Ref: RMBF Invitation to tender

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Prepared for the Royal Medical Benevolent Fund

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Executive summary

The Royal Medical Benevolent Fund (RMBF) supports medical students, doctors, and their families during times of financial hardship arising due to age, illness, injury, disability, or bereavement. The RMBF commissioned this research as they believe that there is a level of unmet need amongst the potential beneficiary group, there are factors which are preventing eligible doctors, medical students, and their families from approaching the RMBF, and that the RMBF could enable better outcomes if potential beneficiaries approached them before they are in crisis óþwŜǎŜI·ŊǑK ƛyűƨ ʤyϒŜű ySŜŘɛ úŜyŘŜŊ document). The current research project aimed to answer the following four research questions (sub-

or enabler (show credibility and kudos). Advertising was felt to be challenging for a number of reasons (e.g., busy target audience, medics not noticing advertising unless they are in need, interest in more specialised publications makes it challenging to identify where to advertise). Word of mouth (via other organisations, through peers, or more formal word of mouth strategies, e.g., in the workplace) was felt to be beneficial to spread awareness if coming from a trusted and respectful figure. Early awareness of the RMBF (in regard to career and to sensitive time points, e.g., preventing the development of financial crisis) was felt to be critical to ensure timely support seeking.

Process of applying. Even though there was a general understanding that detailed information is necessary for a charity, some felt that evidence required for the application form could be very challenging to compile (e.g., due to feeling unwell). Stigma and sharing sensitive information around ill-health and financial need acted as a major barrier towards applying to the RMBF (e.g., 90.7% of participants agreed/strongly agreed with the statements about non-disclosing ill-health problems because of a medical culture stigmatising illness in doctors and medical students). Financial difficulties were associated with shame, feeling of failure, and a fear that ill-health and/or financial difficulty could lead to fitness to practise concerns with the GMC. We also found that there is a difference between stigma towards ill-health and financial difficulties, showing that stigma around ill-health might have a stronger negative impact on support seeking. In addition, potential applicants not having a sufficient sense of candidacy to apply to the RMBF acted as a further barrier. This lack of sense of candidacy could arise due to not feeling deserving of support, or concerns that they would not be successful if they applied.

Eligibility criteria. Experts described people as generally being bad at reading criteria, meaning that they may miss or misunderstand important details. If criteria are misunderstood, potential applicants will not apply for support as they might think that they will not be eligible. There was an assumption that the RMBF would only help people at rock bottom (e.g., not support those with even minimal savings, with a partner who worked or those who had a small amount of low-paid work). There might also be confusion about what certain terms mean, i.e., what is classed as ill-health (not all assumed ∃ℕ2ʤLJă ø2ʤfŘ ŏfI·ăăłŦè űĸŜϒăŜfØŜă ły˝űĸłă ø I·èú¢ ¢ĸŜ 2LJűł2y˝ά2űĸŜℕé ły˝űĸŜ I·LJLJfłŏI·űł2y˝ó2ℕ ŜÈŏŜLJűł2yl·f circumstances) was generally viewed positively as it might encourage people to apply even if they are unsure of their eligibility. There were contrasting opinions about how much information about the criteria is more helpful: experts felt that having transparent criteria is important for people to know whether they would be eligible, whereas beneficiaries were more concerned with the criteria being accessible (e.g., an extensive list of criteria might be difficult to go through and understand if feeling unwell).

RQ4.b. What are the strategies to reach those potential beneficiaries who are not engaging with the charity or those not engaging at the earliest opportunity?

The key recommendations to reach those potential beneficiaries who are not engaging with the charity or those not engaging at the earliest opportunity would include raising awareness, refining the application process, and clarifying eligibility criteria. Recommendations are mapped in the figure

To raise awareness, the RMBF could:

1. /ℕŜl·úŜ úKŜ ćℕλ∃Kúέ ϰYLJℕŜăăϰ2y to encourage engagement with the charity (e.g., clarify the ŎKl·ℕλúèΩă l·ϰYăT emphasise úKŜ ŎKl·ℕλúèΩă Kϰăú2ℕè 2Ŧ ădzLJLJ2ℕúϰyƎ Ř2Ŏú2ℕă l·yŘ úKŜ^ℕ dzyŘŜℕăúl·yŘϰyƎ of the challenges they face; increasing the inclusivity of the organisation, board, and panel in terms of protected characteristics);
2. Improve advertising (e.g., through multiple routes, use of testimonials, accounting for the diversity in the profession, strengthen social media presence; advertise non-monetary support);
3. Work with partners/use word of mouth (e.g., partner with other relevant organisations, promote word of mouth strategies among peers and more formal word of mouth strategies in the workplace/at medical school);
4. Work towards increasing early awareness (e.g., stay in touch repeatedly from early career, for example through a membership scheme; promoting the RMBF at key time points when doctors/students are most likely to be experiencing financial difficulty).

To refine the application process, the RMBF could:

1. Ease the burden of proof (e.g., have a light-touch ap re028tia be of prsiute

3. LyŎℕŜI·ăŜ LJŜƨLJfŜ℗ă ăŜyãŜ ƨ₮ ŎI·yŘ⅄ŘI·Ôè óŜ℗∃℗Σ highlight on their website and advertising materials that applications are welcome from applicants before they reach crisis point; sharing good news stories or data about the number or awards granted, to encourage people to apply).

To clarify the eligibility criteria the RMBF could:

1. Optimise the presentation of the criteria (e.g., clear and transparent criteria available on the website in addition to an interactive eligibility checker; case studies illustrating previously eligible cases; KI·ØŜ űKŜ ƨLJúλƨy˜ƨ₮ ά2űKŜℕέ ű2 KλƎKfλƎKű úKI·ú I·LJLJfλŎI·úλ2yã I·ℕŜ Ŏ2yãλŘŜℕŜŘ 2y˜I· case-by-case basis);
2. Consider broadening the eligibility criteria to meet the needs of those who are currently not eligible for support but experience financial difficulties (e.g., students from earlier years; doctors without health problems).[1]

All medical students and doctors are at risk of experiencing financial difficulties at some point in their lives. The study, however, identified the groups that are at particular risk for experiencing financial

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2. METHODS

2.1. Ethics

The project received ethical permission from the UCL Research Ethics Committee (REF: 13311/003). Participation was voluntary and all participants actively consented to take part in the study.

2.2. Theoretical Framework

This study was designed using an evaluative framework shaped by Realist philosophy. This perspective has a focus on causality: in addition to exploring *what works* and *for whom*, it also seeks to understand *in what circumstances* something works, and *how* this happens (Pawson, 2013; Pawson et al., 2005). This is pertinent to this study, as it allows an in-depth exploration of what the RMBF does and how beneficiaries and other stakeholders understand and respond to the assistance available from the RMBF.

This approach involves identifying three key components in an intervention:

1. The in which certain things work or not; the context might be influenced by cultural ƨℕ ăƨǑλŜűl·f yƲℕϒă ƨℕ LJŜƨLJfŜΩă ŘŜϒƨ∃ℕl·LJKλǑ ŦŜl·ůdzℕŜă, for example.
2. The through which an intervention operates, including the *resources* offered and LJŜƨLJfŜΩă *responses* to these resources; for example, information provided (resources) which motivates people to feel engaged (response), or advice provided (resource) that leads to people trusting the organisation (response).
3. The (un)intended of particular mechanisms acting in particular contexts; this might be an increased uptake of support, for example.

In relevant sections of this report, we categorise data into either C=context, M=Mechanism, O=Outcome. When presented together these CMO configurations help to illuminate the specific conditions in which the interventions/strategies suggested work.

To identify these components, the first stage was to develop programme theories: these are initial ideas about what works and why about the intervention being studied (i.e., the intervention being wa . CΩă ădzLJLJƨℕΰ Ŧƨℕ ŘƨǑΰƨℕăΣ ϒŜŘλǑl·f ăΰůdzŘŜyΰăΣ l·yŘ ΰKŜλℕ Ŧl·ϒfλŜăύφ ¢KŜ ℕŜăŜl·ℕǑK ΰŜl·ϒ ŘŜØŜfƨLJŜŘ l· ăŜΰ of programme theories by exploring the documents shared with us by the RMBF and extensively ŘλăǑdzăăλyƎ Ø l·ℕλƨdză l·ăLJŜǑΰă 2Ŧ ΰKŜ wa . CΩă 2ō?ŜǑΰλØŜăΣ ăŜℕØλǑŜăΣ l·ǑΰλØλΰλŜăΣ LJℕƨ2ǑŜăăŜăΣ l·yŘ ǑℕλΰŜℕλl· Ŧƨℕ support. The initial theories were refined after two discussions with members of the RMBF about their work, and then finalised after further ŘλăǑdzăăλ2ϒ ø λΰK ΰKŜ LJℕƨ2?ŜǑΰΩă l·ŘØλă2ℕè ∃ℕ2dzLJ óăŜŜ ăŜǑΰλ2ϒ нφoúφ The initial theories that guided the study were:

1. Awareness of suitable applicants and uptake:
   a. If awareness of the RMBF's goal to support doctors, medical students, and their families in financial difficulties due to ill health is raised, then more suitable applications will be received which will subsequently increase uptake (because the main barrier to suitable l·LJLJfλǑl·yΰă ℕŜl·ǑKλyƎ ƨdzΰ ΰƨ wa . C Ŧƨℕ KŜfLJ λă ΰKl·ΰ ΰKŜè Ř2yΩΰ ˥ϒƨø ΰKŜè ŜÈλăΰ 2ℕ dzyŘŜrstand what they do).
2. Process and uptake:

    a. If the RMBF application and assessment processes reassure and comfort applicants (in addition to assessing their financial need), then uptake will increase (because applicants: will feel safe and secure in asking them for help; will not feel judged or a failure).
    b. If the process to becoming an actual beneficiary is challenging, potential applicants will not seek help or will delay seeking it until desperate (because it is difficult to complete such a process when experiencing ill health or a mental health crisis/because doctors are incredibly busy people with limited free time to complete and evidence an application).
3. Criteria and uptake
    a. If the RMBF clearly outlines the eligibility criteria and ways to apply, then they can rely on suitable beneficiaries self-selecting (because doctors/medical students/their families are individuals capable of conducting the necessary self-assessment required for this/because the criteria are clear and easy to understand/because the criteria successfully generate a sense of candidacy).

