences of distress, if left untreated, can lead to reduced quality of life, as well as disability, and suicide (Andrews & Titov, 2007; Hawton & van Heeringen, 2009). Most participants were not aware of what support was available for doctors, including the NHS Practitioner Health programme which provides a national support service for doctors and dentists. The findings from this study highlighted the need for more awareness and signposting about support services which are available for doctors.

There is an increased acknowledgement that the organisation, design, and management of workplaces play a more significant role in influencing not only the mental health of doctors but also the quality of patient care (De Lange et al., 2020; Dunning et al., 2022; Teoh et al., 2021). These findings showed a greater need for support for senior doctors, and doctors who trained overseas. These findings showed that doctors would benefit from improved working conditions and facilities such as access to free parking, access to hot

drinks and snacks, recognition for their work, prioritisation of well-being during training and in the profession and acknowledgement from the organisation regarding systemic issues and limitations. These findings highlighted the need for holistic integrative care, which is directed toward doctors' multiple needs, including physical, psychological, cultural, environmental, and social aspects.

More broadly, these findings highlight the need for cultural change within healthcare, including shared accountability for addressing bullying and harassment, dismantling systemic discrimination, and promoting cohesion and staff well-being in the workplace (Saad, 2020; Williams, 2022).

Research Implications

The study offers a tentative model for understanding well-being and help-seeking among doctors of the Global Majority, which can be tested with further groups of doctors. Future research should also target a wider spectre of experiences, for example, those who have left the profession, those who were on extended sick leave and those seeking help from secondary or tertiary healthcare services. The sample consisted of predominantly senior doctors (mostly consultants), further research should also investigate experiences of well-being and help-seeking among junior doctors of the Global Majority.

It has been shown that mental and physical well-being is shaped by diverse factors (e.g. migration) and social structures such as gender, nationality, ethnicity, class, and the associated economic and educational privileges (Kapilashrami & Hankivsky, 2018). Further research should explore how intersectionality impacts the well-being and help-seeking of doctors of the Global Majority, whilst contextualising the findings within the structural and systemic barriers specific to marginalised populations, especially in the UK and NHS context.

Strengths and Limitations

The key strength of this study was exploring a pertinent gap in the literature, which provided a focus on the experiences of well-being and help-seeking among doctors of the Global Majority, some of which may be applicable across a range of professions and ethnic groups but have not previously integrated to provide insights and relationships which explain their experiences. This included consideration of factors such as culture, migration, discrimination, racism, resilience, and coping, within the context of the doctor's well-being and help-seeking.

The present study is not without limitations. It is important to note that this study utilised a modified grounded theory methodology, where convenience sampling and data sufficiency were employed, which meant that theoretical saturation could not be achieved (Willig, 2013). This could have introduced bias into the research, as it may have limited the diversity of perspectives and experiences captured in the study (Chiovitti & Piran, 2003). Given that the sample comprised of all Asian doctors (of which 10 were trained overseas and nine of them were women) who worked in the southeast of England, it is important to note that the theory is not likely to be representative of the experiences of all doctors from the Global Majority, such that the model would need to be tested with further groups of doctors.

The sample consisted of predominantly senior doctors, whereas most prior research has sampled medical students and trainee doctors (Kovoor et al., 2022). It is possible that senior doctors who were more established in the profession felt more comfortable speaking up about their experiences, however, those in junior positions may have been worried about career progression and losing their jobs (Hussain et al., 2023). Most participants were women, which could be explained by gender socialisation theory, where it is more acceptable for women to disclose being stressed than men (Mayor, 2015). Most of the participants were Indian or British Indian, which is consistent with the number of Indian doctors in the UK. For

example, 12% of NHS doctors reported an Asian nationality, of which two-thirds were Indian or Pakistani (NHS, 2017). In 2019, more than 20,000 doctors from India were registered to work in the UK, with the expectation of that number increasing (BMJ Careers, 2019).

Another limitation was that feedback on the model summary was only obtained from two participants. Further measures were taken to increase validity, such as consultation with an expert by experience and two supervisors.

Due to the qualitative methodology, it was not possible to isolate the researcher's perspectives, training, knowledge, assumptions, and biases, which in turn was likely to influence how they interacted with participants and interpreted the data (Lincoln & Guba, 2016). Furthermore, due to the limitations of the scope of a doctoral research project, certain adaptations were made to the methodology, such as prior completion of a literature review before data collection, which increased the risk of the influence of previous theoretical constructions on the developing theory (Ramalho et al., 2015).

Conclusions

This study aimed to develop a grounded theory about well-being and help-seeking, among NHS doctors of the Global Majority. A tentative model was developed based on a group of NHS doctors of the Global Majority experiences of well-being, which addressed their understanding and experiences of well-being, including stressors and protective factors, as well as coping and help-seeking. Limitations, implications, and recommendations for future research were discussed, which included how doctors of the Global Majority can be supported by their organisation and professional body.

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KAROLINA KOSYLA BSc Hons MSc

Section C: Appendix of Supporting Material

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

2024

SALOMONS INSTITUTE FOR APPLIED PSYCHOLOGY
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A - NICE Quantitative Tool

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Appendix B – Critical Appraisal Skills Programme (2022) Quality Tool

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Appendix C - University Ethical Approval

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Appendix D – HRA Research Governance Approval

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Appendix E – Trust Capacity and Capability Approval

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Appendix F - Study Recruitment Material

Appendix G - Information Sheet

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Canterbury Christ Church University

Research Project Information Sheet

Title of project:
A grounded theory study about well-being and help-seeking perspectives amongst NHS doctors of the Global Majority

Background Invitation:
We would like to invite you to take part in a research project. Before you decide whether to take part, it is important for you to understand why the project is being completed and what will be involved. Please take time to read the following information. Please contact us if there is anything that is not clear or if you would like more information.

What is the purpose of the project?
Staff well-being has been a topic of interest for the past couple of decades (Loretto et al., 2005). Doctor's well-being is being impacted now more than ever due to multiple stressors (British Medical Association, 2023). The purpose of this project is to explore the well-being and help-seeking perspectives amongst NHS doctors of the Global Majority.

Who is undertaking this project?
This project is being completed by Karolina Kosyla, a Trainee Clinical Psychologist as part of a doctoral thesis at Canterbury Christ Church University (CCCU). This research project is being facilitated by CCCU, and any reference to 'we' in this information sheet refers to CCCU, and not the collaborating NHS trust. This research project has received ethical approval from Salomons Research Ethics Committee approval, HRA Research Governance Approval (IRAS project ID: 324143) and capacity and capability approval from each NHS Trust.

Why have I been invited?
We are interested to hear about NHS doctor's experiences of working in general hospitals in Kent. Therefore, we are inviting all NHS doctors of the Global Majority who are working in general hospitals, and who are currently employed in clinical roles in one of the following four trusts: Medway NHS Foundation Trust, East Kent Hospitals University NHS Foundation Trust, Dartford and Gravesham NHS Trust, and Maidstone and Tunbridge Wells Trust.

Please note that when we use the term Global Majority, we are referring to people who identify as Black, Asian, Brown, dual-heritage, indigenous to the global south, or have been racialised as 'ethnic minorities' (Campbell-Stevens, 2020). Please be aware that this project is being carried out by White researchers.

How can I take part?
If you decide to take part, you will be invited to an online interview approximately 1 hour in duration with the lead researcher. You will also be asked to complete a short survey with demographic questions. If you require any adjustments, please let the researcher know and this can be arranged. During the interview you will be asked about your experiences of working with in general hospitals as an NHS doctor that have impacted on your wellbeing, your experiences and/or views around seeking help in relation to well-being.

What are the benefits of taking part?
By taking part in this study, you can provide valuable feedback about your views around seeking help from mental health services as an NHS doctor of the Global Majority. This will help inform

future research, policies, and improve future support for NHS Doctors. In order to promote well-being, we are also offering a £10 voucher for everyone who takes part in the study, which can be spent on refreshments for your team.

What are the possible disadvantages and risks of taking part?
Please note that due to the sensitive nature of the topic in this study you may find some of the content discussed upsetting. Should this occur, please let the researcher know. If you are receiving therapy or treatment for a mental health problem (e.g., PTSD related to Covid-19), we'd recommend speaking with your healthcare professional, about whether it would be okay to participate in this study. If you think that talking about your experiences of working during in NHS general hospitals, we'd recommend not participating. Finally, please remember that your participation is voluntary, and you can stop the study at any point.

How will we use information about you?
We will need to use information from you for this research project.

This information will include your initials, and a copy of the interview recording. People will use this information to do the research and to make sure that the research is being done properly.

This information will also include your email address. People will use this information to issue an VEX voucher, as part of your compensation for taking part in this study.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure, in line with GPDR guidance.

However, in the unlikely event that any concerns arise during the interview about your safety or the safety of others, the appropriate professionals may need to be notified and information about you may be shared with relevant third parties, in accordance with standard duty of care practise.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.
After completion of the project, anonymised transcripts from interviews will be stored on a password protected and encrypted memory stick stored in the Institute's office in a locked cabinet for 10 years and then destroyed.

What happens to the results of the research project?

- The lead researcher, Karolina Kosyla, will write a report to be submitted to the CCCU exam board as part of their training course
- Anonymised quotes from your interview may be used in write up of the report and/or any future publications
- Results may be published, but without any information that could identify you
- The results can be sent to you if you would like to have them

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Canterbury Christ Church University

What are your choices about how your information is used?
You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

You have the right to withdraw your data up until four weeks after your participation without any negative consequences. This withdrawal will remain anonymous using your unique participant code and pseudonym. You can withdraw by contacting the researcher by email: kk413@canterbury.ac.uk within four weeks of completing this study. You do not have to give a reason for your withdrawal.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet attached with this information sheet
- by asking one of the research team
- by sending an email to **kk413@canterbury.ac.uk**

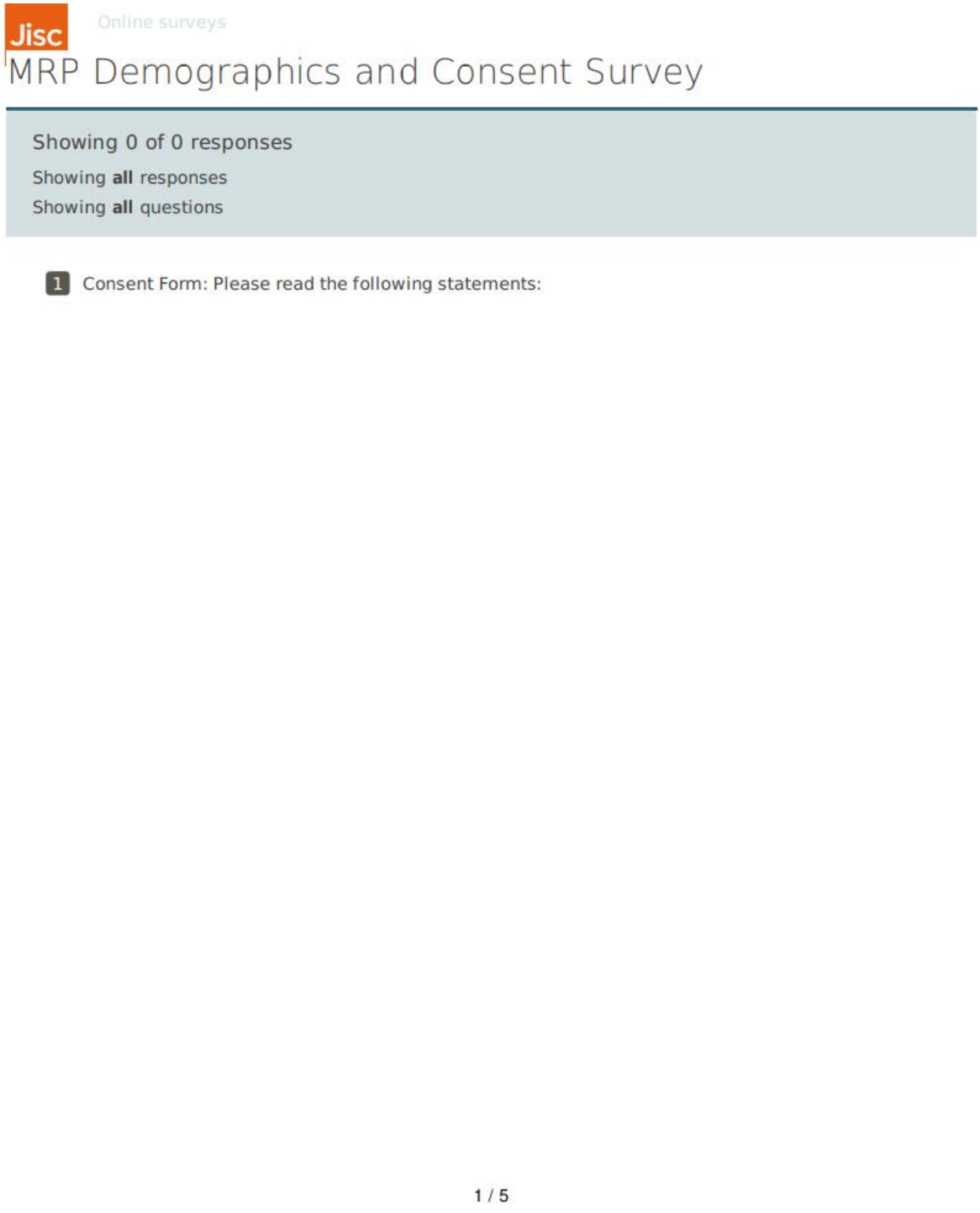
What if I have a concern about this study?
If you have any concerns about this project, you can initially approach the lead researcher, Karolina Kosyla, Trainee Clinical Psychologist, Salomons Institute of Applied Psychology, CCCU, email: kk413@canterbury.ac.uk. Secondly, you may wish to contact the supervisors of this project, Professor (Emeritus) Tony Lavender, Salomons Institute of Applied Psychology, email: tony.lavender@canterbury.ac.uk, or Dr Emma Harding, Consultant Clinical Psychologist, South West London and St George's Mental Health NHS Trust, email: emma.harding@swlstg.nhs.uk. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology at fergal.jones@canterbury.ac.uk.

