Ref: RMBF Invitation to tender

Research into Unmet Need in Medical Practitioners, Medical Students, and their Families

Final Report

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Prepared for the Royal Medical Benevolent Fund

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Executive summary

Research objectives and questions

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 ("Research into unmet need" tender document). The current research project aimed to answer the following four research questions (sub-questions are presented in the results section):

1. Who is experiencing financial hardship within the profession?
    a. What are the reasons for financial difficulties experienced by medical students, doctors, and their families?
2. To what extent does the RMBF meet the needs of those experiencing financial difficulties?
    a. Are there unmet needs of actual and potential RMBF beneficiaries (medical students, doctors, and their families)? If there are unmet needs what is the scale of this?
    b. Does the demographic data vary between current RMBF beneficiaries and the overall cohort of doctors and medical students (including geographical location)?
3. What are the overall strengths of the RMBF's current services, activities, and criteria for support for the profession?
    a. What is the level of awareness of the charity?
    b. Are there geographic differences across the UK in doctors' and medical students' views on and willingness to approach the RMBF?
    c. What is the experience of seeking support from the RMBF from the actual beneficiaries?
4. What aspects of the RMBF's current services, activities, and criteria for support for the profession could be developed to improve their overall effectiveness?
    a. What hinders or drives potential beneficiaries to seek timely support from the RMBF?
    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?

Methodology

Ethics

The project received ethical permission from the UCL Research Ethics Committee (REF: 13311/003).

Theoretical framework

This study utilised a Realist theoretical framework focusing on *what works*, *for whom*, *in what circumstances*, and *how*. This approach 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 charity. To identify what hinders or drives potential beneficiaries to seek timely support from the RMBF and what strategies could be used to reach potential beneficiaries, we explored the **contexts** in which certain things work or not, the **mechanisms** through which an intervention operates, and the intended or unintended **outcomes** of particular mechanisms. We did so through interviews with

experts and actual/potential beneficiaries, and part of the survey which was completed by medical students and doctors. Findings from other research Phases (literature review, survey, secondary data analysis – see below) were used to address parts of the theoretical framework (e.g., explore the reasons for financial difficulties in the profession – *for whom*) or provide background information.

Phase 1: Literature review

A review was conducted to gain an understanding of the existing literature about financial need in medical students and medical practitioners, specifically on: who experiences financial difficulty; why do they experience financial difficulty; and what are the possible consequences of experiencing financial difficulty. Both academic literature (including peer-reviewed research articles, books, and PhD theses) and grey literature (including commissioned research reports, relevant trade publication articles, and relevant organisation webpages) were scanned, focusing on the UK context, and on doctors, doctors-in-training, and medical students. From 1491 initial hits, 47 records were included in the final review.

Phase 2: Interviews with experts

Online semi-structured interviews with 25 experts (individuals with experience supporting doctors, medical students, and their families with ill-health and/or financial needs) were conducted to gain insight into their perspectives on awareness of the RMBF, the process of applying for support, stigma around ill-health and financial need, and the RMBF's eligibility criteria. These were analysed to identify unmet financial needs in the profession, to explore the barriers and enablers for people accessing financial support, and strategies to improve reaching those potentially in need.

Phase 3: Interviews with beneficiaries

Online semi-structured interviews with 16 actual beneficiaries (individuals who have received financial support from the RMBF) and 6 potential beneficiaries (individuals who have experienced ill-health and/or financial difficulty but who have not applied for or received financial support from the RMBF) were conducted to gain insight into the lived experience of seeking financial support, or not seeking support, and to explore the barriers and enablers for people accessing financial support.

Phase 4: Secondary data analysis and survey

A secondary data analysis was conducted using data collected by the RMBF to gain insight into the characteristics of RMBF beneficiaries and to compare these to the characteristics of the overall cohort of doctors and medical students in the UK (using the GMC Data Explorer and the State of Medical Education and Practice in the UK reports).

A survey study was conducted amongst a sample of doctors and medical students in the UK to investigate their experiences of financial difficulties, their awareness of resources to alleviate financial difficulties, their perceptions of and attitudes towards ill-health problems and financial difficulties, and their help-seeking intentions.

Phase 5: Data synthesis

The last phase of this study was to synthesise the findings from all the research phases and provide the RMBF with implications based on these findings.

Results

Research question 1: Who is experiencing financial hardship within the profession?

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

We drew on the findings from Phase 1 (Literature review) and Phase 4 (Secondary data analysis) to explore the reasons for financial difficulties in the profession. All medical students and doctors might be at risk of financial difficulties at some point in their career. Several groups of medical students/doctors were specified as experiencing financial hardship. Regarding students, those coming from a lower income background, international medical students, mature students, disabled students, those experiencing bereavement, those with ill-health, and those studying during Covid-19 were experiencing financial difficulties. Regarding doctors, medical trainees, international medical graduates, doctors with long-COVID, doctors with caring responsibilities, with less secure contracts (e.g., locums), doctors suffering from ill-health, and those who had been sanctioned as a result of the fitness to practise process were all identified as risk groups for financial difficulties. For doctors, time out of work, administrative issues, and childcare factors could lead to financial difficulties. Reasons for experiencing financial difficulties for both doctors and medical students included personal troubles or financial requirements related to studies/training/work that could impact their finances, and barriers to access working or financial support. The consequences of financial difficulties might be significant for medical students' and doctors' lives and careers (e.g., result in dropping out from medical school or developing mental health issues).

Research question 2: To what extent does the RMBF meet the needs of those experiencing financial difficulties?

RQ2.a. Are there unmet needs of actual and potential RMBF beneficiaries (medical students, doctors, and their families)? If there are unmet needs what is the scale of this?

The findings from Phase 2 (Interviews with experts) and Phase 4 (Survey) helped to answer the research question about unmet needs of potential beneficiaries.

A large percentage of medical students and doctors who completed the survey worried about their finances at some point in their lives (84.2%) and one in three (33.5%) experienced financial difficulties (defined as the inability to meet financial obligations). Over half (64.5%) of participants knew colleagues/fellow students who experienced financial difficulties.

Medical students and doctors reported experiencing financial difficulties at all stages of their career (often more than once); for example, approximately one in two experienced financial difficulties during earlier years of medical school. Less than half (38.5%) of those who experienced financial difficulties experienced it due to the same reasons as the RMBF provides support for (illness, bereavement, caring responsibilities). Other reasons for experiencing financial difficulties were related to high costs of living and study (e.g., exams and membership), unexpected bills, delays in pay, contractual issues (e.g., zero-hour contracts), and poor financial planning skills.

When choosing sources of support, medical students and doctors who filled in the questionnaire reported picking services which were well-known to them, easy to access, and trustworthy (e.g., confidential). Most participants (over 50%) sought help from their families, workplace/university, or student loan companies; a lower percentage of participants sought help from charities (23%). A total

of 70.3% participants said that the support they sought (from various resources) was helpful for overcoming their financial difficulties. Support was not helpful when it was a short-term solution followed by longer-term consequences such as paying off debt, when the amount of money received was small so financial issues persisted, or when structural issues (e.g., zero-hour contracts) were not resolved. Some participants felt that the support may be limited in that it may not alleviate all financial pressures and might be insufficient to compensate for low pay or long periods of study.

The main reason why participants did not seek help were said to be stigma, feelings of shame, and considering oneself responsible for their own finances. A lack of clarity about eligibility criteria, a lack of awareness of resources available to alleviate financial difficulties, and lengthy, complex application processes were other important reasons to not seek help.

From the interviews with experts several groups whose needs are (potentially) unmet by the RMBF were identified. Some groups highlighted by experts were ineligible for support from the RMBF (e.g., earlier year students; difficulties not due to ill-health). Some groups were eligible but potentially underserved due to being unaware of the RMBF (including accessibility challenges of promotion material; e.g. neuro-diverse doctors), or finding the application process long/difficult and creating an additional emotional burden (e.g., disabled students, widening participation students, trainees, overseas doctors, those with non-substantive employment, those with caring responsibilities, those with savings, those with addiction issues, domestic abuse victims, and those significantly impacted by the pandemic).

RQ2.b. Does the demographic data vary between current RMBF beneficiaries and the overall cohort of doctors and medical students (including geographical location)?

Phase 4 (Secondary data analysis) findings reveal that the RMBF beneficiaries' demographic characteristics are similar to those on the medical register in terms of gender, age, and region. Even though slight variation was noticed in specialties/grades (e.g., a lower proportion of foundation doctors were helped by the RMBF), due to the large number of missing data in the RMBF dataset firm conclusions cannot be made. Regarding students, a larger percentage of male students approached the RMBF, but that was the only comparison that was possible to make due to limited publicly available data on medical students.

We also compared changes in demographic characteristics of the RMBF beneficiaries over time. More female, younger, and single doctors were helped by the charity more recently. There was no significant change in the regions beneficiaries were from. There was also no significant gender difference among medical students over time, but more of the younger students were supported by the charity more recently.

Research question 3: What are the overall strengths of the RMBF's current services, activities, and criteria for support for the profession?

RQ3.a. What is the level of awareness of the charity?

We draw on Phase 4 (Secondary data analysis and Survey) findings to answer the research question about the awareness of the charity. Overall, just approximately one third of medical students and doctors (36.9%) who completed the survey said that they have been made aware of available financial support for them throughout their career. Survey participants were also specifically asked about the awareness of the RMBF: 44.3% knew about the charity (more so doctors than medical students; 60.4%

vs 25%). Most of the medical students and doctors who responded to the survey were familiar with the financial support provided by the charity, but less so with other services.

Based on the survey and the RMBF data, the largest proportion of medical students and doctors learnt about the charity through advertisement in medical journals, through their medical school/university, an online search, or a family/friend/colleague.

Half of the participants (47.4%) said that they would seek help from the RMBF if they were in financial difficulties. Positive views of the charity from medical students and doctors who completed the survey included the open, honest, supportive, and non-judgemental attitude of the charity and additional non-monetary support provided by the RMBF. Some of the reasons for not approaching the RMBF were a lack of awareness about the support provided by the RMBF, feeling shame or undeserving, and believing that support from the RMBF is only available for people in dire circumstances.

RQ3.b. Are there geographic differences across the UK in doctors' and medical students' views on and willingness to approach the RMBF?

Phase 4 (Survey) findings showed that there were no significant differences between the four UK countries in respondents' awareness of the RMBF and other organisations providing financial support more generally, nor were there significant differences in willingness to approach the RMBF. It should be noted though that participant numbers from Northern Ireland and Wales in this analysis were low.

RQ3.c. What is the experience of seeking support from the RMBF from the actual beneficiaries?

Phase 3 (interviews with actual beneficiaries) helped to answer this research question about the positive experiences of seeking support from the RMBF (more detailed analysis of the experiences is incorporated into Research Question 4). Generally, actual beneficiaries were very happy with the support that they received from the RMBF. They specifically reflected that caseworkers were helpful and supported them in a non-judgemental way, they were impressed by the speed with which the RMBF dealt with their applications and were positive about regular financial support as well as additional unexpected support (e.g., extra support at Christmas; money advice). Beneficiaries felt that the application process was less daunting in comparison to governmental organisations (even though they commented that collecting all the necessary detail could be very difficult). Beneficiaries also wanted to give back to the RMBF in some way (i.e., donations, fundraising, or raising awareness of the RMBF).

It is worth noting that beneficiaries generally reported being unaware of the other non-financial forms of support, such as money advice and coach mentoring, even though when this was offered it was every much appreciated.

Research question 4: What aspects of the RMBF's current services, activities, and criteria for support for the profession could be developed to improve their overall effectiveness?

RQ4.a. What hinders or drives potential beneficiaries to seek timely support from the RMBF?

The main barriers and enablers to seek timely support from the RMBF related to awareness of the RMBF, the process of applying, and eligibility criteria.

Awareness. Being a charity run *by* doctors *for* doctors (being "part of the profession") can be viewed positively by some (trust, legitimacy) and negatively by others (concerns about anonymity). Similarly, the name of the organisation might be viewed as a barrier for applying ("Royal" = for "posh doctors")

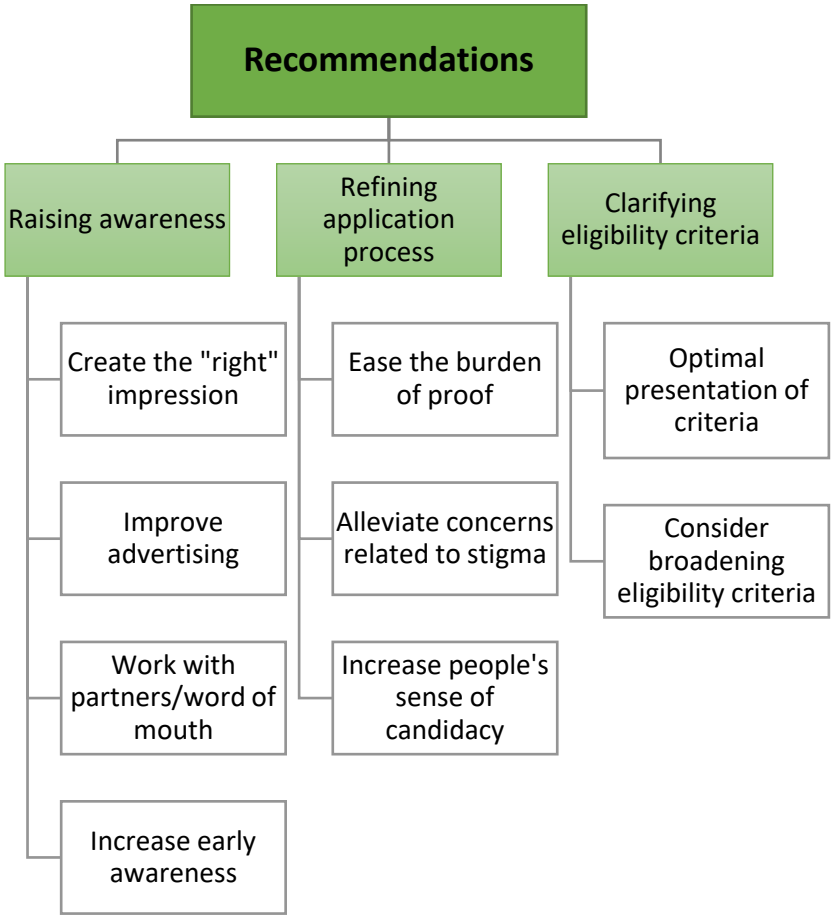
or enabler (show credibility and kudos). Advertising was felt to be challenging for a number of reasons (e.g., busy target audience, medics not noticing advertising unless they are in need, interest in more specialised publications makes it challenging to identify where to advertise). Word of mouth (via 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 groups would classify themselves in this way). The option "other" in the application (or exceptional 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 below:



To ***raise awareness*** the RMBF could:

1. Create the "right" impression to encourage engagement with the charity (e.g., clarify the charity's aims; emphasise the charity's history of supporting doctors and their understanding 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 application, or provide practical help with the application from volunteers or caseworkers;
2. Alleviate concerns related to stigma (e.g., emphasise independence from the GMC; work to reduce stigma and encourage more people to come forward for help; show that the RMBF provides other forms of non-monetary support services);

3. Increase people's sense of candidacy (e.g., 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; have the option of "other" to highlight that applications are considered on a 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]

Conclusion

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 difficulties: medical students from lower income or widening participation backgrounds; international medical students; medical trainees; overseas doctors (international medical graduates and refugee doctors/asylum seekers); doctors out of work due to factors other than ill-health (e.g., under GMC investigation) or with non-substantive employment (e.g., locum) as these are less secure in their jobs; and medical students and doctors who were affected by the pandemic (e.g., being unable to work because of shielding, developing long-Covid, or not being able to find work due to the pandemic). RMBF beneficiaries were generally very positive about their experience with the RMBF, appreciating the non-judgemental and supportive attitude of the casework team. Nevertheless, the study identified a number of barriers in the profession to seeking support or seeking support earlier which might lead to groups at risk being unserved. This report presents a variety of recommendations to reach those with unmet needs (or reach them earlier) focusing on raising awareness, refining the application process, and clarifying the eligibility criteria. This research project is a broad evaluation of the RMBF services, activities (focusing on the RMBF's grants programme), and criteria and we recommend the continued evaluation of strategies that may be implemented by the RMBF to encourage more applications from those in financial need.

[1] The RMBF is legally required to comply with its governing document which sets out its charitable objects, i.e. who the charity can help and in what circumstances.

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1. INTRODUCTION

The Royal Medical Benevolent Fund (RMBF) supports medical students, doctors, and their families during times of financial hardship arising as a result of old age, illness, injury, disability, or bereavement (for more details see the RMBF annual report). The RMBF supports approximately 300 individuals each year, but despite successfully increasing their financial assistance by 18% in 2018/2019, the RMBF believes that (for reasons unknown to them) not all eligible medical students, doctors, or their families approach the charity for help; and that those who do approach them, do so at a late 'crisis' stage, and could have been helped much earlier. The two main research objectives here then, are to explore the causes and extent of unmet needs from doctors, medical students, and their families in financial hardship; and to understand how to improve the effectiveness of the RMBF's current support. This research project answers the following four research questions, and their sub-questions:

1. Who is experiencing financial hardship within the profession?
    a. What are the reasons for financial difficulties experienced by medical students, doctors, and their families?
2. To what extent does the RMBF meet the needs of those experiencing financial difficulties?
    a. Are there unmet needs of actual and potential RMBF beneficiaries (medical students, doctors, and their families)? If there are unmet needs, what is the scale of this?
    b. Does the demographic data vary between current RMBF beneficiaries and the overall cohort of doctors and medical students (including geographical location)?
3. What are the overall strengths of the RMBF's current services, activities, and criteria for support for the profession?
    a. What is the level of awareness of the charity?
    b. Are there geographic differences across the UK in doctors' and medical students' views on and willingness to approach the RMBF?
    c. What is the experience of seeking support from the RMBF from the actual beneficiaries?
4. What aspects of the RMBF's current services, activities, and criteria for support for the profession could be developed to improve their overall effectiveness?
    a. What hinders or drives potential beneficiaries to seek timely support from the RMBF?
    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?

To answer these research questions, we conducted a mixed methods research project which consisted of five study phases: literature review, interviews with experts, interviews with actual/potential beneficiaries, quantitative phase (secondary data analysis and survey), and the synthesis of the results.

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 **contexts** in which certain things work or not; the context might be influenced by cultural or societal norms or people's demographic features, for example.
2. The **mechanisms** through which an intervention operates, including the *resources* offered and people's *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 **outcomes** 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 RMBF's support for doctors, medical students, and their families). The research team developed a set of programme theories by exploring the documents shared with us by the RMBF and extensively discussing various aspects of the RMBF's objectives, services, activities, processes, and criteria for support. The initial theories were refined after two discussions with members of the RMBF about their work, and then finalised after further discussion with the project's advisory group (see section 2.3). 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 applicants reaching out to RMBF for help is that they don't know they exist or understand 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. Advisory group

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.

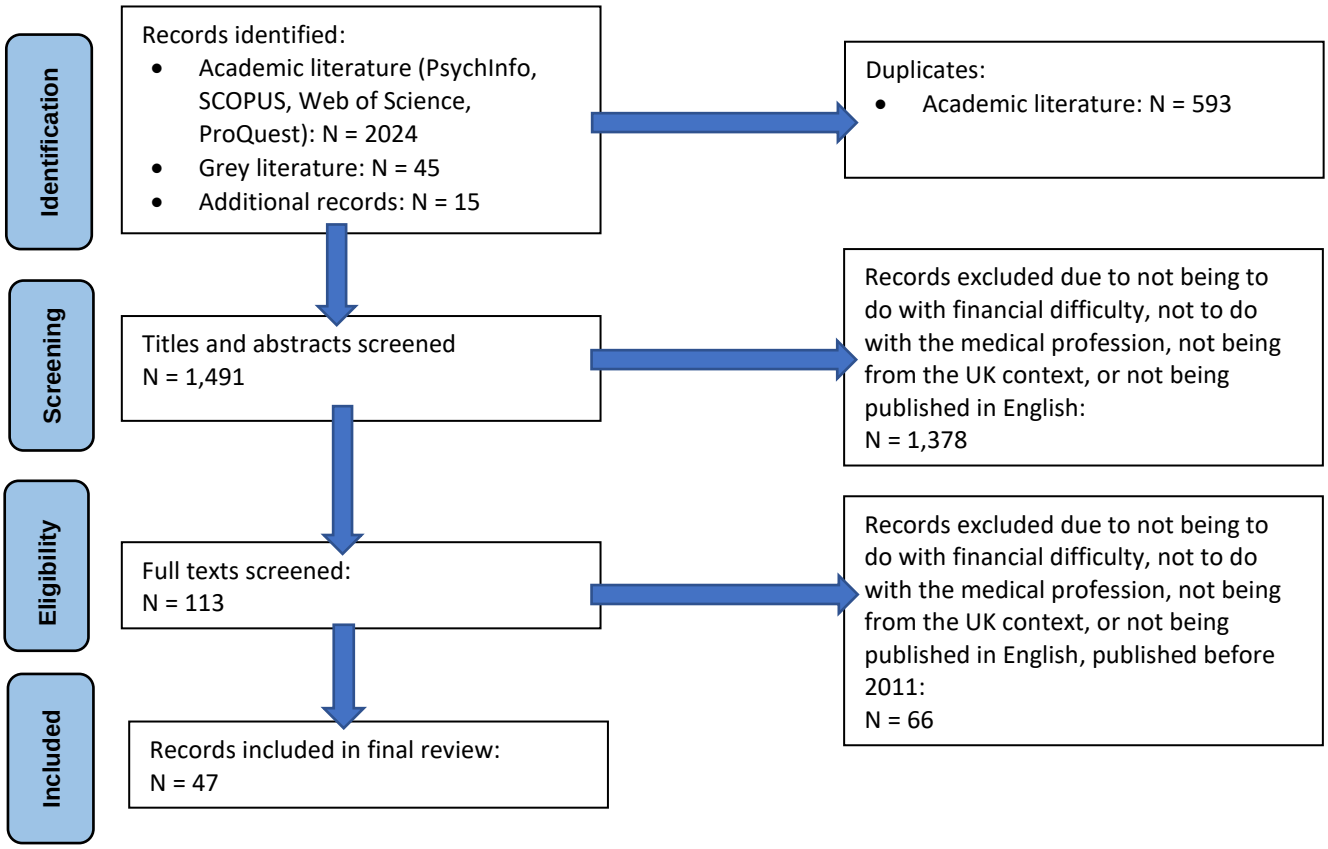

Figure 1. Literature search results.

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 1491 literature items captured were screened. Ten percent of the results were screened by two members of the review team, who achieved a

high agreement; disagreements were resolved through discussion and consensus. After screening, 1378 items were excluded as they did not meet the inclusion criteria.

3. *Eligibility.* All remaining items were read in their entirety by two members of the review team. After assessment, 66 of the 113 items were excluded from further analysis.
4. *Included.* The data from 47 eligible literature items were analysed for patterns and themes: 16 academic papers, 25 items of grey literature, and six from citation search.

2.4.2. Phase 2 and Phase 3: Interviews with experts and with potential/actual beneficiaries

Study setting

Online interviews were conducted with experts (May-November 2021) and with actual/potential beneficiaries (September 2021-January 2022). Experts were regarded as individuals who had experience of supporting doctors, medical students, and their families with financial and/or ill-health difficulties. Actual beneficiaries were those who had received financial support from the RMBF. Potential beneficiaries were those who had experienced ill-health and financial difficulty but who had not received financial support from the RMBF, either because of not applying, or because of being found to be ineligible after enquiring about support.

Recruitment

Experts: We approached individuals from relevant sectors and organisations, including charities, medical schools, and support services for doctors and medical students, using a combination of contacting potential participants via their publicly available email addresses on websites, our existing networks, and snowballing.

Actual beneficiaries: The RMBF contacted former beneficiaries on our behalf, inviting them to participate. Interested beneficiaries were then put in touch with us via a caseworker from the RMBF, after which contact was just between the researcher and the participant.

Potential beneficiaries: We identified relevant groups, approached organisations who might be able to share information about our study via their networks, social media, newsletters, or other channels. These organisations included charities, support networks, royal colleges, medical societies, medical schools, and HR departments. The survey offered an option at the end for people to contact a member of the research team if they would like to take part in an interview.

Process

Participants were sent a link to a short video about the RMBF, hosted on the RDME website; they were asked to watch this video if possible before the interview. This video outlined some basic information about the RMBF to inform or remind participants about some of the topics that would be discussed in the interview.

All interviews took place via the secure online video platform MS Teams. If there were issues with connectivity, the interview switched to telephone and was recorded on a recording device.

Interviews were conducted by members of the research team using a semi-structured interview guide (Appendix 2). This consisted of an introduction, where participants were asked to briefly describe their involvement with the RMBF (if any), followed by a discussion around the theories we had developed on the topics of awareness of the RMBF, the process of applying, and the RMBF's eligibility criteria. The researchers presented an idea (programme theory) about one of these areas, and then asked the participant what they thought of this idea and why.

The recordings were transcribed by a professional transcriber, and the completed transcripts were pseudonymised (all potentially identifiable details removed). Transcripts were imported into the NVivo 12 data management software for analysis.

Participants

We conducted 25 interviews with experts (see Table 1 for professional role details) and 22 interviews with actual and potential beneficiaries. The beneficiary group consisted of 16 actual and 6 potential beneficiaries: 7 from primary care, 12 from secondary care, 1 medical student and 2 trainees. 20 actual/potential beneficiaries sought support due to their own illness and 2 due to family illness.

In addition to financial need, the actual and potential beneficiaries had experienced ill-health due to acute illness, long-term conditions, accidents, addiction, mental health issues, and caring for unwell family members.

Table 1. Expert participant's professional role.

Participant professional role	**Number of participants**
RMBF (caseworkers, trustees, volunteers)	5
Occupational health physician	4
Medical school student support	5
British Medical Association	1
Refugee doctors' charity	2
Professional Support Unit	3
Medical Schools Council	1
Medical school Widening Participation practitioner	2
Doctors' charity	1
NHS Practitioner Health	1

Analysis

The interview data were analysed in three stages.

1. *Descriptive analysis from expert interviews:* Three team members (LK, DH, PC) read through the expert interviews and extracted key information about groups that the experts thought experienced financial need, whether they thought that these needs were unmet, and suggestions they made for increasing awareness of the RMBF among doctors and medical students. This data was then consolidated for presentation in the report to contribute to answering Research Questions 1-3.
2. *Realist evaluation of expert interviews:* Four team members (AG, RV, KA, AR) read through all 25 transcripts, with each team member focusing on one specific topic covered in the interview discussion: awareness of the RMBF, the process of applying to the RMBF, stigma associated with financial difficulties and ill-health in the medical profession, and the RMBF's eligibility criteria. Each team member coded the transcripts to capture relevant talk about their specific area. From this, they then worked through the coded data to identify the contexts, mechanisms, and outcomes to establish the barriers and enablers to people when accessing financial support in order to answer Research Question 4.
3. *Realist evaluation of actual and potential beneficiary interviews:* Two team members (RV, AR) read through all 22 transcripts, focusing on the same specific areas as for the expert interviews

(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 interactions with the RMBF, and how the support they received – or lack thereof – impacted their lives. These case studies are fictitious (not true stories of individuals but based on several individuals' experiences together) and have been constructed from a combination of the interview participants' experiences and could potentially be used by the RMBF to raise awareness of the support they provide.

2.4.3. Phase 4: Secondary data analysis and survey

Secondary data analysis

The RMBF shared anonymised data on their beneficiaries in July 2021. These data covered three topics:

Topic 1. The background characteristics of RMBF beneficiaries: beneficiaries' role (doctor, refugee doctor, medical student, or dependent), gender, age, marital status, region of residence, specialty (doctors only), the university and study year (medical students only), and record date (i.e., date the background characteristics were recorded in the RMBF database);
Topic 2. How beneficiaries heard about the RMBF;
Topic 3. Reasons to approach the RMBF for support (for those who were eligible for the RMBF support and those who were rejected).