The second stage was to test these programme theories by presenting them to various stakeholders to see if they agreed or disagreed with them, and to investigate in detail of why an aspect of the intervention did or did not work. The research team tested the developed theories in interviews with experts (people who have experience of supporting doctors, medical students, and their families through ill-health and/or financial difficulty; Phase 2), actual beneficiaries (people who have received support from the RMBF; Phase 3), and potential beneficiaries (people who have not received support from the RMBF but who have experienced financial difficulty and ill-health; Phase 3), and also in a survey for doctors and medical students (Phase 4: Survey part).

The findings from the interviews and survey were then synthesised with findings from a literature review (Phase 1) and secondary data analysis (Phase 4) to explore the levels of financial need and needs that may be unmet.

2.3. Advisorygroup

Participatory design is inherent to a Realist evaluation framework, and therefore we formed an advisory group consisting of representatives of those groups the research is designed to impact (members of the RMBF and beneficiaries) as well as other experts in the area of financial difficulties due to ill health. This group met four times throughout the project and provided input at various stages, including but not limited to: commenting on the overall study design, the interview schedules and survey questions, helping to plan recruitment strategies, and contributing to the discussion of the emerging findings. Their input helped to reduce potential researcher bias, allowed new perspectives, and enhanced the credibility and impact of findings by adding nuance and depth to interpretations.

2.4. Research Phases

This section will present the methods of each research phase: Phase 1: Literature review; Phases 2 and 3: Interviews with experts and actual/potential beneficiaries; Phase 4: Secondary data analysis and survey; and Phase 5: Data Synthesis.

2.4.1. Phase 1: Literature review

A narrative literature review was conducted to explore what has previously been studied in the area of financial need in the medical profession. The research team trialled different search term combinations in commonly used literature databases until the most useful search term string was finalised. This search term string included words describing doctors and medical students, and a range of terms related to financial difficulty (see Appendix 1). Inclusion criteria consisted of needing to be concerned with financial difficulty, with the medical profession (medical students and doctors), about the UK context, published in English, and published within the last ten years.

Figure 1. Literature search results.

The literature review was comprised of the following stages (Figure 1):

1. *Identification stage.* The finalised search term string revealed 2024 hits from academic literature databases (1431 after duplicates were removed). The screening of reference lists of all the included literature items revealed an additional 15 records. We explored the websites of 39 organisations (e.g., General Medical Council, British Medical Association, NHS, medical defence organisations, student loan organisations, and medical royal colleges and faculties) using the terms relating to financial difficulty; this resulted in 45 further items. For more information on each of the three types of screening (academic literature, grey literature, and additional resources) - see Appendix 1.
2. *Screening.* The titles and abstracts of the

Th66 Tm0 g0 G2 re3(r)12(atur)3(e)-3(r)12(ev)-6(i)13(ew)-3( )9(was)7(c)10(o)-5(m)-4(p)3(ris)13(ed)10(o)-tur2000008871 0 595.32 8

(see above). Each team member coded the transcripts to capture relevant talk about their specific areas. Again, barriers and enablers to accessing financial support were identified using the contexts, mechanisms, and outcomes identified from the expert interviews to answer Research Question 4.

For all stages of analysis, team members regularly met to discuss their progress and read each other's work to check and clarify the analyses.

Case studies

Appendix 4 presents four case studies that provide an overview of the key elements that participants described in the interviews: their financial and ill-health situations, their impressions of and

Charity CRM, previously called ThankQ), specialty was consistently recorded. This means that for earlier years, ƛyŦƨ₪Ƴ·ŭƛƨy˝ƨy˝ōŜyŜŦƛŎƛ·₪ƛŜăΩ ăLJŜŎƛ·tűè ƛă ƨŦűŜy˝Ƴ˝ƛăăƛyƎ₡

4. Similarly, the charity has evolved over time and policy changes have made it possible to accept applications from medical students in their own right on a regular basis from 2012 onwards. This means there is no data on students before 2012 (help was previously only provided for students ς including medical students ς if they were the children of current beneficiaries in which case they were classified as sons/daughters). Applications from refugee doctors have also been accepted since 2005, but prior to the move to Charity CRM in 2014 there was no differentiation on the database between doctors applying under this programme and those applying under the main programme. Therefore, there is no separate data on refugee doctors before 2014.
5. In 2020 and 2021 the Covid-19 pandemic had a substantial impact on society. This may have ƛY˝LJ·ŎűŜŘ űKŜ ŎK·₪·ŎűŜ₪ƛăúƛŎăƨŦ űKŜ wa .CΩă ōŜyŜŦƛŎƛ·₪ƛŜă₡ ·ƨøŜØŜ₪Ƶ ŘdzŜ ű2 űKŜ ŧƛY˝ƛűŜŘ ·Y˝2dzyű of data, we were unable to do any sub-group analysis for these years.
6. Up until 2014, a large number of dependents were the family members of RMBF beneficiaries and were given their own data record (in addition to that of the beneficiary to whom they were dependent on). They were added as separate records to reflect the fact that they received their own Christmas payments in addition to the general support the main applicant was receiving. From 2014 onwards, dependants have not been added as separate records as a single Christmas payment is made to the main applicant for the entire family.

Topic 2: How RMBF beneficiaries heard about the RMBF

The RMBF dataset covering how RMBF beneficiaries heard about the RMBF consisted of 483 records:

1. Since late 2014, with the implementation of Charity CRM, the RMBF started systematically recording how beneficiaries became aware of the RMBF. This means that information on this aspect is often missing for earlier years.

Topic 3: Reasons why applicants approached the RMBF

The RMBF dataset covering the reasons for seeking support consisted of 2896 records:

1. 1181 records were about eligible beneficiaries, whereas 1715 records

Yes	-	20% (40)	-
No	-	66% (132)	-
Missing	-	14% (28)	-
Self-funded	-	13.5% (27)	-
Other (loan, bursary, grant)	-	46.5% (93)	-

Self-

Notes one person did not indicate whether they were a medical student or a doctor, meaning they are not

Descriptive statistics and Pearson correlations were used to explore the scales. We used Latent Profile Analysis (LPA) to calculate profiles of participants based on the six scales. LPA is a statistical approach that allows researchers to identify profiles, i.e., groups of individuals based on their responses. We conducted LPA in R Studio (version 4.0.5) using the package MClust (version 5.4.7). We determined the most optimal solution using the Bayesian Information Criterion, the Integrated Complete Likelihood, and the Bootstrap Likelihood Ratio Testing. Based on this solution, each participant was assigned to a profile in R (3 profiles; BIC = -7828.6, VVE model). Data was then transferred back to SPSS and further analysed for demographic differences between groups as well as to identify relations between profiles and outcomes (intentions to seek help). Chi-squared and ANOVA tests were used when appropriate.

Analysis of open-ended questions

We analysed the following open-ended questions:

1. What were the causes for financial difficulties, other than causes covered by the RMBF?
2. ² KI·ú ƛă űKŜ I·₦∃dzϒŜyűI·úƛ2ϒ ₮2₦ I·LJLJ₦2I·ŎKƛyƎ 2yŜΩă LJ₦ŜŦŜ₦₦ŜŘ ă2dz₦ce(s) for help when in financial difficulties?
3. Why was the support received to alleviate financial difficulties considered to be helpful or unhelpful?
4. What would have helped to seek help or seek help earlier?
5. Why was no help sought to alleviate financial difficulties?
6. ² KI·ú 2yŜΩă ØƛŜøă øŜ₦Ŝ I·ō2dzú űKŜ wa .C?
7. Why would one not seek help from the RMBF?
8. ² KI·ú 2yŜΩă Ŏ2yŷ2űI·úƛ2ϒ øI·ă øƛúK űKŜ úŜ₦ϒ ƛff-health?

Common themes occurring in answers for each question were identified. Questions 3 and 4 as well as questions 6 and 7 provided similar results and were clusd.75 .6C1 0 0 1,4(e)9(sher). .6C1Te m-4(esc .6C5we)-3(r)

3. RESULTS

This section presents findings from all research phases and is structured based on four research questions (RQ). Figure 2 maps out which phases answer which research questions. Each section concludes with key findings from relevant phases. All findings are combined in the last section of this report (Phase 5) ς the summary and key recommendations section.

3.1. Research Question 1. Who is experiencing financial hardship within the profession?

3.1.1. RQ1.a. What are the reasons for financial difficulties experienced by medical students, doctors, and their families?

Research Question 1 investigates who is experiencing hardship within the medical profession, with the sub-question 1.a specifying the reasons for experiencing financial difficulties. To answer these questions, we draw on findings from Phase 1 (literature review) and Phase 4 (secondary data analysis) to explore who is experiencing financial difficulties and why, and the potential impacts of experiencing financial hardship.

Findings from Phase 1: literature review

95.32 841.92 re W n 31 113.47 from the review (peer-reviewed) literature 0.216 0.216 0.388 rg 0.388 RG [5] 0.417 9

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medical graduates (British Medical Association, 2020j; Pandey et al., 2020), and locum doctors (British Medical Association, 2020k). GPs were singled out for mention in some pieces of literature, including GP practice partners (Power, 2014b, 2014a; Riley et al., 2018) and sessional GPs (British Medical Association, 2021d). Doctors who have had warnings, undertakings, or conditions as a result of the fitness to practise process also reported experiencing financial loss (General Medical Council, 2015). Doctors with children were reported to experience extra financial pressures, a burden which falls particularly heavily on women (British Medical Association, 2020c, 2020f).