Contact for further information
For further information about this study, you can scan this QR code to access a webinar about this study.

You can also contact the lead researcher at:
Karolina Kosyla, Trainee Clinical Psychologist, Salomons Institute of Applied Psychology, CCCU, Lucy Fildes Building, 1 Meadow Road, Tunbridge Wells, Kent, TN1 2YG. Email: kk413@canterbury.ac.uk.

Thank you very much for taking an interest in this research project.

Appendix H - Consent Form and Demographic Survey



I have read the information sheet version number X, date Y, and I have had the opportunity to ask questions prior to taking part in the study	0
I consent to taking part in this study	0
I consent to an audio recording being made of this interview, and that this recording will be used confidentially, for the purpose of this research project only	0
I understand that I can withdraw my data from the study up until one month after my interview	0
I consent to anonymised quotes from my interview being used in the write up of the report and any future publications	0
I understand that this recording will remain the property of Canterbury Christ Church University and will be managed in adherence with the General Data Protection Regulations 2016/679 and the Data Protection Act 2018	0
I understand that if any concerns about may rise during the interview about my safety or the safety of others, the appropriate professionals will be notified about this, in accordance with standard duty of care practise.	0

Multi answer: Percentage of respondents who selected each answer option (e.g. 100% would represent that all this question's respondents chose that option)

1.a Full name

No responses

1.b Date

No responses

2 To ensure confidentiality we require you to create a unique participant code consisting of the third letter of your first name, second letter of your surname, and the number month that your primary caregiver was born. So, for example if my name was John Smith and my mother was born in May, the code would be HM05.

No responses

3 What is your current role in the NHS?

No responses

3.a How long have you been in your current role?

No responses

3.b How long have you worked in the NHS?

No responses

4 What is your age? Please note: This question is voluntary.

18-24	0
25-34	0
35-44	0
45-54	0
55-64	0
65 and over	0

5 Which of the following best describes your sexual orientation? Note: This question is voluntary.

Straight/Heterosexual	0
Gay or Lesbian	0
Bisexual	0
Other sexual orientation	0
Other	0

Multi answer: Percentage of respondents who selected each answer option (e.g. 100% would represent that all this question's respondents chose that option)

6 What is your ethnic group? Note: This question is voluntary.

No responses

7 Question: What is your sex? Note: This question is voluntary.

Female	0
Male	0

8 Is your gender the same as the sex you were registered at birth? Note: This question is voluntary. Response options: Yes; No, write in gender

Yes	0
No, please write in	0
Other	0

8.a If you selected Other, please specify:

No responses

9 "What is your religion?"

No religion	0
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	0
Buddhist	0
Hindu	0
Jewish	0
Muslim	0
Sikh	0
Any other religion, please describe	0
Other	0

9.a If you selected Other, please specify:

No responses

Appendix I - Interview Schedules

Interview Schedule – Interviews 1- 5

Ask if they read the information sheet and if they have any questions.

The purpose of this interview is to explore doctors' experiences of well-being and help seeking. This interview will last approximately 60 minutes.

Ask about reasonable adjustments.

Ask if they are comfortable with the term 'global majority'.

Disclaimer about similar questions.

Demographic survey: https://canterbury.onlinesurveys.ac.uk/mrp-demographics-and-consent-survey

We are aware of some of the challenges, which are being faced by doctors right now, and we know that this can be a difficult topic. I would just like to check in with you about how you can look after yourself during and after the interview. Are you happy to continue?

Start recording

Today we would like to ask you some questions about your views on well-being and help-seeking. First, I would like to ask you some questions about your experiences of well-being.

- **What's your understanding of well-being?**

Prompts:

1. What factors do you think are related to well-being?
2. How do you think your own values and beliefs impact on your understanding of well-being?
3. What's your understanding of well-being at work?
4. Can you tell me a bit more about that?
5. How did you feel about that?

According to WHO (2018), one's well-being can be defined as the capacity to understand one's capabilities, manage daily stressors, be productive at work, and make contributions to society. I would like to ask you some questions about your experience of working in NHS general hospitals.

- **How have your experiences of working in NHS general hospitals impacted on your well-being?**

Prompts:

- Issues at work (e.g., sleep, health)
- How do you know when your well-being is being impacted by work?
- Impact on your personal life and relationships? Leisure? Hobbies and interests?
- Have they changed over time?
- Is there anything else you want to add?

Insert segway

- **What do you think you would have found the most helpful when considering seeking support if/when you have felt (very) distressed and concerned about your mental health?**

Prompts:

- Is there anything that would encourage you to speak help if you needed it?
- Do you think there is support available at work?
- Support for people from the global majority
- Adequate support

- Is there anything else you want to add?
- Can you expand on that a little?
- How did you feel about that?

- **Are there any things you've found unhelpful when considering seeking support for your distress/mental health?**

Prompts:

- Barriers or challenges to seeking help?
- Adequate support?
- Can you expand on that a little?
- How did you feel about that?

- **What is your sense of expectations around doctors managing their wellbeing?**

Prompts:

- What are your views on doctors asking for help?
- What would you think of another doctor who was seeking help for mental health?
- Can you expand on that a little?
- How did you feel about that?

- **How do you think other doctors who seek mental help are seen by others?**

Prompts:

- How do you think they are seen by other doctors?
- By colleagues?
- By the general public?
- How do you think doctors of the global majority might be viewed by doctors?
- How do you think doctors of the global majority might be viewed by the general public?
- Can you expand on that a little?
- How did you feel about that?

- **Finally, is there anything else you'd like to tell me that you feel is important to share about your experiences?**

End recording.

Do you have any questions about today's call? Please do not hesitate to contact us if you have any questions about today's interview.

Debrief:

1. Check how participants are feeling
2. Offer debrief with supervisor
3. Collect email address and email written debrief during the call.
4. Check that participant has received the written debrief.

Thank you very much for your time. Your opinions are extremely valuable to us.

Interview Schedule – Interviews 6 - 8

Ask if they read the information sheet and if they have any questions.

The purpose of this interview is to explore doctors' experiences of well-being and help seeking. This interview will last approximately 60 minutes.

Ask about reasonable adjustments.

Ask if they are comfortable with the term 'global majority'.

Disclaimer about similar questions.

Demographic survey: https://canterbury.onlinesurveys.ac.uk/mrp-demographics-and-consent-survey

We are aware of some of the challenges, which are being faced by doctors right now, and we know that this can be a difficult topic. I would just like to check in with you about how you can look after yourself during and after the interview.

Are you happy to continue?

Start recording

Today we would like to ask you some questions about your views on well-being and help-seeking. First, I would like to ask you some questions about your experiences of well-being.

- **What's your understanding of well-being?**

Prompts:

- What factors do you think are related to well-being?
- How do you think your own values and beliefs impact on your understanding of well-being? Are these impacted by your own culture?
- What's your understanding of well-being at work?
- How do you think cultural factors impact on well-being at work?
- How did you feel about that?
- Can you tell me a bit more about that?

According to WHO (2018), one's well-being can be defined as the capacity to understand one's capabilities, manage daily stressors, be productive at work, and make contributions to society. I would like to ask you some questions about your experience of working in NHS general hospitals.

- **How have your experiences of working in NHS general hospitals impacted on your well-being?**

Prompts:

- How has working in the NHS impacted on your mental health/the way that you feel?
- Different domains of well-being (e.g., sleep, health)
- Impact on your personal life and relationships? Leisure? Hobbies and interests?
- How do you know when your well-being is being impacted by work?
- Have they changed over time (e.g. length of time in the NHS)?
- How do you feel about that?
- Is there anything else you want to add?

The next few questions are about managing well-being in the workplace.

- **What do you think you would have found the most helpful when considering seeking support if/when you have felt (very) distressed and concerned about your mental health?**

Prompts:

- Have you previously sought support for your mental health?
- Is there anything that would encourage you to speak help if you needed it?
- How did you feel about that?
- Can you expand on that a little?

- **Are there any things you've found unhelpful when considering seeking support for your distress/mental health?**

Prompts:

- Barriers or challenges to seeking help? Why might it be hard to ask for help?
- Do you think that experiences such as racism and unconscious bias impact on doctors' experiences of seeking help?
- How do you feel about that?
- Can you expand on that a little?
- How did you feel about that?
- Can you give me some examples?

- **What is your sense of expectations around doctors managing their wellbeing?**

Prompts:

- How do you look after your own well-being? How do you cope with difficult life events (at home or work)?
- Do you think there is enough support for doctors in the workplace?
- Do you think there is enough support for doctors of the Global Majority at work?
- What are your views on doctors asking for help?
- What would you think of another doctor who was seeking help for mental health?
- How did you feel about that?
- Can you expand on that a little?

- **Finally, is there anything else you'd like to tell me that you feel is important to share about your experiences?**

End recording.

Do you have any questions about today's call? Please do not hesitate to contact us if you have any questions about today's interview.

Debrief:

- Check how participants are feeling
- Offer debrief with supervisor
- Collect email address and email written debrief during the call.
- Check that participant has received the written debrief.

Thank you very much for your time. Your opinions are extremely valuable to us.

Interview Schedule – Interviews 9 - 13

Ask if they read the information sheet and if they have any questions.

The purpose of this interview is to explore doctors' experiences of well-being and help seeking. This interview will last approximately 60 minutes.

Ask about reasonable adjustments.

Ask if they are comfortable with the term 'global majority'.

Disclaimer about similar questions.

Demographic survey: https://canterbury.onlinesurveys.ac.uk/mrp-demographics-and-consent-survey

We are aware of some of the challenges, which are being faced by doctors right now, and we know that this can be a difficult topic. I would just like to check in with you about how you can look after yourself during and after the interview.

Are you happy to continue?

Start recording

Today we would like to ask you some questions about your views on well-being and help-seeking. First, I would like to ask you some questions about your experiences of well-being.

1. **What's your understanding of well-being?**

Prompts:

1. What factors do you think are related to well-being?
2. What's your understanding of well-being at work?
3. How do you think your own values and beliefs impact on your understanding of well-being? Are these impacted by your own culture?
4. How do you think your own values and beliefs impact on your well-being at work? How do you feel about that?
5. How do you think cultural factors impact on well-being at work?
6. Have your experiences changed over time?
7. How did you feel about that?
8. Can you tell me a bit more about that?

According to WHO (2018), one's well-being can be defined as the capacity to understand one's capabilities, manage daily stressors, be productive at work, and make contributions to society. I would like to ask you some questions about your experience of working in NHS general hospitals.