Topic 1: Background characteristics of RMBF beneficiaries

The RMBF dataset covering the background characteristics of RMBF beneficiaries consisted of 1928 records:

1. Although the RMBF was founded in 1836, the first recorded computerised data on their beneficiaries stems from 1990. Consistent data entry commenced in 1991. Beneficiaries helped prior to this date are also represented in the dataset but with the record date set to 1991 it is impossible to distinguish between a pre-existing or a new beneficiary within that year. This poses challenges for date sensitive variables, such as age at the time of application ("age" variable represents the age an applicant is/would be at the time of data sharing (July 2021)). In these instances, any data before 1992 have been omitted.
2. A new data collection platform was implemented in 2014, which improved the quality and completeness of data. For this reason, data is first analysed for the full available timeframe, and subsequently from 2015 onwards. This is not applicable for those categories of applicants who were only eligible to receive support from the RMBF more recently (see bullet point 4).
3. With the introduction of new data collection platforms, the database evolved too. In late 2014, with the implementation of a new way of recording beneficiaries' data (platform name:

Charity CRM, previously called ThankQ), specialty was consistently recorded. This means that for earlier years, information on beneficiaries' specialty is often missing.

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 – including medical students – 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 impacted the characteristics of the RMBF's beneficiaries. However, due to the limited amount 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 were about non-eligible enquirers.
2. Since late 2014, with the implementation of Charity CRM, the RMBF started systematically recording why applicants approached the RMBF. This means that for earlier years information on this is often missing. For beneficiaries there are incidental data available from 2010 onwards and for non-eligible enquirers from 2012 onwards.

The GMC Data Explorer and SOMEP reports

The GMC Data Explorer is a dataset that reports on the characteristics of doctors on the medical register and doctors in training. The data are publicly available and updated every night. We accessed the dataset on the 14th of October 2021 to investigate characteristics of the overall population of doctors in the UK. On that day the dataset contained information on 348,329 doctors.

To investigate medical students, we used the SOMEP reports from 2016 and 2017 as a comparison to the RMBF data. SOMEP reports summarise trends and provide a statistical interpretation of the state of medical education and practice in the UK.

Survey

Study setting

We invited medical students and doctors from all UK regions to take part in an online survey (platform: RedCap on UCL DSH) from October 2021 to January 2022. We approached various organisations and individuals working with medical students or doctors and requested their support with the distribution of research information and the link to participate to their members. These organisations/individuals included educational institutions (e.g., medical schools, deaneries), widening participation schemes, national professional organisations (e.g., Medical Women's Federation; Royal Colleges; BMA), and support and networking organisations (e.g., NHS Practitioner Health, charities, and locum/SAS agencies). We also advertised the study on Twitter, relevant Facebook groups, and used snowballing techniques to invite potential participants. Due to this recruitment strategy, the researchers were unable to know how many participants received invitations, meaning it was impossible to calculate an accurate response rate. A total of 597 (94.6%) participants started the survey and 442 (70%) completed the survey from the 631 medical students and doctors who consented to take part.

Participants

Most participants were female (69%, 305), on average approximately 32 years old, from white ethnic background (69.5%, 307), and from England (76.2%, 337). Approximately half of participants (45.2%, 200) were students, 40.5% (81 from 200) of whom were in the last two medical school years. The majority of students funded their medical studies through loans, bursaries, or grants (46.5%, 93). From all practising doctors who took part in this study (N=241), the majority worked in medicine (17.4%, 42) or surgery (11.6%, 28). A total of 64.7% (156) worked full time, and 40.2% (97) had additional roles. More details on demographic characteristics are presented in Table 2. Demographic characteristics of the study sample (% (N) or M(SD)).

Table 2 also provides data on additional characteristics potentially linking to financial difficulties. From those who said they had worked while at medical school (57.5%; 254), 3.6% (16) had two or more jobs and 34.6% (153) were working outside of summer jobs too. A total of 3.6% (16) participants were or had been a volunteer for the RMBF and 4.1% (18) sought help from the RMBF.

Table 2. Demographic characteristics of the study sample (% (N) or M(SD)).

Variables	**TOTAL (N=442)**	**Medical students (N=200)**	**Doctors (N=241)**
Gender			
Female	69% (305)	70% (140)	68% (164)
Male	30.3% (134)	29% (58)	31.5% (76)
Missing	0.7% (3)	1% (2)	0.4% (1)
Age (17 to 80) *(M/SD)*	31.71 (11.54)	23.08 (3.97)	38 (10.97)
Missing	31.2% (138)	35% (70)	28.2% (68)
Ethnicity			
White	69.5% (307)	67% (199)	71.4% (172)
Arab/Arab British	2% (9)	1.5% (3)	2.5% (6)
Asian/Asian British	16.3% (72)	22% (44)	11.6% (28)
Black/African/Caribbean/Black British	3.2% (14)	3% (6)	3.3% (8)
Mixed/multiple ethnic groups	5.7% (25)	4.5% (9)	6.6% (16)

Variables	TOTAL (N=442)	Medical students (N=200)	Doctors (N=241)
Other	0.9% (4)	-	1.7% (4)
Prefer not to say	1.6% (7)	1.5% (3)	1.7% (4)
Missing	0.9% (4)	0.5% (1)	1.2% (3)
Sexuality			
Heterosexual	82.1% (363)	76.5% (153)	86.7% (209)
LGBTQ+	12.9% (57)	17% (34)	9.5% (23)
Missing	5% (22)	6.5% (13)	3.7% (9)
Relationship status			
Single/divorced/separated	50.9% (225)	80.5% (161)	26.6% (64)
Married/co-habiting/in relationship	47.7% (211)	18% (36)	72.2% (174)
Missing	1.4% (6)	1.5% (3)	1.2% (3)
Primary medical qualification			
UK/Home student	87.8% (388)	86% (172)	89.6% (216)
Non-UK	11.5% (51)	14% (28)	9.5% (23)
Missing	0.7% (3)	-	0.8% (2)
Region			
England	76.2% (337)	66.5% (133)	84.2% (203)
Northern Ireland	2.5% (11)	2.5% (5)	2.5% (6)
Scotland	12.4% (55)	21.5% (43)	5% (12)
Wales	6.8% (30)	8.5% (17)	5.4% (13)
Other	0.7% (3)	0.5% (1)	0.8% (2)
Missing	1.4% (6)	0.5% (1)	2.1% (5)
Caring responsibilities			
Yes	20.6% (91)	6% (12)	32.8% (79)
No	77.4% (342)	91.5% (183)	65.6% (158)
Missing	2% (9)	2.5% (5)	1.7% (4)
Disability			
Physical	4.1% (18)	2% (4)	5.4% (13)
Mental	7.2% (32)	7% (14)	7.5% (18)
Both	0.5% (2)	0.5% (1)	0.4% (1)
Missing	0.5% (2)	1% (2)	-
Professional status			
Students	45.2% (200)	-	-
Foundation year	3.4% (15)	-	-
Specialty doctors	23.1% (102)	-	-
Consultant	12.2% (54)	-	-
GP	7% (31)	-	-
Other (locum, staff grade, trust grade, etc.)	8.8% (39)	-	-
Missing	0.2% (1)	-	-
Medical school year			
Before final two years	-	59.%% (119)	-
Final two years	-	40.5% (81)	-

Variables	TOTAL (N=442)	Medical students (N=200)	Doctors (N=241)
Graduate entry students			
Yes	-	20% (40)	-
No	-	66% (132)	-
Missing	-	14% (28)	-
Funding medical studies			
Self-funded	-	13.5% (27)	-
Other (loan, bursary, grant)	-	46.5% (93)	-
Self-funded and other resources	-	40% (80)	-
Specialty (specialty doctors, consultants, other)			
Medicine	-	-	17.4% (42)
General practice	-	-	10% (24)
Surgery	-	-	11.6% (28)
Anaesthetics and intensive care	-	-	7.5% (18)
Obstetrics/Gynaecology	-	-	3.7% (9)
Psychiatry	-	-	8.3% (20)
Paediatrics	-	-	7.1% (17)
Other	-	-	15.4% (37)
Missing	-	-	19.1% (46)
Work type			
Full-time	-	-	64.7% (156)
Less than full time			35.3% (85)
Additional roles *(yes)*	-	-	40.2% (97)
Clinical	-	-	27.8% (67)
Other/multiple	-	-	12.4% (30)
Job while at medical school			
Yes	57.5% (254)	61.5% (123)	54.4% (131)
No	42.5% (188)	38.%% (77)	45.6% (110)
Number of jobs while at medical school			
1	42.8% (189)	39% (78)	46.1% (111)
2	10.9% (48)	15.5% (31)	7.1% (17)
>2	3.6% (16)	6.5% (13)	1.2% (3)
Missing	42.8% (189)	39% (78)	45.6% (110)
Working outside of summer jobs			
No	22.9% (101)	22% (44)	23.7% (57)
Yes	34.6% (153)	39.5% (79)	30.7% (74)
Missing	43.5% (188)	38.5% (77)	45.6% (110)
RMBF volunteer			
Yes	3.6% (16)	1% (2)	5.4% (13)
No	40.3% (178)	23.5% (47)	54.4% (131)
Missing	56.1% (248)	24.5% (49)	40.2% (97)
Sought financial help from the RMBF			
Yes	4.1% (18)	1.5% (3)	6.2% (15)

Variables	TOTAL (N=442)	Medical students (N=200)	Doctors (N=241)
No	39.8% (179)	23% (46)	53.5% (129)
Missing	56.2% (248)	75.5% (151)	40.2% (97)

Notes: one person did not indicate whether they were a medical student or a doctor, meaning they are not represented in any of the breakdowns for doctors/students.

An important limitation of the survey study is that, although we used a very extensive recruitment strategy, the total research sample is small compared to the total number of doctors and medical students in the UK. This is especially the case for the sample of doctors and medical students originating from UK countries other than England. Comparing survey participants' characteristics (Table 2) with general doctor/student populations (Table 9 and Table 11), we can conclude that the doctors sample is comparable with doctors on the register in terms of region, age, and specialties but more female doctors took part in our study (68% vs 46.7%). Regarding students, 70% of medical students who completed the survey were female, while 55% of medical students in the UK were females based on data reported in 2017. Furthermore, there might be a selection bias as it is likely that only certain groups of medical students or doctors participated in this study. For example, doctors/medical students who previously experienced financial difficulties (either first or secondhand) might be more interested in participating while doctors/medical students who currently struggle might not express interest in participating.

Measures

We developed a survey (Appendix 3) that used open and closed questions to ask participants about:

1. Their *demographic characteristics* (see Table 2);
2. Their experience of *financial difficulties*. Specifically, we asked participants about:
    a. *Financial worries*: whether they ever worried about their financial situation and if so, what support was sought and from whom;
    b. *Financial difficulties*:
        i. Whether they ever experienced financial difficulties and if so, at what stage during their medical career, what caused them, what support was sought, from whom, why support was sought from these resources, and whether the support was helpful;
        ii. If no help was sought, why was no help sought and what would have helped them to seek support;
        iii. Whether they knew colleagues/fellow students with financial difficulties and if yes, what were the causes of these difficulties.
3. Their *awareness of resources* to alleviate financial difficulties. Specifically, we asked participants:
    a. Whether they were aware of ways to get financial help;
    b. Whether they were aware of the RMBF and if so, how they learnt about the charity, which activities of the charity they were familiar with, what their views were of the charity, and if they would seek help from the charity if needed.
4. Their *perceptions of and attitudes* towards ill-health problems and financial difficulties. Specifically, we asked participants about:
    a. Their definition of ill-health;
    b. Their perceived *stigma*:
        i. Perceived stigma of ill-health. This 8-item scale was adapted from the perceived stigmatization survey as developed by Dyrbye et al. (2015) and divided into two subscales: ill-health stigma (6 items; *"Doctors/medical students experiencing ill-*

health problems are seen in a less favourable way by their peers") and perceptions of risk of ill-health on fitness to practise (FtP) (2 items; "*Doctors/medical students that seek support for ill-health problems risk being involved in fitness to practise processes.").* Answers were provided on a Likert scale ranging from 1 ("completely disagree") to 7 ("completely agree");

ii. Perceived stigma of having financial difficulties. This 7-item scale (e.g., "*Doctors/medical students are unlikely to disclose their financial difficulties as they would feel embarrassed*.") was measured using a Likert scale ranging from 1 ("completely disagree") to 7 ("completely agree").

c. Their perception on *strategies used by a charity*:
   i. Seeking support from a medicine-based charity (meaning the board, support staff and volunteers may be doctors themselves as opposed to a charity that has no medical affiliation). This 6-item scale was measured using a 7-point bipolar scale;
   ii. Seeking support from a charity that, in addition to offering financial help, offers psychological/mental health support to the profession. This 4-item scale was measured using a 7-point bipolar scale;
   iii. Seeking support from a charity that was recommended by peers after they themselves received help from the charity. This 5-item scale was measured using a 7-point bipolar scale.

d. Their *help-seeking intentions*:
   i. Intentions to seek help from a charity which used the three strategies described under 4.c. These three items were measured using a Likert scale ranging from 1 ("completely disagree") to 7 ("completely agree");
   ii. Intentions to seek help from specific resources. For this question participants were presented with a list of nine resources (e.g., partner, bank, workplace) for which participants could indicate the likelihood of using them on a Likert scale ranging from 1 ("extremely unlikely") to 7 ("extremely likely").

All questions were drafted by the authors of this report and amended after receiving feedback from the research project advisory group members.

Quantitative analysis

We used SPSS Version 27.0 and R for the analysis. Participants missing >50% of data were removed.

For Research Questions 2 and 3 descriptive statistics were performed on individual items (using demographic characteristics, variables on participants' experience with financial difficulties, and awareness of resources to alleviate financial difficulties). For Research Question 4 (using variables on perceived stigma and strategies used by a charity), six scales were created:

- Two perceived stigma subscales: ill-health stigma and perceptions of risk of ill-health on FtP;
- Stigma around having financial difficulties;
- Perception on three strategies used by a charity - a medicine-based charity, a charity that offers psychological/mental health support next to offering financial support, and a charity that was recommended by peers.

When calculating scales, participants were allowed to miss up to 1/3 of data for each scale and mean scores were computed over the remaining items. All scales were approximately normally distributed (skewness and kurtosis between -2 and 2; no extreme outliers). Internal consistency (Cronbach's α) was calculated where applicable and deemed sufficient for all scales (>0.7).

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. What is the argumentation for approaching one's preferred source(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. What one's views were about the RMBF?
7. Why would one not seek help from the RMBF?
8. What one's connotation was with the term ill-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 clustered together. Themes were then analysed and potentially clustered further for each question to facilitate a comprehensive write-up for the report.

2.4.4. Phase 5: Data synthesis

The summary and key recommendations section will provide the synthesis of the results from all phases of this research project. Through an assessment of the RMBF's current processes, alongside a detailed and expansive understanding of the various pathways to financial hardship in the profession and what it means to be a medical professional in 21st century, this phase will present key barriers/enablers for seeking support and recommendations of what the RMBF can implement in order to achieve the particular outcomes that they may desire.

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) – the summary and key recommendations section.

Figure 2. Research project Phases and research questions.

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

The findings from the review are presented below covering three key points: who experiences financial difficulty; why do they experience financial difficulty; and what are the possible consequences of experiencing financial difficulty. Although the research questions did not cover the consequences of experiencing financial difficulty, this has been included in our review as it was a key component of the literature. Due to the ongoing Covid-19 pandemic, a portion of the literature published since 2020 relates specifically to financial difficulties arising from this; findings relating to the pandemic are presented separately in each section.

Who is experiencing financial difficulties?

The literature was largely divided between medical students and qualified doctors. The only point where literature covered both students and doctors were in relation to those with disabilities (British Medical Association, 2020i; The RTK, 2018).

Medical students. Several items in the literature mentioned that all medical students were vulnerable to financial difficulties (British Medical Association, 2021; Cohen et al., 2013; Nunez-Mulder, 2018; Patel et al., 2015; Raven, 2014; Vogan et al., 2014), including that finances can be a risk factor for students' wellbeing (Cohen et al., 2013). However, other academic articles and grey literature pieces focused on particular groups of medical students, who may be at increased risk of experiencing financial difficulties.

Much of the literature included in our sample concerned medical students coming from a lower income background. This included academic articles about students from widening participation schemes (Anane & Curtis, 2019; Cleland et al., 2012, 2015) and Medical School Gateway Programmes (Curtis & Smith, 2020; D'Silva et al., 2019). Further academic articles described students from low-income families experiencing financial difficulty (Claridge & Ussher, 2019), and also students who were the first in their families to enter Higher Education (Bassett et al., 2019; Krstić et al., 2021). Vaughan (2013) noted that students of ethnic minority were more likely to come from households with lower socioeconomic status than their white colleagues.

Both academic (Krstić et al., 2021) and grey (British Medical Association, 2021c; Coyle, 2012) literature described the financial pressure that can be experienced by international medical students. One academic article (Krstić et al., 2021) also includes mature students as a group that can experience difficulties due to financial pressures.

Doctors. The literature identified various groups of doctors who might experience financial difficulties in particular circumstances. This included doctor suffering from addiction (O'Hara, 2016), international

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 pandemic. The 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), and international medical graduates with visa issues related to the pandemic (British Medical Association, 2020e).

Another group identified in the grey literature is the families of NHS staff who died from Covid-19 (British Medical Association, 2020b, 2020a). Trainees and medical students were also described as being impacted by the ongoing pandemic (British Medical Association, 2020g, 2020b).

Why are they experiencing financial difficulties?

The literature presented a huge range of possible reasons for doctors and medical students to experience financial difficulty. For both groups, having a disability can put people at increased risk of financial difficulty; this can be due to having to study or work less-than-full-time due to their disability (British Medical Association, 2020i), or in the case of disabled trainees and students having difficulty accessing the financial support they are entitled to and experiencing barriers to work (The RTK, 2018). Both groups are also potentially vulnerable to personal troubles impacting their incomings and outgoings (such as relationship breakdowns or illness). For medical students, however, costs relating to their studies were found to be a key factor in experiencing financial difficulty, whereas for doctors, time away from practice was found to be a major factor.

Medical students. The literature described many factors that could lead medical students to experience financial difficulties, and many of these were specific to studying medicine generally. One factor was the added expenses that need to be met when studying medicine, including professional clothing for placements, commuting to placements, textbooks, attending conferences, accommodation, and high living costs (Bassett et al., 2019; British Medical Association, 2021b; Claridge & Ussher, 2019; Cohen et al., 2013); some of these costs might be unexpected by students when they initially start at medical school, meaning that they have not been factored in to their budgeting (Nunez-Mulder, 2018). The fact that the course and the terms are longer than for other subjects can also lead to financial difficulties, meaning that students need money to pay for their studies and expenses for longer than other students (Bassett et al., 2019; Claridge & Ussher, 2019), and the loans available are not for any more money than for students on other courses (Cohen et al., 2013).

As a result, medical students often need to engage in paid work in order to meet these costs. As courses in medicine have a high workload, there is little time for paid work during term time, and together with the high course fees this can cause medical students to be in debt (Raven, 2014). This

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, 2015; Krstić et al., 2021; Vaughan, 2013), 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 (O'Hara, 2016), or to having to work fewer hours or in different roles due to fitness to practise warnings, undertakings, or conditions (General Medical Council, 2015).

Administrative issues could lead to financial difficulty for some doctors. Examples given in the literature were to do with changes in tax rules leading to lower income (British Medical Association, 2019), administrative errors leading to a delay or loss of pay (British Medical Association, 2021d, 2021e; Royal College of Anaesthetists, 2018; Royal College of General Practitioners, 2017), or international doctors not being aware of what they need to practise, such as medical defence cover (British Medical Association, 2020j).

Doctors with dependent children have the extra cost of childcare, which is generally very expensive (British Medical Association, 2020c, 2020f).

GP practice partners were highlighted as being at risk of financial difficulty due to taking financial responsibility for practices and incurring personal debt from buying in to practices, exacerbated by staff absences and government reforms making GP practices too costly to run (Power, 2014b, 2014a; Riley et al., 2018).

For trainees, the costs of Royal College exams are an added burden which is exacerbated for some by having to sit them repeatedly due to a high failure rate (Woolf et al., 2016) to the point where there is an expectation in the specialty that trainees will fail and resit multiple times (Lonsdale, 2020).

Specifically related to the pandemic. For families of doctors who died from Covid-19, it was reported that the death-in-service benefits were not sufficient and that some groups were not eligible for this support, such as families of fast-tracked final-year medical students and families of retired doctors who re-joined the NHS to help (British Medical Association, 2020b, 2020a).

Training was also impacted for some doctors and medical students. Some trainees experienced a loss of income due to better-paid rotations being cancelled (British Medical Association, 2020g). Some international medical graduates were reported to be unable to work because of Royal College exams being cancelled, which meant that costly visa extensions were needed (British Medical Association, 2020e). Medical students suffered a lack of income because of pandemic-related social restrictions: the retail and hospitality sector were largely closed meaning less opportunity to work to fund their studies (British Medical Association, 2020b). Some students were also still expected to pay for placements and accommodation despite them being cancelled due to the pandemic (British Medical Association, 2020h).

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 effect on students' academic 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 (Anane & Curtis, 2019).

Furthermore, being under too much financial pressure was found to be a contributing factor to dropping out of medical school altogether (Nunez-Mulder, 2018). Some students from households with lower socioeconomic status also find it difficult to fit in with their medical school peers, for example if they cannot afford to take part in social activities or cannot take part due to part-time work commitments (D'Silva et al., 2019; Vaughan, 2013).

It was reported that medical students and foundation doctors intended to postpone having children due to the financial pressure that they feel; while this is not necessarily due to financial difficulty, finances were a factor in this decision due to having study-related debt, and that working part-time and studying meant that it was hard to balance working, studying, and family life (Khadjooi et al., 2012).

Doctors. There can be a clear impact on medics' mental health when they experience financial difficulties. A link has been found between financial difficulty and burnout or stress in trainee physicians (Zhou et al., 2020).

There is also an impact on the overall workforce. Some doctors have reduced their working hours in order to reduce their costs (for example, childcare); this had a greater impact on women, and also means that there are fewer doctors in the workforce (British Medical Association, 2019, 2020c). Financial difficulties can also be a contributing factor to doctors going into Fitness to Practise proceedings, which can lead to restrictions in what they are able to do in their practice (General Medical Council, 2014).

Findings from Phase 4: Secondary data analysis

The second data source which we used to explore why doctors and medical students experience financial difficulties was the RMBF dataset. One of the datasets provided by the RMBF recorded the reasons why applicants approached the RMBF (see Topic 3 in the methods section).

The RMBF dataset consisted of 933 (79%) eligible doctors, 41 (3.5%) eligible refugee doctors, and 207 (17.5%) eligible medical students. There were also 750 (43.7%) non-eligible doctors, 53 (3.09%) non-eligible refugee doctors, and 912 (53.2%) non-eligible medical students represented. Most eligible doctors and medical students approached the RMBF due to mental health issues. Other than for financial reasons, non-eligible doctors most often approached the RMBF for general advice or due to

illness. Non-eligible medical students approached the RMBF for financial reasons, but also for study costs. Eligible and non-eligible refugee doctors approached the RMBF exclusively due to their refugee status. See Table 3 for more information.

Table 3. Reasons why (potential) beneficiaries approached the RMBF [%(n)].

	Doctors		**Refugee doctors**		**Medical students**	
	Eligible (N=933)	**Non-eligible (N=750)**	**Eligible (N=41)**	**Non-eligible (N=53)**	**Eligible (N=207)**	**Non-eligible (N=912)**
Age	4.3% (40)	1.4% (11)	0	0	0	0
Bereavement	2.8% (26)	1.3% (10)	0	0	10.6% (22)	0
Caring responsibilities	0.7% (10)	1.1% (8)	0	0	0	0
Domestic abuse	2.8% (26)	0	0	0	0.5% (1)	0
Exceptional circumstances	1.7% (16)	0	0	0	1.9% (4)	0
Illness	5.8% (54)	11.2% (84)	0	0	11.1% (23)	0
Mental health	43.3% (404)	0	0	0	40.6% (84)	0
Physical health	35.7% (333)	0	0	0	32.9% (68)	0
Disability	0.1% (1)	0	0	0	0	0
Medical student programme	0	0	0	0	2 (1%)	0
Other	0	8.9% (67)	0	0	0.5% (1)	7.1% (65)
Refugee status	0	0	100% (41)	100% (53)	0	0
Covid-19	3.1% (29)	2.3% (17)	0	0	1% (2)	3.6% (33)
Enquiry on behalf of other	0	8.8% (66)	0	0	0	0.3% (3)
Financial	0	40.1% (301)	0	0	0	62.3% (568)
General advice	0	14.5% (109)	0	0	0	0.2% (2)
GMC Conditions	0	17 (2.3%)	0	0	0	0
GMC Erasure	0	11 (1.4%)	0	0	0	0
GMC Suspension	0	26 (3.5%)	0	0	0	0
Location	0	0	0	0	0	2.6% (24)
Year of study	0	0	0	0	0	7.0% (64)
Study costs	0	0	0	0	0	16.8% (153)
Unemployment	0	17 (2.3%)	0	0	0	0

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., "financial" reasons) 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 to answer Research Question 1.a about the reasons for financial difficulties are:

- All medical students and doctors might be at risk of financial difficulties at some point in their career;
- The groups of medical students that were identified as at particular risk for financial difficulties were students coming from a lower income background, international medical students, mature students, disabled students, those experiencing bereavement, those with ill-health, and those studying during Covid-19;
- Medical trainees, international medical graduates, doctors impacted by the pandemic, doctors with children, with less secure contracts (e.g., locums), doctors suffering from ill-health, disabled doctors, and those who had been sanctioned as a result of the fitness to practise process were all identified as risk groups for financial difficulties;
- Some of the reasons for experiencing financial difficulties included living costs, study/training/work costs, limited available support high expenses setting-up and limited knowledge of the UK system for international students/doctors;
- Financial difficulties might have a significant negative impact on medical students' and doctors' lives and careers (e.g., result in dropping out from medical school, developing mental health issues);
- Not all groups of medical students and doctors which were identified as experiencing financial difficulties in the profession seem to be supported by the RMBF (e.g., earlier year students).

3.2. Research Question 2. To what extent does the RMBF meet the needs of those experiencing financial difficulties?

The second overarching research question asks about unmet needs. In this section we explore (i) if there are needs potentially unmet by the RMBF and (ii) if the demographic data of current RMBF beneficiaries is comparable with the overall cohort of doctors and medical students identifying if there are potentially missed groups of beneficiaries.

3.2.1. RQ2.a. Are there unmet needs of actual and potential RMBF beneficiaries (medical students, doctors, and their families)? If there are unmet needs what is the scale of this?

The first sub-question focuses on unmet needs of the profession. Presenting findings from Phase 2 (interviews with experts) we explore if the needs of those experiencing financial difficulties are met by the RMBF, and analysing Phase 4 data (survey) we review the level of financial need in the profession and tendencies of support seeking to provide the RMBF with a better understand of help-seeking behaviours in the profession and why some needs might not be met (or not met earlier).

Findings from Phase 2: Interviews with experts

From the expert interviews, we extracted and summarised information on: 1) who is experiencing financial need and if these needs are unmet by the RMBF; 2) any indication of the scale of this; and 3) suggested changes for the RMBF. The findings are presented in Table 4.

Based on their experience working with medical students and doctors who are struggling in some way, interview participants indicated that there are groups of medical students and doctors whose needs are (potentially) unmet and that these needs may be unmet due to lack of awareness of the RMBF, criteria restrictions, lengthy application processes, or difficulties applying. There was a lack of information on the indication of the scale of the issue. However, the experts noted that students in their earlier years at medical school and doctors who are out of work but not due to ill-health are two of the main groups in need in the profession. The impact of the pandemic was also highlighted, with mental health problems worsening and more people becoming unwell with long-Covid-19. Note that these are the expert interviewees' opinions; they may not be aware of everything that the RMBF does or the details of the eligibility criteria and suggest something that the RMBF does actually do, but that the experts are not aware of (and therefore unable to recommend to the people they support).

Table 4. Findings on unmet needs from the expert interviews.