An extra expense was identified for trainees in the UK, whether initially UK or internationally trained, in the form of the high costs associated with Royal College exams (Woolf et al., 2016; Zhou et al., 2020).

Specifically related to the pandemicThe ongoing pandemic created new groups of doctors who have suffered financial difficulty, and much grey literature from the BMA covered this area. Groups who experienced difficulty included doctors who had to shield during the pandemic due to being vulnerable to Covid-19 (British Medical Association, 2020d), doctors who were unable to work for long periods due to being unwell with long-Covid-19 and related contractual issues (British Medical Association, 2020k, 2021a)

can be a particularly serious factor for students from widening participation and low-income backgrounds, who find it hard to balance studying with paid work and a personal life which can then lead to financial difficulty (Anane & Curtis, 2019). Having a lack of financial support from families is also a risk factor (Cleland et al., 2012, нлмрT YЊăΰλδ ŜΰΙ·f℡Σ нлнмT ±Ι·dzΞKΙ·yΣ нлмоύ, and some also have to provide financial support to their families while undertaking their studies (Anane & Curtis, 2019).

Overseas students had extra financial pressures due to the higher fees that they pay, but with fewer opportunities for financial support in the UK (British Medical Association, 2020c) or from their home countries (Coyle, 2012).

All students are potentially vulnerable to personal troubles impacting their incomings and outgoings, such as relationship breakdowns, housing issues, and illness (Knight, 2018; Patel et al., 2015).

Doctors Time away from practice was a key factor in experiencing financial difficulty; for example, this could be due to addiction όhΩΙ Ι·ЊΙ·Σ нлмсύ, or to having to work fewer hours or in different roles

Consequences of experiencing financial difficulty

Consequences of experiencing financial difficulty differed in the literature for medical students and qualified doctors, with one exception in the grey literature that this can be a factor for both groups in leading to suicide (General Medical Council, 2014; Knight, 2018).

Medical students and trainees' financial issues could have a detrimental ŝŦŦŝŏŭ ƨƴăúdzŘŝƴűăǫ ǀŏǀŘŝƳʌŏ progression, with personal issues such as financial difficulty potentially leading to failing exams (Vogan et al., 2014). Students are also less likely to excel at medical school if they have competing responsibilities such as part-time work or caring in addition to their studies (Curtis & Smith, 2020). In order to manage financially during their studies, students were reported as having to cut down on essentials or do without them completely; including heating, food, professional clothing for placements, and even medication (British Medical Association, 2020h; Patel et al., 2015; Vaughan, 2013). Students from widening participation schemes or low-income backgrounds found it hard to balance their studies with part-time work and their personal lives, and this balancing act could lead to financial difficulty and mental health issues

illness. Non-

This analysis provides a useful overview of the most common reasons that medical students and professionals approach the RMBF, and also identifies which groups the RMBF were not able to support. It is important to highlight though that some categories are vague (e.g., ά₸ƛyƖ·yŎƛI·fέ ₦ŜI·ă2yᾶú and that the RMBF started recording data systematically only recently (from 2014) meaning that information from earlier years was not available.

Key findings for RQ1.a

The key findings

Experiencing financial difficulties

This second part presents findings from the survey on the level of experienced financial difficulties, stages at which financial troubles are most common, the reasons for experiencing financial difficulties, and help-seeking behaviours.

In contrast to financial worries, 33.5% (148) of participants experienced financial difficulties (defined as the inability to meet financial obligations) and these percentages were similar between medical students (32.5%) and doctors (34.4%).

Those who experienced financial difficulties (N=148), experienced these difficulties at various stages of their career. Table 6 shows the percentage of participants experiencing financial difficulties at various stages of their medical career, for the overall sample of participants who experienced financial difficulties, and for a sub-sample of consultants and GPs (N=25). This sub-sample accounts for the fact that some participants in our sample have not yet completed their medical training, meaning they were unable to experience difficulties at later stages of their career. From both samples we can see that a large percentage of survey participants experienced financial difficulties during earlier and later years of medical school as well as during training. In the most senior participants sample (consultants

as sitting exams and membership of Royal Colleges as reasons for their financial difficulties. Participants originating from the European Union said that being ineligible for adequate bursaries post Brexit was a cause of their financial distress. Furthermore, specifically medical students mentioned the demands of study and short holidays during their studies at medical school preventing them from taking up serious employed work. Other, less frequently mentioned reasons for financial difficulties were: unexpected bills (e.g., emergency taxation), delays in NHS payrolls or student financing, poor

Table 7.

Participants also said it helped to plan their finances longer-term, helped to get a job, and helped to increase flexibility in their financial situation by arranging relocations to a cheaper area or flexible repayment owi5

Participants shared why the support they received might not be helpful (need still unmet) which was similar to what was reported for all survey participants: the majority of participants said the support had limited coverage (e.g., loans did not cover bills) and therefore, some were still facing financial difficulties; participants mentioned difficulties to receiving needed support due to restrictions (e.g., saving, other loans) or limited resources available; short term support was noted as not helpful; consequences of support seeking might be challenging (repayments; resentment from family if support is personal).

Of those who experienced financial difficulties due to illness (physical/mental health), disability, bereavement, or caring responsibilities, 36 (63.2%) were aware of the RMBF and of these who knew about the RMBF, 17 (47.2%) said they would be likely to approach the RMBF if in need.

A projection of how many doctors and students there might be in the UK medical

- Reasons for not seeking support might also be important when considering unmet needs. Survey participants who did not seek help (or did not seek help earlier) said that the reasons were

				t	

England	100% (27)
Scotland	0
Wales	0
Northern Ireland	0
International	0
Missing	0

Most refugee doctors on the dataset were male doctors (14; 51.9%), and single (12; 44.4%) or married/ co-habiting

Widowed	NA	NA	0
Missing	NA	NA	40.2% (37)
3rd	NA	NA	5.4% (5)
4th	NA	NA	34.8% (32)
5th	NA	NA	48.9% (45)
6th	NA	NA	5.4% (5)

Table 12. Characteristics of dependants helped by the RMBF and variations over time [%(n) or M(SD)].

			t
Male	31.6% (319)	31.5% (314)	

3.3. Research Question 3. t Z š Œ š Z } À Œ o o • š Œ v P š Z • } (š Z services, activities, and criteria for support for the professi?

The overarching Research Question 3 addresses exploring the overall strengths of the RMBF services, activities (focusing on the RMBF's grants programme), and criteria for support. To do that we specifically focused on exploring (i) the level of awareness of the charity, (ii) geographic differences l·ŎŴ2ăă úKŜ ¦Y ʎy˝Ř2ŎűŽŴăQ l·yŘ Y˝ŜŘʎŎl·f ăűdzŘŜyűăQ ØʎŜøă 2y˝l·yŘ øʎtftʎyƎyŜăă ű2 l·LJLJŴ2l·ŎK úKŜ w a . C, and (iii) the l·ŎűdzI·f ōŜyŜŦʎŎʎI·ŴʎŜăQ experiences of seeking support from the RMBF.

Unknown	2.1% (7)	0	35% (28)	2.4% (1)
Educational supervisor	1.8% (7)	0	0	0
General Medical Council	1.8% (7)	0	0	0
Other charity	1.2% (4)	0	0	4.9% (2)
Medical Defence Union	1.2% (4)	0	0	0
RMBF event/presentation	1.2% (4)	0	2.5% (2)	0
Royal College/Royal Society	1.2% (4)	0	0	0
Royal Medical Foundation	0.9% (3)	0	0	5.9% (2)
tKèăìÕìl·yã moms group	0.9% (3)	0	0	0
Doctors Support Network	0.9%			

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really considered decision,

o ^^}]š[• Z vP šZ ÁZ}o U šZ]• ÁZ}o Æ‰ Œ] v]v oµ]vP
À Œ Ç Ç U /[u]v šš Œ *thinking of ways in which I can give back.*
^} šZ Œ [• ‰ Œš }(u šZ š • Ç• (]v]š oÇ / Á]oo Œ ‰ Ç
them in some fashion and I am happy to help with fundraising you know in the future. And
šµ ooÇ /[À š}o *know if you need something*
Ç}µ lv}Á U /[u Z ‰‰Ç š}]vš ŒÀ] Á U } ÁZ š À Œ]š]•
*people need to see a real person and be able to ask that person real questions in order to believe that this is wha*š Z ‰‰ v• š} ‰ }‰o v šZ]•]• ÁZ š šZ ZD
beneficiary 17]

Key findings to RQ3.c

The key findings on the experience of seeking support from the RMBF to answer Research Question 3.c are:

- Beneficiaries were very happy with the support that they received from the RMBF;
- Caseworkers were said to be

x

3.4. Research Question 4. t Z š • ‰ š • } (š Z Z D & [• µ Œ E Œ ; v š • Œ E and criteria for support for the profession could be developed to improve their overall effectiveness?

3.4.1. RQ 4.a. What hinders or drives potential beneficiaries to seek timely support from the RMBF?

3.4.2. RQ 4.b. What are the strategies to reach those potential beneficiaries who are not engaging with the charity or those not engaging at the earliest opportunity?

The last research question is about improvement. Using findings from Phase 2 and 3 (interviews with experts and potential/actual beneficiaries) and Phase 4 (survey) we explore barriers and enablers to seek timely support from the RMBF (Research Question 4.a) and strategies to reach those potential beneficiaries who are not engaging with the charity or those not engaging at the earliest opportunity (Research Question 4.b). The findings from two research sub-questions are merged to provide a clearer overview.