2. **What are your experiences of working in NHS hospitals? How have they impacted on your wellbeing?**

Prompts:

1. How has working in the NHS impacted on your mental health/the way that you feel?
2. Different domains of well-being (e.g., sleep, health)
3. Impact on your personal life and relationships? Leisure? Hobbies and interests?
4. How has working in teams impacted on your well-being?
5. How do you know when your well-being is being impacted by work?
6. Have they changed over time (e.g. length of time in the NHS)?
7. How do you feel about that?
8. Is there anything else you want to add?

1. **The next few questions are about managing well-being in the workplace.**

Help-seeking

1. Have you previously sought support for your mental health? If yes, what was your experience of seeking help? Did you seek help through work?
2. Would you consider seeking help in the work place? Why? Why not?
3. Is there anything that would make it easier for you to seek help at work?
4. Is there anything that can make it harder for you seek help at work?
5. Do you think workplace culture impacts on seeking help at work? (e.g. team, organisation, profession)?
6. If relevant, have you raised concerns in the workplace? What was your experience?
7. How did you feel about that?
8. Can you expand on that a little?
9. Can you tell me a little bit more about that?

The next question is about how individual doctors might look after their well-being.

2. **How do you know when your well-being is being impacted by work?**

Prompts:

1. How do you look after your own well-being?
2. How do you cope with difficult life events (at home or work)?

3. **What is your sense of expectations around doctors managing their wellbeing?**

Prompts:

3. What are your views on doctors asking for help?
4. What would you think of another doctor who was seeking help for mental health?
5. Do you think there is enough support for doctors in the workplace?
6. Do you think there is enough support for doctors of the Global Majority at work?
7. How do you think doctors of the Global Majority are treated when seeking help?
8. What kind of support do you think would be helpful for doctors at work?
9. How did you feel about that?
10. Can you expand on that a little?

4. **Finally, is there anything else you'd like to tell me that you feel is important to share about your experiences?**

End recording.

Do you have any questions about today's call? Please do not hesitate to contact us if you have any questions about today's interview.

Debrief:

1. Check how participants are feeling
2. Offer debrief with supervisor
3. Collect email address and email written debrief during the call.
4. Check that participant has received the written debrief.

Thank you very much for your time. Your opinions are extremely valuable to us.

Appendix J - Debrief Form

Canterbury Christ Church University

Debrief Form

Title of project: A grounded theory study about help-seeking perspectives amongst NHS doctors of the Global Majority

Thank you very much for your participation in this project. We would like to provide some further information about the purpose of the study.

Doctor's well-being is being impacted now more than ever due to ongoing stressors such as the withdrawal of the United Kingdom from the European Union, the Covid-19 pandemic, industrial strikes action, and cost of living crises (British Medical Association, 2023). However, studies have shown that doctors find it difficult to raise mental health difficulties in the workplace and are unlikely to seek support from psychological services (Hassan Ahmed, White, & Galbraith, 2009), due to perceived stigma and concerns around damage to future career prospects (Chew-Graham, Rogers, & Yasin, 2003). Staff of the Global Majority make up 25.7% of all NHS staff and 49.9% of all community and hospital doctors. Research shows that doctors of the Global Majority are at most risk in terms of their well-being, whilst at the same time the least likely to seek help (The Kings Fund, 2021). Doctors who are of the Global Majority are less likely to access mental health support from the wellbeing hubs (NHS, 2020). To the best of our knowledge, no studies have been conducted looking at the experiences of NHS doctors of the Global Majority. We are interested to hear about the experiences of well-being and help-seeking perspectives amongst NHS doctors of the Global Majority to gain a better understanding of these factors to help inform future support, recommendations, and policies.

We understand the sensitive nature of the topic discussed in the study. If you found any of the content of the study distressing, we would like to offer you an opportunity for a video debrief session with one of the supervisors of this project. To arrange this please contact the researcher at: kk413@canterbury.ac.uk. In addition, please see below local services who provide support for NHS doctors:

BMA offers a counselling service provided through their accredited provider Health Assured - Counselling and peer support for doctors and medical students (bma.org.uk)

A variety of mental health, physical health and financial health resources are available via the East Kent Hospitals University Foundation Trust at - https://meded.ekhuft.nhs.uk/opportunities-and-support/wellbeing/

Please see further information about the term global majority: final-leeds-beckett-1102-global-majority.pdf (leedsbeckett.ac.uk)

If you would like to withdraw your data, please contact the researcher by email: kk413@canterbury.ac.uk within 1 month of completing this study. You will need to quote your unique participant code to withdraw. You do not have to give a reason for your withdrawal.

If you have any queries about this research or would like to ask any further questions, please contact the researcher at kk413@canterbury.ac.uk.

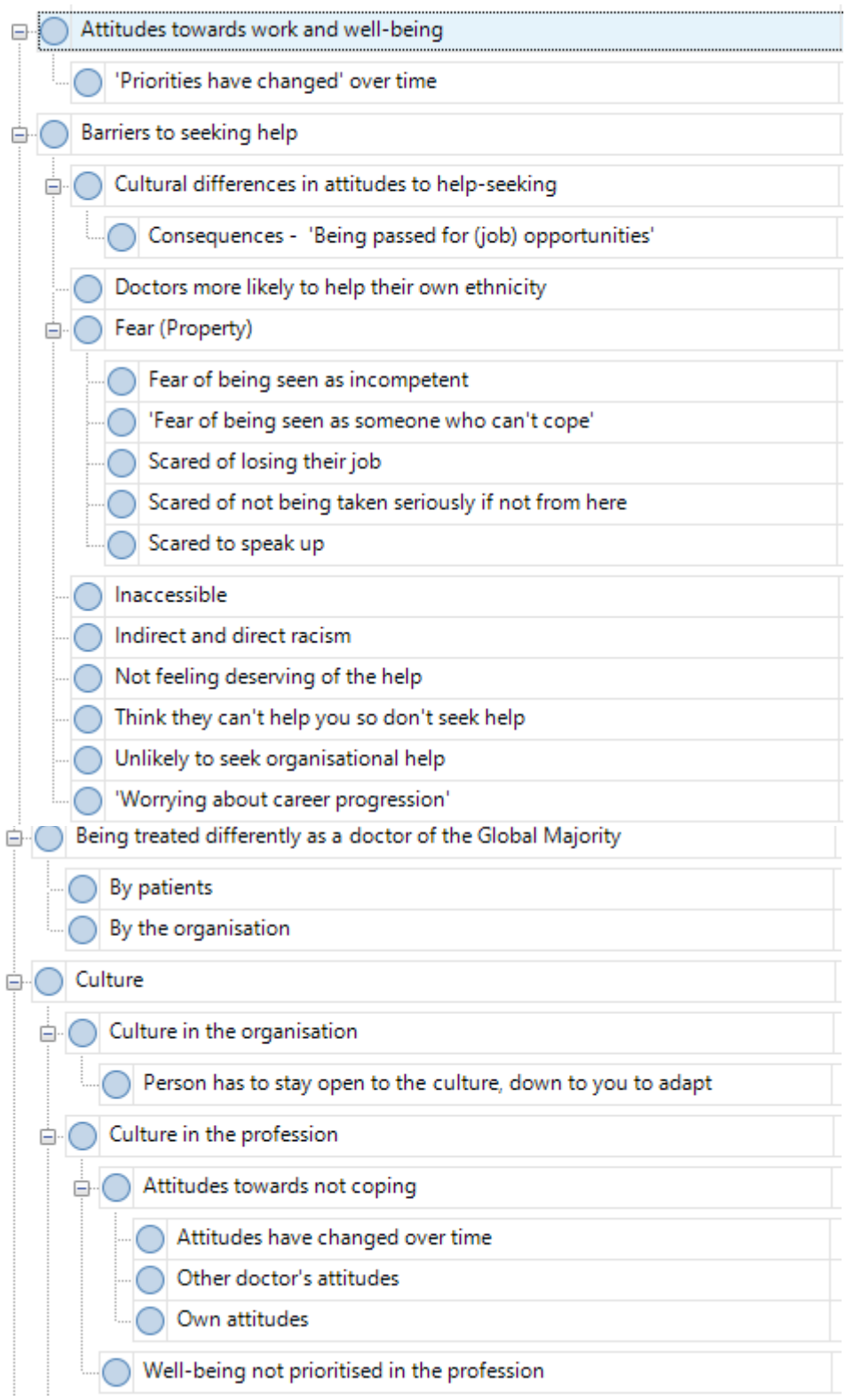
Once again, we would like to thank you for your valuable contribution to this research. Your participation is greatly appreciated.

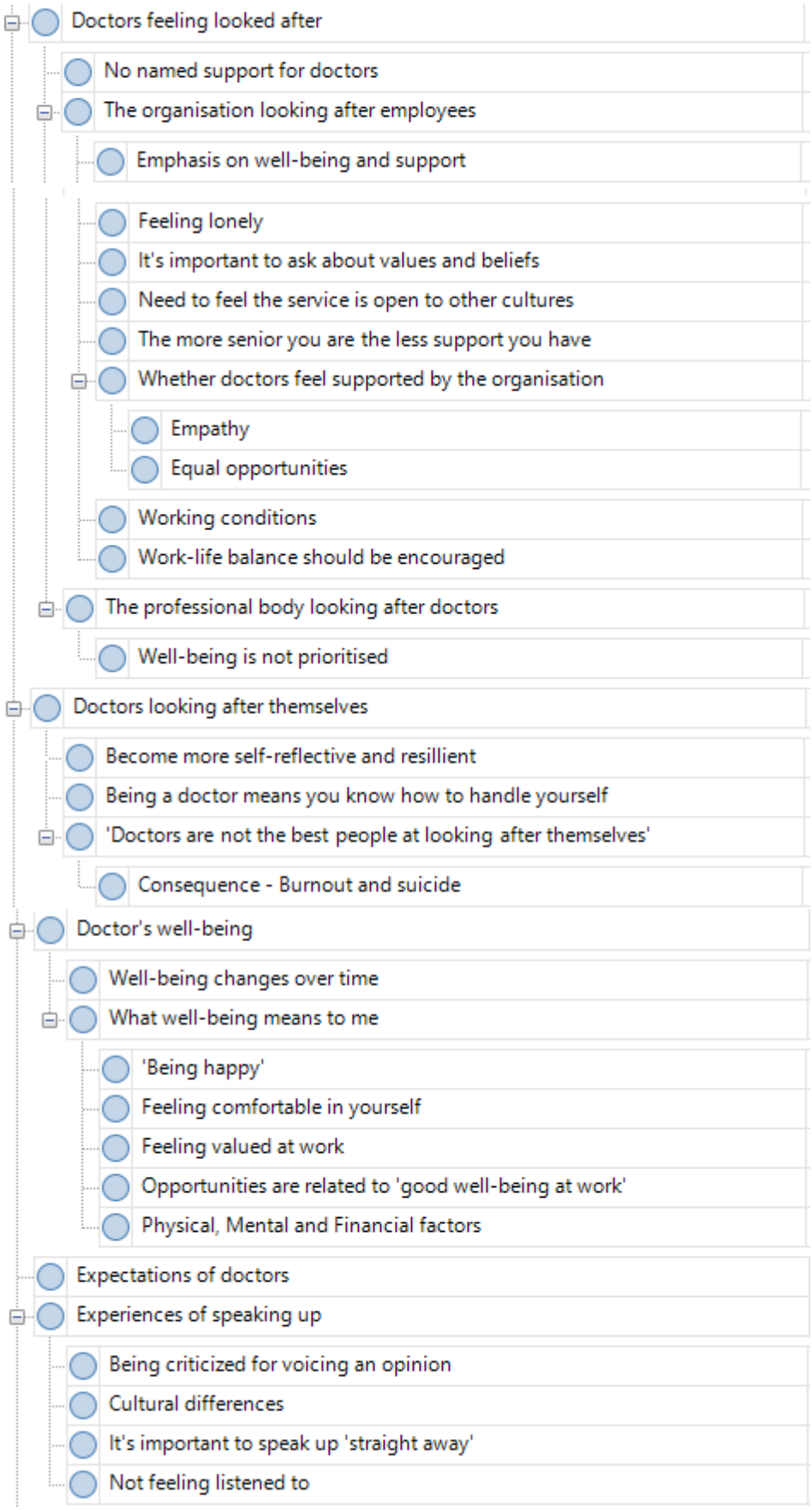
Appendix K– Excerpts from Transcript Open Coding