Who is experiencing hardship in the profession?	**Is this need unmet?**	**Any indication of the scale of the issue?**	**Suggested changes**
Those who are "very very ill"	Potentially a missed group who do not apply	n/a	Help from the RMBF staff with filling in lengthy application forms

Who is experiencing hardship in the profession?	Is this need unmet?	Any indication of the scale of the issue?	Suggested changes
Those with mental health problems	Potentially a missed group who do not apply	No, but worsening due to the pandemic	Help from the RMBF staff with filling in lengthy application forms
Those abusing drugs or alcohol, or gambling	Potentially a missed group if not linked to mental health, disability. Lack of awareness of the RMBF	n/a	Clearer eligibility. Increasing awareness and "it is for you" message through making case studies more visible
Domestic abuse victims	Yes. Might be partially met with exceptional circumstances	n/a	Help from the RMBF staff with filling in forms as it might be emotionally difficult and there might be a lack of language understanding for some groups
Carers	Potentially a missed group as unable to help in the timely way the "emergency situation" demands	n/a	Greater flexibility on decision making process/more streamlined eligibility assessments
Widening access students	Potentially a missed group who do not apply	n/a	Raising awareness of the RMBF and encouraging students to approach the charity as soon as something happens in their life that could potentially lead to financial trouble in the future and then they could be helped as soon as they are eligible. Use social media
Disabled students	Potentially a missed group as lack of awareness on available support	n/a	Raising awareness of the RMBF
Earlier year medical students	Yes. No support available for early year medical students	One of the main groups in need in the profession	Change of policies, clearer eligibility criteria
Students doing retakes after Covid-19 interruptions	Potentially a missed group	n/a	Broadening definitions of ill-health; targeting what adjustments are needed rather than identifying health issues

Who is experiencing hardship in the profession?	Is this need unmet?	Any indication of the scale of the issue?	Suggested changes
Foundation year doctors	Potentially a missed group for additional support (non-financial support)	n/a	Financial education - preventative approach rather than reactive. Give information booklet and offer services that teach them the skills they need. Ingrain awareness of the RMBF from medical school
Refugee doctors/asylum seekers	Yes. Often do not meet current criteria	n/a	n/a
International Medical Graduates	Potentially a missed group as lack of awareness of institutions and cultural requirements	n/a	n/a
Professionals with long-Covid-19	Potentially a missed group	Lots of doctors. Described as an approaching "tsunami"	Need to raise awareness of the RMBF and specifically target this group, e.g., dedicated part of website/promotional materials
Neuro-diverse doctors	Potentially a missed group	n/a	Need to raise awareness of the RMBF and specifically target them, e.g., offer alternatives to written word to raise awareness of the RMBF
Out of work doctors, not due to ill-health, e.g., doctors under GMC investigation	Yes. Possibly met by the other organisations that caseworkers direct them to but no way of knowing	One of the main groups in need in the profession	Consideration of financial need alone as criteria, rather than the need for "proof" of an illness
Those in financial need, but with access to savings	Yes. Possibly a missed group if savings are higher than outlined in the RMBF criteria	n/a	Change eligibility criteria
Salaried GPs and locums	Yes. No coverage for legal fees	Big issue among Muslim female GPs	Raise awareness of the RMBF, share stories, use social media
Doctors working privately (not for NHS)	Possibly a missed group as lack of awareness on available support. This group could fall off a cliff edge despite previously earning high salary	n/a	n/a

Among the suggested changes, participants listed increasing people's awareness of the charity and targeting groups whose needs might be unmet, supporting potential beneficiaries with the application processes, changing/making clearer eligibility criteria, and providing additional support (e.g., financial education) (see Table 4).

Findings from Phase 4: Survey

The findings from Phase 4 consists of an analysis of (i) the level of financial worries and (ii) of financial difficulties experienced by medical students and doctors who filled in the questionnaire. Both parts also explore help-seeking behaviours adapted by the profession helping to understand why some of the needs might be unmet (not met earlier).

Financial worries

We first explored the level of financial worries and what support survey participants sought to deal with these worries. A total of 84.2% (372) participants said that they had worried about finances at some point in their life and this percentage was similar for medical students (82.5%) and doctors (85.5%). From those who worried, 35.2% (131) participants (38.2% of medical students and 32.5% of doctors) sought help for this. Table 5 shows what organisations/people/services those who sought help engaged with. Most of the participants sought help from their workplace/university (45%), family or friends (42.7%), or professional organisations (29%).

Table 5. Organisations/people/services participants who worried about finances sought help from [(% (n)].

	TOTAL (N=131)	**Medical students (N=63)**	**Doctors (N=67)**
Family/friends	42.7% (56)	44.4% (28)	41.8% (28)
Workplace/university	45% (59)	65.1% (41)	26.9% (18)
Professional organisations	29% (38)	6.3% (4)	49.3% (33)
Charity	18.3% (24)	12.7% (8)	23.9% (16)
Bank	8.4% (11)	4.8% (3)	11.9% (8)
Government	3.1% (4)	4.8% (3)	1.5% (1)
Loan	3.1% (4)	3.2% (2)	3% (2)
Medical professionals	1.5% (2)	-	1.5% (1)
Private funded counselling	1.5% (2)	1.6% (1)	1.5% (1)

From Table 5 we can also see some differences between doctors and medical students. While almost half of doctors (49.5%) sought help from professional organisations, just 6.3% of students did. In addition, more medical students sought help from their workplace/university (65%) in comparison to doctors (26.9%), but more doctors sought help from the bank (11.9%) or a charity (23.9%) than students (4.8% and 12.7%).

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 and GPs), we can also see that almost half of participants experiencing financial difficulties experience these difficulties after obtaining the CCT.

Table 6. Percentage of participants experiencing financial difficulties at various stages of their career [%(n)].

	Participants who experienced financial difficulties (N=148)	**Consultants and GPs who experienced financial difficulties (N=25)**
Before medical school	33.8% (50)	16% (4)
During medical school (early years)	50.7% (75)	48% (12)
During medical school (last two years)	56.1% (83)	56% (14)
During foundation training	25% (37)	16% (4)
During specialty training	25% (37)	28% (7)
During work as a locum/SAS	9.5% (14)	12% (3)
After obtaining the CCT	8.8% (13)	48% (12)

About one third of all participants experienced financial difficulties once (36.5%, 54), but others experienced difficulties multiple times in their careers. For example, 12.2% (18) of participants experienced financial difficulties during four or more stages (out of six) of their medical training and practice.

Those participants who experienced financial difficulties for reasons other than those the RMBF provides support for were able to explain the cause of their financial difficulties in an open-text box in the survey. Most of those who answered mentioned financial difficulties due to a lack of financial support from family. This could be due to the socio-economic background of the family, or family circumstances such as illness, living in a single-parent household, or redundancy of one or both parents/carers. Participants also frequently mentioned the high cost of living in the UK in general and the high cost of undergraduate and postgraduate education as well as other professional costs such

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 financial planning, expensive but necessary purchases (e.g., a car), and religious reasons for not taking up loans. For GPs specifically the nature of the work could mean completing unpaid work to finish GP training, working towards parity as a new partner in a practice, and working on zero hours contracts or dealing with contracts which did not allow paid leave.

The majority of participants sought support from their family/friends (84.5%) and sought financial help (in contrast to financial advice, etc.) (94.6%) (more information is presented in Table 7).

In Table 7, results are broken down by doctors and medical students. More students used student loan companies (75.4%) and medical school/university services (69.2%) in comparison to doctors (44.6% and 43.4%). Doctors were more inclined to use banks (49.4%) than students (29.2%).

Participants were also asked to write in an open-text box why they preferred the resources they chose to support them through their financial difficulties. Most participants said they chose resources that were well known to them and were easy to access. While overall, participants frequently said they tried all or most options available to them to find help, they were discouraged to approach some sources as they felt they would not be eligible for these sources of support:

"Unfortunately charities have very specific criteria to qualify for support. For example, you have to be from a poorly developed area/country or be part of a minority ethnic group."

This was, for example, particularly the case for non-British citizens, even if they had been in the country for a substantial amount of time. For some participants this meant they felt as if their family was the only source able and willing to help. Some participants said they looked for sources with a high chance of acceptance, as rejection could be hard to swallow:

"I previously found applying for assistance from benevolent fund to be quite humiliating as my financial history was being heavily critiqued (the context being, until a sudden change of circumstance, I was living well within my means). I took significant affront to this."

Other reasons mentioned were that participants looked for resources with a specific focus on medics/medical students and resources that did not require interest payments. Another frequently desired aspect for support was confidentiality, as this made it easier for participants to trust the support. This was particularly important as some participants mentioned shame and stigma to play an important role in choosing their support, for example some participants mentioned it was easier to speak to services/organisations disconnected from their workplace or personal network. One participant drew attention to the fact that some resources can bring a risk of penalty or punishment.

Table 7. Support sought by participants in financial difficulties (N=148, 65 medical students/83 qualified doctors).

	Total % (% medical students, % doctors)				
	Financial help	**Financial advice**	**Practical help**	**Help with mental health**	**TOTAL**
Family/friends	70.9% (72.3%, 69.9%)	38.5% (43.1%, 34.9%)	23% (9.2%, 33.7%)	32.4% (47.7%, 20.5%)	**84.5% (86.2%, 83.1%)**
Student loan companies	56.1% (72.3%, 43.4%)	5.4% (10.8%, 1.2%)	0.7% (1.5%, 0%)	0.7% (0%, 1.2%)	**58.1% (75.4%, 44.6%)**
Workplace/ university (e.g., bursaries)	48.6% (58.5%, 41%)	12.2% (23.1%, 3.6%)	2.7% (1.5%, 3.6%)	7.4% (10.8%, 4.8%)	**54.7% (69.2%, 43.4%)**
Banks/ Building societies	31.8% (18.5%, 42.2%)	13.5% (13.8%, 13.3%)	0.7% (1.5%, 0%)	-	**40.5% (29.2%, 49.4%)**
Medical professionals (e.g., GP)	3.4% (1.5%, 4.8%)	2% (0%, 3.6%)	1.4% (0%, 2.4%)	31.8% (32.3%, 31.3%)	**35.8% (33.8%, 37.3%)**
The government (e.g., Universal Credit)	20.9% (21.5%, 20.5%)	6.1% (7.7%, 4.8%)	2.7% (1.5%, 3.6%)	3.4% (6.2%, 1.2%)	**27% (29.2%, 25.3%)**
Charity	16.2% (12.3%, 19.3%)	8.1% (9.2%, 7.2%)	1.4% (0%, 2.4%)	4.1% (1.5%, 6%)	**23% (20%, 25.3%)**
Professional organisations (e.g., BMA)	6.8% (6.2%, 7.2%)	12.8% (9.2%, 15.7%)	0.7% (0%, 1.2%)	4.7% (3.1%, 6%)	**20.9% (16.9%, 24.1%)**
Privately funded counselling	0.7% (1.5%, 0%)	0.7% (0%, 1.2%)	-	18.2% (15.4%, 20.5%)	**19.6% (16.9%, 21.7%)**
Help lines	0.7% (0%, 1.2%)	4.1% (3.1%, 4.8%)	0.7% (0%, 1.2%)	7.4% (7.7%, 7.2%)	**10.1% (10.8%, 9.6%)**
Payday loans / credit agencies (non-governmental)	0.7% (3.1%, 9.6%)	0.7% (1.5%, 0%)	-	-	**7.4% (4.6%, 9.6%)**
TOTAL	**94.6% (96.9%, 92.8%)**	**57.4% (64.6%, 51.8%)**	**25% (12.3%, 34.9%)**	**50% (60%, 42.2%)**	

A total of 70.3% (104) participants said that the support they received was helpful for overcoming their financial difficulties. In an open-ended question, participants were able to explain why they thought the support they received was helpful or unhelpful. Most participants considered support helpful when it helped them pay for things in a timely manner, such as exam and tuition fees, rent, loans, travel, childcare, other bills, and food. Some participants said that the support they received helped to relieve stress and contributed to their mental health:

"Eventual progress with my mental health resulted in me actively addressing issues rather than avoiding."

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 options. However, it was said by some that financial support might be limited in that it may not alleviate all financial pressures and might be insufficient to compensate for low pay or long periods of study. Support was found particularly unhelpful when short term solutions were followed by longer term consequences such as paying off debt, when the amount of money received was small so financial issues persisted, or when structural issues (e.g., zero-hour contracts) were not resolved. Furthermore, some participants felt as if there was a general lack of information and support available.

Participants that indicated they did not seek help when experiencing financial difficulties had the opportunity to explain in writing why this was the case and what would have helped them to seek support (earlier). Stigma, feelings of shame, and feelings of personal responsibility were most frequently mentioned as reasons not to seek support when in financial difficulties:

"I think my parents taught me money is a shameful thing to speak about, I wish I had learnt earlier to talk about it more."

Other reasons mentioned were the feeling that nobody would be able to help, lack of clarity about eligibility for support, having to complete a complex and time-consuming process to arrange support, and the fear of bringing family in disrepute. Some participants mentioned they were simply unaware of where to get help.

In terms of what would have helped them to seek support (earlier), participants most often mentioned the need for more awareness about financial support and possible resources to alleviate financial difficulties, which would include organisations taking a proactive role in sharing information (e.g., about the consequences of loans) and signposting. Participants also needed more awareness on the costs of becoming a doctor. Furthermore, less stigma was frequently mentioned as a necessary requirement to be willing to seek help as well as the need for earlier personal recognition of financial difficulties. Other, less frequently provided, answers included: more awareness on eligibility criteria for support, receiving tailored advice from relevant people/departments such as supervisors, trusts, and occupational health, less intimidating routes to support, better financial advice/education or advocates that can assist when seeking help, anonymous helplines, and counselling.

In addition, over half of medical students (74.1%) and doctors (58%), knew colleagues/fellow students who experienced financial difficulties (total: 64.5%, 286) and 15.1% of medical students and 27.9% of doctors (total: 21.3%), said that those financial difficulties were (partly) caused by experiencing ill-health (e.g., physical illness/disability, mental illness/disability).

Experiencing financial difficulties due to ill-health

When reviewing the reasons why participants were experiencing financial difficulties, results showed that 38.5% (57) of the participants experienced financial difficulties due to reasons that qualify for RMBF support (illness, bereavement, and/or caring responsibilities); this was the case more so for doctors (44.6%; 26.5% experienced difficulties due to illness, 6% due to bereavement, and 27.7% because of caring responsibilities) than for students (30.8%: 18.5% experienced difficulties due to illness, 7.7% due to bereavement, and 13.8% because of caring responsibilities).

Fifty-five (96.5%) of the 57 participants who experienced financial difficulties due to illness (physical/mental health), disability, bereavement, or caring responsibilities sought financial help. Generally, participants sought help from a variety of resources (e.g., family, loans, mental health support) and for variety of reasons (e.g., financial, advice, practical support). Forty (70.6%) participants said that the support from these various resources was helpful in overcoming financial difficulties.

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 population with financial difficulties due to illness (physical/mental health), disability, bereavement, or caring responsibilities is presented in Appendix 5.

Key findings for RQ2.a

The key findings from the expert interviews and survey to answer Research Question 2.a on unmet needs are:

- Based on the expert opinions, there are groups of medical students and doctors whose needs are (potentially) unmet and that these needs are unmet due to a lack of awareness of the RMBF, criteria restrictions, lengthy application processes, or difficulties applying due to the emotional burden of applying;
- All groups of doctors and medical students could potentially have unmet needs. Some groups highlighted by experts were ineligible for support from the RMBF (e.g., earlier year students; difficulties not due to ill-health) and some eligible but potentially underserved due to reasons mentioned above (disabled and widening participation students, trainees, overseas doctors, those with non-substantive employment, with savings, addiction issues, domestic abuse victims, and those significantly impacted by ill-health, the pandemic);
- A large percentage of survey participants indicated that they worried about their finances at some point in their lives (84.2%; from whom, 35.2% sought help for this) and one in three (33.5%) experienced financial difficulties. Over half (64.5%) of participants knew colleagues/fellow students who had experienced financial difficulties;
- Financial difficulties were experienced at all stages of the medical career (often at more than one stage), approximately half of participants saying that they experienced difficulties during the earlier years of medical school. This fits with the findings from interviews highlighting early year students as one of the main groups in need;
- Less than half (38.5%) of those survey participants who experienced financial difficulties experienced it for the same reasons as the RMBF provides support for (illness, bereavement, caring responsibilities). Other reasons for experiencing difficulties (e.g., high costs of living and studying, changes due to Brexit, unexpected bills, delays in pay, contractual issues, and poor financial planning skills) are important to review and might uncover additional unmet needs in the profession;
- Most of the survey participants experiencing financial worries or difficulties sought help from their family, workplace/university, and student loan companies. A smaller percentage of participants sought help from charities (23%);
- Medical students and doctors picked support based on whether the resources were well-known to them, easy to access, and were trustworthy (e.g., confidential);

- 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 stigma, feelings of shame, being unclear about eligibility criteria, a lack of awareness of resources available for support, and lengthy, complex application processes;
- Participants from interviews and survey listed a number of suggestions that would help to meet the needs of those in difficulties: increase awareness of available support, clearer eligibility criteria (or changing them to meet needs of those who are currently not eligible), reducing stigma, additional support (e.g., financial education), and tailored advice and support.

3.2.2. RQ2.b. Does the demographic data vary between current RMBF beneficiaries and the overall cohort of doctors and medical students (including geographical location)?

The second sub-question of Research Question 2 explores if certain groups are potentially not reached by the charity. To answer this research question, we analysed secondary data provided by the RMBF (Phase 4) identifying the trends of changing beneficiaries' demographics over time and comparing demographic characteristics with the general population of doctors and medical students.

Findings from Phase 4: Secondary data analysis

The RMBF dataset on demographic characteristics of RMBF beneficiaries (Topic 1; see the methods section) consisted of 801 (41.5%) doctors, 27 (1.4%) refugee doctors, 92 (4.8%) medical students, and 818 (42.4%) dependents. This information was missing for 190 (9.9%) beneficiaries. Table 8 provides further details.

Table 8. Type of beneficiaries helped by the RMBF before and after the introduction of Charity CRM [%(n)].

Subgroup	Total (% of total sample)	< 2015 (% of total N of subgroup)	2015 – 2021 (% of total N of subgroup)
Doctors	801 (41.5%)	578 (72.2%)	223 (27.8%)
Refugee doctors	27 (1.4%)	NA[1]	NA[1]
Medical students	92 (4.8%)	NA[1]	NA[1]
Dependents	818 (42.4%)	808 (98.8%)	10 (1.2%)
Missing	190 (9.9%)	190 (100%)	0
TOTAL	1928 (100%)	NA[2]	NA[2]

Note. [1]Data for medical students are available from 2012 and data for refugee doctors are available from 2014 onwards. Due to the limited data available before 2015 for these groups, their data are not split before and after 2015. [2]Totals were not calculated due to missing information for refugee doctors and medical students (see note [1]).

Characteristics of each type of beneficiary will be detailed in the sections below.

Doctors

The characteristics for 801 doctors were investigated for the entire timeframe available, and then split to before 2015 (578) and during/after 2015 (223) (Table 9).

Gender. Just over half of doctors represented in the RMBF dataset were male (405; 50.6%) (Table 9). This is similar to the general population of doctors: (185,765; 53.33% male doctors; GMC Data Explorer, 2021). See Table 9 for more information.

Data in the RMBF dataset shows that there were more male (326; 56.4%) doctors in the dataset before 2015, whereas after 2015 there were more female (144; 64.6%) beneficiaries in the dataset and this difference was significant ($\chi^2(1, 797) = 29.341$, $p < 0.001$) (Table 9).

Age. Age was calculated from 1992 onwards to achieve an accurate estimate of the beneficiaries' age at time of recording (see methods). The average age of doctors in the RMBF dataset was 39.98 years (SD = 45). Both the RMBF dataset and the GMC data explorer indicate the largest doctor group represented is the group aged 30-39. The smallest group represented is the group aged over 60 for the RMBF dataset. For the general population of doctors this is the group aged under 30 and the group above 60. See Table 9 for more information.

Statistical analysis shows that the age of doctors on the RMBF dataset significantly decreases over time ($r = -0.15$, $p < 0.001$), meaning younger doctors are supported by the charity more recently.

Marital status. Table 9 shows that most doctors were married/co-habiting (297; 37.1%) or single (148; 18.5%). Slightly fewer married/co-habiting and widowed doctors were supported more recently and slightly more single and divorced/separated doctors ($\chi2(3, 743) = 8.410$, $p = 0.038$). Unfortunately, the GMC Data Explorer does not provide data on this, which means no comparison was possible.

Table 9. Characteristics of doctors helped by the RMBF and variations over time [%(n) or M(SD)].

	Doctors on the register (GMC data)	**RMBF dataset: Total**	**RMBF dataset: < 2015**	**RMBF dataset: 2015 – 2021**	**Statistics**
TOTAL N	**349 028**	**801**	**578**	**223**	
Gender					
Male	53.31% (186078)	50.6% (405)	56.4% (326)	35.4% (79)	**$\chi^2(1, 797) = 29.341$, $p < 0.001$**
Female	46.69% (162950)	48.9% (392)	42.9% (248)	64.6% (144)	
Missing	0	0.5% (4)	0.7% (4)	0	
Age *(M/SD)*	NA[1]	39.98 (12.29)	41.2 (13.27)	38.3 (9.69)	**$r = -0.15$, $p < 0.001$**
<30	13.24% (46194)	17.6% (141)	18.5% (107)	15.2% (34)	
30-39	29.99% (104665)	39% (312)	34.6% (200)	50.2% (112)	
40-49	25.25% (88143)	22.5% (180)	23.2% (134)	20.6% (46)	
50-59	17.48% (60993)	13.5% (108)	14.2% (82)	11.7% (26)	

	Doctors on the register (GMC data)	RMBF dataset: Total	RMBF dataset: < 2015	RMBF dataset: 2015 – 2021	Statistics
TOTAL N	**349 028**	**801**	**578**	**223**	
>60	14.05% (49033)	6.9% (55)	8.7% (50)	2.2% (5)	
Missing	0	0.6% (5)	0.9% (5)	0	
Marital status					
Married/ co-habiting	NA	37.1% (297)	38.1% (220)	34.5% (77)	**χ^2(3, 743) = 8.410, *p* = 0.038**
Single	NA	34.1% (273)	31.3% (181)	41.3% (92)	
Divorced/ separated	NA	18.5% (148)	17.3% (100)	21.5% (48)	
Widowed	NA	3.1% (25)	3.8% (22)	1.3% (3)	
Missing	NA	7.2% (58)	9.5% (55)	1.5% (3)	
Region[2]					
England	84.47% (250511)	83.3% (667)	83% (480)	83.9% (187)	χ^2(4, 801) = 1.322, *p* = 0.858
Scotland	8.25% (24465)	8.1% (65)	8.3% (48)	7.6% (17)	
Wales	4.27% (12656)	4.5% (36)	4.7% (27)	4% (9)	
Northern Ireland	2.68% (7943)	3.9% (31)	3.6% (21)	4.5% (10)	
International	NA	0.2% (2)	0.3% (2)	0	
Specialty top-5/grade[3]					
1.	GP (22.8%; 79611)	GP (28.2%; 105)	GP (34.4%; 53)	GP (23.9%; 52)	NA
2.	Psychiatry (3.19%; 11121)	Psychiatry (12.9%; 48)	Psychiatry (15.6%; 24)	Psychiatry (11.0%; 24)	
3.	Anaesthetists (4.01%; 13981)	Anaesthetists (8.1%; 30)	Anaesthetists and Surgery (9.1%; 14)	Anaesthetists (7.3%; 16)	
4.	Surgery (5.5%; 19208)	Surgery (6.7%; 25)	Obstetrics/ gynaecology (7.8%; 12)	Paediatrics (5.5%; 12)	
5.	Medicine (8.14%; 28400)	Medicine (4.8%; 18)	Medicine (4.5%; 7)	Surgery and Medicine (5.0%; 11)	
Foundation doctors	14.74% (51449)	5.1% (19)	0.6% (1)	8.3% (18)	
Junior doctors	4.54% (15848)	14.5% (54)	9.1% (14)	18.3% (40)	
Missing	0	53.8% (431)	73.4% (424)	3.1% (7)	

Note. [1]The GMC dataset does not provide the average age for the cohort.
Note. [2]Sum of doctors per region is smaller than the overall number of doctors in the GMC Data Explorer due to the way this data is displayed by the GMC (see: https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report).
Note. [3]Percentages provided for specialty are calculated after exclusion of missing data.

Region of work. Most doctors (667; 83.3%) were from England (Table 9) which is very similar to the overall cohort of doctors (250,070, 84.7%; the GMC Data Explorer). There were no significant differences before 2015 and after regarding where supported doctors were from ($\chi^2(4, 801) = 1.322$, $p = 0.858$).

Specialty/grade. The doctors in the RMBF dataset represented more than 13 different specialties. Unfortunately, there was a high number of missing data: 431 (53.8%). The top-5 represented specialties, after exclusion of missing data, were GP (105; 28.2%), Psychiatry (48; 12.9%), Anaesthetics (30; 8.1%), Surgery (25; 6.7%), and Medicine (18; 4.8%) as displayed in Table 9. In total, 19 foundation doctors (5.1%) and 54 junior doctors (14.5%) were helped by the RMBF.

The GMC Data Explorer shows that, similarly to the RMBF dataset, most doctors work as a GP (79,616; 22.9%). The other four specialties with the largest number of doctors were: Medicine, Surgery, Anaesthetics, and Psychiatry (the GMC Data Explorer). The largest number of doctors on the register were Specialty Doctors and Associate Specialists (SAS)/Locally Employed (LE) doctors (101 563; 29.1%). Due to the high number of missing data, any interpretation of trends over time must be made very carefully and statistical comparisons were not possible. Although there is a lot of uncertainty in the findings, the top-5 of specialties seems to be relatively stable over time with GP, Psychiatry and Anaesthetics making up the top-3 consistently over time (Table 9).

Refugee Doctors

The characteristics of refugee doctors were investigated for the entire timeframe available, and not split, because support for refugee doctors began to be recorded separately only from 2014 onwards. As the group of refugees was small (27), no time differences were presented.

Table 10. Characteristics of refugee doctors helped by the RMBF and variations over time [%(n) or M(SD)].

	RMBF dataset (N=27)
Gender	
Male	51.9% (14)
Female	48.1% (13)
Missing	0
Age *(M/SD)*	31.69 (6.96)
Marital status	
Married/co-habiting	44.4% (12)
Single	44.4% (12)
Divorced/separated	7.4% (2)
Widowed	0
Missing	3.7% (1)

	RMBF dataset (N=27)
Region	
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 (12; 44.4%). Their average age was 31.69 years (SD = 6.96). All applicants in the dataset were from England. More information about refugee doctors' demographic characteristics is presented in Table 10. As refugee doctors are not explicitly represented in the GMC Data Explorer, comparisons were not possible.

Medical students

The characteristics of medical students were investigated for the entire timeframe available, and not split, because medical students were only added on the RMBF dataset from 2012 onwards.

The majority of medical student applicants in the dataset were male (61; 66.3%). No significant gender differences were found over time (r_s = -0.025, p < 0.810). Most students were single (49; 53.3%), in year 5 in the medical school (45; 48.9%), and studying in England (77; 83.7%). For these variables a time analysis could not be conducted due to small numbers of data in subgroups. Students were on average 26 years old (SD = 4.47) and statistical analysis shows that the age of students decreased over time (r = -0.316, p < 0.002), meaning more recently younger students are supported by the charity.

Students were from 19 different universities. The top-3 represented universities, were Hull York (9; 9.8%), Brighton and Sussex (8; 8.7%), and Nottingham (7; 7.6%). More details about medical students' demographic characteristics can be found in Table 4.

The only possible comparison with the overall cohort of students was by gender. In 2017 it was reported that overall, in the UK there were more female students (21 566; 55%) (SOMEP) which is opposite to the trend noticed in the RMBF dataset. This was also the case for the SOMEP report in 2016 (see Table 11).

Table 11. Characteristics of medical students helped by the RMBF and variations over time [%(n) or M(SD)].

	SOMEP 2016 (N=40,078)	SOMEP 2017 (N=39,185)	RMBF dataset (N=92)
Gender			
Male	45.2% (18,129)	45.0% (17,619)	66.3% (61)
Female	54.8% (21,949)	55.0% (21,566)	33.7% (31)
Age *(M/SD)*	NA	NA	26 (4.47)
Marital status			
Married/co-habiting	NA	NA	4.3% (4)
Single	NA	NA	53.3% (49)
Divorced/separated	NA	NA	2.2% (2)

	SOMEP 2016 (N=40,078)	SOMEP 2017 (N=39,185)	RMBF dataset (N=92)
Widowed	NA	NA	0
Missing	NA	NA	40.2% (37)
Year			
3rd	NA	NA	5.4% (5)
4th	NA	NA	34.8% (32)
5th	NA	NA	48.9% (45)
6th	NA	NA	5.4% (5)
Final[1]	NA	NA	5.4% (5)
Region			
England	NA	NA	83.7% (77)
Scotland	NA	NA	8.7% (8)
Wales	NA	NA	4.3% (4)
Northern Ireland	NA	NA	2.2% (2)
International	NA	NA	1.1% (1)
University top-3			
1.	NA	NA	Hull York (9.8%; 9)
2.	NA	NA	Brighton and Sussex (8.7%; 8)
3.	NA	NA	Nottingham (7.6%; 7)

Note. [1]Some students indicated that they are final year students but did not specify the exact year they are in.