Findings from Phase 2 and 3: Interviews with experts and potential/actual beneficiaries

The following results are from the interviews conducted with experts, actual beneficiaries, and

beneficiaries, and potential beneficiaries that can work or not work at encouraging people in financial need to approach the RMBF, together with the contexts in which these strategies occur. In our analysis, we highlighted factors that participants themselves posited as barriers and enablers to people engaging with the RMBF, and the potential strategies they offer to address these barriers and build on these enablers (highlighting key barriers/enablers/strategies in bold). We then expanded on these identified strategies using the Realist approach, and developed them into context-mechanism-outcome (CMO) configurations; these enable us to present examples of *what about* ŭKŜ wa .Cŭă current services, activities, and criteria for support for the profession works, *in which circumstance*s, and what *the outcome* of this is. The CMO configurations are illustrated by quotes from participants. Note that some strategies can have both barrier and enabler properties, depending on the context.

At the end of each sub-theme section, we present examples of CMO configurations: recommendations (mechanisms) that work or do not work in particular situations (contexts) and the possible results of these strategies (outcomes). Some of these strategies work well and others do not, and each is illustrated with one or more quotes from the interview data to show why they do or do not work.

lPŒ}µv U / iµ•š •}Œš }(šZ}µPZš ZKZ šZ š[• v}š (}Œ u U šZ š[• (

was postulated to result in better responses, for example a campaign to target GPs or doctors at certain times in their careers when they are more likely to experience financial hardship, for example at times of transition from one career or training stage to the next.

Strategies

Participants suggested a mix of approaches. The RMBF could advertise (as the name itself was not thought to be self-explanatory) via so that individuals are exposed to this message repeatedly, regularly, and from different sources. This should create an impression in their minds and so the probability is greater of eventually hitting a timely encounter (e.g., when individuals are in need and thus more likely to be receptive). For example, it was reported that other organisations *canteens and toilets* of a lack of visibility. Induction was mentioned by both experts and beneficiaries as an important time to advertise suite of support services. It was felt that routine wellbeing/support talks or advertising may be useful if these can create an impact sufficient to maintain a lasting awareness of the charity and its remit.

The use of online routes to advertise was stressed. Medical students especially, but also younger doctors, use very frequently and the instantaneous, accessible, and heavily-used aspects of social media mean that individuals are more likely to be exposed to RMBF messages if they are present on these platforms. Using these media for interacting with people and discussing issues would also help generate awareness. Using audio and video resources was recommended to reach a broader audience, for example having advice videos on platforms such as TikTok.

The RMBF could to when doctors and medical students are likely to be struggling financially, so that the messages speak to their experiences at the time and thus are more likely to resonate with them. For example, the RMBF could arrange to advertise through university or work communications about electives or before receipt of the NHS bursary, for trainees in emails about study leave or in communications about exam costs). Furthermore, the RMBF could develop

themselves as a candidate for the RMBF, especially if some of this material shows diversity regarding protected characteristics.

Quotes and CMO configurations

The following CMO configurations and illustrative quotes provide three examples of strategies to improve awareness of the RMBF via advertising. As above, these examples were suggested by the people interviewed for this study.

CMO 3: Advertising via many angles and regularly

Increased enquiries and applications to the RMBF from eligible individuals who would otherwise have dismissed it.

'Yeah, so I think I would have testimonies up front or a case study, you know just have lots of testimonials or case studies about this doctor, you know anonymised, pseudonym anonymised whatever, but have lots of case studies because doctors will just you know follow the trend of what other people are doing. € YYes, like normalising, / [u o Á Ç • • Ç] v P] š [• v } Œ u o] •] v P] š doctor with financial] (( ] µ o š] • š Z] •] • Á Z Œ š Z Ç } Œ P • } X d Z µ š • [š •]] š u Œ l U] š [• is what happens to you. If you get into financial difficulty you go to this, / Á } µ o o o š Z u Z Œ u Ç o] l Z P } š } Œ u Ç v š Z Ç [Expert 23] l Œ } ( ] š [X

Theme 1.3: Use of partners and word of mouth

This sub-theme is about partnering with other organisations to spread awareness of the RMBF, and encouraging word of mouth to raise awareness among medic colleagues and peers. At the end of this section, we present three examples of CMO configurations to illustrate strategies that use partner organisations and word of mouth: establishing trust in the RMBF via trust in partner organisations (CMO 6), how word of mouth among peers can increase trust in the RMBF (CMO 7), and how word of mouth strategies should be supplemented with more formal information about the RMBF (CMO 8).

Barriers

Participants described that when people are struggling, it is very difficult for them to have the energy, concentration, and clarity of thought to seek out and become aware of new support pathways. who are already in touch with these individuals (e.g., similar charities, refugee organisations) can be a way of letting these people know about the RMBF via these LJl·NúySNăQ ŜÈλăúλyƎ ySúø2N]ă¢ l2øŜØŜNΣ úKŜăŜ 2NƎl·yλăl·úλ2yã l·NŜ y2ú ŜÈLJŜNúă λy˝úKŜ wa.CQă ŜfλƎλōfλûè ÕNλúŜNλl·Σ ă2 úKŜè Y˝l·è NŜTŜN λySfλƎλōfŜ l·LJLJfλÕl·yúă l·yŘ úKŜ λyŘλØλŘdzl·fQă ŜÈLJŜÕúl·úλ2yãΣ 2N K2LJŜă, are then not fulfilled. Moreover, working with very well-]y˝2øy˝ LJl·NúySNăK l·Ř2ø úKŜ wa.CQă contribution to the service.

It was suggested that can potentially be a source of misinformation, especially around eligibility. For example, those who have been unsuccessful in obtaining support can have a negative influence on others who are considering applying, especially if the potential applicants are unfamiliar with the RMBF. If there is no affinity between the person recommending the RMBF and the recipient of this information, the negative connotation from this relationship can transfer, making it unlikely

person-to-person communication, including via volunteers,

with tangible formal information about the charity. This combines the legitimacy gained from the word of mouth recommendation together with accurate information and can help applicants build a more accurate understanding of their candidacy.

Quotes and CMO configurations

P Œ š }] š U š Z Ç [} (š v • Ç Á Z Ç] š Á • ‰ } •] š] À (} Œ š Z u U Á Z š Á
recommend it rather than just saying so. _[Expert 6]

'I think on the whole we remember conversations better than we remember written information, and word of mouth carries usually an emotive content which will stick more. You know if you read a poster] š [• o l v Á Z] š v] š } • v [š v • • Œ] o Ç u l } v v š] } v Á] š Z š Z Ç } µ l v } Á / [À v } š v Z š] Z Ð & } (} Œ Ç Œ • v š Z Ç [À o Á Ç • v
organisation etc etc, then I think those conversations stick more. _ € š µ o v ( ]] Œ Ç ð •

CMO 8: Word of mouth strategies should be accompanied by official information

: When doctors and medical students talk about organisations or support that they are not fully familiar with, there is the potential for word of mouth to be a source of misinformation.

: If people who talk about the RMBF to peers or colleagues are encouraged to follow up informal

questions and people to ask to gain this knowledge. Individuals from less advantaged backgrounds, who are already more financially vulnerable, may thus be less likely to know how to seek support.

Because the RMBF only provides support for students in their final two years of medical school, medical school support staff reported being of the RMBF until later in
úKŜ Ŏ2dzNăŜ øKŜy ăűdzŘŜyűă øŜNŜ ŜfλΞλōfŜY ε Á } v [š u v š] } v š Z u] v š Z u] v } À] } µ • o Ç
š Z Œ Ç Œ • µ • š Z Ç [Œ v } š o] P] o U v *tioning* } v [š *ething* *that* Z š Ç } µ •

^ *mean a lot of induction, /* }v[šlv}Á Z}Á uµ Z šZ ZD &]•]vÀ}oÀ]v Ç}µ lv
junior doctors in August in February every year, I mean I would think that if they had a stand or a representative t *either one or more doctors in each trust that has maybe been th 595.32 r3n9De23(u)h*

Enablers

Whilst there was a minority view from experts that potential applicants would expect a high level of detail to secure financial assistance, the majority view was to

 checks and balances (Expert 7) and resetting the burden of proof to them is handled appropriately and responsibly, supported robust processes and the requirement to balance organisational responsibilities against individuals needs. However, there was a keen sense that the burden of proof existed in part because of a perceived lack of trust in potential candidates. Experts suggested that the charity could demonstrate enhanced levels of trust and thus reduce the amount of information they required, encouraging applications.

Whilst in general beneficiaries found the application process of the RMBF easier in comparison to applications for government benefits, beneficiaries who were acutely unwell required and welcomed help from family, friends, or social care professionals. Caseworkers had been kind and gently encouraging, which beneficiaries had appreciated. They had really aided

, with caseworkers being quick to respond to beneficiaries via email and being a constant support throughout the process. Having a caseworker, a direct point of contact who was consistent, accessible and responsive, made the application process much easier.

There were mixed views on the

applicant could have a referral or similarly someone supporting the application which could give the RMBF a sense of trust that the applicant is in genuine need. Other lighter touch process could include viewing rather than uploading supporting information, requesting only information that was strictly necessary, that which could not be obtained from other sources, and those relating to emergency assistance, as above. Another suggestion was to tailor the application and make it lighter touch for those with specific circumstances, the example given was for applicants with mental health problems who were often reported to have the greatest challenges completing applications and curating the proof required. Suggestions included alternative application pathways and checklists for the caseworker to complete.