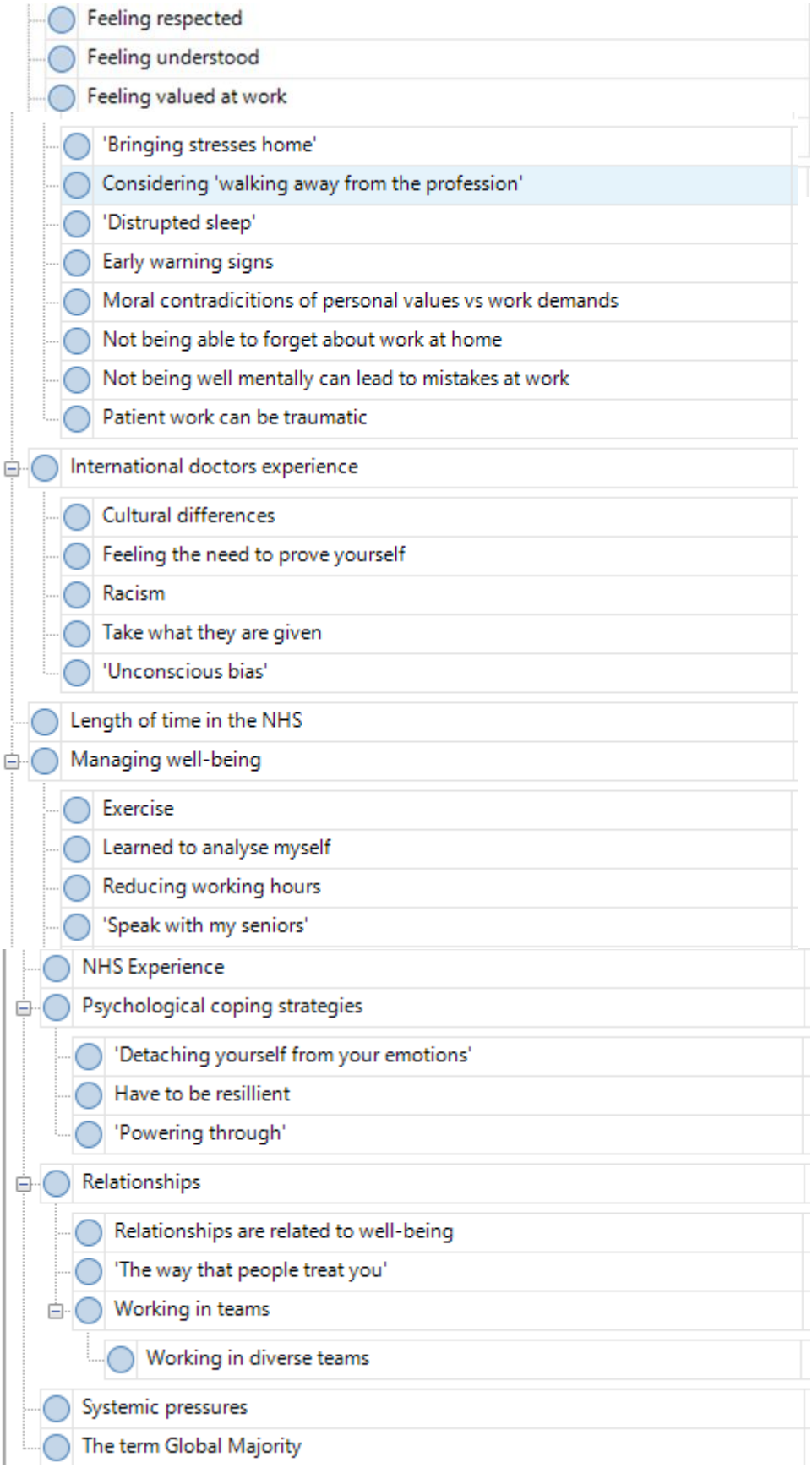
This has been removed from the electronic copy.

Appendix L – Initial Coding Clusters

Tentative and Early Categories Based on Interviews 1- 5




Doctors feeling looked after
No named support for doctors
The organisation looking after employees
Emphasis on well-being and support
Feeling lonely
It's important to ask about values and beliefs
Need to feel the service is open to other cultures
The more senior you are the less support you have
Whether doctors feel supported by the organisation
Empathy
Equal opportunities
Working conditions
Work-life balance should be encouraged
The professional body looking after doctors
Well-being is not prioritised
Doctors looking after themselves
Become more self-reflective and resillient
Being a doctor means you know how to handle yourself
'Doctors are not the best people at looking after themselves'
Consequence - Burnout and suicide
Doctor's well-being
Well-being changes over time
What well-being means to me
'Being happy'
Feeling comfortable in yourself
Feeling valued at work
Opportunities are related to 'good well-being at work'
Physical, Mental and Financial factors
Expectations of doctors
Experiences of speaking up
Being criticized for voicing an opinion
Cultural differences
It's important to speak up 'straight away'
Not feeling listened to


Feeling respected
Feeling understood
Feeling valued at work
'Bringing stresses home'
Considering 'walking away from the profession'
'Distrupted sleep'
Early warning signs
Moral contradicitions of personal values vs work demands
Not being able to forget about work at home
Not being well mentally can lead to mistakes at work
Patient work can be traumatic
International doctors experience
Cultural differences
Feeling the need to prove yourself
Racism
Take what they are given
'Unconscious bias'
Length of time in the NHS
Managing well-being
Exercise
Learned to analyse myself
Reducing working hours
'Speak with my seniors'
NHS Experience
Psychological coping strategies
'Detaching yourself from your emotions'
Have to be resillient
'Powering through'
Relationships
Relationships are related to well-being
'The way that people treat you'
Working in teams
Working in diverse teams
Systemic pressures
The term Global Majority

Appendix M - Abridged Research Diary

24/03/2023
I met with a consultant of respiratory medicine today regarding the potential of him becoming a local collaborator for the project. It was a really interesting meeting, and it was great to speak to someone passionate about research in this area but also has the experience of being a doctor. We spoke about my proposal and my aims and research questions. He commented on the Covid-19 focus and suggested that this was not that relevant to doctors currently as there are a lot of new and emerging issues that doctors are currently facing such as the cost-of-living crises and strikes. In a follow up email he wrote to me " we talked about how much confounded the responses to the questionnaire potentially could be due to the time that has passed since the pandemic and other major factors that have taken over since then, some of which are chronic (clinical resource constraint as above, multiple IT system issues during day-t-day work, industrial action by pretty much all group of staff etc)."

This is something that I've been thinking about a lot, given the length of time that it has been since we started designing this project and the anticipated timeline of write-up and publishing. I am wondering whether it would make more sense to broaden the scope of the MRP to look at staff well-being in general, especially given the current context of the NHS. This would allow for doctors to bring experiences which are most salient to them. I think that discussions around COVID-19 will emerge in interviews, but I'm wondering if it would be more helpful to take more of a holistic approach. I don't think it would require too many amendments to the proposal and ethics application. I have emailed my supervisors who agree about the change, which is a relief.

09/06/23
After doing more research in this area, I have decided to narrow down my aims and research questions even more. As I have done more research, I have become interested in the idea of help-seeking. Research shows that doctors are less likely to seek help, and I am intrigued to find out more about this. I can see some research has been completed on doctors in general. I can also see that some groups of doctors are even less likely to seek help (e.g., from well-being hubs), such as those from 'Black, Asian and Minority Ethnic' backgrounds. I can't see much research in this area, and I would like to narrow down my focus to explore the experiences of these doctors specifically. I am passionate about supporting and advocating for underrepresented groups, so this direction fits well with my ethos and values. However, as a White researcher with two White supervisors I am also worried that due to my own biases, I may miss or not be able to capture the experiences of people who are underrepresented in terms of ethnicity in the UK. I am also worried that participants won't feel comfortable sharing or discussing certain experiences with a White researcher. However, I feel like this is an important topic, and I wouldn't want the pressure of these types of projects falling to researchers who are marginalised. To help minimise any biases, I am going to recruit an expert by experience to consult on the project.

I have discussed it with my supervisors and submitted my amendment, which has been approved. This means that I can proceed with NHS ethics, which is a huge relief.

25/10/23
I have completed the first few interviews. I have been positively surprised by how many people have reached out to take part based on the advertisement materials. I feel like the interviews have gone really well, and that participants have been really open and shared a lot of their experiences. A lot of

participants have shared how passionate they are about their experiences, and how they are pleased that this project is being completed, which has been helpful to hear that it feels important and relevant to doctors of the Global Majority. Participants have also felt comfortable sharing their experiences of racism and discrimination, which shows an element of trust between us. I am hopeful that I can capture these experiences accurately in my write-up.

I am starting to analyse the first few interviews, but I am finding it quite difficult to get into the data being on placement and working on my Part A. I am listening back to the interviews on my way to and back from placement, which is helping with familiarisation of data, but I am finding it difficult to fully immerse myself in the data to be able to hold in mind an overview of all experiences which are emerging.

05/10/23
I have finally received full ethical approval for my study, Salomons, HRA and capacity and capability approval from several Trusts. It has been such a long progress, but I have learnt a lot about doing research in the NHS, and I feel much better equipped if I were to complete the process again. It has been frustrating going through the process and having to rely on local collaborators, and ethical panels to be able to proceed with my project. It has been a weird experience to not be in control of the process, but I have learned about how to navigate these types of situations in the future. I wish I started chasing people sooner and prioritised sending things off, as I didn't know how long it would take for people to get back to me. It has also been so long since I wrote my proposal and consulted doctors about the project, that I have had to find new local collaborators as the previous ones had left their roles or could no longer commit to the project.

09/10/23
We also spoke about language and terminology and considered limitations of the use of terms such as 'Global Majority'. We considered alternative terms such as 'racially marginalised' with is commonly used in psychology. Our EBE suggested that this is rarely used in medicine and is considered by doctors to have more negative connotations. We decided to continue using 'Global Majority' for our next round of interviews. We spoke about how we can make it a bit clearer what we mean by this term, as well as the limitations of the term in the advertisement materials.

30/11/23
I wasn't sure how many interviews to complete in the first phase of data collection. I wanted to allow for a range and depth of concepts to give me a clear sense of direction about where to go next with the data collection and data analysis. The number of interviews was also based on feasibility based on interest from potential participants. I didn't want to turn people down or postpone interviews in case participants changed their minds and no longer wanted to participate. However, as I started to complete each interview in turn, I noticed emerging themes which were coming up in multiple interviews, and I found that I naturally started to adapt the questions and prompts between each interview.

After the first phase of interviews, I wondered whether my initial topic area was too broad, and would reveal so many concepts, which would be unmanageable for me to process, and analyse. I also worried about how by starting with a broad area I wouldn't be able to reach the amount of depth for the data to be meaningful. I wondered whether it would be helpful to narrow it down into just well-being or just help-seeking or another area which emerged from the first round of interviews (e.g., coping).

I wondered about the relationships between the emerging concepts. I drafted out some initial diagrams to explain the relationships between the emerging concepts. For example, I noticed patterns of the process of help-seeking, such as help-seeking need > help-seeking ideation > help-seeking intention > help-seeking behaviour > and help-seeking outcomes. However, I found that this was a reductionist way of looking at the data, and it did not allow space for the processes, context, and relationships between concepts. For example, concepts may appear across these separate categories.

I considered the context of the emerging concepts. I drew on the ecological model to think about individual, team, community, organisational and societal factors. I wondered how I could integrate them into the theory. As a novice analyst, I wondered about how that would fit into the emerging theory later on in the analysis.

07/12/23
I met with our expert by experience to discuss emerging concepts from the first round of interviews (5 in total). We spoke about some of the lesser concepts, which have emerged based on the first round of interviews. We spoke about how the initial interviews elicited numerous concepts related to help-seeking. We spoke about how despite balanced questions, the interviews elicited predominantly challenges and concerns, as opposed to facilitators or sources of support. Our EBE highlighted how due to the inductive nature of our methodology, this could be important information about our participants' experiences. We spoke about the findings were 'grounded' in the data and gave us an indication of what might feel most salient to participants. For example, if positive experiences are not being identified by participants, then it could be because they are not relevant. This could also be an example of negativity bias.

During interviews, we checked out our terminology with participants. Most participants expressed that they did not mind the terminology we have chosen (e.g., Global majority), but also did not mind other commonly used terms such as 'black and minority ethnic' or 'BAME'. One participant expressed that they did not like any term. We had an interesting conversation about the limitations of the term, but also acknowledged the language of doing research without using labels.