Dependants

The characteristics of dependants were investigated for the entire timeframe available and split into before 2015 and after. Time analyses were not performed due to the limitations of the dependants group described in the methods (i.e., prior to 2015 all family members were included in the 'dependant' statistics; after 2015 figures only included those applying as a dependant of a doctor in their own right). Time analysis would imply there are fewer beneficiaries who are dependants on the RMBF dataset in more recent years, but this appearance is caused in part by the fact that more recently family members have not been given their own data entry.

The majority of dependants in the dataset were female (668; 66.3%), single (402; 39.9%), and from England (804; 79.8%). Their average age was 31.9 years (SD = 21.3). More details on their characteristics can be found in Table 12.

We were not able to find a comparative national dataset as the dependant data is so diverse.

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

	RMBF dataset (N=1008)	< 2015 (n=808)	2015 – 2021 (n=10)
Gender			
Male	31.6% (319)	31.5% (314)	50.0% (5)
Female	66.3% (668)	66.4% (663)	50.0% (5)
Missing	2.1% (21)	2.1% (21)	0
Age	31.9 (21.3)	32.02 (21.35)	25.5 (10.6)
Marital status			
Married/co-habiting	4.6% (46)	4.5% (45)	10% (1)
Single	39.9% (402)	39.7% (396)	60% (6)
Divorced/separated	10.9% (110)	10.9% (109)	10% (1)
Widowed	19.8% (200)	19.9% (199)	10% (1)
Missing	24.8% (250)	24.9% (249)	10% (1)
Region			
England	79.8% (804)	80.0% (798)	60% (6)
Scotland	8.0% (81)	7.7% (77)	40% (4)
Wales	4.7% (47)	4.7% (47)	0
Northern Ireland	3.3% (33)	3.3% (33)	0
International	0.6% (6)	0.6% (6)	0
Missing	3.7% (37)	3.7% (37)	0

Key findings for RQ2.b

The key findings from the analysis of the demographic characteristics of the RMBF beneficiaries to answer Research Questions 2.b are:

- Over 80% of RMBF beneficiaries were doctors (41.5%) and dependants (42.4%);
- Demographic characteristics of doctors who were supported by the RMBF were similar to the general population of doctors in terms of gender, age, and region. Some slight differences were noticed in specialties/grade; for example, a smaller proportion of foundation year doctors were helped by the RMBF. However, due to missing data in the RMBF dataset it was not possible to draw any firm conclusions;
- Regarding students, a larger percentage of male students approached the RMBF (66.3%) in comparison to national data on medical students (45%), but this was the only comparison it was possible to make;
- More female, younger, and single doctors and more of the younger students are supported by the charity more recently;
- More recently, there seems to be fewer beneficiaries who are dependants on the RMBF dataset, but that could be caused in part by the way data is reported (more recent beneficiaries were not given their own data entry).

3.3. Research Question 3. What are the overall strengths of the RMBF's current services, activities, and criteria for support for the profession?

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 across the UK in doctors' and medical students' views on and willingness to approach the RMBF, and (iii) the actual beneficiaries' experiences of seeking support from the RMBF.

3.3.1. RQ3.a. What is the level of awareness of the charity?

The first sub-question set out to explore the awareness of the charity. We did so by analysing the Phase 4 data (secondary data analysis and survey). Then we analysed how familiar the medical students and doctors who completed the survey are with the financial support available to them, and more specifically how familiar they are with the RMBF and their services. We also explored willingness to seek support from the RMBF (survey data) to identify the strengths/weaknesses of the RMBF services. In this section, we firstly present the findings from the secondary data analysis, looking at how those who applied to the RMBF heard about the charity. We then present the findings from the survey regarding respondents' familiarity with financial support and willingness to seek support.

Findings from Phase 4: Secondary data analysis

The RMBF dataset on how RMBF beneficiaries heard about the RMBF (Topic 2; see the methods section) consisted of 335 (69.4%) doctors, 27 (5.6%) refugee doctors, 80 (16.6%) medical students, and 41 (8.5%) dependants. Table 13 shows that doctors on the RMBF dataset most often heard about the RMBF through colleagues (54; 16.1%), whereas refugee doctors most often heard about the RMBF (26; 96.3%) through the Refugee and Asylum Seekers Centre for Healthcare Professionals Education (REACHE). Medical students most often heard about the RMBF through their university or medical school (40; 50%) and dependants were most often introduced to the RMBF by family or a friend (12; 29.3%). See Table 13 for more details.

Table 13. How applicants heard about the RMBF [% (n)].

	Doctors (N=335)	**Refugee doctors (N=27)**	**Medical students (N=80)**	**Dependants (N=41)**
Colleague	16.1% (54)	0	1.3% (1)	0
Health/social care professionals	14% (47)	0	0	7.3% (3)
Website	10.7% (36)	3.7% (1)	6.3% (5)	2.4% (1)
Family/Friend	10.4% (35)	0	0	29.3% (12)
British Medical Association	9% (30)	0	1.3% (1)	4.9% (2)
Previous beneficiaries	6.3% (21)	0	0	17.1% (7)
Practitioner Health Programme	5.1% (17)	0	0	0
Other	4.8% (16)	0	0	14.6% (6)
RMBF publication/advert	3.3% (11)	0	1.3% (1)	0
Deanery	2.7% (9)	0	0	0
Postgraduate Dean	2.1% (7)	0	0	0

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)
Physicians' moms group	0.9% (3)	0	0	0
Doctors Support Network	0.6% (2)	0	0	2.4% (1)
NHS England	0.6% (2)	0	0	0
Professional Support Unit	0.6% (2)	0	0	0
Area visitor	0.3% (1)	0	0	2.4% (1)
Citizens Advice Bureau (Guilds)	0.3% (1)	0	0	2.4% (1)
British Medical Journal	0.3% (1)	0	0	0
Other medical society	0.3% (1)	0	0	0
Trustee	0.3% (1)	0	0	0
Refugee and Asylum Seekers Centre for Healthcare Professionals Education	0	26 (96.3%)	0	0
Medical school/university	0	0	50% (40)	0
Social media	0	0	1.3% (1)	0
Turn2us	0	0	1.3% (1)	0
Guild	0	0	0	4.9% (2)

Findings from Phase 4: Survey

About one third (36.9%, 163) of survey participants said that throughout their career as a doctor/medical student, they have been made aware of ways to get financial help should they need it (corresponding to 48.7% medical students and 27.5% doctors).

We also asked if participants were familiar with organisations (e.g., bursaries at university, trusts, charities), other than the RMBF, that helped doctors, students, and their families in financial need. Just 17.4% (77) of participants said they could name at least one organisation that supports doctors, 44.3% (196) that support students, and 7% (31) that supports family members (50% (221) could name any of three types of organisations).

A total of 44.3% (196), or 25% medical students and 60.4% doctors, of participants had heard about the RMBF before they were invited to participate in this study. Table 14 presents avenues through which survey participants learnt about the RMBF (also split between doctors and medical students). Approximately one in five survey participants heard about the RMBF via advertisement in medical journals, through their medical school/university, an online search, other routes (e.g., social media), or a friend/colleague.

Using open-ended questions, we asked participants about their views of the charity. Positive views included the perception of the charity being open, honest, supportive, and non-judgmental (e.g., "*Brilliant and glad that such an organisation exists*"). Participants also mentioned that the RMBF was seen as a charity offering more than money and providing excellent resources (e.g., a good website). A substantial number of participants said the RMBF is *"the best kept secret, nobody knows they exist*"

and said that the RMBF needs a higher profile, including promoting the RMBF's non-financial services more widely. Some participants had an inaccurate understanding of what the aim of the charity was (e.g., "*I thought that RMBF was a service that signposts you towards other organisations that may be able to offer help and support*") or that the charity helps just those with extreme financial challenges or that does not help "*someone like me*" (e.g., focus just on overseas doctors). Furthermore, some participants perceived the charity as old-fashioned ("*old boys network*") which linked to the name (royal, benevolence) being considered unhelpful. Some also highlighted challenges related to accessibility of the support (e.g., limited criteria, difficult to apply).

Table 14. How participants learnt about the charity [%(n)].

	TOTAL (N=196)	**Medical students (N=50)**	**Doctors (N=145)**
Via advertisement in medical journals	23% (45)	12% (6)	26.2% (38)
Medical school/university welfare departments	20.9% (41)	30% (15)	17.9% (26)
Through an online search/the RMBF's website	20.9% (41)	40% (20)	14.5% (21)
Other (social media, other charities etc.)	20.7% (21)	2% (1)	13.8% (20)
From a friend/colleague	19.4% (38)	18% (9)	20% (29)
Unsure	14.3% (28)	10% (5)	15.9% (23)
Poster/video at work/medical school	9.7% (19)	6% (3)	11% (16)
RMBF events/volunteers	5.1% (10)	6% (3)	4.8% (7)
Poster/video outside of work/medical school	4.1% (8)	8% (4)	2.8% (4)
Via the radio	-	-	-

Those who knew about the RMBF listed services they were familiar with (see Table 15). The majority of survey participants (75.5%) knew about the financial support that the RMBF provides for doctors. Participants were less familiar with 'phone a friend'; less than 10% of those who were familiar with the RMBF knew about this service. A comparison between medical students and doctors is presented in Table 15.

Table 15. The RMBF services that participants are familiar with [% (n)].

	TOTAL (N=196)	**Medical students (N=50)**	**Doctors (N=145)**
Financial support for doctors	75.5% (148)	58% (29)	81.4% (118)
Financial support for medical students	59.7% (117)	74% (37)	54.5% (79)
Financial support for doctors' dependants	37.2% (73)	14% (7)	44.8% (65)
Money advice	25.5% (50)	32% (16)	22.8% (33)

Financial support for refugee doctors	17.3% (34)	14% (7)	17.9% (26)
Online well-being material	15.8% (31)	14% (7)	15.9% (23)
DocHealth	14.3% (28)	2% (1)	17.9% (26)
Phone a friend	8.7% (17)	8% (4)	8.3% (12)
Other	0.5% (1)	2% (1)	0.7% (1)

Participants who knew about the RMBF indicated how likely it is that they would seek support from the RMBF if they were in financial difficulty. Almost half (47.4%, 93) of participants said they would likely approach the RMBF, 28.6% (56) were unlikely to approach the RMBF, and 24% (47) answered "neutral". A total of 58% of medical students said they would be likely to approach the RMBF if in financial difficulty and 43.4% of doctors.

Using open-ended questions, we asked those who said they did not want to approach the RMBF when in financial difficulty why this was the case. Several participants assumed ineligibility. Participants mentioned that the RMBF "*did not seem like they would help someone like me*" (e.g., perception that support is just for those from poor-economic/underprivileged background; restrictions regarding the criteria - due to ill-health), and their impression that the charity would only help when someone was in dire circumstances. Some participants said they would not seek help from the charity because they preferred to try other resources first (e.g., university hardship fund or family), and they were reluctant to use a charity as others may be more deserving of the help. Feelings of shame, feeling responsible for their own financial situation ("*we've failed and don't deserve support*"), and preferring to sort things out themselves were given as other reasons. A few participants indicated that they were unaware of the RMBF's services and the degree of financial support the charity provides.

Key findings for RQ3.a

The key findings around the awareness of available financial support and more specifically awareness of the RMBF to answer Research Questions 3.a are:

- Approximately one third of medical students and doctors who completed the survey (36.9%) said that they have been made aware of available financial support for them. A larger percentage of medical students (48.7%) than doctors (27.5%) were aware of this;
- Less than half (44.3%) of medical students and doctors knew about the RMBF (more so doctors than students, 60.4% vs 25%) and were the most familiar with the financial support provided by the charity while less familiar with other services;
- Based on the survey and the RMBF data, the largest proportion of medical students and doctors learnt about the charity through advertisement in medical journals, through their medical school/university, an online search, or a family/friend/colleague;
- Positive views of the charity from medical students and doctors who completed the survey included attitudes of the charity towards potential beneficiaries (being supportive and non-judgmental) and the fact that the RMBF was providing additional non-monetary resources;
- Half of the medical students and doctors who completed the survey (47.4%) said that they would seek help from the RMBF if in financial difficulties;
- Some of the reasons for not approaching the RMBF were a lack of awareness of support provided by the RMBF, preference to try other resources first, reluctance to use charity as others may be more deserving of the help, shame, and perceived challenges related to

accessibility of the support (e.g., impression that the RMBF helps just when someone is in dire circumstances).

3.3.2. RQ3.b. Are there geographic differences across the UK in doctors' and medical students' views on and willingness to approach the RMBF?

The second sub-question explored geographic differences in views on, and willingness to approach, the RMBF (Phase 4: Survey).

Findings from Phase 4: Survey

The comparison of awareness of different financial resources across the different UK regions is presented in Table 16. There were no significant differences in awareness of financial support, including the RMBF between the four regions of the UK (See Table 16). Even though we can see that the survey participants from Northern Ireland (68.6%, 7) and Wales (60%, 18) were the most familiar with the RMBF and participants from Scotland the least familiar (32.7%, 18), we were unable to prove these differences to be statistically significant due to the small number of participants from these regions.

Table 16. Regional differences in awareness of financial support [%(n)].

	England (N=337)	**Northern Ireland (N=11)**	**Scotland (N=55)**	**Wales (N=30)**	**Statistics**
Made aware of ways to get financial help throughout the career (*yes*)	36.3% (122)	27.3% (3)	44.4% (24)	33.3% (10)	$\chi^2(3,431)=1.972$, $p=0.578$
Know at least one organisation (other than the RMBF) that helps doctors (*yes*)	17.2% (58)	-	14.5% (8)	23.2% (7)	$\chi^2(3,433)=3.367$, $p=0.338$
Know at least one organisation (other than the RMBF) that helps medical students (*yes*)	44.2% (149)	36.4% (4)	52.7% (29)	33.3% (10)	$\chi^2(3,433)=3.326$, $p=0.344$
Know at least one organisation (other than the RMBF) that helps doctors' dependants (*yes*)	7.4% (25)	-	3.6% (2)	10% (3)	$\chi^2(3,433)=2.308$, $p=0.511$
Aware of the RMBF (*yes*)	44% (148)	68.6% (7)	32.7% (18)	60% (18)	$\chi^2(3,432)=7.659$, $p=0.054$

There was also no significant difference between regions in the likelihood of seeking help from the RMBF when/if in need ($F(3,190)=1.116$, $p=0.344$).

Key findings for RQ3.b

The comparison of views on and willingness to approach the RMBF between doctors and medical students from different UK regions to answer Research Questions 3.b revealed:

- Awareness of the RMBF and other organisations providing financial support did not differ significantly between the four UK regions;
- There were no regional differences in willingness to approach the RMBF;
- It is important to highlight that numbers of survey participants from some regions were small and might have impacted the findings.

3.3.3. RQ 3.c. What is the experience of seeking support from the RMBF from the actual beneficiaries?

The last sub-question of the overarching Research Question 3 on the overall strengths of the RMBF's current services, activities, and criteria is about experiences of seeking support from the RMBF. We present a brief synopsis of positive findings from Phase 3 (interviews with actual beneficiaries) to answer this question. A detailed analysis of the full dataset from Phase 3, which presents a more nuanced picture of individuals' perspectives of experiences of seeking support, is detailed in section 3.4.

Findings from Phase 3: Interviews with potential and actual beneficiaries

Overall, actual beneficiaries were happy with the support that they received from the RMBF. They reflected on their experiences regarding caseworkers, completing forms, timelines, financial support and other kinds of support received, and the idea of giving back to the RMBF in some way (e.g., financially, raising awareness, etc.).

- **Caseworkers:** The actual beneficiaries were overwhelmingly positive about their interactions with the RMBF caseworkers, who were found to be helpful, non-judgemental, and easy to talk to.
    - *"And RMBF were really helpful of just making things as easy as possible – the caseworker I had, which I think, she was very experienced and I had her for several years, was really kind." [Actual beneficiary 5]*
    - *"Anybody that was having difficulties I would really recommend they contacted them and, yeah once you're in the process and once you have that contact it's actually very accessible and very, given it's an uncomfortable topic finances, it's actually dealt with very respectfully." [Actual beneficiary 9]*
- **Completing forms:** When describing the process of completing the application forms, interviewees described the RMBF's form as less daunting than those from governmental organisations such as the Department for Work and Pensions (DWP). Most also understood why the RMBF needed to ask for applicants' personal information and details about their financial situation, although the process of having to collect all the necessary detail could be very difficult.
    - *"And having been through that process [applying to DWP for state support], and then having been through this, it's not comparable because like applying for benefits is, I went to medical school and got a medical degree – it's bloody hard, and I do wonder how people who maybe aren't as educated and don't have the time to be able to fill in all this paperwork, it's a tricky process to navigate going through state benefits. So I actually would say that comparing the two, the application form for the RMBF was like a walk in the park." [Actual beneficiary 16]*

- *"… and every time I've reached to RMBF for something or the other, it has always felt a really considered decision, and not, yeah, and absolutely treating me as individual in my individual circumstances, and thinking about the best possible solution, which may not be what you thought it is – there might be something else, and the feeling is they're walking with you. It's not like 'Yeah, sorry that's not what we do, so we can't help you on this' – it's never been like that, it's been like 'Okay let's think about what is possible' – because of course as an organisation they have their limitations, and they also have limited resources. So it's always felt considered to me." [Actual beneficiary 3]*

- **Timelines:** Interviewees were also generally impressed at the speed with which the RMBF dealt with their applications and the provision of subsequent awards.
  - *"… they were very responsive as far as I can remember – quite a different experience from like say the benefits office who took forever." [Actual beneficiary 21]*
  - *"But once it was done and I sent the form in [caseworker name] the lady who I've always sort of made my key contact, she told me the date that the kind of, I think it's called a panel, I'm not 100% sure, the day that they would sit down, look through it all, decide, and so she told me that day, the date that that would happen on, and I think that was maybe about a week, something like that. And then after that they, it was really quick that I got the financial help through." [Actual beneficiary 9]*
- **Financial support:** Beneficiaries of financial help were positive about regular financial support that covered their needs. In certain instances, they also could request money for unexpected expenses. Sometimes support was beyond their expectations. For example, the offer of some extra support at Christmas to cover extra expenses related to the festive period.
  - *"So yeah it's been a huge help to us, and also just that security of if we have a big unexpected expense they're just very supportive and we can write to them and normally get a response within a few days, they'll say okay yes we'll help with that, or why don't you try something else. So, yeah, but they've just been brilliant." [Actual beneficiary 15]*
  - *"Yeah, you know at Christmas they always sent out a Christmas card and they always gave you like an extra payment in December, so it was just like really, like nice, not in just say oh money nice, but like it felt nice you know, it made you feel appreciated. [Actual beneficiary 10]*
- **Other kinds of support:** Beneficiaries seemed to be unaware of the other kinds of support the RMBF provide, such as money advice and coach mentoring, until this support was offered to them. For those that took up this extra support, it was very much appreciated and was credited with helping some beneficiaries back to either medical work or an alternative career.
  - *"I mean really just the support they provide, you know it's a lifeline. And it's not just the money, because I had the coaching and I had the financial advisor, and all of it was really valuable. And I wasn't aware of any of that at the beginning either, I didn't realise that it's more like a holistic thing, it's not just that they pay money into your bank account, that actually they can provide support in other ways." [Actual beneficiary 6]*
  - *"And then they also provided a financial advisor who helped me review my accounts to see if there were things that could be changed like my mortgage provider, so that my outgoings would be reduced. And then things like you know identifying unnecessary direct debits and all of that, so all of that was very very helpful." [Actual beneficiary 17]*
- **Giving back:** Some beneficiaries wanted to give back to the RMBF once they were in a position to do so; this could be in the form of spreading awareness, sharing their stories, fund-raising, or donating back to the RMBF the amount of money that they had been given during their time of need. However, beneficiaries were not approached to do this, even when it would have been welcomed.

- *"So it's changed the whole, this whole experience including RMBF has changed, in fact every day, I'm in a better position now and I keep thinking of ways in which I can give back. So there's a part of me that says definitely I will be repaying the amount what I got from them in some fashion and I am happy to help with fundraising you know in the future. And actually I've told them that you know if you need somebody who is not afraid to be named, you know, I'm happy to be interviewed, do whatever it is because you know sometimes people need to see a real person and be able to ask that person real questions in order to believe that this is what happens to people and this is what the RMBF does." [Actual 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 helpful, non-judgemental, and easy to talk to;
- Beneficiaries understood why the RMBF asked for detailed information about them and their financial situation (even though this might be difficult to collect) and reported that the application was less daunting in comparison to governmental organisations;
- Support provided was viewed as speedy;
- Beneficiaries appreciated regular financial support and that sometimes support was beyond their expectations;
- Some beneficiaries wanted to give back to the RMBF in some way;
- Beneficiaries were generally unaware of the other non-financial forms of support, such as money advice, but those who took up this extra support were very appreciative of it.

3.4. Research Question 4. What aspects of the RMBF's current services, activities, and criteria for support for the profession could be developed to improve their overall effectiveness?

3.4.1. RQ4.a. What hinders or drives potential beneficiaries to seek timely support from the RMBF?

3.4.2. 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 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 potential beneficiaries. The results are presented in three sections: people's awareness of the RMBF, the process of applying to the RMBF, and the RMBF's eligibility criteria. Each of these sections are made up of several sub-themes, as can be seen in Figure 3.

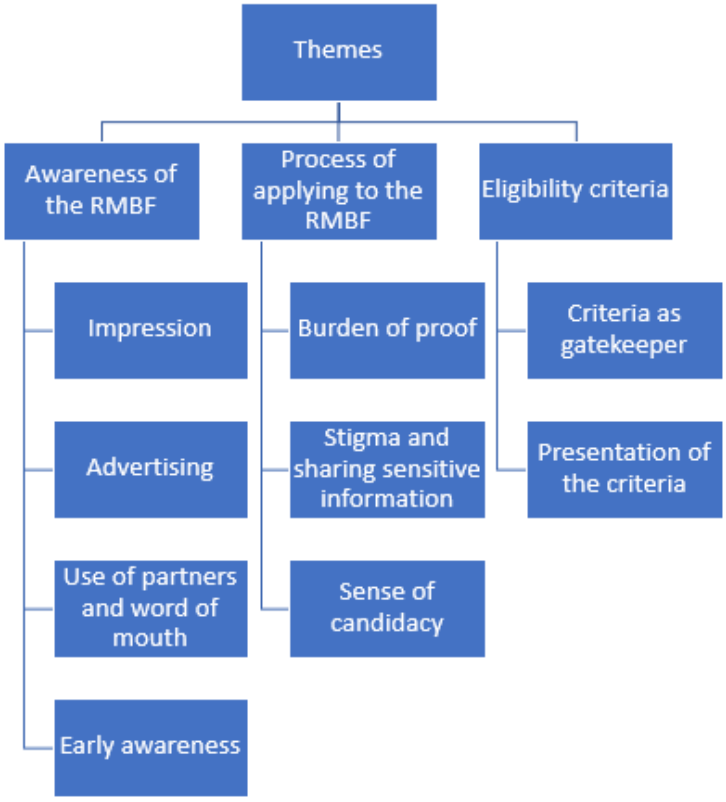

Figure 3. Analysis of experts' and beneficiaries' interview data.

The sub-themes were developed using Realist methodology as described in methods section 2.2. Analysis involved identifying the various strategies described or suggested by the experts, actual

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* the RMBF's 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. These strategies are not ideas that the research team have produced; rather they have been raised in discussion by the experts, actual beneficiaries, and potential beneficiaries. Please note that the quotes represent participants' own perceptions and views: if they are inaccurate regarding an aspect of the RMBF's work this still illustrates what they understand of the RMBF from whichever avenue they learnt about the charity.

Theme 1: Awareness of the RMBF

This first theme concerns people's awareness of the RMBF, and the factors that can hinder or improve how aware the medical profession are of the charity. This theme covers four sub-themes: impression, advertising, use of partners and word of mouth, and early awareness.

Theme 1.1: Impression

This sub-theme examines people's impression of the RMBF, and whether the charity is considered a 'part of the profession' (rather than independent of it), and the impact this 'insider status' has on supporting or undermining feelings of candidacy in potential applicants (whether or not potential applicants feel eligible for support). At the end of this section, we present two examples of CMO configurations to illustrate strategies concerning improving the impression people have of the RMBF: the possible gap between younger medics and their perception of the RMBF (CMO 1), and how the RMBF represents potential beneficiaries (CMO 2).

Barriers

The notion that the RMBF is '**part of the medical profession**', that is an organisation run *by* doctors *for* doctors, in some instances can act as a barrier to applications. It was suggested by participants that medics worried that divulging their circumstances might make them identifiable to other medics, and that this was more concerning for more senior doctors. Thus, there were concerns about confidentiality of information, and fear that someone on the RMBF panel may know them personally.

The **name** of the organisation could be a barrier to applications and insufficient to evoke feelings of candidacy in potential applicants. For example, the term "Benevolent Fund" may be too vague, suggesting that it is a support organisation but no more information than this and that charitable donations come from the rich and privileged. It should be noted that the RMBF has had a Royal Patron of the charity for many years, and this is the reason behind having "Royal" in the name. However,

being a “Royal” organisation was raised by experts who queried whether this presented the RMBF as an elite organisation, and off-putting to some potential applicants, for example people whose first language is not English might feel that the word “Royal” sounds more like a high society club (Expert 23). Similarly, a beneficiary who described their background as working-class felt the organisation was only for “*posh doctors*” (Potential Beneficiary 7, see below for full quote). Finally, medical students may not assume that a “doctors’ charity” would apply to them, as it is unclear how much they feel a part of the medical profession when still in medical school.

Overall, there were perceptions from some experts that the RMBF was regarded as old-fashioned and had not quite moved with the times, particularly in terms of its **organisational demographic**. Some felt the RMBF should put more emphasis on their focus on prevention and early intervention instead of the older established image (e.g., of supporting widows) to be more in line with the current orientation of the charity.

Enablers

While a possible barrier for some applicants, being viewed as an organisation that was ‘**part of the profession**’ also had some advantages, engendering a sense of familiarity and mutual respect, and thus increasing candidacy. Doctors in the RMBF were regarded to have a shared understanding of the professional environment, working pressures, and impact of long periods of training. Doctors, perhaps uniquely, could understand how doctors get into financial difficulties, including how finances work, particularly in primary care.

Being a ‘doctors only’ charity, could also give the impression to potential beneficiaries that they would be more likely to be successful in an application, in contrast to a general charity where they might be overlooked because they are a doctor where others are likely to erroneously assume that by virtue of their profession they would be in a financially strong position. There was also comfort expressed by one beneficiary in knowing that if other doctors would be looking through their medical record, they would fully understand their medical condition.

Being a **national**, as opposed to local or regional, charity was considered a helpful feature because this was more likely, in some experts’ views, to make applications more anonymous and alleviate concerns regarding confidentiality.

Some experts thought that the **name** of the organisation (including “Royal”) provided legitimacy as applicants were managing their professional and personal identity during challenging times and may find it more reassuring to approach an organisation with credibility and kudos, in comparison to other support (e.g., benefits) because it is less of a threat to their self-image.

Strategies

Strategies for capitalising on the strengths of being ‘**part of the profession**’ included emphasising the RMBF’s long legacy of supporting doctors, to promote the fact that it has a fundamental and profound understanding of professional and personal issues of doctors that result in financial difficulties.

The name was off-putting to some (such those from lower socioeconomic backgrounds or from overseas) but encouraging to others (such as those from medical family backgrounds), so altering this would come with advantages for some, disadvantages for others. It was, however, clear that more information is required to illustrate **what the RMBF does**, as being aware of the charity in name alone is insufficient to make medical students and doctors recognise that their situation as relevant, and/or to recognise themselves, or those they know, as potential candidates.

This might be achieved by an obvious demonstration of the range of beneficiaries and situations the RMBF may be able to support (e.g., via typical examples/case studies of those the RMBF help). If the RMBF stress more significantly their charitable role, strict confidentiality, and independence, this might reduce common barriers to application.

Increasing the organisation's **diversity and inclusivity**, such as having board and panel memberships that are representative of the medical population's demographics and possibly including former beneficiaries, and sharing this information with potential applicants would increase the relevance and acceptability of the organisation to current medical audiences, who themselves are very diverse in terms of protected characteristics. The visual look and the feel of advertising should be accessible to, and reflective of the medical population (e.g., including people with disabilities, and various ethnicities and belief backgrounds).

Quotes and CMO configurations

The following CMO configurations and illustrative quotes provide two examples of strategies concerning the impression that people have of the RMBF.

CMO 1: The generation gap

Context: Names of organisations are important in communicating their relevance to doctors and medical students.