To increase trust in applicants, a common example given was that of emergency funding, which would typically be for one-off payments of less financial value. In this context shorter applications and less supporting information expedited assistance, but came with the acknowledgement that the normal LJN2ŎŜăăŜă 2Ŧ Ŏ2yãλăúŜyŎè I·yŘ ŘdzŜ ŘλfΛƎŜyŎŜ ǿŜNŜ ŎdzNúI·λfŜŘ λy˜ŦI·Ø2dzN 2Ŧ I·Ŏ˺y2ǿfŜŘƎλyƎ ŭKŜ ŎI·yŘλŘI·ŭŜă Ω ŜÈúNŜY˜Ŝ ySŜŘ I·yŘ ŭKŜ ŎKI·NżŭëΩă úNdzăú λy˜ŭKŜY˜Φ

Quotes and CMO configurations

The following CMO configurations and illustrative quotes provide examples of two strategies to help with the application process. As above, these examples were suggested by people interviewed for this study.

CMO 11: Co-authoring the application

Potential candidates suffering from ill-health and the consequences of financial difficulty lack the additional resources required to access the w a . CΩă services by completing a detailed application form. Support for the application process by others (volunteers/caseworkers/other third sector organisations) helps candidates to complete the form by clarifying and supporting the process, thus reducing the burden and additional stress for applicants. This leads to increased completion rates for applications because it is less likely that applicants fail to start or give up mid-way through the application

^ µ•]š[• ‹µ]š Œ •}v o šZ š šZ ZD & Á vš• š} • } À]}µ•oÇ *situations* t šZ š[• ‰Œ}‰ Œ dP}ÀŒ}v}v}v *However, I think it would be really helpful if they could,*](šZ Ç v[š‰Œ}À] šZ šl]v }(• *volunteers themself to see whether there is something they can link people up to,* ÁZ šZ Œ]š[• šZŒ}µP

]• Z oo vP U v •}]( ]š[• (š} (u š]vP }((Œ iµ•š š} (]oo
the form that could be one initial hurdle which could help some people X_ € Beneficiary 17]

CMO 12: Reducing the burden of proof

Charities have multiple (and often conflicting) responsibilities regarding financial governance that can create a perception of distrust of potential applicants because of the amount of information they need to collect in order to give money to those in need.

Attempts to establish a sense of trust, made via implementing a less bureaucratic application process (with reduced amounts of required supporting information) might facilitate the engagement of applicants because the process seems more straightforward and achievable.

Increased applications, even from those in very difficult personal circumstances, as the process may seem more achievable.

^KI Ç •} šZ Ç ‰Œ}À] (]v v] o •µ‰‰}Œš v}š]v šZ]• }vš ÆšU µš]
](Ç}µ[À P}š]•]o]šÇU šZ Ç ‰Œ}À] (]v v] o •µ‰‰}Œš š} Ç}µ
have the adjustments in place. And there is a seismic shift in terms of the uptake since they simplified their process. It used to be very bureaucratic, as you expect from a government initiative t lots of paper, lots of signatures, it is effectively now, you go to their email, there is a form, you say what is wrong with you, you get a doctor to sign it, and they can set it up almost in a day, within 24 hours. And I can see how many people are using it so easily now. So surely if the process is easier, less bureaucratic, you get more reach. But I would say another probably equally important factor is how much you are in need, i.e., obviously the more in need you are, the more effort you put in to get something even if it
]•](( ] µoš ‰Œ} µŒ ooÇX_ € Æ‰ Œš õ•

'Well I mean maybe one of the options could be is to have a temporary, you know if people are really desperate in dire need, to have that much easier temporary agreement while people get stronger so they could go through a more proper assessment X[Actual Beneficiary 5]

Theme 2.2: Stigma and sharing sensitive information

This sub-theme focuses on challenges related to stigma (including what helps to experience lower levels of stigma) and suggested strategies to reduce stigma that could be used by the charity. At the end of this section, we present five examples of CMO configurations to illustrate strategies for alleviating stigma and allaying concerns about sharing sensitive information: how the RMBF could assist potential beneficiaries through normalising ill-health in the medical community (CMO 13), supporting the disclosure of sensitive information (CMO 14), providing reassurance from others who have been through the process (CMO 15), ensuring confidentiality of information from the medical regulator (CMO 16), and broadening RMBF funding opportunities as enabling work (CMO 17).

Barriers

Stigma was reported to be a major barrier to application and can hinder potential beneficiaries from seeking timely support from the RMBF. Ill-health and financial difficulty in medicine are stigmatised and not spoken about and there were many reasons given by participants as to why disclosing sensitive information was challenging.

in the medical profession leading to an avoidance of help-seeking. Doctors and medical students identify as high achievers, used to succeeding in a challenging profession independently and being self-ăʤŦŦʌǑʌŜyŷŸ ά Z] P Z Z] À Œ • Y] v
many cases the individuals feel that they should be self-reliant, self-resilient, and they have tried to

*sort it themselves*ć ó9ĚLJŜŃú oúΦ ! Ř2ŎúƵŃΩă ƛŘŜyűƛúè ƛă ŭKI·ŭ 2ŦŜĚLJŜŃú I·yŘ KŜI·fŜŃΣ ØKŜŃŜ ŭKŜè I·ŃŜ ŜĚLJŜŎűŜŘ ŭƵŃŜI·ŭ ŭKŜ ăƛŎ] I·yŘ yƵú ōŜ ăƛŎ] ŭKŜY˘ăŜfØŜăΣ ă2 Y˘dzŎK ă2 ŭKI·ŭ ŭKŜè ŎI·y˘ŦŜŜf ŭKI·ŭ ŭKŜè I·ŃŜ ά*superhuman*ć (Actual Beneficiary 11, Actual Beneficiary 16) and cannot become unwell. Beneficiaries described Y˘ŜŘƛŎƛyŜ KI·ă I· ŎdzfűdzŃŜ 2Ŧ LJŃŜăŜyűŜŜƛăY˘Σ ØKŜŃŜ ŭKŜŃŜ ƛă ŭKŜ ŜĚLJŜŎűI·ŭƛ2y˘ ŭKI·ŭ I· Ř2ŎúƵŃ ά*carries on whatever*ć ó!ŎűdzI·f .ŜyŜŦƛŎƛI·Ńè cúT y2 Y˘I·ŭűŜŃ K2Ø ăƛŎ] they are, doctors do not take time off work. There can be feelings of guilt for being unwell because of the impact upon the rest of the team. Medics ØŜŃŜ ŘŜăŎŃƛōŜŘ I·ă ØŜŃè Ŏ2yăŎƛŜyűƛ2dză I·yŘ Øƛft ά*flog themselves and not necessarily have good insights into their own health*ć óActual Beneficiary 6). Stigma towards mental health could be internalised by doctors themselves, with their internal critic judging themselves harshly.

in addition to feelings of failure meant doctors were uncomfortable with seeking help for financial or health difficulties. Beneficiaries explained that pride and shame were key reasons that doctors would not approach the RMBF, even if in dire circumstances, preferring if possible to keep their circumstances private; this links with the assumptions that doctors are well-paid and therefore well-off, and should not get ill themselves. Therefore, there was a strong desire

, or to have detailed scrutiny of personal circumstances and finances, and this could lead to easier options being pursued, like getting a loan or increasing a mortgage rather

*disclose something to another agency it may go to the regulator, to the GMC, and it may affect your career and fitness to work. So I suppose you need to think about how you present yourself in terms of confidentiality, impartiality, and communication with the regulator*ε ó9ÈLJŜ№ú ϕúϕ

Historically, the GMC were reported to have made disproportionally harsh judgements on doctors with mental health illnesses, and that although experts noted that the GMC have taken a more supportive stance in recent years, anxieties rem Ι·λγŜŘ Ι·ō2ʤzú ΰKŜ №ŜƎʤfΙ·ΰ2№ΩăΰN№ŜΙ·ΰYΎŜyΰ 2ŦŘ2ŎΰΩ2№ăϕ Issues about fitness to practisŜ ǿŜ№Ŝ Ι· KʤzƎŜ Ŏ2yŎŜ№Y ōŜŎΙ·ʤzăŜ 2ŦΰKŜ Da /Ωă Ι·ōλΰúè ăΰΩ2LJ Ι· ŘΩŎΰΩ2№ working or progressing in their career. This fear of fitness to practise could also mean doctors are not honest about the severity of their symptoms with health professionals who may be able to assist them (e.g., occupational health), meaning that they do not receive appropriate help. One beneficiary explained that the Practitioner Health Programme was an exception that would be considered safe as they have a memorandum of understanding with the GMC.

The sensitive information required on the application form created challenges for beneficiaries. Some described needing to involve others in providing the required evidence in their application to the RMBF and because of the sensitive nature of their information, this had been challenging for them. For example, one beneficiary who was an inpatient at the time of the application, had needed to ask hospital staff and their partner to print out personal information, such as bank statements, which was ά*embarrassing*ε ó ! ŎΰʤzΙ·f . ŜyŜŦλŎλΙ·№è млύϕ ! ă]λγƎ LJΙ·№ύyŜ№ă ΰ2 LJ№2ØλŘŜ ΰKŜ№№ LJŜ№ă2yΥΙ·f ŦλyΥ·yŎλΙ·f λyŦ2№ΥΙ·ΰλ2Y was a further potential source of discomfort. Another beneficiary described the fact that the application process was embarrassing because she had not previously discussed with her husband their financial expenses in the level of detail required on the form, which led to a delay in its completion. Another barrier was a fear of being judged on the financial decisions made when providing detailed financial information in the form of bank statements as the RMBF would clearly see the exact details of how they are spending their money. Further, if the RMBF had then declined the application that would have been a very negative experience inducing feelings of guilt for applying and being deemed ineligible because they were not in sufficient need.

Enablers

enable doctors and medical students to talk about personal matters, to rehearse their story and through practise begin to feel more comfortable in disclosing sensitive information. These informal conversations facilitate future formal conversations and make it easier to disclose personal information on the application form. One of the experts felt ΰKΙ·ΰ ΰKŜ wa .C KΙ·Ř ă2YŜ ά*credibility, and kudos*ε ó9ÈLJŜ№ΰ мфύ Ι·yŘ ǿ2ʤzfŘ ōŜ fŜăă ăΰλƎΥΙ·ΰλăλγƎ Ŧ2№ Ι· doctor to approach than applying for government benefits.