We discussed concepts which have come up in multiple interviews, and considered which ones we might be important to develop further in our next round of interviews. For example, we spoke about how religion did not come up during phase 1 of the interviews, but all participants indicated as being religious in the demographic questions. The expert by experience felt like religion was important to them concerning help-seeking, but they acknowledged that they wouldn't have considered speaking about this in the interview. Therefore, we decided to add it to the interview.

09/02/24
I am relieved to say that I have finished my phase 2 of data collection. I feel like the last 3 interviews have gone really well, and I feel like I have been able to elicit in-depth experiences from my participants, which have allowed me to saturate existing concepts through development of properties and dimensions. I have also been able to start to develop relationship between concepts, by identifying action-interactions amongst them. I have also started to be more curious about the context (e.g., family, team, organisational, societal), as well as the consequences of the action-interactions between concepts. I have made changes to the interview schedule, where I have been able to devise open-ended questions to target these areas, which I feel like is something that I have struggled with at the end of phase 1. I have a better understanding now of the analysis method

(open coding and axial coding), as well as about process and context, which has given me a sense of direction for my next round of interviews. I am curious to find out what I will discover.
So far, participant 8 was the fifth consultant doctor that I interviewed, and two doctors were in senior positions supervising junior staff. I find it interesting that my study had a self-selection sample of consultant doctors, as I would have assumed that those would have been the hardest to reach. I am interested to hear from more consultant doctors, but I would also like to recruit doctors across grades to provide greater variation, to reach concept saturation.

Although it is too soon to think about a core category, I can see an overarching theme/category emerging of 'culture' which links to the culture in the profession, culture in the workplace, team culture, individual culture etc. At the moment, I have gathered data about the "culture in the organisation", and the "culture in the profession". We also have the concept of "family culture" evolving, where doctor's upbringing impacts their experiences at work, and they may not feel like they fit in or are understood by colleagues.

19/03/24
I've been thinking a lot lately about the emerging central notion of the study. The main theme that kept coming back to me throughout the analysis was “culture”. My original research questions set out to investigate doctor's experiences of working in the NHS, with a focus of their well-being and perceived experiences of help-seeking. Throughout the data collection and analysis process, the theme of "culture" emerged from participant's responses, initially in the context of workplace culture (in the organisation, in the profession), but also in the context of doctor's family culture, and then more widely societal culture. Participants continually returned to the idea of culture when discussing emerging categories such as impact on well-being, whether doctors feel looked after by their organisation, and relationships, which are integral to the well-being and help-seeking process. After re-reading all the memos and reviewing all the codes I have started to map out an initial process and context. I can see the overarching categories emerging such as doctor’s well-being, stressors which impact on doctor's well-being, which subsequently leads to the impact on doctor’s well-being. Based on the level of the impact on doctor’s well-being, this leads to a contemplation stage where doctors ‘think about seeking help’. Based on the emerging data from interviews, I can see that whether doctors seek help or how they cope depends on the presence of barriers to seeking help. I can see that those doctors who didn’t seek help were likely to rely on their own coping strategies such as ‘powering through’ or “detaching themselves from their emotions”. If doctors do decide to seek help, they are most likely to seek informal support initially such as relying on support networks or reducing their working hours. Some doctors sought formal support such from the organisation, professional body or healthcare services.

05/04/24
I met with my supervisor to discuss the preliminary model summary, which included analysis using selective coding. We discussed the theory together, and it was really helpful to be able to brainstorm together. I really appreciated how she was able to be inquisitive, and creative and we were able to join forces and consider whether the data was fully captured in the theory. For example, it was interesting to discuss how we could capture the dominant narratives within categories within the diagram. For example, for “understanding well-being" making the circles bigger for those factors e.g. physical that were more salient for participants over other factors such as “financial”.
We also spoke about the “coping” category, and different conceptualisations of the subcategories that have emerged from the data. My supervisor suggested for me to think about intended outcomes and consequences, as a way of thinking about the categories. I think this is a helpful way

of making sense of the data, which can be interpreted in several different ways. The analysis and diagram are starting to come together.

10/04/24
Following meeting with my supervisors to discuss the preliminary model of my theory, I have gone back to re-read all of my theoretical memos to develop my thinking process. I have managed to do this in a couple of days, which has allowed me to fully immerse myself in the data, and be able to hold it all in mind as I prepare to write a draft of my results section and review my diagrammatic model. I keep coming back to the central idea of culture – culture in the profession, culture in the organisation and the doctor's individual culture. I feel like these themes are integral at every stage of the well-being and help-seeking process. I have wondered what is the best way of integrating this into the theory. Initially, I thought that I would discuss the culture at each stage, but I think it makes more sense to have "culture in the profession", and "culture in the organisation" as separate subcategories and discuss them in depth as part of the context for the well-being and help-seeking process. The category of context has also emerged as very significant concerning doctors' experiences, and I think will allow me to situate the experiences of doctors to a particular situation and context.

I guess there are running themes of "doctors are not the best people at looking after themselves" and "being a doctor means you can handle yourself". Firstly, "doctors are not the best people at looking after themselves", which relates to doctor's individual upbringing, which in turn is influenced by family culture, and shapes their understanding of well-being and coping mechanisms. Secondly, "being a doctor means you are able to handle yourself", which is reflective of the assumptions and expectations that others have of doctors as "superheroes", which doctors have experienced as the "culture in the profession". In the background, doctors experience a range of stressors and have access to a range of protective factors which mitigate the impact on their well-being. Doctors who have trained overseas experience additional stressors such as "navigating a new system", "feeling the need to prove yourself", and "imposter syndrome".

I can also see a crucial element, which I haven't put much attention to in the earlier version of the diagram. Perhaps, this was because it felt too complicated, as there were too many possible pathways or processes to map out clearly. However, I think there is a theme of "consequences" or "outcomes" of coping processes and seeking help.

16/04/24
I have sent out my feedback to participants a couple of weeks ago. One person replied straight away to say that the model described his experiences perfectly, which was very reassuring. However, I haven't heard back from anyone. I know that doctors are very much under pressure at the moment. However, participants spoke about how they were interested in this research area and how they would like to be involved in the research process, so I was hoping to get more feedback from participants, even if it is brief. After sending out reminders, I received feedback from one more participant which was a bit more constructive, and I have been able to incorporate it into the diagram and write-up of the results section. However, I am disappointed that I haven't received feedback from more participants.

19/04/24
I met with my supervisors today to discuss the feedback from my draft of the report. It was a thought-provoking and interesting meeting. They give me a lot of theoretical and practical feedback,

which I have started to incorporate into the final report. It is challenging to fit into the word count, as I think that this is an important topic which deserves a lot more consideration, detail in the results section and more attention to the implications, which I am finding hard to fit in. I am trying to prioritise the key themes and messages that kept coming up, but I feel like I haven't been able to pay as much attention to coping and help-seeking as I would have wanted.

Appendix N - Example Theoretical Memos

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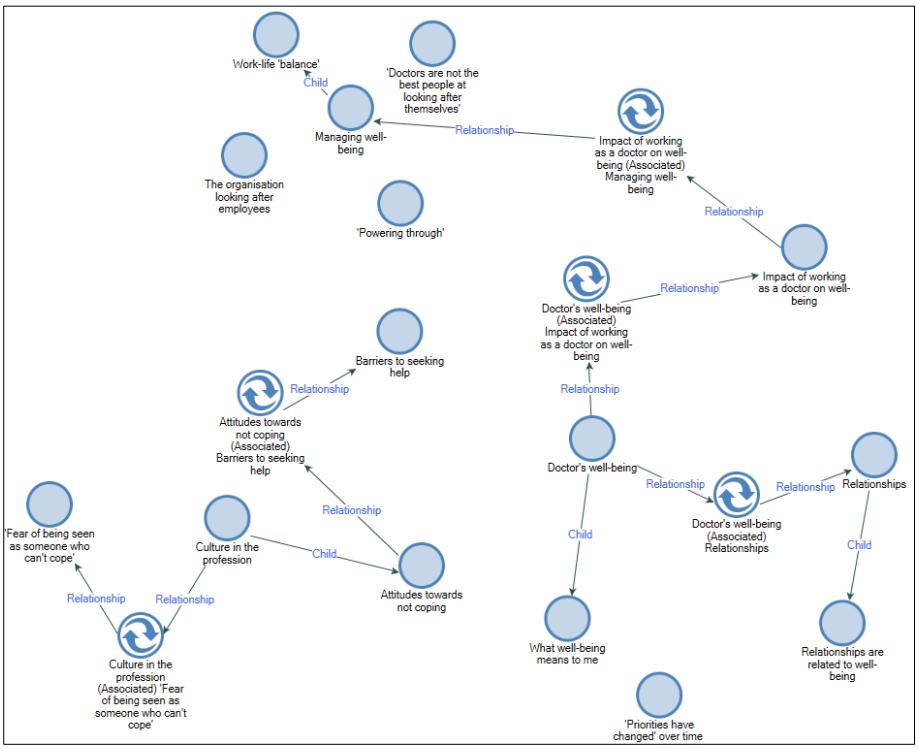
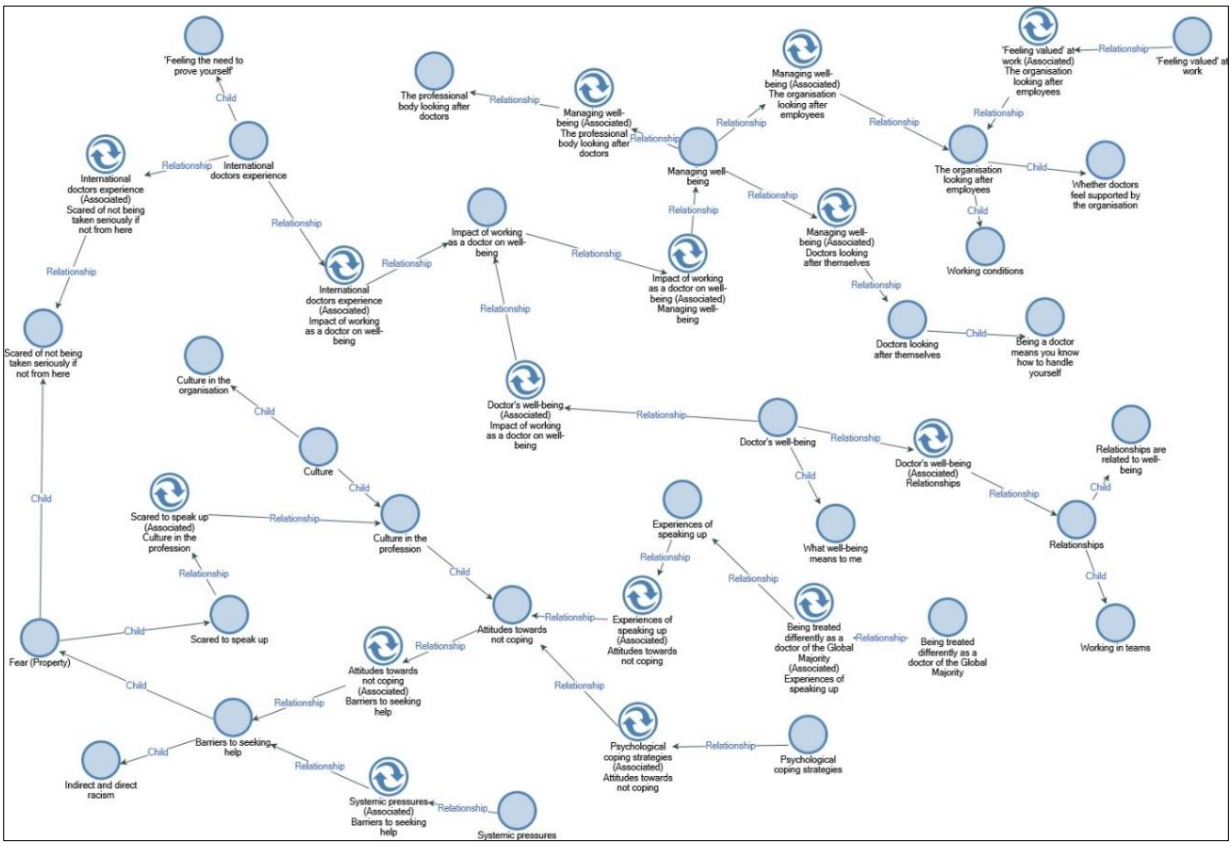
Appendix O - Diagram Examples of Model Development, Codes, and Categories