Mechanism: The RMBF's use of the terms "Royal" and "Benevolent" evokes assumptions of an older, elite organisation, which is only for certain types of doctors, particularly older ones.

Outcome: The name, and the potential applicants' misunderstanding of it, can lead to a failure in identification and reduces candidacy, particularly for younger applicants.

Illustrative quote:

"I mean I haven't, obviously I'm just thinking about it for the first time, thinking 'benevolent' – I have to say when I have told clients about the Royal Medical Benevolent Fund I've felt like oh God this is such an old fashioned, it's like Rotarians or the Masons – the freemasons or something. So I have felt I wouldn't say embarrassed, but I didn't say with a lot of pride 'Oh you can apply to the Royal Medical Benevolent Fund'. I think 'benevolent' – I was just I guess, thinking about it I was thinking it's a big word, perhaps it could get lost in translation. Are you the beneficiary? – you know you the refugee doctor say. Or are they looking for you to give to their charity as a benefactor? – or whatever the word is." [Expert 23]

CMO 2: The representation agenda

Context: How an organisation portrays itself through its external image and marketing materials is important in making it relatable to all the groups (doctors, medical students, their families) it wishes to attract.

Mechanism: Portraying the RMBF as an organisation that seeks to support doctors from the widest range of backgrounds and protected characteristics through its external image and marketing material, evokes feelings amongst all medics that this organisation does represent them and can help them.

Outcome: Doctors are more likely to approach the RMBF for support.

"And when I was unwell one person had mentioned to me 'Have you thought about the Royal Medical Benevolent Fund?' Now the image that was in my mind of the Royal Medical Benevolent Fund was an austere sort of 'men in suits' organisation that, I don't know that, I'm from a very working class

background, I just sort of thought 'Oh that's not for me, that's for posh doctor families' and stuff like that – that's just the incorrect image that I had in my mind. […] But I've been really amazed and surprised by the range and depth of things that they actually do provide – I thought it was solely you fill in a form and you apply and I probably wouldn't be accepted because I'm not really a doctor family." [Potential Beneficiary 7]

Theme 1.2: Advertising

This sub-theme concerns how advertising can help to spread awareness of the RMBF, and the kinds of advertising that may prove most useful. At the end of this section, we present three examples of CMO configurations to illustrate strategies that use advertising to spread awareness of the RMBF: regular advertising via multiple routes (CMO 3), targeting advertising at key points throughout medical training and qualification (CMO 4), and using case studies to normalise seeking help for financial difficulty (CMO 5).

Barriers

Experts noted that medics are very busy and thus selective in what they notice, **reading only what they believe is relevant to them**. This can hinder early awareness strategies as they will not necessarily pay attention to impersonal or generic mentions of the RMBF. Advertising campaigns often do not hold the audience's attention if they do not speak to an individual's current situation (i.e., a person who is in financial difficulty is likely to be very alert to possible support for this; someone who is not, and does not foresee this, is less likely to pay attention). Timing these interventions is naturally very difficult to predict given the huge range of individuals' possible circumstances.

Not all doctors and medical students read the traditional medical journals, particularly paper-based publications "*It's not like the old days of flicking through the BMJ or General Practitioner or Pulse or Medeconomics where you've got a physical magazine that you might look through"* (Expert 3). Instead, younger doctors and medical students in particular were reported to favour more **speciality publications** or free access journals making the choice of where to advertise the RMBF difficult, as just advertising in one or two journals might not be enough to reach all potential applicants.

Enablers

It was suggested that advertising that gives a **wider perspective** on the issues associated with financial hardship and acknowledges issues beyond the place of work/study, can make individuals feel less isolated and recognise themselves as candidates. If this is done whilst maintaining the feel of a small organisation (i.e., being approachable and having named contacts) individuals can feel reassured that they will not be dismissed.

Experts advised that awareness of the RMBF is best raised via **multiple routes**, and to target the same individual or group several times in their medical career, for example at medical school through training and to final qualification; this helps to keep awareness of the RMBF fresh in people's minds, so that the RMBF is more likely to be remembered if these people experience financial difficulty.

Advertising material which accounts for the **diversity of the medical profession** (across protected characteristics) was felt to be important to emphasise that financial hardship due to ill-health could happen to anyone and thereby reduce stigma and increase candidacy with medics from all demographic groups. Experts noted that a welcoming web page which gave a clear understanding of the support provided was crucial to making it straightforward for individuals to see themselves as candidates. This is something that the RMBF already includes in their strategy, reflecting the importance that the experts also placed on this point.

Targeted advertising 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 **what it does** (as the name itself was not thought to be self-explanatory) via **many routes** 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 use posters in hospital premises' "*canteens and toilets*" (Expert 24) to address the issue of a lack of visibility. Induction was mentioned by both experts and beneficiaries as an important time to advertise services and ensuring that those with supervisory and appraisal roles were also aware of the RMBF's 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 **social media** 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 **target their communications** 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 expensive points in a doctor's career (e.g., at medical school in 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 advertising campaigns demonstrating their deep awareness of the causes of medical hardship, for example explicitly targeting newly qualified doctors who leave medical school with free educational resources about money matters. Equally they could target groups of doctors and medical students, welcoming applicants from under-represented groups: "*even saying we're aware we don't get a lot of applications from within this setting or this group of people, or people experiencing these things – please be aware we're very keen to receive applications in those circumstances"* (Expert 22).

The RMBF could also highlight their characteristics in advertising. It may be that **smaller organisations such the RMBF are seen as more approachable**. There is a feeling amongst medical students in the early years that big organisations are impersonal and "too big" to care about individual students, whereas a smaller organisation with a named contact person can reassure applicants who they should contact, and that this person will want to hear from them – that they will not be dismissed.

It was suggested that the RMBF advertise in non-subscription journals which practitioners visit regularly to increase their visibility. Several beneficiaries reported finding out about the RMBF via internet searching, rather than via the less anonymous way of speaking to colleagues. Therefore, if the RMBF continue to advertise via **Google ads or promoted results** for certain searches then they will be more likely to be seen.

Testimonials from someone who has used the service are particularly powerful. Case studies are accessible information sources, which individuals can more easily identify with and thus come to see

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

Context: Timing is very important in catching people's attention, but this is very difficult to get right. Seeing something many times creates a vague awareness of the charity and its remit before doctors are in serious need.

Mechanism: Advertising what the RMBF does (name not self-explanatory) via many routes means that individuals are exposed to the RMBF repeatedly, regularly and from different sources, so a vague awareness is already created so that the probability of a timely encounter is greater, and applicants are more likely to be receptive when this occurs.

Outcome: Increased uptake of support from the RMBF.

"So multimedia seems to be important. […] and that critical mass and that being a thing, you're not discovering it for the first time but it's a thing and a place and people know what it does as well, so they're hearing about it and then knowing what it does, which seems to be, it's not apparent necessarily in the name, certainly for young people." [Expert 4]

CMO 4: Targeting advertising via key times in medical training

Context: At times when extra financial demands are placed on all students/trainees (e.g., electives, courses, exams) individuals in difficulty may first admit that they are struggling financially.

Mechanism: If the RMBF advertises through medical school communications about these expensive points in a doctor's career (e.g., at medical school in elective communications, in emails about study leave, in communications about exam costs) then they tap into a time of need for those already on the edge and communications are more likely to resonate with the audience.

Outcome: More effective communication and greater awareness.

"Yeah, I'm just thinking what you said about targeted advertising and thinking about when we get told about our exams and we get sent a letter saying this is how much your exam is going to be costing you – maybe something on there regarding you know if you are in financial difficulties, if you meet these criteria then you may be eligible for financial support. And I guess in that sense people may feel it's more acceptable to access the financial support for exams, but actually making that application and approaching the RMBF actually it probably transpires that they're definitely eligible for additional support for day to day living rather than just the professional exam aspect of it." [Expert 6]

CMO 5: Case studies will help normalise experiencing financial difficulty and seeking support from the RMBF

Context: Financial hardship is seen as an atypical experience for doctors.

Mechanism: Having lots of case studies on the RMBF website will show doctors and medical students that financial difficulty is a recognised issue in the medical profession. Illustrating this makes them feel they are not atypical, prompting individuals to identify with previous recipients and thus see themselves as candidates for the RMBF.

Outcome: 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. […] Yes, like normalising, I'm always saying it's normalising it. If you are a doctor with financial difficulties this is where you go. That's it – there's no question mark, it's just this is what happens to you. If you get into financial difficulty you go to this, I would call them 'remedy' – like 'go to remedy and they will take care of it'." [Expert 23]

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. **Working with partner organisations** 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 partners' existing networks. However, these organisations are not experts in the RMBF's eligibility criteria, so they may refer ineligible applicants and the individual's expectations, or hopes, are then not fulfilled. Moreover, working with very well-known partners can overshadow the RMBF's contribution to the service.

It was suggested that **word of mouth** 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 that candidacy will be built in the recipient. Word of mouth cannot be solely relied upon, given the general lack of awareness of the RMBF or support organisations like them.

Enablers

Using **partner organisations** to spread awareness can mean that these partners' existing communication systems can be drawn on (e.g., mailing lists, social media channels), and larger numbers of individuals can be contacted (e.g., at medical school or via a royal college). Being made aware of, or referred to, the RMBF in this way via very well-known organisations or sources of support (e.g., GPs, PHP) means struggling individuals do not have to invest further energy searching for sources of support.

Word of mouth is an awareness raising strategy that has the potential to change people's minds about hard-set beliefs more effectively than other approaches. For example, a recommendation of the RMBF from a trusted person can reassure a potential applicant that this is a worthwhile charity to engage with, even if they are resistant to the idea of charity support. Experts suggested that, where possible,

person-to-person communication, including via volunteers, about the RMBF can be more effective than print or online sources, as it creates a space in which the individual is permitted to see support as an option for them and therefore challenges their beliefs about not feeling entitled. Several actual beneficiaries reported only hearing of the RMBF via recommendations from colleagues or supervisors, and felt comfortable approaching the charity based on these recommendations. Word of mouth is most effective when from someone who has had the experience themself is recommending, "*a peer-to-peer thing really, it's the respect of another fellow professional and the feeling that another doctor will understand you know the years and years of training and how they've got to where they are*" (Expert 20), building a trust-by-association which may be particularly important to attract applications from individuals who, because of their previous experiences, may be especially distrustful of organisations.

Trusted sources could be anyone with authority to speak directly about the support that was available; these could be peers, colleagues, supervisors, medical student staff, RMBF volunteers and staff, and endorsements could be electronic as well as verbal.

Strategies

Having candidates referred via individuals' existing support networks means the RMBF can draw on existing successful and trusted support routes, and thus a recommendation is more likely to evoke feelings of candidacy. For example: it is likely that the applicant has already had to open up about their difficult circumstances to the **partner organisation**, and in being recommended the RMBF gained a feeling of validation by the referral. Increased feelings of candidacy may make applicants less hesitant to wait before contacting the RMBF. It was recommended that when partnering with a very well-known organisation, the RMBF branding should be very clear so that it is not just assumed that the offer is from the bigger well-known organisation, and that individuals recognise the RMBF's contribution. Participants felt that using high-profile and respected medical professionals to talk about the RMBF may also help due to their potentially broad reach in the medical community.

Interviewees suggested several organisations that might be useful to partner with. For doctors this included: NHS services such as HR departments and employee assistance programmes, occupational health services, deaneries, national health education organisations, Royal Colleges, the British Medical Association, the Doctors' Support Network, the Practitioner Health Programme, and Doctors in Distress. For medical students this included: medical schools, medical school/professional societies and clubs, national medical student organisations, the British Medical Association student groups, exam preparation organisations, Medical Schools Council, widening participation groups, disabled students' groups, and the Worshipful Apothecaries.

An awareness strategy that successfully promotes **word of mouth amongst peers** was felt likely to be effective. This is because peers share an understanding of the specialty/medical context, a mutual respect, a mutually appreciated way of communicating (explaining why something is being recommended) and have a strong shared understanding of confidentiality. This could be particularly useful for groups under-represented as RMBF beneficiaries, who may be more likely to trust recommendations from colleagues who understand their situation.

Incorporating **formal word of mouth approaches** into channels of communication with doctors (e.g., via managers at an induction or at appraisal) means that they will be exposed to information about the RMBF in an impactful way and are thus more likely to have it register with them. Both experts and beneficiaries felt that HR professionals should be made more aware of the RMBF's support, as they are in a strong position to recommend the charity to those employees they are aware of being in ill-health. Moreover, those recommending the RMBF should be encouraged to follow up their advice

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

The following CMO configurations and illustrative quotes provide three examples of strategies to improve awareness of the RMBF via working together with other organisations and using word of mouth. As above, these examples were suggested by people interviewed for this study.

CMO 6: Trust in a partner organisation can be harnessed to generate trust in the RMBF

Context: Eligible individuals may be wary of sharing personal information with organisations such as the RMBF; this may be particularly the case for refugee doctors for example.

Mechanism: Partnering with organisations or charities that these individuals already trust establishes faith in the confidentiality and trustworthiness of the RMBF; if the RMBF works with trusted refugee charities, then the trust the charity has in the RMBF transfers via their recommendation and is enough to convince the refugee to also trust the RMBF.

Outcome: Increased enquiries and applications to the RMBF from eligible individuals who might have otherwise dismissed the charity as an option.

"They send an email saying oh my psychiatrist told me to ring you, my GP told me to contact you – so I think it's a very strong argument of peers and relevant organisations telling them, we get a lot of people who come in from [name of organisation]. You know we've had, for years now we've had pretty much ever since it started, we've been having referrals from them. And I think, because they're having to open up to the health professionals at [name of organisation], they've told them pretty much everything about their lives. I think them saying 'Well try the RMBF' – I think that's almost like a golden ticket for them to just contact [the RMBF] straight away". [Expert 1]

"Yeah. Well even if it didn't come to us, but we said 'Here you go, go to them', You know if I would say 'I need your firstborn's date of birth' you know they would because that trust is there – and also they're desperate to do whatever they need to do for accessing this grant or getting this role or going to this housing association. So I don't think there's any improvements needed there, you know I'm sure the trust is there already." [Expert 13]

CMO 7: Word of mouth between trusted individuals evokes a trust in the suitability of the charity

Context: Doctors are reluctant to seek support and talk to others about their predicament.

Mechanism: Encouraging word of mouth among peers and colleagues to spread awareness, from people who have a shared understanding of the specialty/medical context and of ill-health/financial issues, makes it easier to talk about problems, allay concerns, and give encouragement to take action.

Outcome: An individual is more likely to approach the RMBF.

"And I think especially in the medical profession I think you're much more likely to listen to colleagues, listen to senior colleagues or even junior colleagues if they've had experience of anything, I guess it's you know a shared understanding of the difficulties within the profession, it's likely that that person that you're speaking to has similar needs to yourselves and similar pressures to yourselves. So I think you know there's lots of shared characteristics within the profession, or therefore again I think you're much more likely to trust colleagues especially if they've had a positive experience and they can explain why it's been a positive experience, which I think doctors would often do. They wouldn't say yes this is

great do it, they'd often say why it was positive for them, what was beneficial for them and why they'd 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 it's black and white and it doesn't necessarily make a connection with the person, but if somebody says you know I've been donating to the RMBF for years and they've always been a really helpful organisation etc etc, then I think those conversations stick more." [Actual Beneficiary 4]

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

Context: 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.

Mechanism: If people who talk about the RMBF to peers or colleagues are encouraged to follow up informal advice with tangible formal information, then the legitimacy gained from the word of mouth recommendation, together with accurate information, can create a more accurate understanding of candidacy.

Outcome: Increased understanding of the charity and uptake of support.

"Word of mouth is not controllable is it? You can't control how word of mouth happens. You know you can find it's a little bit like Chinese whispers, you know you say one thing to one person and they slightly, not maliciously say something subtly different and then you know it just goes round […] The students are always like 'Yeah but I did it and I got in, so it must be what's necessary'. […] So taking that example out to this situation, I'm not very familiar with you know 'Oh you wouldn't get it if you had this condition' – whereas actually you might […] because they haven't researched it themselves or seen an advert they've just heard from someone else, they might think well that person has a physical disability I have a mental health disability, it's not going to apply to me." [Expert 15]

Theme 1.4 Early awareness

This sub-theme is about making people aware of the RMBF at an early stage, and not just at the point of need. At the end of this section, we present two examples of CMO configurations to illustrate strategies for spreading early awareness of the RMBF: the importance of early awareness of the RMBF for early engagement with them (CMO 9), and how a free membership scheme could help spread early awareness of the RMBF (CMO 10).

Barriers

Experts noted that potential applicants had a limited awareness of the RMBF; even if they had been introduced to them at medical school or in another context, it was felt that doctors and medical students just forgot about their existence.

Increasingly, students and doctors are from **backgrounds** which cannot provide them with implicit cultural knowledge about the support systems at university or whilst a doctor, for example from lower-income backgrounds or being the first in their family to go to medical school. Experts felt that individuals who had parents or other relatives who were doctors were more likely to know about the RMBF than those not from this background, and the only beneficiary who reported knowing about the RMBF in this way learnt this from their parent who was also a doctor.

The **hierarchical nature of medicine** means that it is difficult for those medical students and doctors who do not have this knowledge to display their lack of awareness of systems or to know the right

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 **reluctant to raise awareness** of the RMBF until later in the course when students were eligible: "*we don't mention them in the main obviously for the first three years because they're not eligible, and I don't feel that you should be mentioning something that then someone's not allowed to apply for"* (Expert 22).

Enablers

Having **early reminders** that the RMBF existed was regarded as crucial for doctors and medical students to seek help early rather than at points of crisis. As described above, this means the RMBF maintaining a visible presence and being at the forefront of medical students' and doctors' minds through the use of timely promotional material and engagement activities. Severe financial difficulties caused by health issues do not always come on very suddenly but can be foreseen to an extent, so advertising support at early stages of difficulty can increase candidacy for when there is need.

Strategies

Early interventions strategies mean that the RMBF can ask potential candidates to keep in touch, and perhaps be in touch themselves repeatedly. This helps create a presence in individuals and the collective group of who they should re-contact if their difficulties become severe. For example, signing individuals up to a free membership-type scheme of the RMBF whilst at medical school conveys a free benefit to them from interacting with the organisation, whilst signing up for ongoing contact to the RMBF in the future. A membership format would have to be well thought-through and trialled.

Promoting the RMBF at **useful times** is also important, for example via medical schools for students entering their final two years when they become eligible for support; this means that students are made aware of the RMBF at the earliest opportunity that could also apply.

Quotes and CMO configurations

The following CMO configurations and illustrative quotes provide examples of two strategies to improve uptake of support at an early stage. As above, these examples were suggested by people interviewed for this study.

CMO 9: Early awareness leads to earlier uptake

Context: Severe financial difficulties caused by health issues often do not come on very suddenly, and instead can be foreseen to an extent.

Mechanism: Outreach activities and effective marketing ensure a constant awareness in the back of doctors' minds of who they should contact if in need.

Outcome: When difficulties become severe, individuals know to contact the RMBF.

"So I think earlier visibility always helps improve things, because people do keep it in the back of their mind. […] So I think it's about trying to get to people before something bad occurs, so that when something bad does occur you're at the forefront of their mind rather than something happening and it being two or three weeks down the line […] they shouldn't be at panic point before they apply. […] Because a lot of things we've got listed are things that are not just going to happen immediately, it's not like a house fire, it's changes to caring responsibilities, it might be a bereavement, it might be that someone in their family like has cancer and they know that something's going to happen in the immediate future, so the guidance tells them to get in touch at the point that they know that something is going to happen, rather than when they're at crisis point." [Expert 21]

"I mean a lot of induction, I don't know how much the RMBF is involved in you know the induction of junior doctors in August in February every year, I mean I would think that if they had a stand or a representative – either one or more doctors in each trust that has maybe been through the process, they could just put up a little stand and have a chat with people for five minutes or whatever it is on induction week in most trusts twice a year. But literally I was just vaguely aware of them, and I just never knew of the process." [Actual Beneficiary 17]

CMO 10: A membership scheme

Context: Because doctors and medical students have other pressing priorities, they are likely to forget information about support organisations, including the RMBF.

Mechanism: A free membership organisation which encourages doctors and medical students to sign up, creates a large database and sends updates or reminders of its services. This activity acts as a constant reminder about the services the organisation offers as well as generating a sense of familiarity and belongingness.

Outcome: The RMBF remains at the forefront of doctors' minds and the existing membership encourages early engagement with the charity.

"The [name of organisation] has a membership where they help their members first, and they have a membership fee, and then they have help to people after that." [Expert 20]

"But it did make me think if the Royal [Medical] Benevolent Fund just came and did a little talk to medical students and had a scheme whereby people could fill out a form and say I want to become a friend of, or a member of, the Royal Medical Benevolent Fund would then have a data list of all these people that they could then keep in regular touch with, and people who had joined would then have a sense of partnership, they'd have a sense of belonging, so if ever they needed help in the future there would be less reluctance to reach out." [Actual Beneficiary 1]

Theme 2: The process of applying to the RMBF

This theme considers the application process, including the amount of information to provide, stigma around ill-health and financial need in the medical profession, and the feeling of being a suitable candidate for support from the RMBF.

Theme 2.1: Burden of proof

This sub-theme is about the amount of information required to process an application and outlines the barriers and enablers to applying to the RMBF in terms of the application form and supporting information required, as well as the strategies that might mitigate against these barriers and develop these enablers. At the end of this section, we present two examples of CMO configurations to illustrate strategies for reining in the application process: how the RMBF could assist potential beneficiaries through co-authoring the application (CMO 11) and reducing the amount of evidence requested from potential beneficiaries (CMO 12).

Barriers

Long application forms and the requirement for **significant amounts of supporting information**, in the context of challenging personal circumstances, can act as a major barrier to application. Potential candidates typically seek help when they are in crisis and dealing with multiple concerns over personal, financial and health issues. Having a long application form is a significant deterrent for applicants

dealing with multiple challenges, such as mental and/or physical difficulties, and/or who do not have significant help from friends or family to complete the application form. Late help-seeking behaviour was reported as extremely difficult to change, regardless of the application process, because the tendency for individuals to deny the severity of their situation until in extremis and the cultural norms in medicine which discourage disclosure of "weakness".

While some interviewees found the application forms less onerous than those of other organisations (such as the Department for Work and Pensions), others reported finding the RMBF's application process difficult. In the context of personal resources and capacity already being stretched due to illness and its sequalae, additional complex and time-consuming tasks represent an often-overwhelming block to application. The application process had been challenging for most of the beneficiaries. The application form was described as "*daunting*" (Actual Beneficiary 5) and "*overwhelming"* (Actual Beneficiary 9). This was due to its length and the level of detail necessary, but also because of the requirement to submit all the evidence required. Some beneficiaries reported challenges to locating the necessary documents, for example, being unable to locate their passport because of having lost their home. One beneficiary described the application process as an "*intrusion of privacy*" (Actual Beneficiary 12) because of the amount of detailed information required, which they thought implied a sense of mistrust and suspicion of the applicant. Two of the six potential beneficiaries we spoke to had started the application but abandoned the process at the submission of evidence because it was just too difficult. Experts also recalled individuals for whom this had been the case. Other beneficiaries had had to delay their application until they were in a position to be able to complete it. One beneficiary who had received assistance from the RMBF and then faced financial difficulty once again chose not to apply subsequently because they found the first application process too onerous. Another beneficiary found the reapplication process difficult because it meant explaining their personal circumstances which involved reliving the trauma that had caused their current situation.

In addition, the application process itself could involve financial costs, such as photocopying or printing documents, which was challenging as beneficiaries did not always have access to a photocopier or printer. Given the desperateness of their financial situation, this was prohibitive. One beneficiary had had support from his social worker in printing documents, but that had necessarily meant travelling to their office which required a bus fare. One beneficiary explained how grateful they were for the stamped addressed envelope the RMBF provided. Being able to subsequently email and upload documents which were required every six months had been easier.

Potential applicants were also deterred by a '**fear of failure**', especially when their options to extricate themselves from financial difficulties were narrowing, and concerns that their application would not be successful. When their human resources were so stretched, they made decisions about where best to invest their energies and would opt for pragmatic solutions which could include paid work, getting a loan or reducing financial outlay by moving house; however, these options were only available to those who were physically/mentally able to do so.

In terms of context, and what works for whom in what circumstances, experts suggested that certain groups of doctors face additional barriers. International medical graduates and refugee doctors have the additional hurdle of being unfamiliar with UK systems and it was suggested that international medical graduates were less likely to disclose information because of their previous negative experiences of sharing personal information with organisations connected to immigration.

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 **simplify and support the application process**. Experts discussed a process of "*checks and balances"* (Expert 7) and resetting the burden of proof to increase applications. They recognised the charity's duty to ensure the money gifted 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 **facilitation of the application process**, 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 reapplication process. Several beneficiaries had made more than one application to the RMBF because they had faced financial difficulty at a subsequent point in their lives. For the majority, this reapplication had been much easier because they were familiar with the process, had had a positive experience with the RMBF and thus had much less hesitancy about applying again.

On balance, the application process was not a legitimising process for candidates, but experts and some beneficiaries recognised that the detailed process allowed for fair evaluation of applications and supported the board in making decisions.

Strategies

Experts noted that **brief online enquiries** and **interactive eligibility checkers** may increase the sense of candidacy by informing potential candidates early on in the process about their chances of success.

Experts suggested several strategies to ease the completion of application forms. One of the strategies involved **enhanced support** from the charity (e.g., caseworkers) or from other organisations with filling in paperwork with applicants to facilitate completion. Guidance about the process, completion by bitesize chunks and clarification as to why certain supporting information is required would provide insights for applicants and help them understand the process better.

The RMBF **assigns a caseworker to applicants** at the application stage. Several beneficiaries felt that if the caseworker could provide practical assistance with completing the application form, this would help overcome some of the challenges some beneficiaries face when completing all the necessary paperwork. It was also suggested that the caseworker visit the potential beneficiary in their home as this may give the charity more insight into their financial situation than merely the financial sums. It was felt that this offer of assistance should be initiated by the RMBF as opposed to being requested by the potential beneficiary, as it would be easier for the potential beneficiary to accept help offered as opposed to requesting help. It was also suggested RMBF volunteers could assist with completion of the paperwork for those who were alone.

Both experts and beneficiaries recommended **lighter-touch processes** to reduce the burden of proof on applicants. It was suggested the RMBF could support beneficiaries for a short time period, which would give them more time to complete a more substantial application. It was also suggested that an

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 processes of consistency and due diligence were curtailed in favour of acknowledging the candidates' extreme need and the charity's trust in them.

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

Context: Potential candidates suffering from ill-health and the consequences of financial difficulty lack the additional resources required to access the RMBF's services by completing a detailed application form.

Mechanism: 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.

Outcome: 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

"Because it's quite reasonable that the RMBF wants to see obviously evidence of people's financial situations – that's proper governance and accountability, and requires people to fill in forms as well. However, I think it would be really helpful if they could, if they can't provide that kind of service through volunteers themself to see whether there is something they can link people up to, whether it's through MIND, or if there are other places that I don't know about. Because otherwise it's not possible for them to really be accessible and to provide the service that they're trying to provide. Because these are people often in dire circumstances, and the thought of actually having to get all this stuff together and fill out forms is often such a big barrier that they don't do it. And actually, I've got clients who have even been allocated financial support from RMBF but haven't actually gone ahead and done the final steps of actually collecting it, because they are not able to organise themselves to do so, and often where there are mental health issues as well. Rightly or wrongly, they will prioritise other things with the small amount of being able to cope and manage that they can do." [Expert 24]

"Now what about if a service was offered where you could have like a Teams meetings or Zoom meeting or whatever it is, and actually somebody who's there to help them actually fill a form live. It just occurred to me that yeah because, like I said I'm okay, but in certain circumstances it might be helpful for somebody to know that there's a human being who acknowledges that even to fill the form

is a challenge, and so if it's a face to face meeting offered just to fill the form, or a Zoom meeting to fill the form that could be one initial hurdle which could help some people." [Actual Beneficiary 17]

CMO 12: Reducing the burden of proof

Context: 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.

Mechanism: 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.

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

"Okay so they provide financial support not in this context, but if you need say any adjustments in place if you've got a disability, they provide financial support to you and your employer to make sure you 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 – 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 is difficult procedurally." [Expert 9]

"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." [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.