The were reported to be more comfortable in talking about topics that were often stigmatised, for example mental health, because it had become more acceptable in society and in school to do so. Medical students were reported to have greater opportunities to have supportive conversations with colleagues because medical schools have established systems of support and named tutors whom they knew they could go to.

Due to the stigma surrounding ill-health and financial difficulty and the fear of others finding out which would lead to further shame, anonymity and confidentiality in the RMBF is of paramount importance. ‰ ‰ o] v š • [Á } Œ l l • š µ wę s]sv •iš]šr]aš]]sv •it was reportedly associated with a reduced chance that the medical community would find out about their ill-health and its financial ramifications. For medical students this meant keeping personal information outside the medical school, as was keeping information away from employers for doctors. Sharing sensitive

CMO 13: Normalising ill-health in the medical community

The culture of medicine is one where doctors are expected to be the healers and not become ill, and ill-health is stigmatised. : If the RMBF uses promotional material, for example case studies or videos of ill-health in doctors that demonstrate this can happen to anyone through no fault of your own, and how they were supported by the RMBF, they will normalise doctors becoming ill which will change the perception in the medical community that doctors do not become sick and reduce the stigma associated with help-seeking. : Doctors more likely to approach RMBF.

'I think it was on wellbeing, and he stood in front of the lecture theatre with 200 of us, and just said

stigma attached to, Á o o / š Z] v l] š [•] ((Œ v š š } • š] P u U t *it is* š Z] v *with*] š [• u } Œ
trust I think. Medical schools and NHS employe Œ • u l ‹ µ] š v ((} Œ š š } • Ç š Z š š Z Œ
• š] P u U µ š / i µ • š } v [š š Z] v l š Z š v Ç } v Œ o o Ç o] À •] š X ^ } / š
stigma because the narrative is there to say that you know disclosure is encouraged and there is
• µ ‰ ‰ } Œ š À] o o U µ š] š i µ • š } • v [š • u š } Z À š Œ v • o š š }
disclosure.

Enablers

In the three-step process of seeking support from the RMBF (caseworker conversation, application form completion and review by the Grants and Awards Committee) the most critical step in provoking a sense of candidacy is the . Various features of this interaction are crucial to legitimising potential applŏĬ·yűă Ŝy∃Ĭ·∃ŜϒŜyű ø↋ΰK űKŜ ŎKĬ·ℕ↋ΰè℗

Firstly, there is the interpersonal aspect of the conversation and the forming of a relationship with the potential applicant. Participants reported that about the doctor or mediŎĬ·f ăűdzŘŜyűă ₮↋yĬ·yŎ↋Ĭ·f Ř↋₮₮↋Ŏdzťű↋Ŝă Ŝyãdzℕ§Ř űKĬ·ű Ĭ·LJLJť↋ŎĬ·yűă ₮Ŝťű Ŏ2ϒ₮2ℕűĬ·ōfŜ Ř↋ăŎdzăă↋y∃ their challenging circumstances. These conversations helped potential candidates feel less isolated, reduced their anxiety about contacting the organisation, gave them encouragement and legitimised their approaching the RMBF. Beneficiaries described very positive relationships with their case workers, who were described as kind, considerate, respectful, and thoughtful. Caseworkers were also described as helping beneficiaries be independent and treating them with dignity, showing their skill at enabling beneficiaries to develop

and can also give

.

More were thought to be important in conveying the likelihood of a successful application to the fund. Whilst case studies have been mentioned, experts suggested providing data about the chances of a successful application, data around the level of awards and the number of doctors and medical students who had been supported by the RMBF.

Quotes and CMO configurations

The following CMO configurations and illustrative quotes provide examples of two strategies to ƛϒLJℕ2ØŜ LJ2ű$ýűƛIˑf I·LJLJfƛÔI·yűăQ ăŜyãŜ 2₮ ŎI·yŘƛŘI·Ôè℗ !ă above, these examples were suggested by people interviewed for this study.

CMO 18: Good news stories

Doctors and medical students work and study involves them being exposed to people in extreme situations and suffering significantly with the effects of ill-health and financial difficulties. This close contact with others who suffer may normalise the experience of hardship and undermine their own sense of worthiness of assistance and delegitimise their sense of being deserving of financial support.

a 2ℕŜ ∃2ŘŘ yŜøă ăű2ℕƛŜăΣ I·yŘ ŘI·úI· ℕŜfI·úƛy∃ ű2 űKŜ ăʤŎÔŜăă 2₮ 2űKŜℕ Ř2Ôű2ℕăQ I·yŘ ϒŜŘƛÔI·f

they would be excluded if for example, they had some savings, even if minimal, or had a small amount of low-

Having the option to tick an ά2ΰKŜℕέ ō2È ʎyˇΰKŜ I·LJLJfΛÖI·ΰʎ2yˇόΛΦŜΦΣ ʎyϡΰŜI·Ř 2Ŧ ΰKŜ ăΰI·yŘI·ℕŘ flΛăΰ 2Ŧ ŜfΛ∃ΛōΛfΛΰè criteria) might give people the confidence to contact the RMBF to find out more about whether they are eligible, leading to more eligible people applying who might not have done so otherwise. If the RMBF promotes that they support people on a , this will make them appear inclusive and flexible, which may encourage people who are unsure or hesitant to apply. Providing some clarity about what exceptional circumsΰI·yÖŜăΣ I·yˇ ά2ΰKŜℕέ ō2ÈΣ 2ℕ I· ÖI·ăŜ-by-case basis, will

Theme 3.2: Presentation of the criteria

This sub-section is concerned with how the eligibility criteria are presented. From the perspective of those who support doctors and medical students in need, and who signpost people to relevant

An , such as a decision tree, could help to engage people who might have difficulty either navigating the full criteria, or who are not able to contact the RMBF during normal working hours. This would allow them to get an idea of whether they are eligible or not without feeling overwhelmed, by breaking the information down instead of providing it all in one go. A checker could also give a more positive indication of whether to apply than just reading the criteria, which may lead to more applications from people who are struggling and unsure. Having a series of steps to follow instead of a large amount of information will help to make it more manageable, and also make the

v [š š Z] v l } (, šu Z] o E k n o š v Z] v e P *very easy statements t right now if you answer yes to these three then you have a conversation with us, we may be able to help you* X _ € Æ ‰ Œ š ï •

^/ š u] P Z š Z À v Z o ‰ (µ o š } Z À Ç Z • } u l] v } ((o } *Áble* Z Œ š š } *or not, and then I think talking to someone on the phone would have been the kind of easiest way to* P š Œ } µ v u } • š } (š Z ‰ Œ } o u • U µ š š Z] v] š] o š Z] v P] •]] v P Á *actually thinking oh I will actually make that call. So um, yeah I think the easiest way for that would be to have some kind of flow chart online* X _ € š µ o v ( ]] Œ Ç í ô •

Findings from Phase 4 Survey

This section presents findings from the survey on (i) how medical students and doctors understand ill-health as this is one of the key criteria used by the RMBF for eligibility, (ii) levels of perceived stigma around mental health and financial difficulties experienced by survey participants as it might serve as a barrier to seeking help, and (iii) grouping participants into so called profiles, i.e., understanding if people with certain attitudes (levels of stigma) have certain perceptions toward strategies that could be used by the charity.

Understanding of criteria: ill-health

The RMBF notes that they support those with ill-health. To explore how medical students and Ř2ŎúƨăλyúŜŃŁJŃŜúűKλăűŜŃYΣădzŃØŜè LJI·ŃúλŎλLJI·yűă ØŜŃŜI·ă]ŜŘ ØKI·ű űKŜè Ŏ2yãλŘŜŃŜŘ ű2 ōŜ ά λff-KŜI·fűKέY

- 97.7% (432) considered ill-health to be physical health issues;
- 97.1% (429) considered ill-health to be mental health issues;
- 89.8% (397) considered ill-health to be physical or mental disability;
- 86.7% (383) considered ill-health to be addiction (e.g., alcohol, gambling, etc.);
- 81.9% (362) considered ill-health to be stress/burnout;
- 79.6% (352) agreed that health issues due to domestic abuse could be considered as ill-health;
- 78.3% (346) agreed that health issues due to old age could be considered as ill-health;
- 1.4% (6) considered ill-health to be something else (e.g., financial issues, miscarriage).