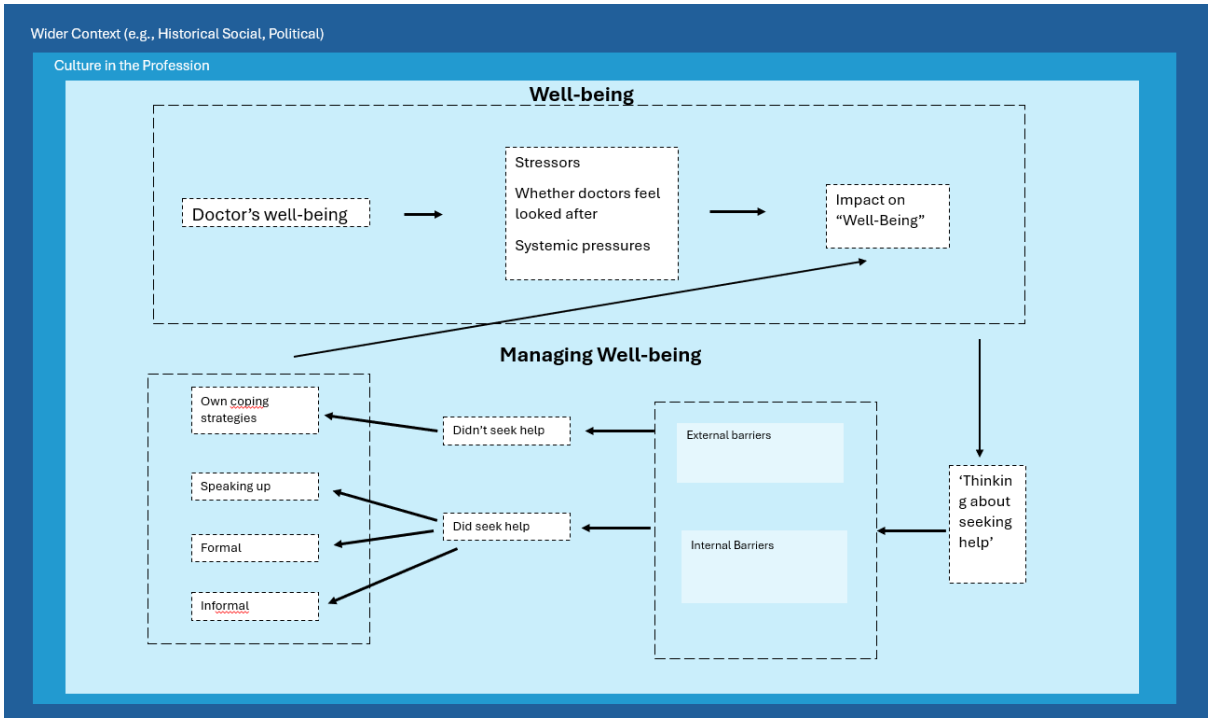
14.11.23



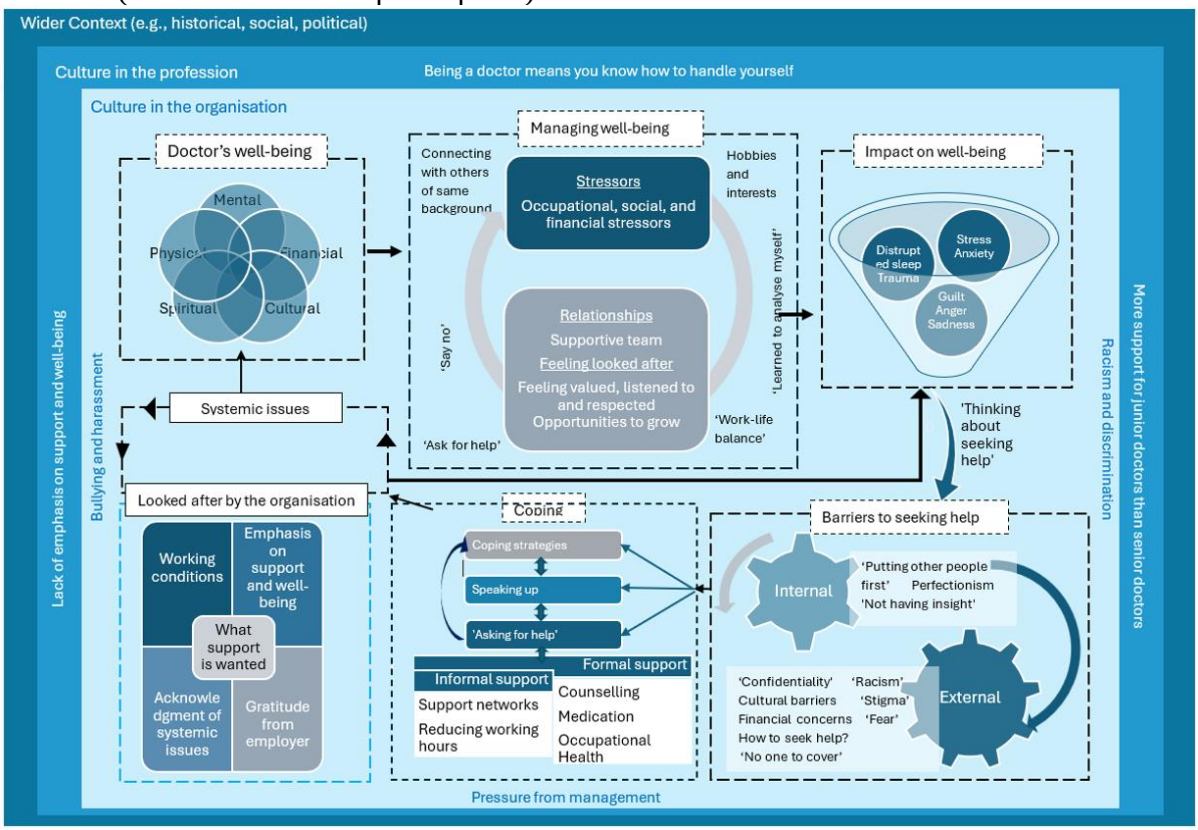
04.12.22



21.03.24



04.04.24 (Model shared with participants)



Appendix P - Model Summary and Feedback Sent to Participants

Email to participants:

"Dear Dr XXXXXXX,

Thank you very much for taking part in the project: A grounded theory study about help-seeking perspectives amongst NHS doctors of the Global Majority.

As part of our data analysis process, we would like to invite you to share feedback about the emerging grounded theory. Please find attached a preliminary model summary.

We hope to hear from by the 16th of April 2024. Please could you return your feedback via email. If you would like to discuss the results of the study further, please do not hesitate to contact me. Please note that feedback is **optional.**

We would like to remind you that all participant data is confidential and that any reference to individual participants in the write-up will be using selected pseudonyms. If you have a preference regarding which pseudonym will be selected for you, please let me know via email.

Once again, thank you very much for taking part in this study. Your opinions are extremely valuable to us.

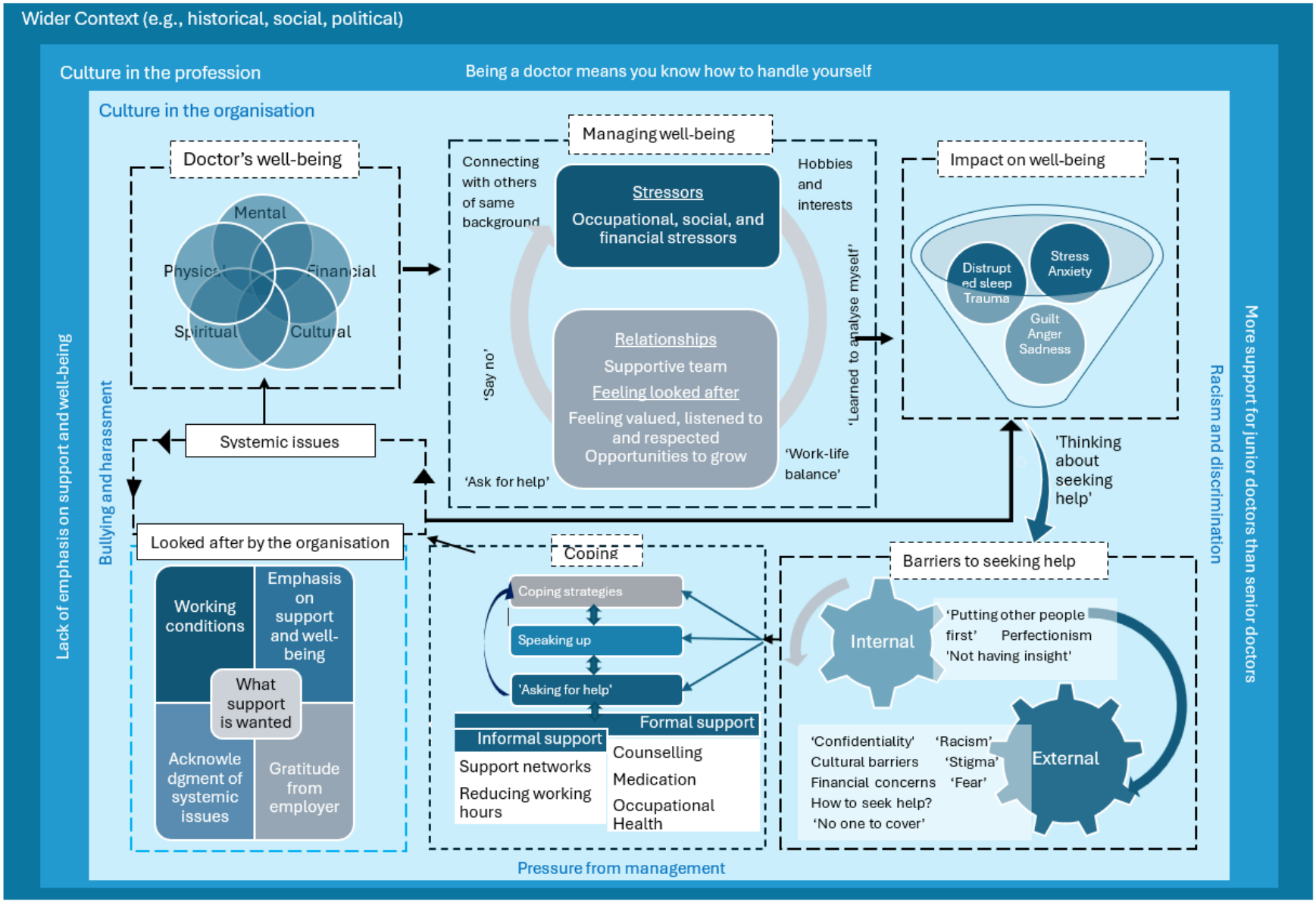
We will be in touch again with the complete findings from the study.

Kind regards,

Karolina

Karolina Kosyla (She/Her)
Trainee Clinical Psychologist

Salomons Institute of Applied Psychology
Canterbury Christ Church University
Lucy Fildes Building
1 Meadow Rd
Tunbridge Wells
TN1 2YG"


Wider Context (e.g., historical, social, political)
Culture in the profession
Being a doctor means you know how to handle yourself
Culture in the organisation
Lack of emphasis on support and well-being
Bullying and harassment
More support for junior doctors than senior doctors
Racism and discrimination
Doctor's well-being
Mental
Physical
Financial
Spiritual
Cultural
Systemic issues
Looked after by the organisation
Working conditions
Emphasis on support and well-being
What support is wanted
Acknowledgment of systemic issues
Gratitude from employer
Managing well-being
Connecting with others of same background
Hobbies and interests
Stressors
Occupational, social, and financial stressors
'Say no'
'Learned to analyse myself'
Relationships
Supportive team
Feeling looked after
Feeling valued, listened to and respected
Opportunities to grow
'Ask for help'
'Work-life balance'
Impact on well-being
Distrupted sleep Trauma
Stress Anxiety
Guilt Anger Sadness
'Thinking about seeking help'
Coping
Coping strategies
Speaking up
'Asking for help'
Informal support
Support networks
Reducing working hours
Formal support
Counselling
Medication
Occupational Health
Barriers to seeking help
Internal
'Putting other people first'
Perfectionism
'Not having insight'
External
'Confidentiality'
'Racism'
Cultural barriers
'Stigma'
Financial concerns
'Fear'
How to seek help?
'No one to cover'
Pressure from management

Overview

We interviewed 13 doctors from across the four Acute Trusts in Kent between October 2023 and March 2024. All doctors identified as either Asian or British Asian. Most doctors (n = 11) who participated in the study were employed in senior positions in the NHS.