Illness and financial difficulty are synonymous with failure 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-sufficient: "*high achievers… in many cases the individuals feel that they should be self-reliant, self-resilient, and they have tried to*

sort it themselves" (Expert 3). A doctor's identity is that of expert and healer, where they are expected to treat the sick and not be sick themselves, so much so that they can feel that they are "*superhuman*" (Actual Beneficiary 11, Actual Beneficiary 16) and cannot become unwell. Beneficiaries described medicine has a culture of presenteeism, where there is the expectation that a doctor "*carries on whatever*" (Actual Beneficiary 6); no matter how sick 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 were described as very conscientious and will "*flog themselves and not necessarily have good insights into their own health*" (Actual Beneficiary 6). Stigma towards mental health could be internalised by doctors themselves, with their internal critic judging themselves harshly.

Feelings of shame and guilt 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 **not to share sensitive information**, 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 than seeking help from a charity. Some experts reported that doctors and medical students may be reluctant to accept help from a charity rather than from an organisation that they felt they had paid into, for example from the medical school or from a membership organisation, such as an insurance provider or a trade union.

Certain doctors may perceive and face greater stigma and be more reluctant to share sensitive information. Senior doctors could be reluctant to share sensitive information because of a perception that, as well-established medical practitioners, they should have sufficient reserves and resilience to be able to cope. Cultural background was believed to play an important role in stigma and readiness to accept charitable funds: *"there are some places where it's an intelligence test not to take something that someone's given to you – and in other places that's a source of shame to accept charity*" (Expert 4). Some experts felt that international medical graduates may have even greater difficulty with transitioning from the status of the role of doctor and advice giver to the role of help-seeker. One expert who worked with refugee doctors said they often came from cultures which have an even greater taboo on mental health and ill-health and thus do not readily disclose problems. Another expert, who worked with medical students, noted that it was often more challenging to encourage international medical graduates to disclose mental health issues.

Some jobs presented a barrier to having supportive conversations with colleagues and undermined sharing sensitive information. Doctors with peripatetic working patterns, for example locums and junior doctors, who lacked well established workplace relationships found it more difficult to have a conversation about delicate matters. Informal conversations with colleagues acted as a dress rehearsal for future sharing of sensitive information in more formal settings and therefore a lack of these opportunities prevented doctors and medical students becoming comfortable with talking about ill-health and financial difficulty, reinforcing stigma. A **lack of belongingness** thus led doctors and medical students to "fly under the radar", making it easier for them not to talk about their problems.

Another major barrier was the **fear of any sensitive information being shared with the medical regulator** the General Medical Council (GMC) and possible implications for fitness to practise:

"*There is an awful lot of fear and avoidance when it comes to doctors i.e., you don't necessarily go and seek support, whether it is health support or financial support or else – because you think that if you*

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" (Expert 9).

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 remained about the regulator's treatment of doctors. Issues about fitness to practise were a huge concern because of the GMC's ability stop a doctor 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 "*embarrassing*" (Actual Beneficiary 10). Asking partners to provide their personal financial information 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

Supportive conversations with peers and colleagues 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 that the RMBF had some "*credibility, and kudos*" (Expert 19) and would be less stigmatising for a doctor to approach than applying for government benefits.

The **younger generation** 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. **Externality to the applicants' work/study institutions** was also important, as 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

information with a charity was also regarded as being easier because of higher degrees of trust in charitable organisations by some.

Strategies

Normalising ill-health in the medical community is a strategy which could help reduce stigma. One of the suggestions would be publicising statistics about the numbers of doctors who suffer from mental health difficulties or sharing promotional material including case studies of ill-health in doctors would clearly demonstrate this can happen to anyone through no fault of your own. Moreover, the RMBF has a pool of former beneficiaries who might be willing to talk to other doctors who are hesitant and have concerns, and several actual beneficiaries expressed in interest in doing this. As these case stories illustrate real experiences of the process and receiving support it may help reassure future applicants to also come forward for support. It was also suggested that the RMBF works to help change the culture of medicine to one where looking after yourself as a doctor is positively embraced, and doctors are educated in self-care from the beginning of their training in medical school.

A further strategy could be repositioning the RMBF as **providing broader opportunities** beyond paying bills to increase the acceptability of receiving funds; this could be done by highlighting the support available to enable doctors to return to work or seek an alternative career, such as funding for courses or specialist equipment.

To **counter fears around anonymity and confidentiality**, the RMBF could demonstrate their national reach within advertising so that doctors feel more confident that their privacy will be maintained: *"you can get hidden […] your identity, like people are not always going to recognise you on a national level"* (Expert 8). A process of myth busting, countering commonly held (mis)perceptions about how the GMC deals with doctors and medical students with physical and mental health issues would help to overcome fear and anxiety about this issue. Additionally, promotional material, caseworkers and volunteers could emphasise the independence of the RMBF from the GMC, clarifying that the charity is not connected to doctors' registration or medical regulation. Stressing to potential and actual applicants the charity's independence from the medical regulator was fundamental to ensure that doctors and medical students had the confidence to come forward and talk about their concerns openly. Being explicit about how and what data may be shared with the GMC in a fitness to practise investigation would alleviate anxiety, as would the RMBF's practices of redaction so that identifiable information is not shared. Some other professionals do not keep any records about their clients' details and therefore there is nothing to share with the regulator should there be any requests. This they reported as being very helpful in allowing clients to feel confident about coming forwards for support. The RMBF communicating what records they kept, their redaction process, and that nothing would be shared with the GMC would reduce fear about divulging sensitive information to the RMBF.

When using case studies, an explanation about the process of selection and protection of personal details exemplifies the measures the RMBF takes to protect applicant's confidentiality.

Strong statements regarding confidentiality, how the information is shared and with whom encourages candidacy and therefore strong consistent messages about confidentiality and data handling are vital is gaining trust and supporting disclosure.

Quotes and CMO configurations

The following CMO configurations and illustrative quotes provide examples of five strategies to help address stigma around ill-health and financial difficulty in the medical community. As above, these examples were suggested by people interviewed for this study.

CMO 13: Normalising ill-health in the medical community

Context: The culture of medicine is one where doctors are expected to be the healers and not become ill, and ill-health is stigmatised.

Mechanism: 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.

Outcome: 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 'I'm bipolar, I'm a doctor – been this that and that, fire away – ask me what you want'. And he didn't care what people asked him, they asked very personal how you can be a doctor with that – all these things that actually it opened up a massive discussion that made it feel like it was really acceptable that you can have this severe mental illness and be a practising doctor. We all remember that day, I remember that, other people remember that. It took a lot, it took a lot for him to do that, it can't have been an easy thing to do. But it was so powerful, and it just, yeah it just took off a massive strain." [Actual Beneficiary 13]

"And also somehow dealing with that kind of stigma and shame and guilt in the words that are used as well, you know through no fault of your own and that kind of thing, or things happening to people, rather than, I think some of the language is sometimes about finding yourself in certain circumstances, that kind of thing, that it's really quite important to convey to people that it's not their fault and that these things can literally happen to anybody." [Expert 24]

CMO 14: Supporting disclosure of sensitive information

Context: In medicine there is a strong cultural norm not to show weakness and therefore applicants tend to withhold sensitive information because of the discomfort and sense of failure it causes them.

Mechanism: Having informal conversations with colleagues or talking to a member of the charity's staff or volunteers about personal difficulties in advance of completing the application form acts as a dress rehearsal for the formal application. Talking about sensitive and detailed personal information thus becomes easier and acceptance of the situation by others legitimises taking the formal application further.

Outcome: People more likely to disclose sensitive information which allows decision makers to make appropriate decisions and results in funding.

"I see their scholarship application, and I know things that have happened to them and might have impacted their exams or their household income or whatever, and they've not revealed that as part of the application because they're just not comfortable talking about it. And that might mean that they then lose out on that funding. So I think if that student has an opportunity to contact you, or, sorry, foundation year training student, or wherever they are (laughs) in the process, if they have an opportunity in advance to talk to you about their circumstances then they're more likely to reveal more in their actual application that they submit to you that you're making a decision on." [Expert 21]

CMO 15: Providing reassurance from others who have been through the process

Context: Culture of doctors not showing weakness and stigma around ill-health and financial difficulty.

Mechanism: The RMBF has a pool of doctors who can talk to other doctors who are hesitant and have concerns and because these volunteers are sharing their own experience of the process and receiving support it will reassure potential applicants about applying.

Outcome: Doctors more likely to approach the RMBF.

"Actually maybe that's the way to go, maybe if you had a handful of people who'd been previous beneficiaries, maybe RMBF could offer, you know if they had a list of people like that prepared to have conversations with early applicants, who are thinking about applying but not sure if they dare, or want to go through the process, you know maybe previous beneficiaries would be best placed to help people come to terms with the difficulties of making an application – because they know they've gone through something similar. You know I would be more than happy to talk to people and say it's really difficult for me to seek help, it's not what I do you know." [Actual Beneficiary 2]

"I think videos are things [that can help], we've done that. I think it's like people who are comfortable, because I know it's a very tricky situation, but who are comfortable talking about the fact that they did approach the RMBF and how it helped them. So maybe junior doctors or more senior doctors that in a time of crisis they did come to RMBF, but then they talk about what they've achieved since then, and how it's supported them saying that you know at least my financial worry is taken away so I could concentrate, so I became a consultant plastic surgeon, GP or consultant ophthalmologist – something where you know the student could look up for role modelling, say that look that consultant surgeon tapped into the RMBF as a student or as a junior doctor, but now look at their success – I think it's that visualisation of that at the end of the day you can achieve your dreams." [Expert 17]

CMO 16: Confidentiality and the medical regulator

Context: Other organisations which deal with doctors suffering ill-health or in other highly sensitive situations do not record any information about the doctors or the medical student at all; this means there is nothing to share with the medical regulator if they did ask for information and is the ultimate way of maintaining the confidentiality of applicants.

Mechanism: This means redacting any identifiable data from applications throughout the process and not recording anything about the nature of the ill-health or cause of the financial difficulty**.** This would mean that there was nothing to share with the regulator or any other investigative body if there was a request for information and increased reassurance for the applicant that sensitive information could not be shared.

Outcome: These reassurances would increase likelihood of application.

"When our committees and trustees consider the application we've taken everything out that could make them identifiable. So I suppose if we could possibly stress more that the process is completely confidential, we could tell them exactly what process they have to go through and who knows their name – and that's just really the initial thing because we do need to know this information, I think there's concern that they think we might be working with the GMC. You know we stress that we are completely independent. Some people think that we're linked with NHS pensions, I think it's people's perceptions. So it's kind of like are we stressing enough that we are completely independent from any other organisation." [Expert 1]

"And then there's the group of students that would be so worried about that, about everyone knowing, that they wouldn't disclose, or that if they do disclose they always finish it with 'But I don't want anyone to know'. And you think well that's quite restrictive – if we're going to help we do need to tell a few people. So I think there is an assumption that information is shared, and we also know that there is a

stigma attached to, well I think it's different to stigma, I think it's more than stigma – it is to do with trust I think. Medical schools and NHS employers make quite an effort to say that there shouldn't be stigma, but I just don't think that anyone really believes it. So I think it's a slightly different concept to stigma because the narrative is there to say that you know disclosure is encouraged and there is support available, but it just doesn't seem to have translated to a change in behaviour around disclosure." [Expert 25]

CMO 17: Broadening RMBF funding opportunities as enabling work

Context: There is a culture of stigma around seeking financial help for paying bills.

Mechanism: The RMBF can reposition funding opportunities more broadly, such as grants to enable work or get back to work (e.g., a better wheelchair), which will increase the acceptability of receiving funding, which in turn will reduce the stigma in approaching the RMBF.

Outcome: Doctors will be more likely to approach the RMBF.

"So yeah there could be some concerns about you know confidentiality, that sort of comes back to my point about your peer group and not wanting others knowing that you needed financial assistance. But it's not just paying your bills, standard bills, we can help with you know converting you home, converting your, you know giving a grant, giving monies towards a vehicle that's more suitable. So in a way there's some more, 'acceptable' doesn't sound the quite word, but you know a more acknowledged, well if I can get a grant for this, you know convert something in my home or whatever, you know so making it clear to people we can facilitate you know a better wheelchair, you know a streamlined chair that can give you access and ability to do your job. So I think those things you know perhaps are kind of easier ways of getting into the conversation rather than saying it's because you can't pay your mortgage or your rent or you know nursery place or whatever, but actually maybe widening the conversation to all the many things that it could do. So to keep you in work or to get you back to work, so I think maybe it's a repositioning in that way." [Expert 3]

Theme 2.3: A sense of candidacy

In this sub-theme we identify what aspects of the application process support doctors and medical students to believe that they are eligible for support from the RMBF. After identifying factors that act as barriers to feelings of candidacy, this theme identifies how these feelings are, or could be, changed to make potential applicants more likely to apply. At the end of this section, we present two examples of CMO configurations to illustrate strategies to increase potential candidates' sense of candidacy: sharing good news stories (CMO 18), and increasing board diversity (CMO 19).

Barriers

There are many barriers to candidacy which act at the level of the individual, the interaction with the organisation providing support, the ease of engagement with their processes as well as wider sociocultural barriers, all of which have been mentioned in other themes. For example, a barrier at the level of interaction with the organisation would be a complex and lengthy application form acting as a barrier to becoming a candidate. Individual level factors mentioned in other themes include feelings of embarrassment and shame, and fear of being judged by others. Individual feelings of candidacy might also be undermined through perceptions of not feeling worthy of support, and a tendency to not come forward due to the cultural norm in medicine not to show weakness.

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 **conversation with the caseworker**. Various features of this interaction are crucial to legitimising potential applicants' engagement with the charity.

Firstly, there is the interpersonal aspect of the conversation and the forming of a relationship with the potential applicant. Participants reported that **empathic and non-judgemental discussions** about the doctor or medical students' financial difficulties ensured that applicants felt comfortable discussing 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 a sense of candidacy.

Talking through a situation that has resulted in financial difficulty was regarded as the most appropriate form of communication, which supports applicants in their understanding of the RMBF aims and processes. The conversation was a more appropriate format in which the caseworkers could describe what the charity is looking for with regards to financial hardship and ill-health.

Caseworkers were also reported to take the application very seriously, provide guidance on what information should be included in the application form, and give a very strong sense as to whether or not the request for support would be successful. **Positive feedback about applicant's eligibility and the likelihood of their success** increases doctors and medical students' sense of candidacy and therefore, the likelihood of completing a long application form. These conversations with caseworkers were also regarded to level the playing field ensuring that all applicants have information regarding what is important to include in the application, thereby not disadvantaging anybody who is not good at filling in paperwork. Caseworkers could also signpost other services and organisations that could provide support.

Experts stressed that caseworkers, often the first point of contact with the charity, need to have highly developed communication skills, be resilient, and also be supported themselves to deal with the difficult stories that they hear.

The board was an important element of the process with the differing perspectives of members and their own lines of questioning acting to mitigate against assumptions about medics in financial difficulties and leading to a better understanding of the context. This safeguarded against subjective decisions. Whilst it was postulated that the RMBF board would be made up of medical professionals it was suggested that they should be representative of the various protected characteristics and be a mixture of people with different values and experiences.

Trustees also act to increase candidacy, see theme 1 for more details and the use of word of mouth.

Strategies

Encouraging applicants to have **informal discussions with their assigned caseworkers** could increase candidacy more than applicants just reading lists of criteria detailed on the RMBF's website. It was felt that doctors and medical students' negative perceptions of themselves may mean they judge themselves too harshly against prescribed criteria and therefore assess themselves as ineligible for support. The RMBF could stress on their promotional materials and website that they would **welcome**

applications from doctors before they reached a point of financial desperation and can also give **support for short-term difficulties**.

More **good news stories** 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 improve potential applicants' sense of candidacy. As above, these examples were suggested by people interviewed for this study.

CMO 18: Good news stories

Context: 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.

Mechanism: More good news stories, and data relating to the success of other doctors' and medical students' applicants would convey a strong message that support is available for medics going through similar problems. This would reassure potential applicants that they were worthy candidates, that their difficulties were valid reasons for getting support and that the chances of being helped were favourable.

Outcome: Increased sense of candidacy and that the RMBF would consider their application credible because it had done exactly that for other applications.

"But I think having been told beforehand that you're likely to be you know one of those who may be successful is going to increase your likelihood of completing a long boring form." [Expert 14]

CMO 19: Board diversity

Context: For decision making to be unbiased, objective, and fair it is important that any group of people making those decisions are representative of the diversity of the medical and wider community.

Mechanism: Independent and diverse panel members, who have multiple perspectives on the application in front of the panel, results in unbiased views regarding the application and robust lines of questioning.

Outcome: This will result in objective and fair decision making, and increased uptake due to potential applicants feeling represented by the RMBF.

"I think by having an independent panel it's an attempt to overcome that [subjective decisions]. I don't know who's on the panel, but I know that students would like to know if there were other medical students or even you know service users and carers or whoever on the panel rather than just what they see as professionals on that panel." [Expert 19]

Theme 3: Eligibility criteria

This theme considers how the eligibility criteria, and how they are presented, can encourage or discourage people from applying for support. Opinions varied in some areas, for example some advocated presenting the eligibility criteria fully for people to see whether they are eligible and what they would need to evidence in an application, whereas others felt that too much information could be overwhelming and misunderstood. This variety is presented here, together with suggested strategies that might help to encourage eligible people to apply. This theme covers two sub-themes: criteria as gatekeeper and presentation of the criteria.

Theme 3.1: Criteria as gatekeeper

One of the potential barriers to people applying for help in a timely manner is how the eligibility criteria can act as a gatekeeper to individuals applying or not. This sub-theme looks at how the criteria can encourage or discourage applications, and the potential of applications citing exceptional circumstances. At the end of this section, we present four examples of CMO configurations to illustrate strategies to help people navigate the criteria: encouraging people to enquire about the criteria (CMO 20), providing case studies (CMO 21), providing an option to choose exceptional circumstances if unsure about the criteria (CMO 22), providing examples of what might count as an exceptional circumstance (CMO 23).

Barriers

Experts described people – and themselves – as being generally **bad at reading criteria** and terms and conditions. They felt that even if the criteria are fully laid out on the RMBF website, people who are not eligible may still apply, because they do not necessarily read this information fully. If there is a lot of information presented about the eligibility criteria, then people are less likely to read it properly, and more likely to just skim it. This can also lead to people misunderstanding some of the information and being deterred from applying. If people do read the criteria fully, they can still be deterred from applying unless they feel that they have a very good chance of being successful in their application. This can lead to people not applying who may well have been eligible.

Different people can also interpret the criteria differently, meaning that some people think they are eligible when they are not, and vice versa. Some people might **not realise that their situation or illness makes them eligible** if it is not obvious in the information provided, or might not think that their situation is severe enough to be eligible for support; one potential beneficiary, for example, did not feel eligible despite their status as carer for an ill family member leading them into financial difficulty. Actual beneficiaries from lower income backgrounds also described not feeling that their situations were severe enough, perhaps being more used to managing with less money than individuals from higher income backgrounds. Some people find it difficult to see themselves as part of a category or group, for example labelling themselves as having a disability, mental health issue, physical ill-health, or being bereaved. People might also find it unclear what falls under the heading of ill-health and so not know whether their situation would be covered, for example substance or gambling addictions, or would not realise that situations around domestic violence might also be considered even if that does not obviously involve ill-health. This could lead them to not realising that they would be eligible for support in their situation. Negatively framed criteria could also potentially deter people from applying, for example by focusing on what the RMBF does not fund, as opposed to what they do fund.

A further barrier expressed by potential beneficiaries were concerns regarding whether or not their application would meet the criteria. There was an assumption that their case would not warrant support because they incorrectly thought that the RMBF would **only help people at rock bottom** and

they would be excluded if for example, they had some savings, even if minimal, or had a small amount of low-paid work or a partner who worked. Potential beneficiaries did therefore not apply because they thought that they would have had to explore all other possible options (e.g., selling their house, taking out a loan) before being considered, and could only apply for help once they were *"penniless"* (Potential Beneficiary 22). These assumptions can stop people from attempting to apply, or only doing so once at a crisis point. There was also a concern that they were not deserving enough, for example, not having dependants, not living in rented accommodation or not being in debt.

For the criterion that medical students can only apply in their final two years of study, this can be confusing as **medical schools have different course lengths**; this means that the criterion of being in the final two years can apply to different schools – and different students within the schools – differently. This was reported as confusing by both beneficiaries and medical support staff who were interviewed.

Having the option of applying citing **exceptional circumstances** was reported as having both barrier and enabler properties. People who are experiencing difficult situations might not think that their circumstances are exceptional, and so not feel that they could apply for support. Furthermore, the exact meaning of the term may differ between contexts and organisations, and so it might not be clear to people what is considered in this context.

Enablers

While there might be some confusion about what is included in the eligibility criteria, several beneficiaries expressed understanding that a charity such as the **RMBF needs to have boundaries** and therefore needs to have clear criteria for applicants to adhere to. One beneficiary also expressed concern that if there were not strict criteria that the charity could be open to "*abuse*" (Potential Beneficiary 14).

If an applicant is unsure whether their circumstance fits with the eligibility criteria provided, having the option of **exceptional circumstances** may be a way for applicants to describe their situation on the form. Most participants viewed this as a positive option, and did not feel that there would be stigma attached to applying in this way. Medical students and doctors are generally used to the concept of exceptional circumstances, as this is something that they will have been aware of during medical school and postgraduate training.

The experts we spoke to were also mostly in favour of having the option of some kind of exceptional circumstances category, allowing people to apply or enquire about financial support even if it is not clear that their situation falls in the eligibility criteria. It was also suggested that, instead of naming it 'exceptional circumstances' this was framed as considering applications on a case-by-case basis or extenuating circumstances, to reduce the perceived barrier that their hardship is not 'exceptional'.

Strategies

Experts and beneficiaries suggested having a **simple list of aims** rather than specific criteria, and that this might help to stop people being overwhelmed and deterred from applying. Allowing people to get in contact by phone to talk through whether they might be eligible or not would be another way of encouraging people to approach the RMBF even if they are not certain about the criteria.

There was also the suggestion that encouraging people to **contact the RMBF** about applying for support regardless of their situation and eligibility, will help ensure that those people who would be eligible do not miss out on support because they did not think that they would be eligible. Having a range of **different case studies** to illustrate the variety of situations that have been considered eligible previously can also help people realise that their situation could also be covered.

Having the option to tick an "other" box in the application (i.e., instead of the standard list of eligibility 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 **case-by-case basis**, 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 circumstances, an "other" box, or a case-by-case basis, will encourage people to get in contact and apply. Case studies of things that have been supported in the past, including those that might not appear to be within the eligibility criteria at first glance, will help people to understand whether their situation would be appropriate for support.

Quotes and CMO configurations

The following CMO configurations and illustrative quotes provide examples of four strategies around people engaging with the criteria and with the possibility of applying stating exceptional circumstances.

CMO 20: Encourage people to enquire about the criteria

Context: People are generally bad at reading terms and conditions/criteria.

Mechanism: Encouraging potential applicants to contact the RMBF to discuss their eligibility may give eligible individuals the confidence to apply, and save ineligible individuals the time and effort of completing the application form, thus increasing people's sense of certainty about what they might be entitled to.

Outcome: Appropriate potential beneficiaries are more likely to self-select for application following advice from the RMBF.

"Um, mm, that's a tricky one. Because they would have to make their eligibility criteria extremely explicit in order to [rely on suitable applicants self-selecting to apply], and that would involve an awful lot of reading of T&Cs by doctors who were applying. And if doctors are as bad at reading T&Cs as I am then I suspect that wouldn't be very selecting of the doctors that actually need the help." [Expert 7]

"I just think considering individual case by case basis needs to be emphasised rather than, you know might have overall aims, but rather than specific criteria. I think a contact number for support to discuss whether you think you've got a case – I think that's really important. Rather than lots of information for students." [Expert 19]

CMO 21: Provide case studies

Context: People are unsure if their situation applies to the RMBF's criteria.

Mechanism: Providing a range of varied case studies to show the breadth of things that are considered will give people a greater understanding of whether their situation applies.

Outcome: More people will appropriately self-select to apply for support.

"But I think if you just put the eligibility from the financial side of it without giving maybe a case study or scenario as an example of 'Right this an example anonymised of person A – X, Y, Z – when they fill in the form these are some of the information that helps meet the criteria and this is what' if you just put the form bit on there, I think it might put some people off from the point of view that oh here's another form I need to fill in, I'm having to admit to having financial difficulties etc etc. I think consideration would need to be put to telling a story, rather than just putting a form or listing the criteria. So if it can be done within the context of telling a story then the potential beneficiary can say

'Oh okay, that sounds a little bit like my story, maybe I'll actually download it and then, especially if there is also an offer of helping people to fill the form." [Actual Beneficiary 17]

CMO 22: Option to choose exceptional circumstances if unsure about the criteria

Context: People do not think that they fit into any of the categories that cover support.

Mechanism: If the RMBF clearly promotes that it supports people on a case-by-case basis by providing an "other" box for people to tick, then they create an impression of inclusively and flexibility which applicants understand as encouragement to apply.

Outcome: More people applying even though they might not be sure if they are eligible; more support being provided for bespoke reasons.

"Yeah, it's all positive isn't it? – [having the option of exceptional circumstances] promotes inclusivity, and people are not tick boxes, and there may be something in that story from the applicant that does warrant them to be considered as well, so I think that's, that's really positive, shows flexibility of the organisation, and it accommodates, and I think that would be encouraging for anyone applying (inaudible 39:54) shouldn't apply because I don't meet the criteria. It's more about encouraging them to apply, and if they don't meet the criteria then a case-by-case consideration is still going to be made. So I think that's a really positive step by RMBF." [Expert 17]

"Yeah no I mean [having the option of exceptional circumstances] is useful, it kind of shows that like, because even when I applied I kind of vaguely remember thinking I'm still not sure if I'm, like if there's any point applying for this. And then when it says things like that you kind of think oh okay well at least they think outside the box sometimes." [Actual Beneficiary 18]

CMO 23: Examples of what might count as an exceptional circumstance

Context: People think that there are others worse off than them, their own circumstances do not feel exceptional.

Mechanism: Provide case studies as examples of things that have been accepted as exceptional circumstances in the past, leading to increased understanding of what exceptional circumstances includes.

Outcome: Higher likelihood of people applying citing exceptional circumstances.

"But equally you don't want to be put off by thinking well what does an exceptional circumstance mean, do I necessarily fulfil that just because I've been off sick for 6 months with my depression and I'm not going to be able to pay the mortgage next month. Many people may not necessarily think that was an exceptional circumstance, particularly if they've got concerns about guilt, low self-esteem. So that's where I think clear examples and case histories on the website might come in handy for potential applicants to understand whether they're more likely or less likely to benefit from application process." [Expert 7]

"The only thought is the word 'exceptional' – I think nobody ever thinks they're exceptional. Well maybe some people do, but I guess the phrasing of that wouldn't make me think oh my situation's exceptional. Which probably looking back now it probably was with three children in hospital and health problems. But at the time I would have not said we're in exceptional circumstances, so I guess the wording of that probably wouldn't make me feel it was more accessible. […] Maybe just individual, you know we're happy to discuss an individual's situation and review it on a case by case basis – something along those lines. Or we do consider all applications case by case looking at individual situations." [Actual Beneficiary 9]

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 resources, having fully transparent, detailed criteria can be helpful for their role. However, there is an opposing view: making the criteria more accessible by simplifying what is presented. Both ends of this spectrum are presented in this sub-theme. At the end of this section, we present two examples of CMO configurations to illustrate strategies regarding how to present the eligibility criteria: indicating the likelihood of a successful application (CMO 24) and providing a simple way for potential applicants to self-check their eligibility (CMO 25).

Barriers

Support staff in medical schools who were interviewed were concerned to not signpost students to the RMBF if they are unlikely to be eligible, whether that is to do with their situation, status, or with what they need to provide as evidence for their application; they want to avoid sending students to an organisation, only to find out later that the student would not have been successful anyway. People are **less likely to apply for support if they think they are unlikely to be successful**, as applying requires a lot of effort to find all the necessary evidence. So, if support staff do not have a thorough understanding of the RMBF's eligibility criteria, they may be less likely to recommend them.

However, people who are feeling unwell or who are in a difficult situation can feel very tired; this makes it **difficult to go through large amounts of information**, and can make people feel overwhelmed and unsupported. For example, one beneficiary reported finding it so difficult to complete the application and claiming process due to their mental ill health, that they just gave up. Some people may also have accessibility needs such as visual impairment or dyslexia, and might find reading through a list of criteria difficult, meaning that they will not have the necessary information to decide whether to apply or not.

Experts also worried that people who are in financial difficulty may be unavailable during normal working hours, meaning it is hard for them to speak to someone in an organisation like the RMBF unless it is out of normal working hours.