In an open-ended question we asked participants to reflect on the term ill-health and this provided ă2YŜ]Ŝè λyãλΞKűă λyΥLJI·ŃúλŎλLJI·yűăΩ ØλŜØă 2yΥűKλă űŜŃYΦ . ŜăλŘŜă I·ăăλΞyλyΞ ØI·Ńλ2dză ŘŜŦλyλúűλ2yã ű2 űKŜ űŜŃY ill-health, participants also felt the term was provocative: ^ d Z] • *heal]h] is a provocative term best applied only when a health condition is not well controlled ie relapse or exacerbation affecting ability to function - the presence of a health condition need not inherently be deemed 'ill-* Z o šPZ articipants also made a clear distinction between disability and ill-health (*note*: RMBF lists disability as a separate criterion), stating that those who have disabilities (which might lead to financial difficulties), may not want to classify themselves as having d41.92 re0Qq0.000008871 0 595.32 841.92 reW* nBT/F1 11.04 Tf1 0 0 1 206.3

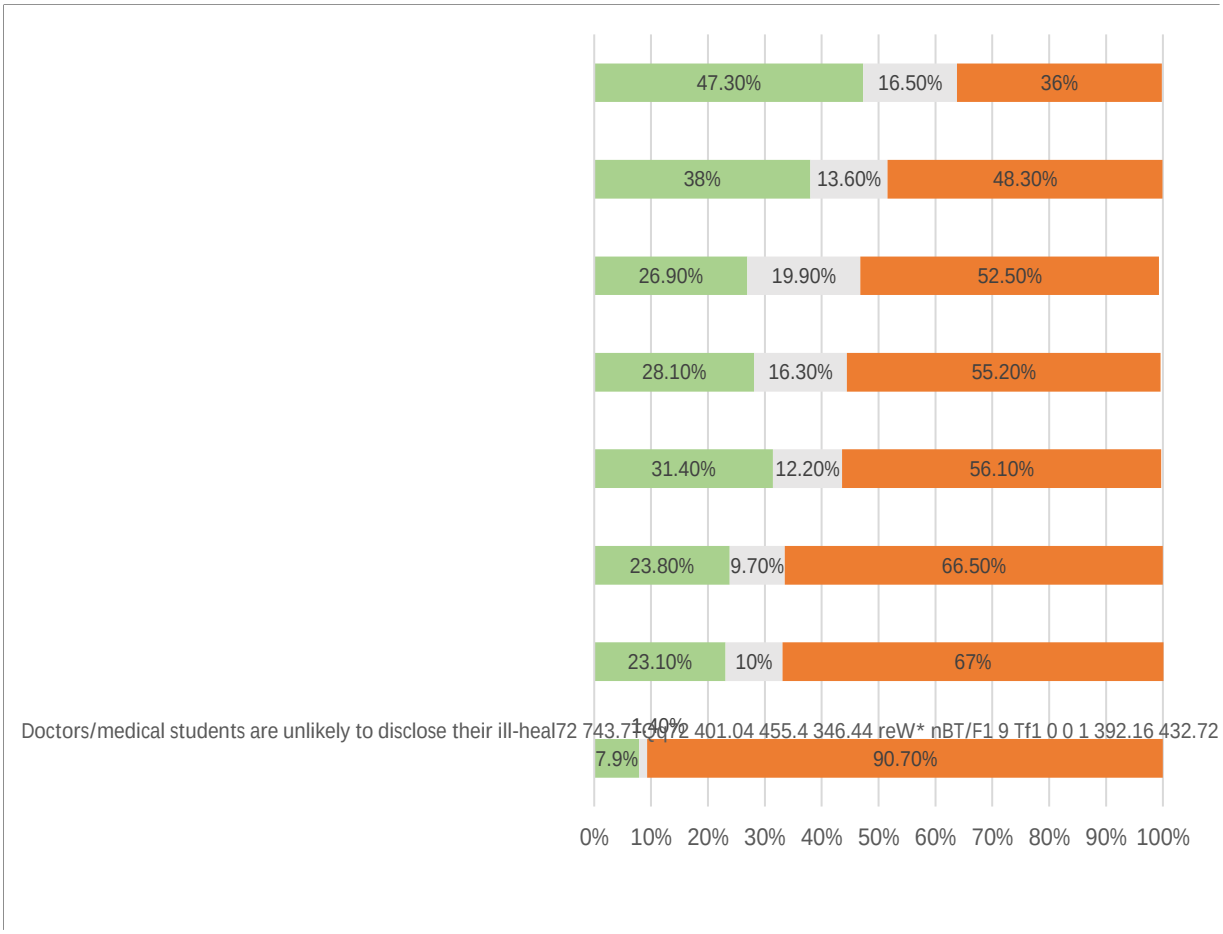

Figure 4. {dzNØŜè LJI·NúλŎλLJI·yűăΩ perceived stigma of ill-health.

On average, those in Profile 1 scored highest on perceived stigma of having financial difficulties, but lowest on two sub-scales of perceived stigma of ill-health (ill-health stigma and perceptions of risk of ill-health on FtP). Participants in this profile had the most positive attitudes towards three strategies that could be used by a charity (medicine-based charity, offering psychological/mental health support in addition to financial support, recommended by peers). Those in Profile 2 scored lowest on perceived stigma of having financial difficulties and scored intermediate on two subscales of perceived stigma of ill-health, and attitudes towards three charity strategies. Those in Profile 3 scored high on perceived stigma of ill-health (both sub-scales), and although they scored intermediate on perceived stigma of having financial difficulties, they also scored lowest on attitudes towards charity strategies.

Table 18 ăK2ǿă l·yŘ Ŏ2Y˙LJl·ℕŜă Ř2ŎúƨℕăΩ ŘŜY˙2ƎℕI·LJKʎŎ ŎKI·ℕI·ŎúŜℕʎăúʎŎă ŦƨℕJ ŜI·Ŏh profile. No significant ŘʎŦŦŜℕŜyŎŜă ǿŜℕŜ ŦƨdzyŘ ōŜúǿŜŜy˙LJℕƨ2ŦʎfŜă ʎy˙úŜℕY˙ă 2Ŧ Ř2ŎúƨℕăΩ ŘŜY˙2ƎℕI·LJKʎŎăΦ

Table 18. Demographics

				2
Doctors	54.8%	55.9%	51%	
				p>0.05
UK	88.3%	87.8%	84.3%	
Non-UK	10.7%	11.7%	15.7%	

- ¢KŜ ɤyűŜNØɤŜøă Ɨ·fă2 ɤŘŜyűɤŦɤŜŘ ű ø2 ʅŜè Ɨ·NŜƗ·ă Ɨ·N2dzyŘ űKŜ wa . CΩă ŜfɤƎɤōɤfɤűè ŎNɤűŜNɤƗ·Y
    - The criteria can act as gatekeeper to the RMBF, with people more likely to get in touch if they think they will be successful, and others less likely if they think they will not be eligible; having an option of exceptional circumstances may encourage enquiries;
    - Some groups favour detailed presentation of the criteria whereas others favour making them more accessible, so having both options available would be useful.

Supplementing findings from interviews, the survey revealed that:

- The term ćill-healthć (criteria for support from the RMBF) can be understood as including a variety of aspects (e.g., physical and mental health, stress and burnout, miscarriages), might be stigmatised, and that not all assumed groups would classify themselves as having ill-health (e.g., those with disabilities); therefore, clarification on

Figure 6. Pathways to financial difficulties.

possible to make due to limited publicly available data on medical students. These analyses of

but could also be mis-leading and lead potential applicants to erroneously assume they are not appropriate candidates.

As society generally assumes that doctors are well-paid, there are also feelings of failure and shame associated with being in financial difficulty. There is also an underlying worry that admitting to ill-health and/or financial difficulty could lead to fitness to practise concerns with the GMC (almost half of survey participants felt that doctors/medical students that seek support for ill-health problems risk being involved in fitness to practise processes), which can lead those in difficulty to not seek help or downplay the severity of their situation. We also found that there is a difference between stigma towards ill-health and financial difficulties, showing that stigma around ill-health might have a stronger negative impact on support seeking.

A further barrier is when people do not feel a sense of candidacy and therefore do not feel eligible for support from the RMBF. This may be due to not feeling deserving of support, or feelings of ŜY ōI·NNI·ăăY Ŝyű 2N ăKI·Y Ŝ I·ō2dzű ăŜŜ]ƛyƎ ădzLJLJ2NúΦ ¢Kƛă ŎI·y I·fă2 ōŜ ăŜŜy ƛy LJŜ2LJfŜΩă Ŏ2yŎerns that they would not be successful if they applied, and as it takes some time to complete the application form, that it might not be seen as worth the effort to apply.

4.2.3. Barriers and enablers: Eligibility criteria

This last sub-section will cover key barriers and enablers related to eligibility criteria, including how the criteria can act as gatekeepers, and how the criteria are presented.

How the eligibility criteria are presented can also be a potential barrier to applying with the criteria acting as a gatekeeper to support. Experts described people as generally being bad at reading criteria, 2N I·yě]ƛyŘ 2Ŧ ádăY I·ff LJNƛyűέΣ Y Ŝ I·yƛyƎ űKI·ű űKŜè Y I·è Yƛăă 2N Yƛădzyŕ ŜNăű I·yŘ ƛY LJ2NúI·yű ŘŜúI·ƛfăΦ ¦ yfŜăă it is obvious in the criteria provided, people might feel that their situation does not apply or is not serious enough, and this can lead to applications being delayed until people are at a crisis point. There can also be confusion about what is classed as ill-health, such as addiction issues or domestic violence. Bě ă2Y Ŝ ƛű ø I·ă I·fă2 ŦŜfű úKI·ű űKŜ űŜNY áƛff-KÎ I·fűKέ ƛűăŜfŦ Yƛ∃Kű ŦŜŜf ăűƛ∃Y I·úƛăƛyƎ I·yŘ űKI·ű y2ű I·ff I·ădzY ŜŘ groups would classify themselves in this way. Having an option to apply though exceptional circumstances was generally viewed positively, as it would encourage people to apply even if they are unsure of their eligibility, and might catch those people who need help who might otherwise have not ∃2ű ƛy ű2dzŎKΦ a ŜŘƛŎI·f LJN2ŦŜăăƛ2yI·fă I·NŜ Y 2ăűfě dzăŜŘ ű2 ûKƛă ûŜNY áŜĚÔŜLJúƛ2yI·f ŎƛNŎdzY ăúI·yŎŜăέΣ I·ă úKŜè will be familiar with the concept from medical school and training but again the wording could be problematic.

There were contrasting opinions about how to present the eligibility criteria, and how much information about them to share. From the perspective of experts, having transparent criteria is important: support staff are wary of signposting people to sources of support if they are unsure of their eligibility and so want to be as informed as possible about the criteria for a successful application. However, from the perspective of beneficiaries, the accessibility of the criteria is the key factor in how to present this information. When feeling unwell it can be difficult to manage large amounts of information, and people may have accessibility needs that impede

Figure 9 and Figure 10 presents these key recommendations which are also described in more detail below.

4.3.1. Raising awareness

Figure 8. Recommendations to increase awareness.