Well-being

We found that the concept of "well-being" was defined by several physical, mental, emotional, spiritual, and financial factors, and was influenced by the doctor's own beliefs and values. We also found that in most cases this was highly influenced by the doctor's upbringing, which included familial, cultural, and religious values.

According to our analysis, doctors were faced with extreme pressures and demands, which greatly affected their well-being. We found that doctors reported several occupational, social, and financial stressors, as well as experiences of racism and discrimination in the workplace. For example, doctors reported poor working conditions and shift patterns, emotional demands of patient work, and working with "difficult people". We found that most doctors felt like they were treated differently due to their Asian heritage, and reported experiences of discrimination (e.g., due to religion), and racism, for example, increased complaints from patients, and less likely to be hired for a job. However, we also found that some doctors did not feel like their heritage was fundamental in their experiences of well-being and the way that they were treated by the organisation, and they placed greater emphasis on their individual values and beliefs as key factors contributing to their experiences.

In terms of experiences of working in the NHS, we found that doctors, particularly junior doctors, or doctors who recently joined the NHS, reported positive experiences such as "feeling supported" and "having opportunities to grow". We also found that junior doctors faced additional challenges related to their training, such as settling into new job roles, whereas senior doctors had to balance additional demands such as "being a team leader", and "management interference". We also found that international doctors faced additional challenges such as “being away from support networks”, "not feeling deserving of help", and "having to adapt to a new system and culture".

We found that one of the key concepts related to doctor's well-being was whether doctors felt looked after and supported by their organisation. Doctors consistently reported that there is not a lot of emphasis on well-being and support throughout training and development in the role of a doctor, and that work-life balance does not tend to be encouraged. We found that a lot of doctors did not feel valued, respected, or listened to in the workplace.

We also found that relationships were integral to doctor's experiences of well-being. We found that doctors valued working in “supportive” and “diverse” teams. This was important for all doctors, including both junior and senior doctors.

In our interviews, we found that doctors "managed their well-being" by prioritising work-life balance, including hobbies and interests and spending time with friends and family, becoming more self-aware and assertive, asking for help, and connecting with others of the same background.

Impact on well-being

We found that working as a doctor in the NHS had a significant impact on doctor's well-being. We also found that doctors recognised early signs of the impact on their well-being such as "bringing stressors home", feeling irritable, and impact on their relationships at work and outside of work. We found that being a doctor is a "stressful job", for example, "patient work can be traumatic" which can impact on doctor's well-being such as "disrupted sleep", "anxiety, “stress”, "not being able to forget about work at home", as well as feelings of “guilt”, “anger”, and “frustration”. Regarding experiences at work, we found that some

doctors felt like their personal values were at odds with work demands, which impacted their well-being. We found that some doctors reported feeling the need to prove themselves and were scared to speak up due to their ethnicity.

Attitudes towards well-being and help-seeking

According to our analysis, we found that spoke about attitudes towards not coping, for example, how doctors are expected to be "resilient" and “know how to handle themselves”. We found that "well-being is not prioritised in the profession", and that senior doctors are more likely to hold stigmatising views of those who seek help. We also found that doctors may initially hold judgemental views of others seeking help, but over time realised that it is a normal reaction to the demands of working in the NHS.

We also found that all doctors had positive views of doctors asking for help. We found that there should be more emphasis that “doctors are human beings too”, and that difficult emotions and experiences at work should be normalised.

Barriers to seeking help

Our data showed that most doctors felt that "doctors are not the best people at looking after themselves". We found that "barriers to seeking help" were related to both "external" and "internal factors". "External" factors were related to culture in the profession and the organisation, and systemic pressures. We found that ‘fear’ was the most described barrier to seeking help, for example, “fear of being seen as someone who can’t cope”, “fear of losing their job’ and “fear of not being seen as competent”. According to our interviews, doctors reported several barriers to seeking help such as 'lack of confidentiality', financial pressures, cultural differences, “racism”, “stigma”, and “not enough awareness and signposting” of available support, indicating a lack of trust (e.g., ‘confidentiality’) and understanding from others (e.g., cultural barriers) as well as impact of wider systemic issues (e.g., ‘no one to cover’).

We also found that "internal factors" were a barrier to seeking help, such as doctor's "own values and beliefs", which were shaped by their “upbringing". Therefore, we found that doctors were more likely to put other people first, have high standards for their work (e.g., strive for perfectionism), found it hard to say no, less likely to have insight into their difficulties, which was at a cost to their well-being.

Coping and seeking help

We found that doctors developed various coping strategies in the face of adversity in the workplace. For example, we found that some doctors coped with occupational and social stressors by ‘powering through’ and “detaching themselves from their emotions”. Some doctors also reported “letting out their emotions”, and “talking” to colleagues as helpful ways of coping with difficult situations at work, for example, experiences of racism or difficult cases with patients.

In addition, we found that doctors were most likely to consider reducing working hours and seeking support from support networks as a first point of help.

Our analysis also showed that doctor’s well-being changed over time and that doctors were more likely to speak up at work, especially the longer they worked in the NHS. We found that some doctors did not feel listened to, that their concerns were not heard and that they didn’t receive updates about feedback that they shared.

Some of the doctors sought formal support from the organisation, professional body, or healthcare system. We found that some doctors who sought formal support reported difficult experiences such as limited support, lack of signposting, lack of representation amongst support staff and lack of recognition of systemic issues. Some doctors reported positive experiences of seeking help such as feeling supported by their team, and organisation.

We found that doctor's experiences of help-seeking were most influenced by whether they felt supported and looked after by their organisation, and their team.

The organisation looking after doctors

We found that it is essential for doctors to feel like their employer is interested in their well-being. We found that in order for doctors to feel looked after and supported by their organisation and professional body, they needed adequate working conditions such as access to free parking, access to hot drinks and snacks, recognition for their work, support and emphasis during training and in the profession and acknowledgement from the organisation regarding systemic issues and limitations. We also found that there was less support available for senior doctors, in comparison to junior doctors We also found that international doctors may "need more guidance", as they adjust to a new system and culture.

Culture in the profession and organisation

We found that experiences of well-being and help-seeking were shaped by the culture in the profession and the culture in the organisation. We found that there was a lack of emphasis on support and well-being, both in the profession and in the organisation. In terms of the culture in the profession, we found that doctors felt like they were expected to "know how to handle themselves" and that there was less support designed and implemented for senior doctors. In terms of the culture in the organisation, some doctors reported pressures from management, as well as experiences of bullying, harassment, discrimination, and racism, which impacted on doctor's well-being as well as the likelihood of speaking up and accessing help from the organisation.

We also found that well-being and help-seeking were shaped by wider culture in the community and nationally, which were related to the wider context (e.g., historical, social, political).

Appendix Q - Participant Feedback

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Appendix R – End of Summary Letter to Salomons Ethics

Thank you for your support for the project "A grounded theory study about help-seeking perspectives among NHS doctors of the Global Majority". We would like to share the findings of the study.

Aims and objectives: Research shows that doctors of the Global Majority are at higher risk in terms of their well-being, whilst at the same time less likely to seek help. The project aimed to develop a grounded theory about well-being and help-seeking experiences and perceptions, among a group of NHS doctors of the Global Majority.

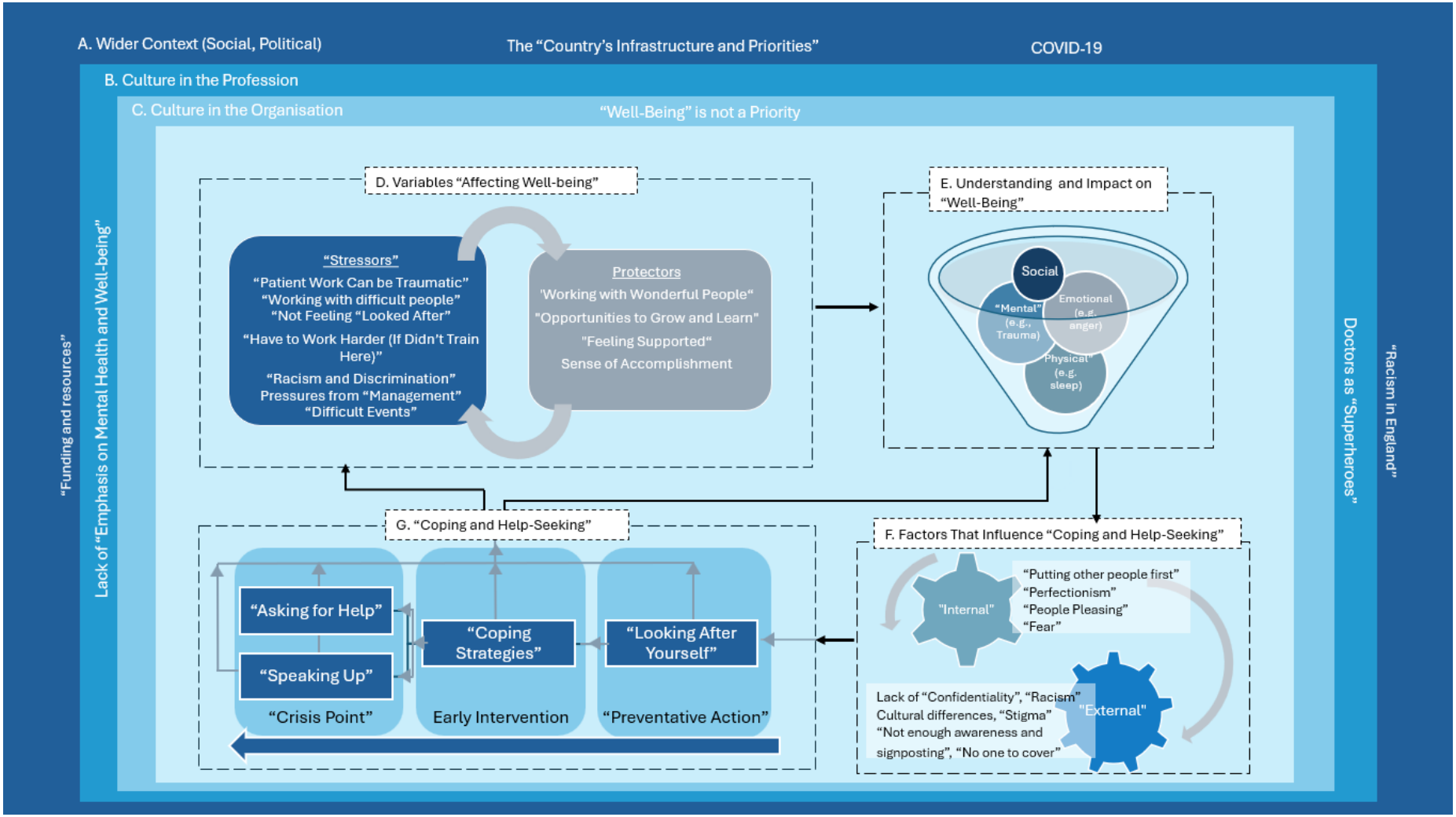
Method: A qualitative grounded theory methodology was employed using semi-structured interviews. Thirteen doctors employed in acute hospital NHS Trusts In Kent were interviewed between October 2023 and March 2024. All doctors identified as either Asian or British Asian. Most doctors (n = 11) who participated in the study were employed in senior positions in the NHS. A draft model was shared with participants for respondent validation and feedback was incorporated into the finalised model.

Findings: A model of doctor's experiences and perceptions of well-being and help-seeking was devised. The findings were based on the researcher's interpretation of the data. Grounded theory does not attempt to find an 'objective' reality, but instead one possible explanation for a social phenomenon. The 'core category' defined by the data was "the experiences and perceptions of well-being and help-seeking among doctors of the Global Majority". Please find attached a copy of the final model. The model depicted a recursive process of how well-being and help-seeking were experienced by a group of NHS doctors of the Global Majority. Seven main categories and seventeen subcategories were identified. The following categories were identified: wider context (social, political), understanding well-being, factors affecting well-being, impact on well-being, factors that influence coping and help-seeking, and coping and help-seeking.