Enablers

Some experts reported signposting people who needed support to the RMBF even if they did not know the full criteria, because they knew at least that the RMBF would possibly be able to help medical professionals and medical students in financial need; this would only apply, however, if the staff member was at least vaguely aware of the RMBF's processes.

Some beneficiaries were very appreciative of the possibility to **contact a caseworker** either by phone or email to discuss their eligibility, as this meant that they could make an informed decision about whether to complete the application form and have a high likelihood of success. Going by the website alone was not as informative as speaking to someone.

Strategies

Having **transparent clear criteria** available for everyone to see, including both applicants and professionals who support medical students and doctors in financial difficulty, will make it clearer to potential applicants, and particularly for support staff signposting people, whether they are likely or unlikely to be successful in their application, and so increase the likelihood of appropriate applicants self-selecting to apply.

An **interactive eligibility checker**, 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 organisation appear more supportive of people in difficulty from the outset. Also, providing **additional ways to access information about criteria**, such as an audio option, will be helpful for those who need alternative ways to access this information (particularly as the charity is targeted at those with health issues or disability).

Quotes and CMO configurations

The following CMO configurations and illustrative quotes provide examples of two strategies concerning how to present the criteria in ways to increase people's engagement with them.

CMO 24: Likelihood of a successful application

Context: Support staff working with doctors and medical students are reluctant to signpost to RMBF without knowing the likelihood of success.

Mechanism: Criteria are clearly described on the RMBF website, so support staff know what will be covered and what will not, boosting their confidence to refer a student/client/colleague.

Outcome: Support staff working with doctors and medical students are more likely to refer individuals experiencing ill-health and financial difficulty to the RMBF, knowing that they have a good chance of success.

"I think if it is there people will read about it, and there's obviously like you know the worry that people might say they've got X and Y conditions when it isn't there, but for the majority of people I think it would work, say if you were to go on the website and you find okay this would apply to me, and then I'm going to take the time to apply for it, or else I'm not going to qualify for it. So if you already know you're not going to qualify there's no point in going through a very lengthy process." [Expert 8]

"I think there's nothing worse than us bigging something up to a student and then them going well actually I was never going to be able to get that because they've come back to me and said actually no you don't meet the criteria for this reason. And I think the eligibility criteria should be really really clear, and what financial thresholds you need to meet or not meet, or what you have to have shown that you've tried already." [Expert 22]

CMO 25: Provide a simple way for potential applicants to self-check their eligibility

Context: People in difficult situations and who are unwell find it hard to navigate large amounts of information.

Mechanism: A simple tool, such as an interactive decision tree or a series of simple steps to follow will make the criteria easier to navigate and less overwhelming.

Outcome: More people will engage with the tool and appropriately self-select to submit applications.

"I think if you're in a state of distress, if you're really ill, if your partner's dying, you know you're being threatened with eviction from your own property, you know common sense almost goes out the window. So I think yes, I think it would need to be very simple, like are you a registered doctor working in the UK, have you stopped work because of accident or illness or death and, I don't know,

can't think of a third thing, but you know three very easy statements – right now if you answer yes to these three then you have a conversation with us, we may be able to help you." [Expert 3]

"It might have been helpful to have yeah some kind of flow chart to help you decide if you're eligible or not, and then I think talking to someone on the phone would have been the kind of easiest way to get around most of the problems, but the initial thing is deciding whether you're eligible or not and like 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." [Actual Beneficiary 18]

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 doctors interpret this term, survey participants were asked what they considered to be "ill-health":

- 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 some key insights in participants' views on this term. Besides assigning various definitions to the term ill-health, participants also felt the term was provocative: *"This [ill-health] 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-health".* Participants 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 ill-health. In addition, the term ill-health was considered to be stigmatised, with many participants describing the possible discrimination and judgement they would face should they label themselves as having ill-health.

Perceived stigma

A high percentage of participants agreed with statements on perceived stigma of ill-health in medicine and on stigma related to financial difficulties (Figure 4 and Figure 5). For example, survey 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 (90.7%) or non-disclosing of financial difficulties because of being embarrassed (90.3%).

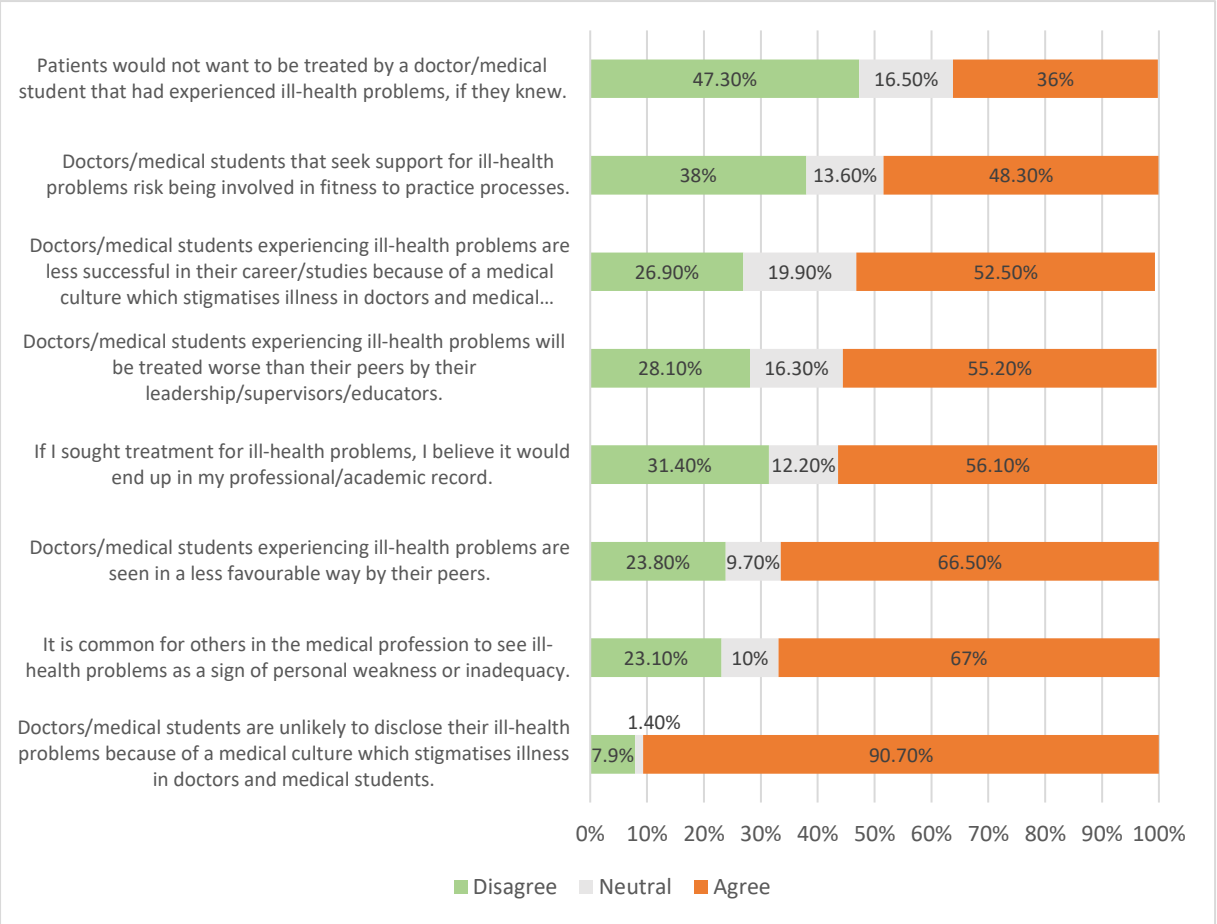

Figure 4. Survey participants' perceived stigma of ill-health.

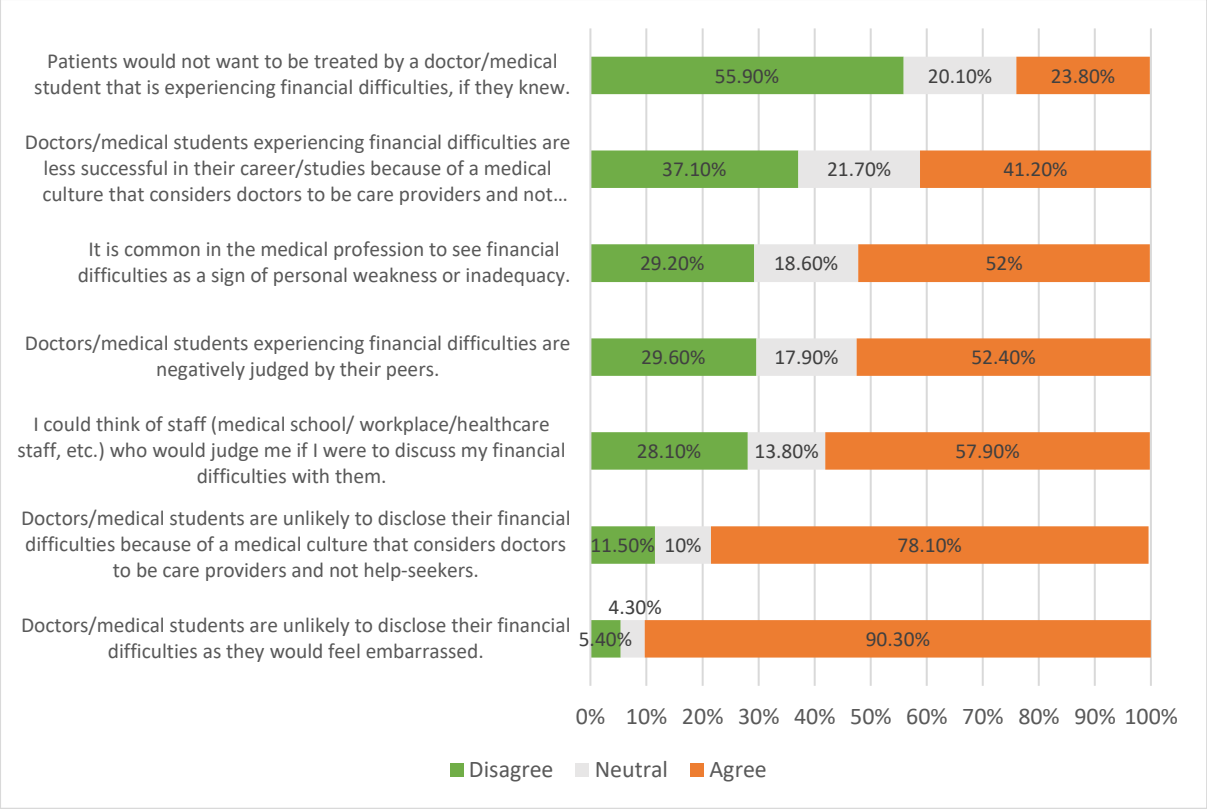

Figure 5. Survey participants' precepted stigma of having financial health.

Profiles: perceived stigma and perception of strategies used by a charity

Latent profile analysis identified three profiles: Profile 1 (*Financial stigma & positive towards strategies*, n = 197), Profile 2 (*Neutral stigma & strategies*, n = 188), Profile 3 (*Ill-health stigma & sceptical towards strategies*, n = 51). Mean scores for each profile are presented in Table 17.

Table 17. Participants' profiles and mean scores for each scale per profile.

	Profile 1 (n = 197)	**Profile 2 (n= 188)**	**Profile 3 (n = 51)**
Stigma: ill-health	4.57	4.60	4.79
Stigma: perceptions of risk of ill-health on FtP	4.04	4.41	4.54
Stigma: financial difficulties	4.61	4.46	4.58
Charity's strategy: a medicine-based charity	5.13	4.11	4.02
Charity's strategy: offer psychological/ mental health support next to financial support	6.10	4.83	3.87
Charity's strategy: recommended by peers	6.40	5.37	4.90

Note. Profile 1-Financial stigma & positive towards strategies, Profile 2-Neutral stigma & strategies, Profile 3-Ill-health stigma & sceptical towards strategies. Higher scores for stigma indicate more stigma, and higher scores for charity strategy questions mean more positive attitudes and perceptions.

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 shows and compares doctors' demographic characteristics for each profile. No significant differences were found between profiles in terms of doctors' demographics.

Table 18. Demographics per profile [% or M(SD)].

	Profile 1 (n = 197)	**Profile 2 (n= 188)**	**Profile 3 (n = 51)**	**Statistical significance**[2]
Gender				*p*>0.05
Female	69.5%	68.6%	66.7%	
Male	29.4%	31.4%	31.4%	
Age *(M/SD)*	32 (11.4)	31.6 (11.5%)	31.9 (12.9)	*p*>0.05
Sexuality				*p*>0.05
Heterosexual	82.2%	81.9%	80.4%	
LGBTQ+	15.2%	11.2%	11.8%	
Region				*p*>0.05
England	73.1%	78.7%	84.3%	
Northern Ireland	4.6%	0.5%	0%	
Scotland	13.7%	11.7%	9.8%	
Wales	16.7%	7.1%	5.9%	
Relationship status				*p*>0.05
Single/divorced/ separated	46.2%	54.3%	54.9%	
Married/co-habiting/in a relationship	52.8%	43.6%	45.1%	
Ethnicity				*p*>0.05
White	71.6%	69.7%	58.8%	
BAME	24.9%	28.7%	39.2%	
Disability				*p*>0.05
No	87.8%	84%	76.5%	
Yes	11.2%	13.3%	21.6%	
Caring responsibilities				*p*>0.05
No	77.2%	78.7%	74.5%	
Yes	21.8%	19.1%	21.6%	
Profession				*p*>0.05
Students	45.2%	43.6%	49%	

	Profile 1 (n = 197)	Profile 2 (n= 188)	Profile 3 (n = 51)	Statistical significance[2]
Doctors	54.8%	55.9%	51%	
PMQ				p>0.05
UK	88.3%	87.8%	84.3%	
Non-UK	10.7%	11.7%	15.7%	
Full/less than full time job				*p*>0.05
No	20.8%	17%	19.6%	
Yes	34%	38.8%	31.4%	
Med school year				*p*>0.05
Before the final two years	24.9%	26.1%	33.3%	
Final two years	20.3%	17.6%	15.7%	

Note. Missing values are not displayed in this table. [2]Chi-square test is used for all variables, except for age (Anova is performed).

Table 19 shows how each profile differs in terms of outcomes. Those participants in Profile 1 were more likely to seek help from a charity using any of the three strategies (medicine based, additional support and recommended by peers) in comparison to participants from Profile 2. Participants from Profile 1 were also more likely to seek help from a medicine-based charity and a charity that was recommended by peers than participants in Profile 3. Intentions to seek help from various resources (e.g., family, government, workplace/medical school, charities, bank) were also compared between the three profiles. Those from Profile 1 were most likely to seek support in general (including from a charity) and those from Profile 3 least likely. No significant differences were found between the profiles in terms of seeking help for the financial worries. We did find, however, a significant difference in participants' likelihood to seek help from the RMBF: participants in Profile 1 were more likely to seek help from the RMBF than participants in Profile 2.

Table 19. Profile differences in outcomes [% or M(SD)].

Outcomes	**Profile 1 (n=197)**	**Profile 2 (n=188)**	**Profile 3 (n=51)**	**Statistical significance***	**Group differences**
Likelihood of seeking help from a medicine-based charity	4.72 (1.61)	3.87 (1.34)	4.20 (2.03)	**F(2, 435) = 14.203, *p*<0.001**	Profile 1 vs Profile 2
Likelihood of seeking help from a charity that offers psychological/mental health support in addition to financial support	5.73 (1.09)	5.04 (1.10)	4.63 (1.80)	**F(2, 435) = 25.470, *p*<0.001**	Profile 1 vs Profile 2 Profile 1 vs Profile 3
Likelihood of seeking help from a charity that was recommended by peers	6.44 (0.73)	5.92 (0.92)	5.78 (1.33)	**F(2, 435) = 20.636, *p*<0.001**	Profile 1 vs Profile 2 Profile 1 vs Profile 3

Outcomes	Profile 1 (n=197)	Profile 2 (n=188)	Profile 3 (n=51)	Statistical significance*	Group differences
Likelihood to seek help from any sort of resource[1]	4.04 (0.75)	3.93 (0.75)	3.34 (0.78)	**$F_{Welch}(2, 138) = 11.262$, $p<0.001$**	Profile 1 vs Profile 2 Profile 1 vs Profile 3 Profile 2 vs Profile 3
Likelihood to seek help from a charity	3.95 (1.60)	3.59 (1.44)	2.75 (1.66)	**$F_{Welch}(2, 140) = 16.520$, $p<0.001$**	Profile 1 vs Profile 2 Profile 1 vs Profile 3 Profile 2 vs Profile 3
Sought help for worries				$\chi^2(2,367)=0.41$, $p>0.05$	n/a
No	53.8%	55.9%	54.9%		
Yes	31%	27.7%	29.4%		
Likelihood to seek help from the RMBF	4.60 (1.49)	3.81 (1.39)	3.95 (1.84)	**$F_{Welch}(2, 193) = 6.511$, $p<0.01$**	Profile 1 vs Profile 2

Note. * ANOVA is performed, except for the variable "sought help for worries" for which a Chi-square test was performed.

Scales on likelihood to seek support are scored from 1 to 7.

[1]resources include partner, family, friends, government, workplace/medical school, professional organisations (e.g., the BMA), charities, bank, payday loans/credit agencies.

Key findings for RQ4

The key findings from the qualitative analysis of the expert and actual/potential beneficiary interviews regarding what hinders or drives potential beneficiaries to seek timely support, and the strategies to reach potential beneficiaries, are:

- The interviews identified four key areas to consider for increasing awareness of the RMBF:
    - The impression that people have of the charity, including assumptions people might make about the name, the RMBF being "part of the profession", and how inclusive the charity appears to be will impact whether people feel that they "fit" with it and would therefore apply;
    - Advertising was felt to be challenging, but targeted advertising, using testimonials, and advertising via multiple routes were recommended;
    - Working with partner organisations can help to spread awareness and trust in the RMBF, as can encouraging spreading awareness using word of mouth among peers;
    - Ways of making people aware of the RMBF from early in their career (particularly at vulnerable times) can mean that they remember the charity for longer and so know about them in case of ever experiencing difficulty;
- The interviews also identified three key areas to make the process of applying more manageable:
    - Applicants can feel a burden of proof, especially if completing an application is difficult due to ill-health, which can be helped by strategies to reduce the amount that people have to submit, or by providing assistance;
    - There is stigma around experiencing ill-health and financial difficulty in the medical profession, and working to alleviate that stigma may encourage people to apply for support; maintaining an applicant's confidentiality and anonymity, and emphasising the independence of the RMBF from the GMC is important;
    - Applicants feeling a sense of candidacy (that they are eligible and entitled to support) can help to encourage applications;

- The interviews also identified two key areas around the RMBF's eligibility criteria:
    - 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 "ill-health" (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 what is meant by "ill-health" might be useful;
- Perceived stigma around ill-health and financial difficulties among participants was high:
    - 90.7% agreed/strongly agreed with the statements about non-disclosing ill-health problems because of a medical culture stigmatising illness in doctors and medical students;
    - 48.3% agreed/strongly agreed with the statements that doctors/medical students that seek support for ill-health problems risk being involved in fitness to practise processes;
    - 90.3% agreed/strongly agreed with the statement about non-disclosing of financial difficulties because of being embarrassed.
- The highlights of profiling analysis are:
    - Participants experiencing the highest stigma towards financial difficulties and lowest stigma towards ill-health (Profile 1) 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, and being recommended by peers);
    - Those who scored highest on perceived ill-health stigma and intermediate on perceived stigma towards having financial difficulties, expressed the least positive attitudes towards the three strategies (Profile 3);
    - Participants in Profile 1 were more inclined to seek support from a charity when in financial difficulty (including specifically from the RMBF) and to seek support more generally.

4. SUMMARY AND KEY RECOMMENDATIONS

The two main research objectives were to explore the causes and extent of unmet needs from doctors, medical students, and their families in financial hardship; and to understand how to improve the effectiveness of the RMBF's current support. Generally, former RMBF beneficiaries were overwhelmingly positive in their descriptions of their interactions with the RMBF. They appreciated the caseworkers' helpfulness and that they were non-judgmental, and the speed with which they were notified about the outcome of their applications. Several interviewees stated that they were keen to give back to the RMBF in some way, either by repaying what they had been given in the form of donations, fundraising, or by helping to spread awareness of the RMBF to other people by sharing their stories. They found the financial support a great help and were grateful for the unexpected extra support such as financial help at Christmas, money advice, and coach mentoring. These aspects of the RMBF's activities are something that the charity would be encouraged to keep doing.

The following sub-sections focus on the areas that could be improved, summarising key results from all of the different research Phases (literature review, interviews with experts and actual/potential beneficiaries, secondary data analysis and survey) and present (i) *unmet needs*: discussing findings on the level of the problem of financial difficulties in the profession, who is experiencing financial difficulties, and whose needs are potentially unmet; (ii) *barriers/enablers:* presenting findings on key barriers and drivers of seeking timely support covering the three topics of awareness of the RMBF, process of applying, and eligibility criteria; and (iii) *recommendations*: presenting key recommendations based on the discussed barriers and enablers.

4.1. Unmet needs

The study revealed that all medical students and doctors might be at risk for financial difficulties at some point in their lives and these difficulties might have a significant impact on them (e.g., dropping out of medical school, cutting down or doing without essentials, developing mental health issues, delaying life decisions due to financial constraints). Indeed, a large percentage of medical students and doctors who took part in the survey indicated that they worried about their finances at some point in their lives (84.2%) and one in three (33.5%) experienced financial difficulties (defined as the inability to meet financial obligations). Participants reported experiencing financial difficulties at all stages of their career; for example, approximately one in two of all participants experienced financial difficulties during medical school and approximately one in four during training. Of more senior doctors (consultants and GPs) who experienced financial difficulties, almost half experienced these difficulties after obtaining the Certificate of Completion of Training (CCT).

To identify which groups are experiencing financial difficulties and provide a better understanding of medical students and doctors who have financial needs (and whose needs are potentially unmet) we drew on the findings of all research Phases and present the key pathways to financial difficulties (see

Figure 6). The five pathways that can lead to financial difficulties were physical (such as illness), psychological (such as mental health or barriers to seeking help, e.g., stigma), social (such as caring responsibilities), financial (such as fees), and professional (such as contractual issues).

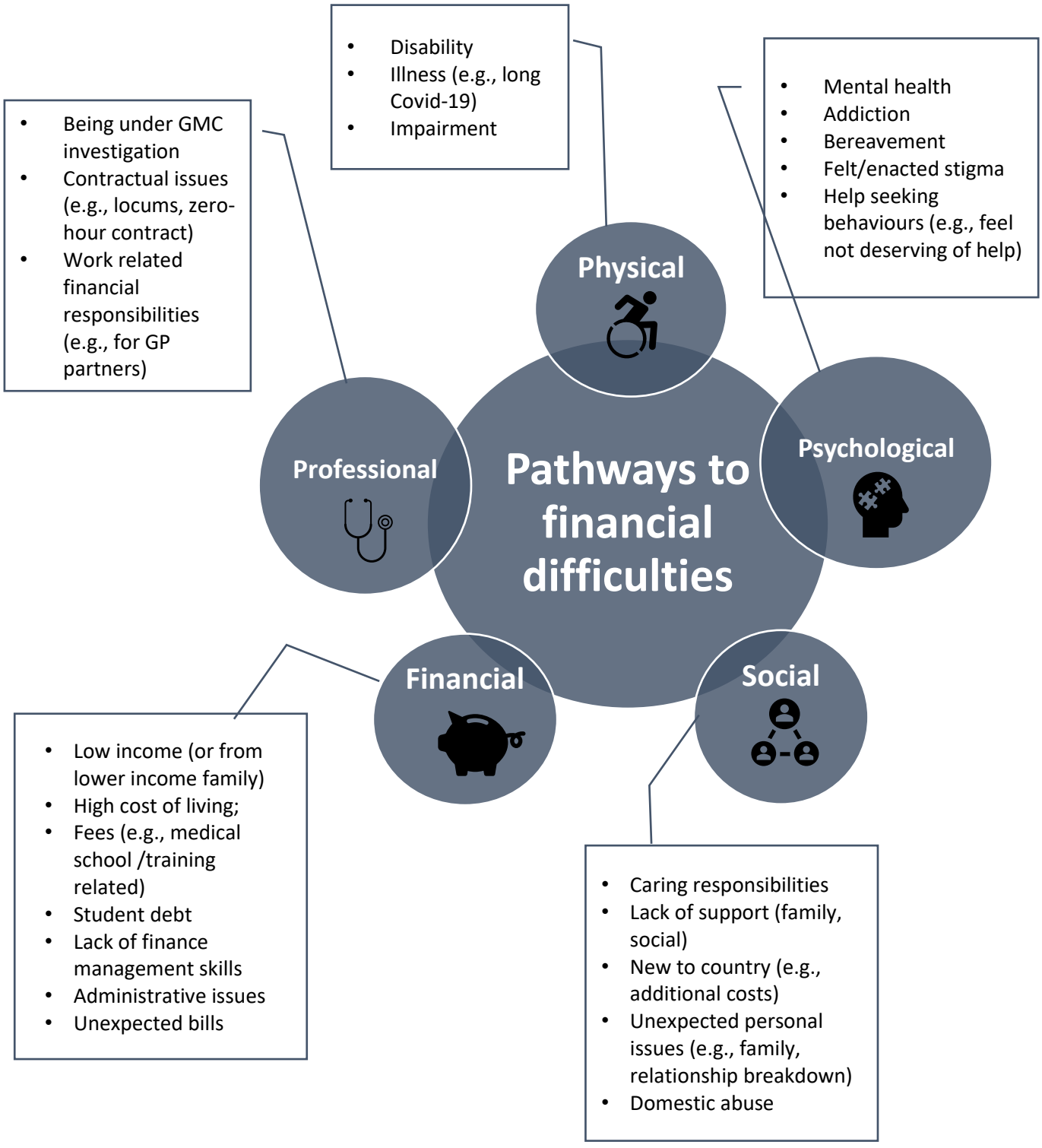

Figure 6. Pathways to financial difficulties.

The groups that were particularly highlighted in different research Phases as having particularly high levels of need were:

- Medical students because of study expenses (e.g., course fees, commuting to placements), high cost of living and limited possibilities for additional paid work (e.g., due to high workload on their course). That was particularly relevant to students from widening participation backgrounds or overseas students;
- Medical trainees because of student debt (vulnerable to financial mismanagement) and training costs (e.g., exams);
- Overseas doctors (international medical graduates and refugee doctors/asylum seekers) because they have high expenses setting-up and as they are new to the UK they may be unfamiliar with UK systems;
- Doctors out of work not due to ill-health (e.g., under GMC investigation) or with non-substantive employment (e.g., locum) as these are less secure in their jobs;
- Medical students and doctors who were affected by the pandemic (e.g., being unable to work because of shielding, developing long-Covid, or students not being able to find work outside medicine due to the pandemic).

Interviewed experts said that needs by some of these groups might be unmet by the RMBF due to a lack of awareness of the charity, challenging application process, or criteria restrictions (recommendations are presented below).

This framework of pathways to financial difficulties also highlights some of the challenges that might deepen financial difficulties, like stigma and help-seeking behaviours. This might be reflected in the findings that only approximately one third of those who *worried* about finances sought help (35.2%). Many of those who were *experiencing financial difficulties*, however, sought help but mainly from their families, workplace/university, or student loan companies (over 50%). Medical students and doctors who experienced financial difficulties were less likely to seek help from charities (only 23% who experienced financial difficulties did so). When we specifically asked about intentions to seek help from the RMBF, 47.4% of survey participants said that they would seek help from the RMBF if they were in financial difficulties. From interviews with potential beneficiaries and survey findings, it became clear that some of the barriers of applying included the accessibility of the RMBF: the perceived difficulty of meeting the criteria and the perception that the charity will only help in extremis or when being destitute (e.g., that the applicant would not be eligible if they still owned a home or worked a few hours per week). Participants also mentioned feeling undeserving of help from a charity (i.e., feeling others were worse off and therefore more deserving), feelings of shame, and some participants were unaware of the RMBF and the services they provide. More details on the barriers and enablers are presented in the next section.

In order to identify unmet needs in the profession, this research project also explored demographic characteristics of RMBF beneficiaries. More recently, the charity supported more female, younger, and single doctors and more of the younger students. No significant changes were found in the geographical regions that beneficiaries come from, or gender differences among medical students over time.