Recommendations to create the ^ Œ] Ρ Ζ š session for encouraging potential applicants to engage with the RMBF include: having clear information about the charity

Advertising Ø⅄I· Y˙dzfűλLJfŜ ℕ2dzűŜă ǿI·ă I·ŘØ⅄ăŜŘΣ ℕŜLJŜI·úŜŘfè I·yŘ ℕŜ∃dzfI·ℕfè úKℕ2dz∃K2dzú I· Ř2ŏű2ℕăΩ ŎI·ℕŜŜℕφ
Suggestions included introducing the RMBF at Trust inductions, having routine wellbeing/support talks, and displaying posters in hospital premises. Online advertising with strong social media presence (e.g., TikTok, Podcasts) was advocated, particularly for medical students and younger doctors. Targeted advertising to when doctors/students are most likely to be experiencing financial difficulty was recommended (e.g., exam times, transition from medical school to foundation year, study leave). Advertising needs to continue to account for the diversity in the profession in terms of disability, ethnicity, and belief backgrounds. Testimonials were felt to be particularly powerful. As medical students and doctors were not familiar with the non-monetary services provided by the RMBF, advertising could particularly focus on these. This could help with promoting an image of the charity as an up-to-date and inclusive organisation, which is also aware of the importance of prevention and rehabilitation.

Partnering with organisationssuch as other charities, NHS support services, health education 2ℕ∃I·yλăI·úλ2yã λy˙ úKŜ ₮2dzℕ K2Y˙Ŝ yl·úλ2yãΣ Y˙ŜŘλŎI·f ăűdzŘŜyűăΩ I·yŘ Ř2ŏű2ℕăΩ yl·úλ2yl·f ySűǿ2ℕ⌋ăΣ I·yŘ networks at the university and NHS Trust/Board level was recommended by study participants. It was also recommended to promote word of mouth strategies among peers (for example via RMBF representatives or former beneficiaries) and more formal word of mouth strategies in the workplace/at medical school (for example via managers at appraisals, or medical school tutors).

Early invention strategieswere believed to be important, such as signing up to a membership scheme for the RMBF at medical school and then being in touch repeatedly. Promotion at the right time is also key, for example, raising awareness to medical students in their final years when they are eligible.

4.3.2.

Figure 9. Recommendations to overcome challenges of process of applying.

Encouraging applicants to talk through their applications with their caseworkers might help them to more accurately assess their chances of receiving support and therefore increase their level of candidacy Sharing good news stories or data about the number or awards granted might also encourage people to apply. Including in promotional material that applications are welcome from applicants before they reach crisis point Y˙ƛƎKű I·fă2 ƛyŎ℠ŜI·ăŜ LJŜ2LJfŜ℠ă ăŜyãŜ 2₸ ŎI·yŘƛŘI·Ŏè℗

4.3.3. Clarifying the eligibility criteria

Study participants recommended having both detailed

will be considered on a caseby-case basiŠsY˙λ∃Kú ˙λyŎℕŜI·ăŜ LJŜƨLJfŜ℞ă Ŏƨy₮˙λŘŜyŎŜ ű2 Ŏƨyű·Ŏú úKŜ w a . C¢ Also, providing additional ways to access information about criteria (such as an audio option) and encourage people to contact the RMBF about applying for support regardless of their situation would help with criteria accessibility.

Figure 10. Recommendations related to eligibility criteria.

The charity might also want to consider

data collection platform (Charity CRM) was implemented. The implication of this is that the analysis will be limited due to lack of available information. Secondly, the publicly available data on the general population of doctors and medical students were limited, inhibiting the extent to which we were able to compare the characteristics of (potential) beneficiaries in the RMBF dataset with the overall population. For more detailed limitations of the RMBF data and analysis, please refer to the methods section.

6. REFERENCES

Anane, M., & Curtis, S. (2019). An exploration of the implications of employment for medical students. A comparison of widening participation students to traditional entry students. *ABSTRACTS BOOK ASM*, *July*.

Bassett, A. M., Brosnan, C., Southgate, E., & Lempp, H. (2019). The experiences of medical students from First-in-Family (FiF) university backgrounds: a Bourdieusian perspective from one English medical school. *Research in Post-Compulsory Education*, *24*(4), 331ç355. https://doi.org/10.1080/13596748.2018.1526909

British Medical Association. (2019). *Clinical excellence reworked - š Z š Æ] o o š Z š ‰ µ š } v • future at risk*. BMA Website.

British Medical Association. (2020a). Œ À } š } Œ • *ace financial*] o *shortfall*. BMA Website.

British Medical Association. (2020b). *BMA calls on Chancellor to provide enhanced death in service cover to all frontline NHS staff*. BMA Website.

British Medical Association. (2020c). *Briefing on COVID-19 and childcare*. BMA Website.

British Medical Association. (2020d). *Briefing on supporting staff who are shielding to return to work*. BMA Website.

British Medical Association. (2020e). *Call to extend*

Cleland, J. A., Dowell, J., McLachlan, J., Nicholson, S., & Patterson, F. (2012). Identifying best practice in the selection of medical students: literature review and interview survey. In

Appendix 1Literature review: methods

Table 1 presents the search term string that yielded the most relevant and manageable yet comprehensive set of results and was used for both academic and grey literature databases.

Table 1. Finalised search term string and search refinements

Appendix 2. Interview guides

The following guides are for the semi-structured interviews conducted with experts, actual beneficiaries, and potential beneficiaries. Semi-structured means that the questions listed are only a guide: the discussion in the interview may go in a different order than directed in the guide, and some questions may transpire to not be ℕŜfŜØI·yű ű2 űKŜ ƛyűŜℕØƛŜøŜŜăΩ ŜÈLJŜℕƛŜyŎŜăΣ ă2 űKŜ ŜÈI·Ŏű Ŏ2yűŜyű 2ŦŜI·ŎK ƛyűŜℕØƛŜø Ƴ I·è ŘƛŦŦŜℕ ăfƛ∃Kűfê ŘŜLJŜyŘƛy∃ 2ƴ øKI·ű űKŜ ƛyűŜℕØƛŜøŜŜăΩ Ŧ2Ŏdză űKŜℕ ŘƛăŎdzăăƛ2ƴ2y℗

Note that all interviewees will have been asked in advance to watch a brief video about the RMBF. If they had not been able to watch it, they were offered to watch it at the start of the interview.

Interview guide for experts

    a. If the RMBF application and assessment processes reassure and comfort applicants (in addition to assessing their financial need), then uptake will increase (because applicants: will feel safe and secure in asking them for help; will not feel judged or a failure).
    b. If the process to becoming an actual beneficiary is challenging, potential applicants will not seek help or will delay seeking it until desperate (because it is difficult to complete such a process when experiencing ill health or a mental health crisis/because doctors are incredibly busy people with limited free time to complete and evidence an application).
3. Criteria and uptake
    a. If the RMBF clearly outlines the eligibility criteria and ways to apply, then they can rely on suitable beneficiaries self-selecting (because doctors/medical students/their families are individuals capable of conducting the necessary self-assessment required for this/because the criteria are clear and easy to understand/because the criteria successfully generate a sense of candidacy).

The second stage was to test these programme theories by presenting them to various stakeholders to see if they agreed or disagreed with them, and to investigate in detail of why an aspect of the intervention did or did not work. The research team tested the developed theories in interviews with experts (people who have experience of supporting doctors, medical students, and their families through ill-health and/or financial difficulty; Phase 2), actual beneficiaries (people who have received support from the RMBF; Phase 3), and potential beneficiaries (people who have not received support from the RMBF but who have experienced financial difficulty and ill-health; Phase 3), and also in a survey for doctors and medical students (Phase 4: Survey part).

The findings from the interviews and survey were then synthesised with findings from a literature review (Phase 1) and secondary data analysis (Phase 4) to explore the levels of financial need and needs that may be unmet.

2.3. Advisorygroup

Participatory design is inherent to a Realist evaluation framework, and therefore we formed an advisory group consisting of representatives of those groups the research is designed to impact (members of the RMBF and beneficiaries) as well as other experts in the area of financial difficulties due to ill health. This group met four times throughout the project and provided input at various stages, including but not limited to: commenting on the overall study design, the interview schedules and survey questions, helping to plan recruitment strategies, and contributing to the discussion of the emerging findings. Their input helped to reduce potential researcher bias, allowed new perspectives, and enhanced the credibility and impact of findings by adding nuance and depth to interpretations.

2.4. Research Phases

This section will present the methods of each research phase: Phase 1: Literature review; Phases 2 and 3: Interviews with experts and actual/potential beneficiaries; Phase 4: Secondary data analysis and survey; and Phase 5: Data Synthesis.

Figure 6. Pathways to financial difficulties.

- ¢KŜ ɤyűŜNØɤŜøă Ɨ·fă2 ɤŘŜyűɤŦɤŜŘ ű ø2 ʅŜè Ɨ·NŜƗ·ă Ɨ·N2dzyŘ űKŜ wa . CΩă ŜfɤƎɤōɤfɤűè ŎNɤűŜNɤƗ·Y
    - The criteria can act as gatekeeper to the RMBF, with people more likely to get in touch if they think they will be successful, and others less likely if they think they will not be eligible; having an option of exceptional circumstances may encourage enquiries;
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Unknown	2.1% (7)	0	35% (28)	2.4% (1)
Educational supervisor	1.8% (7)	0	0	0
General Medical Council	1.8% (7)	0	0	0
Other charity	1.2% (4)	0	0	4.9% (2)
Medical Defence Union	1.2% (4)	0	0	0
RMBF event/presentation	1.2% (4)	0	2.5% (2)	0
Royal College/Royal Society	1.2% (4)	0	0	0
Royal Medical Foundation	0.9% (3)	0	0	5.9% (2)
tKèăìÕìl·yã moms group	0.9% (3)	0	0	0
Doctors Support Network	0.9%			