Conclusions: The study aimed to get a rich understanding of a small sample of doctors of the Global majority experiences using a rigorous methodology. This means that our sample was not representative, but instead offers a tentative model for understanding well-being and help-seeking among doctors of the Global Majority.

Based on previous findings workplace health interventions commonly target individual-level factors such as coping behaviours and resilience among doctors. However, there's an increased acknowledgement that the organisation, design, and management of workplaces play a more significant role in influencing not only the mental health of doctors but also the quality of patient care (De Lange et al., 2020). Implications of our study included consideration of how doctors of the Global Majority can be supported by their organisation and professional body, which included adequate working conditions such as access to free parking, access to hot drinks and snacks, recognition for their work, support, and emphasis during training and in the profession and acknowledgement from the organisation regarding systemic issues and limitations. It was also highlighted that "overseas trained" doctors may need more support in the workplace as they adjust to a new system. Participants also highlighted the need for more awareness and signposting about available support services

Model Summary



Appendix S - End of Study Letter to Participants, HRA and NHS Trusts

End of study summary to Participants, HRA, and NHS Trusts
Thank you for your support for the project titled "A Grounded Theory Study about help-seeking perspectives amongst NHS Doctors of the Global Majority". We would like to share the findings of the study. Please find attached a brief summary of the study design and results.

Aims and objectives: Research shows that doctors of the Global Majority are at higher risk in terms of their well-being, whilst at the same time less likely to seek help. The project aimed to develop a grounded theory about well-being and help-seeking experiences and perceptions, among a group of NHS doctors of the Global Majority.

Method: A qualitative grounded theory methodology was employed using semi-structured interviews. Thirteen doctors employed in acute hospital NHS Trusts In Kent were interviewed between October 2023 and March 2024. All doctors identified as either Asian or British Asian. Most doctors (n = 11) who participated in the study were employed in senior positions in the NHS. A draft model was shared with participants for respondent validation and feedback was incorporated into the finalised model.

Results: A model of doctor's experiences and perceptions of well-being and help-seeking was devised. The findings were based on the researcher's interpretation of the data. Grounded theory does not attempt to find an 'objective' reality, but instead one possible explanation for a social phenomenon. Due to the nature of our methodology, not everything in our findings will be relevant to every participant. The 'core category' defined by the data was titled "the experiences and perceptions of well-being and help-seeking among doctors of the Global Majority". Please find attached a copy of the final model at the end of this summary.

Model Summary:
Participants identified that their understanding and experiences of well-being and help-seeking were shaped significantly by the wider social and political context, the role of culture in the organisation and the profession, as well as their upbringing, which included cultural and religious influences.

The impact on participants' well-being was determined by whether the "stressors" identified by participants were balanced by the number and availability of identified "protectors" and were shaped by their understanding of well-being. Participants identified that the perceived impact on their well-being was related to different aspects of their well-being such as mental, physical, emotional and social.

Participants identified that when their well-being was impacted, they would resort to searching for and employing various coping and help-seeking strategies. Whether participants engaged in coping and help-seeking behaviours were influenced by "internal" and "external" influences and determined which (if any) strategies they sought out or employed to look after their well-being. Participants identified a hierarchy of "coping and help-seeking" which included preventative, early intervention and "crisis" measures that they have undertaken or would undertake to cope with their well-being at work. Depending on whether participants coping, and help-seeking strategies were effective, this in turn influenced the impact on their experiences at work and their well-being.

During the analysis, seven main categories were identified from the data, including associated subcategories, and additional lower-level categories within subcategories (where relevant).

A. Wider Context (Social, Political)
Participants identified that their understanding and experiences of well-being and help-seeking were significantly shaped by the wider social and political context. The following factors were identified as significant: working in a Western context, “the lack of resources, the financial issues”, the impact of the COVID-19 pandemic, and the experiences of “racism in England”.

B. “Culture in the Profession”
All participants discussed the role of culture in the profession, in the context of their understanding and experiences of well-being, coping and help-seeking. This included the lack of “emphasis on mental health and well-being”, and the expectations of doctors being seen as “superheroes”.

C. “Culture in the Organisation”
All participants discussed the role of culture in the organisation, in the context of their understanding and experiences of well-being, coping and help-seeking, for example, it was recognised that well-being was not prioritised in the organisation.

D. Variables “Affecting Well-Being”
This category addressed factors which impacted participants' well-being at work such as the “stressors” and protective factors.

“Stressors”
This subcategory referred to the “stressors”, which participants identified as impacting their well-being, which included “patient work can be traumatic”, “working with difficult people”, not feeling “looked after”, “having to work harder if didn’t train here”, experiences of “racism and discrimination”, pressures from “management” and difficult events.

Protective Factors
This subcategory addressed factors which served a protective function on the well-being of participants. Protective factors included “working with wonderful people”, “opportunities to grow and learn”, a sense of accomplishment, and feeling “supported” by the organisation.

E. Understanding and Impact on Well-Being
Participants identified that the perceived impact on their well-being was related to different aspects of their well-being such as mental, physical, emotional and social. This was related to the perceived impact on their well-being such as “emotional well-being” (e.g., feelings of frustration), impact on “mental well-being” (e.g., anxiety), impact on “physical health” (e.g., “disrupted sleep”, and impact on “relationships” (e.g., “family can get the brunt of it”. Understanding of well-being was influenced by “values that are imparted to you by your family”, such as “cultural”, and “religious” values.

F. Factors That Influence on “Coping and Help-Seeking”
This category addressed key factors which impacted how participants coped with adversity and whether they considered and sought help for their well-being. Participants identified "internal" and "external factors".

Participants spoke about how "internal factors" were a barrier to seeking help, for example, participants shared how doctors were more likely to “put other people first”, due to their "own values and beliefs", which were shaped by their “upbringing". Participants shared their own “internal” factors, such as “finding it hard to say no”, “people pleasing”, and “high productive perfectionism”, which impacted how they “looked after” their well-being.

"External" factors were related to the influence of culture in the profession and the organisation, as well as the NHS context as outlined above. The most recognised “external” barrier was the “stigma associated with seeking help”, followed by lack of “confidentiality”, impact on salary, inequalities in accessing help, “not enough awareness and signposting” of available support, as well as the impact of issues with “funding and resources” (e.g., “no one to cover”).

G. “Coping and Help-Seeking”
This category addressed how doctors developed “ways of navigating” their well-being. Several participants shared how "doctors are necessarily the best people at looking after themselves”. Participants who have worked in the NHS for several years were less likely to look after themselves. However, participants reported that well-being became more of a priority over time. Participants who were new to the NHS reported greater attempts to “look after” their well-being, by “balancing” work and personal lives, through hobbies, leisure, spending time with family, and “connecting with others of the same background”.

Participants shared that when faced with work “stressors”, they would “take a break” and “reduce their working hours” in the first instance. Several participants also discussed how they would be more likely to “ask for help” from family.

Participants also shared about how they “spoke up” to raise concerns. Depending on whether participants felt “supported” and “listened to” when raising concerns and seeking help, this would be related to the impact on their well-being.

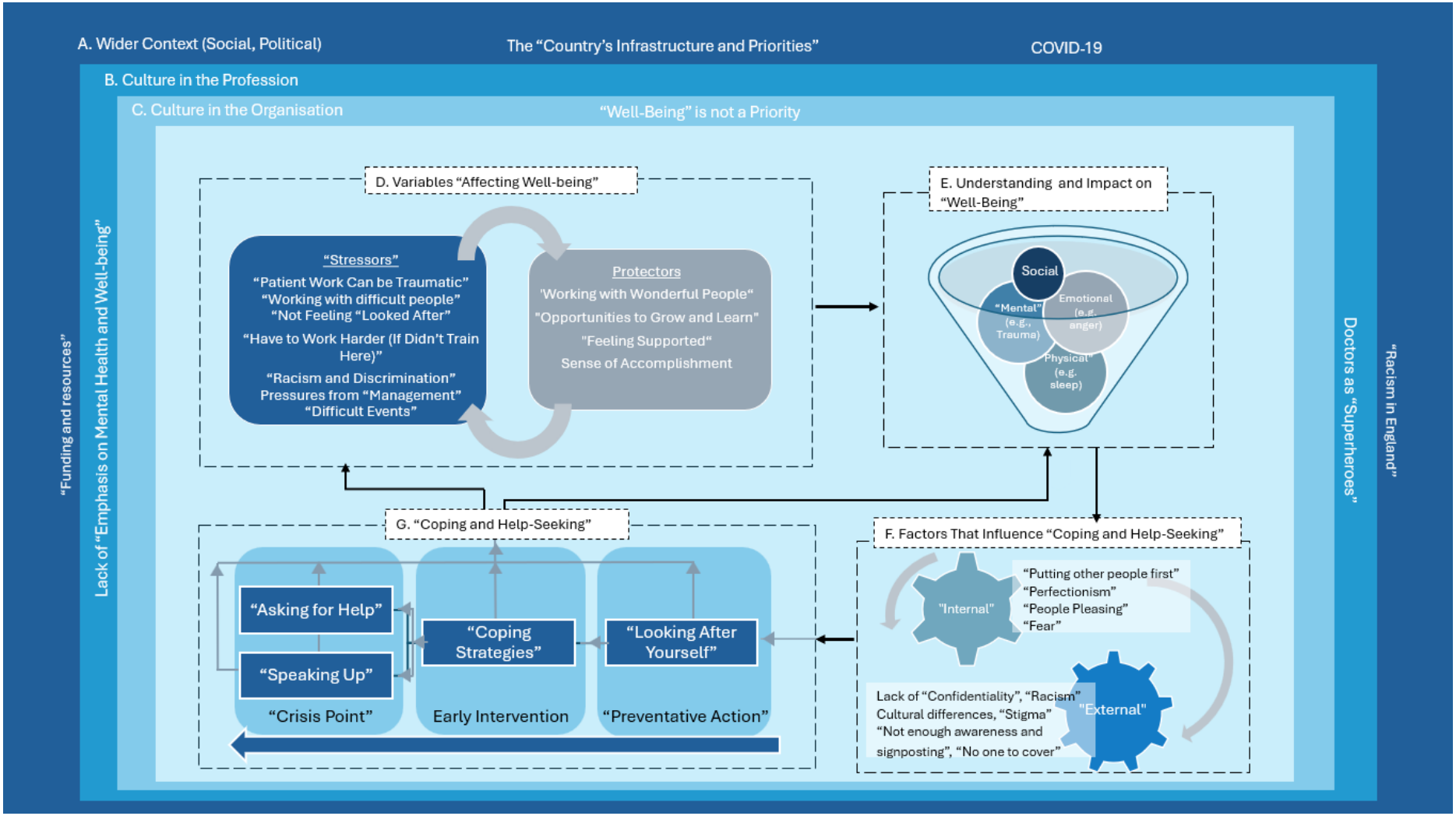
Participants spoke about how they found “healthy ways of navigating” work “stressors” such as “letting out their emotions”, and “talking” to colleagues. Participants also shared about how they “spoke up” to raise concerns. Some participants reported that they sought “formal” support, for example through the healthcare system, organisation, or professional body, which included “therapy” and taking “medication”.

All participants emphasised how “there should be a good support system available for all doctors, including doctors of the Global Majority, and that there should be more signposting to “easily available resources to access”.

Conclusions:
The study aimed to get a rich understanding of a small sample of doctors of the Global majority experiences using a rigorous methodology. This means that our sample was not representative, but instead offers a tentative model for understanding well-being and help-seeking among doctors of the Global Majority. The understanding that comes from the analysis was checked with participants and its utility rests on the value it has in terms of generating ideas to inform practice and further research (Corbin, & Strauss, 2008).

Based on previous findings workplace health interventions commonly target individual-level factors such as coping behaviours and resilience among doctors. However, there's an increased acknowledgement that the organisation, design, and management of workplaces play a more significant role in influencing not only the mental health of doctors but also the quality of patient care (De Lange et al., 2020). Implications of our study include consideration of how doctors of the Global Majority can be supported by their organisation and professional body, which included adequate working conditions such as access to free parking, access to hot drinks and snacks, recognition for their work, support, and emphasis during training and in the profession and acknowledgement from the organisation regarding systemic issues and limitations. It was also highlighted that “overseas trained” doctors may need more support in the workplace as they adjust to a new system. Participants also highlighted the need for more awareness and signposting about available support services.

Model Summary



Appendix T – Author Guidelines for Prospective Journal

PAPTRAP AUTHOR GUIDELINES

4. PREPARING THE SUBMISSION

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