Despite the changing demographics of beneficiaries over time, a comparison of data revealed that the RMBF beneficiaries' demographic characteristics are similar to those on the medical register in terms of gender, age, and region. Although some differences were noticed in doctors specialties/grade helped by the RMBF (e.g., a larger proportion of psychiatry and lower proportion of foundation doctors were helped by the RMBF), firm conclusions are unfeasible due to the large number of missing data in the RMBF dataset. Regarding students, a larger percentage of male students approached the RMBF in comparison to the general student's population, but that was the only comparison that was

possible to make due to limited publicly available data on medical students. These analyses of demographic characteristics showed no clear indication of groups underserved by the RMBF.

4.2. Barriers and enablers

In this sub-section we present key barriers and enablers of seeking timely support identified through findings from research Phases 2-4. This sub-section covers three topics: awareness of the RMBF, process of applying, and eligibility criteria (as presented in Figure 7).

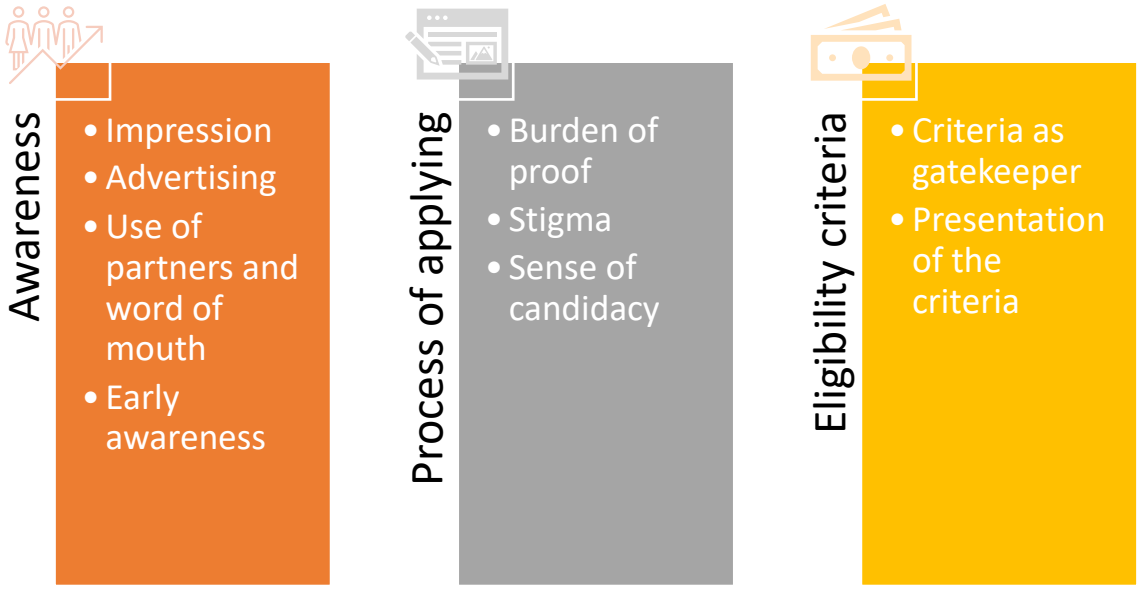

Figure 7. The map of key barriers and enablers for seeking timely support.

4.2.1. Barriers and enablers: Awareness

There seems to be a gap in awareness of available support in the profession. Just approximately one third (36.9%) of survey respondents said that they were made aware of ways to access financial help throughout their career as a doctor/medical student, more so medical students than doctors (48.7% vs 27.5%). Less than half of survey participants knew about the RMBF (44.3%; more so doctors than students, 60.4% vs 25%). It is important to mention that awareness of the RMBF and other organisations providing financial support more generally did not differ significantly between the four UK countries.

The main barriers and enablers related to awareness were related to the charity being "part of the profession", advertising, Use of partner organisations, early awareness, and awareness of no-monetary services provided by the RMBF.

The ***impression*** that the RMBF is "part of the profession" had both positive and negative connotations for potential applicants. Being a charity run *by* doctors *for* doctors can engender trust, but sometimes raised concerns about anonymity. The name of the organisation was seen to raise credibility by some

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

From the survey and data provided by the RMBF, we know that doctors and medical students heard about the RMBF through a variety of resources. The largest proportion of survey participants and RMBF beneficiaries learnt about the charity through advertisement in medical journals, through their medical school/university, an online search, a family/friend/colleague, or routes such as social media and other charities. However, ***advertising*** was felt to be challenging because medics are busy and advertising campaigns do not hold an audience's attention if they are not relevant in their current situation. Traditional medical journals were no longer read as much (especially in print) in favour of more speciality publications or free access journals; thus, it is challenging to identify where to advertise.

Use of partner organisations to spread awareness of the RMBF was felt to be beneficial as a wider number of individuals can be contacted and referred to the RMBF via existing and trusted support routes. Potential candidates who are recommended from a respected figure by ***word of mouth*** are likely to gain a feeling of validation via the referral and have increased feelings of candidacy. Word of mouth amongst peers was felt to be effective, as a recommendation by a trusted person is a powerful persuader.

Early awareness and regular reminders through timely promotional material were believed to be key as the general view was that there is limited awareness of the RMBF, even if they had been introduced at medical school.

It was also evident that many medical students and doctors were not familiar with the wide range of services that the RMBF offers. For example, from those who were familiar with the RMBF, 75.5% knew about the financial support provided by the charity to doctors but <25% knew about ***non-monetary services***.

4.2.2. Barriers and enablers: Process of applying

The following barriers and enablers related to the process of applying were found to be important: burden of proof, stigma, and sense of candidacy.

There was a ***burden of proof*** felt by some actual beneficiaries, for whom it could be difficult to gather all the necessary evidence when feeling unwell, or for whom the expense of printing documents could be prohibitive; without help this burden could prove insurmountable leading to people not submitting applications. However, there was a general understanding from both beneficiaries and experts that it is necessary for a charity to have this evidence to justify their spending.

It was felt that ***stigma*** around ill-health and financial need in the culture of medicine is a major barrier to people applying to the RMBF for support and makes them very reluctant to ***share sensitive information***. From survey results, 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. Participants felt similarly about stigma towards financial difficulties: 90.3% agreed/strongly agreed with the statement about non-disclosing financial difficulties because of being embarrassed and 78.1% agreed/strongly agreed with the statement about non-disclosing financial difficulties because of a medical culture that considers doctors to be care providers and not help-seekers.

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 embarrassment or shame about seeking support. This can also be seen in people's concerns 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, or any kind of "small print", meaning that they may miss or misunderstand important details. Unless 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. By some it was also felt that the term "ill-health" itself might feel stigmatising and that not all assumed 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 got in touch. Medical professionals are mostly used to this term "exceptional circumstances", as they 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 their ability to navigate an extensive list of criteria.

4.3. Recommendations

This last part of the report presents a variety of suggestions how to overcome the barriers discussed above related to a lack of awareness, challenges with the application process and criteria. Figure 8,

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

4.3.1. Raising awareness

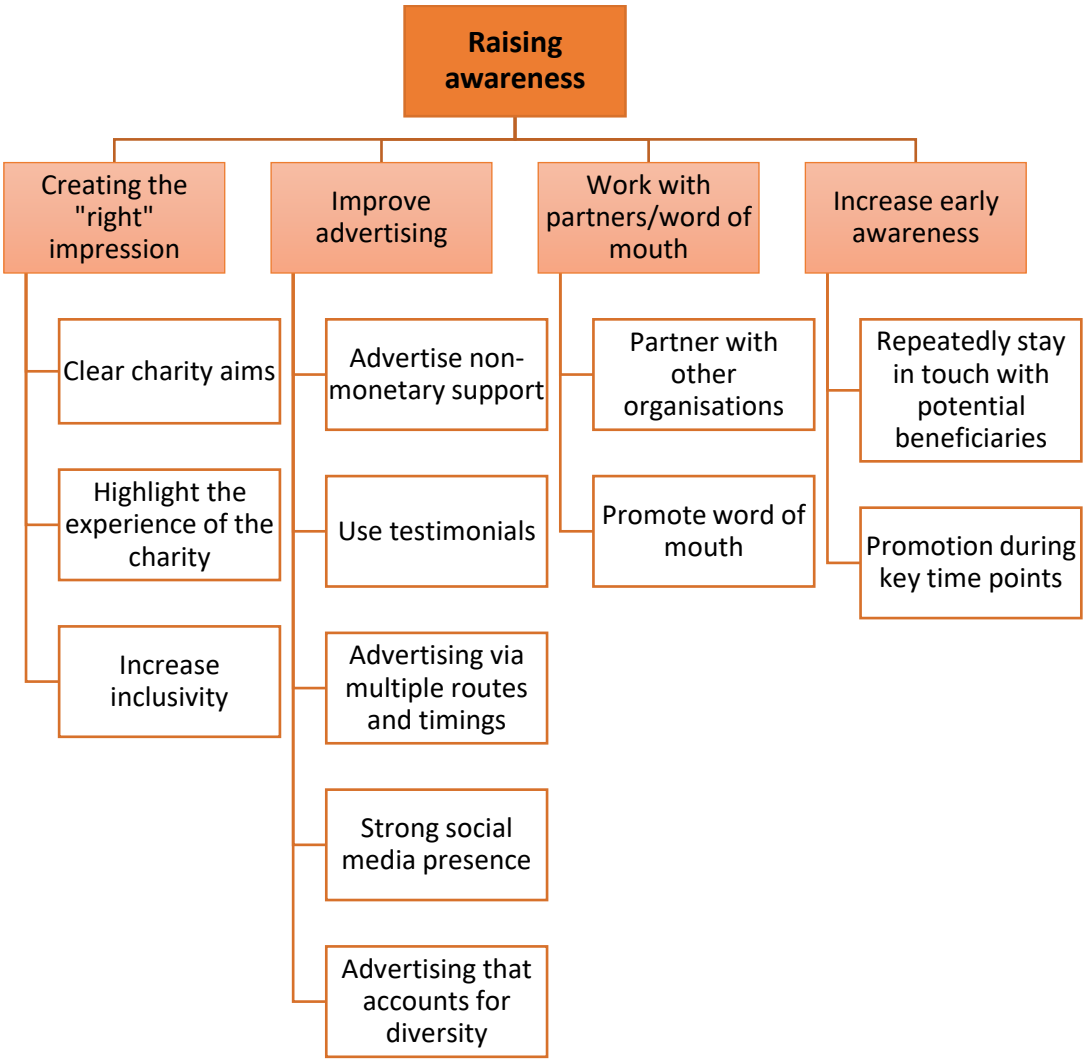

Figure 8. Recommendations to increase awareness.

Recommendations to create the ***"right" impression*** for encouraging potential applicants to engage with the RMBF include: having clear information about the charity's aims following the name of the charity to help people identify themselves as potential candidates, particularly for younger applicants who may be less likely to identify themselves with the RMBF; building on the advantages that being "part of the profession" confers by emphasising the charity's history of supporting doctors and their understanding of the challenges they face; this might be achieved by an obvious demonstration of the range of beneficiaries and situations the RMBF may be able to support (e.g., via typical examples/case studies of those the RMBF help); increasing the inclusivity of the organisation, board, and panel, and making advertising reflect the medical population in terms of protected characteristics, to make the charity feel more relevant to more medics.

Advertising via multiple routes was advised, repeatedly and regularly throughout a doctors' career. 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 organisations such as other charities, NHS support services, health education organisations in the four home nations, medical students' and doctors' national networks, and 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 strategies were 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. Refining the application process

Having a light-touch application or providing practical help with the application from volunteers or caseworkers, could help alleviate the ***burden of proof*** and increase the number of completed applications. Clarifying why each stage of the application and supporting evidence is necessary might also help to ease the burden of proof.

Maintaining confidentiality and anonymity, and emphasising their independence from the GMC, were felt to be essential for the RMBF to persuade people to apply for support. Working to normalise ill-health in the medical profession could also help to reduce ***stigma*** and encourage more people to come forward for help. Sharing case stories to show that ill-health and financial difficulty can happen to anyone is one of the ways to both raise awareness and potentially reduce stigma. The RMBF should also show that the charity does more than just provide financial support for paying bills, but can help with returning to work in medicine or seeking an alternative career.

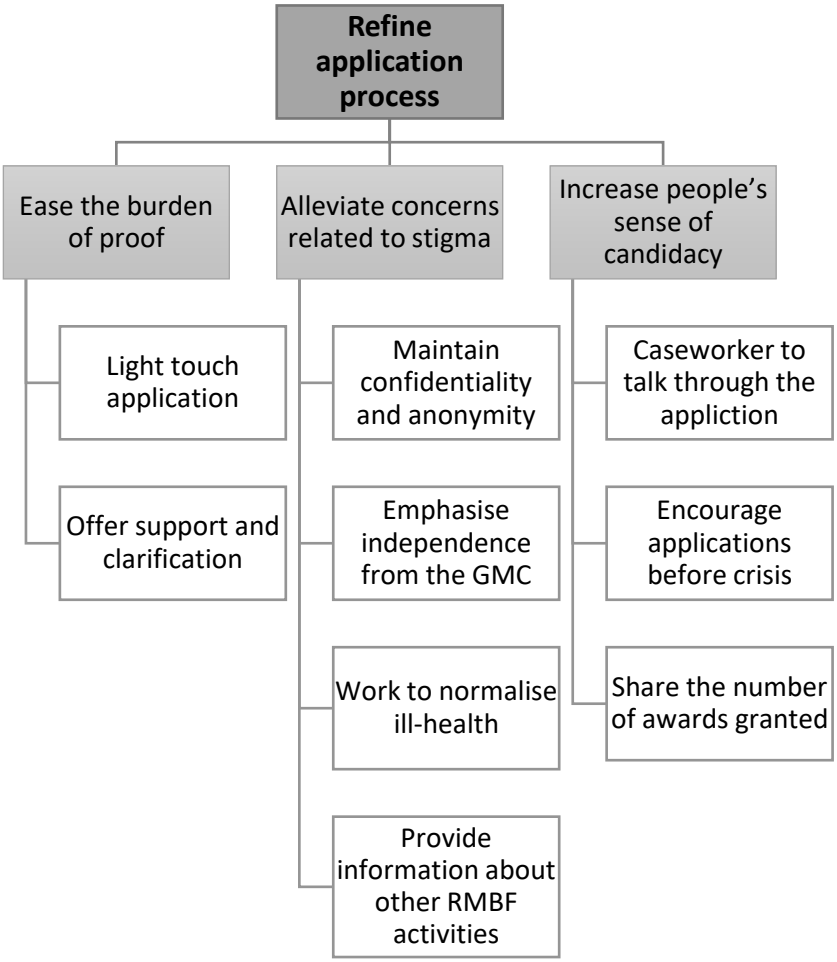

Figure 9. Recommendations to overcome challenges of process of applying.

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 might also increase people's sense of candidacy.

4.3.3. Clarifying the eligibility criteria

Study participants recommended having both detailed ***transparent*** information and more simple accessible information available about eligibility criteria, so that visitors to the website can choose which level of detail is most helpful for them at the time. Having clear and transparent criteria available on the website allows people to make an informed choice about whether or not to try applying based on the likelihood of success (this is also useful for staff in partner organisations to know whether to refer individuals to the RMBF). In addition, having a series of simple, short steps to follow, or an ***interactive eligibility checker***, could make this more manageable for people who are struggling with ill-health. Having a variety of ***case studies*** illustrating previously eligible cases might help to clarify the eligibility criteria. Providing an "other" or exceptional circumstances box for people to tick in their application if they are unsure about fitting the eligibility criteria, and emphasising that applications

will be considered on a ***case-by-case basis***, might increase people's confidence to contact the RMBF. 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.

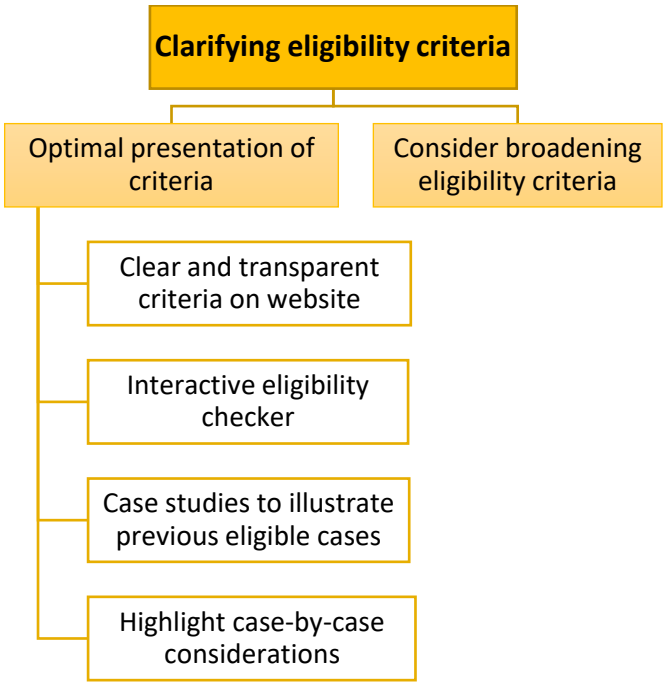

Figure 10. Recommendations related to eligibility criteria.

The charity might also want to consider **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).

We also recommend that any strategies implemented to encourage more applications from those in financial need should be subject to continued evaluation, to ascertain which strategies are the most useful and therefore where resources would be most helpfully expended.

5. LIMITATIONS

Phase 1: Literature review

Certain decisions about inclusion and exclusion criteria were made to ensure that the review was manageable within the timeframe available and captured the most relevant pieces of literature; however, some of these decisions may have excluded some relevant literature. After conducting some initial scoping exercises to help narrow down our focus, we decided to focus on the contexts of immediate relevance to this study: medical students and medical professionals experiencing financial difficulty in the UK. This focus, while practical and yielding useful data, meant that information from other contexts was not captured; for example, literature from other healthcare professions and other geographical areas were not considered, making it possible that useful insights from these contexts were missed. Our decision to only include literature published in English means that insights from non-English sources may also have been missed.

Phase 2: Interviews with experts

We conducted 25 interviews with experts: people who are experienced in supporting medical students and doctors through ill-health and/or financial difficulty. Our recruitment method included approaching people directly via their publicly available contact details, and snowballing. The people we spoke to came from a range of sectors and roles, meaning that while our scope across professions and geographical areas was broad, the amount of people we interviewed in each sector was small; this makes generalisations within sectors difficult, for example with medical schools, or within charities.

Phase 3: Interviews with potential and actual beneficiaries

We conducted sixteen interviews with people who had received support from the RMBF. They were initially invited by staff members at the RMBF, who approached former and current beneficiaries who they felt were likely to be interested in taking part. Those beneficiaries who were interested were then introduced to members of our research team, and an interview was arranged if they still wanted to take part. A limitation of this method of recruitment is potential bias around participation. Firstly, there is potential bias in the initial selection of beneficiaries to approach from the RMBF's side. Secondly, there is the risk of bias in which of these beneficiaries self-select to continue and take part in an interview; for example, they may be more likely to self-select to take part if they have had a particularly good experience, so that more data about positive experiences are gathered than about negative experiences.

Only six of our interviews were with potential beneficiaries, i.e., people who had not received support from the RMBF. While our findings from these interviews are interesting and rich, it is not possible to generalise due to this limited sample.

Phase 4: Secondary data analysis and survey

There are two main limitations for the secondary analysis. Firstly, the RMBF data are administrative data and as a result the level of detail and the quality of the data over time vary. For example, data collected before 2014 are less complete and detailed than more recent data collected after the new

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.

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Appendix 1. Literature 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

Finalised search term string:	(doctor* OR Clinician* OR Surgeon* OR Physician* OR GP OR "General Practitioner*" OR "Medical specialist*" OR "Medical trainee*" OR Resident OR Fellow* OR "Medical student*" OR "Medical Intern*") AND ("Financial hardship" OR "Financial difficult*" OR "Financial struggle" OR "Financial worr*" OR "Financial grant" OR "Widening participation" OR "Non-traditional student*" OR "nontraditional student*" OR "Disadvantage* student*")
Search refinements:	time range: 2011-2021 language: English

Academic literature. After searching the four academic databases (PsychInfo, SCOPUS, Web of Science, and ProQuest) using the finalised search term string, 1,431 hits were captured. The titles and abstracts of these articles were screened by the research team. 1,378 articles did not meet the inclusion criteria and were excluded. The full text of each of the remaining 53 articles were screened by two team members; this led to 16 meeting the inclusion criteria to be included in the final synthesis (Figure 1).

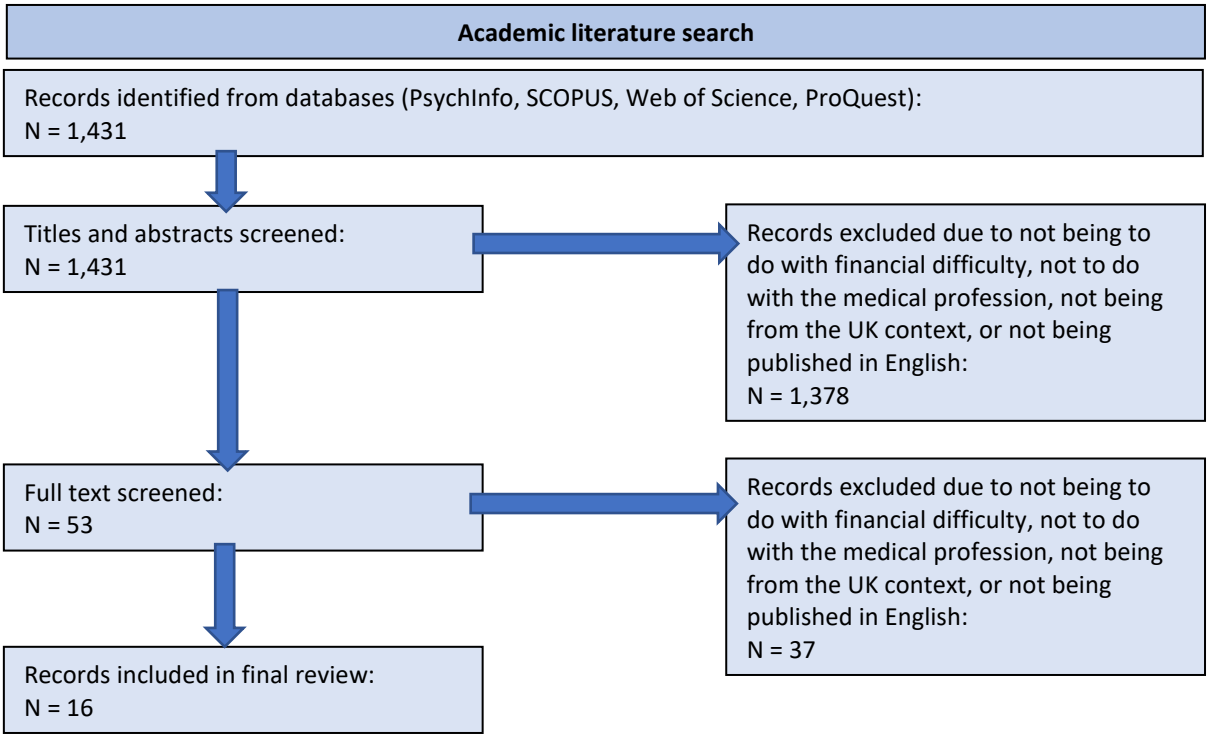

Figure 1. Academic literature search results

Grey literature. After searching the three grey literature databases (Open Grey, Kings Fund, and PsychEXTRA) using the search term string described above, very few hits were captured. None of these were assessed as relevant for this review after title and abstract screening. We explored the websites of twenty organisations; this included the GMC, BMA, NUS, NHS and NHS Education, medical defence organisations, student loan organisations, and partner organisations of the RMBF (e.g., Medics Money, the Cameron Fund). We also explored the websites of the nineteen medical royal colleges and

faculties. As these websites did not have the facility for advanced searching that the databases provided, we were unable to use the search term string in the same way; instead we used the terms relating to financial difficulty and not those specifying doctors or medical students, as the websites were already targeted at medics. The search involved using these search terms in the websites' search functions, and scanning through relevant individual webpages, for example if the website had a news section or a list of commissioned reports. Webpages were screened using the inclusion criteria by team members at the time of searching, with those assessed as relevant added to the literature for this review.

The search of relevant organisations' websites led to 45 news articles, press releases, and reports being captured. The full text of each of these news items and reports were then screened by two team members; this led to 24 meeting the inclusion criteria to be included in the final synthesis (Figure 2).

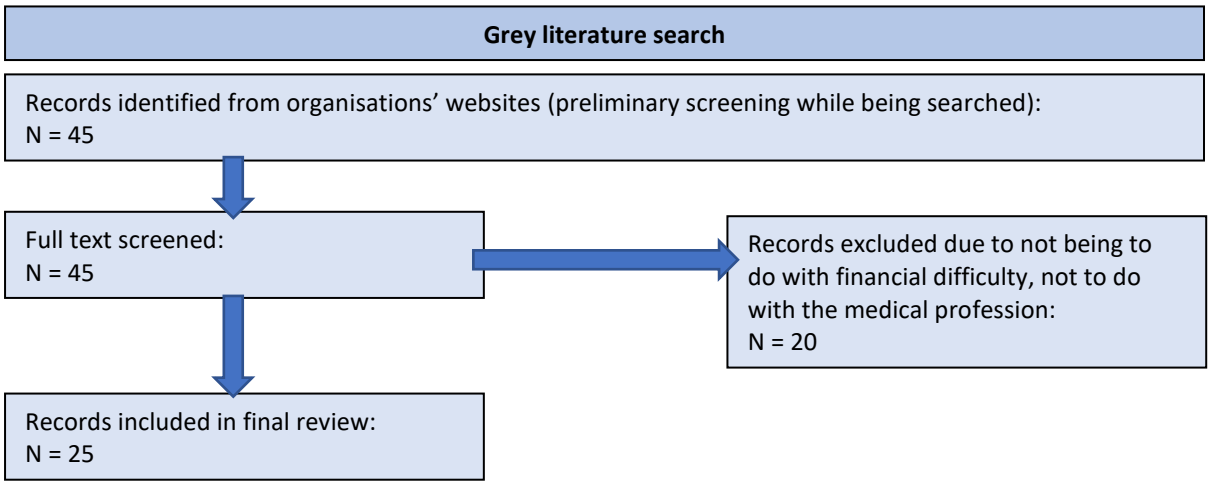

Figure 2. Grey literature search results

Citation searching. Citation searching led to a further 15 results; after full-text screening 6 met the inclusion criteria and were added to the final synthesis (Figure 3).

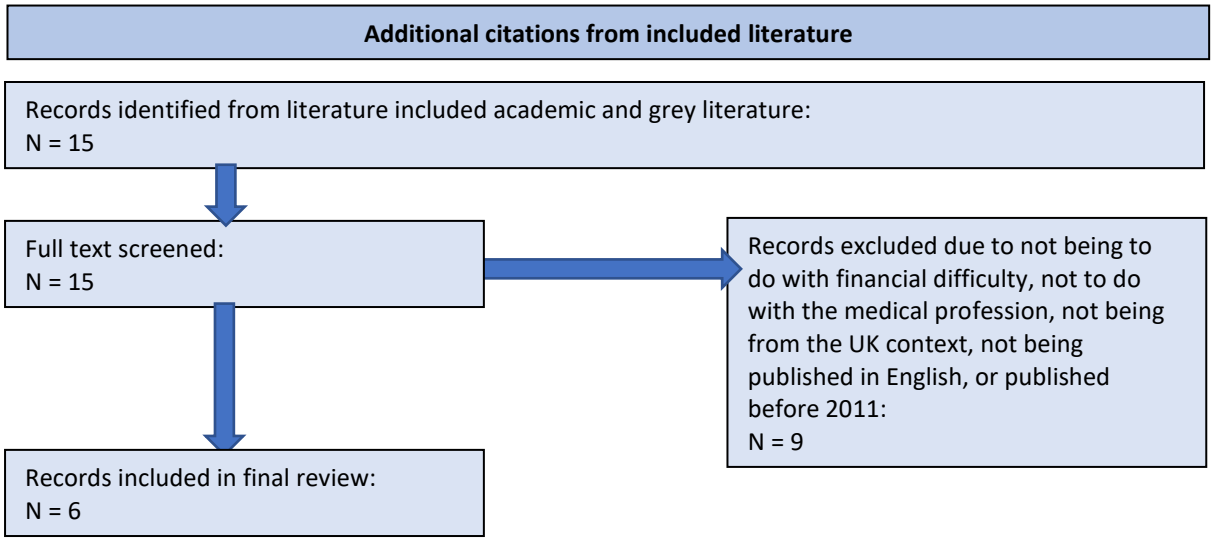

Figure 3. Additional citations search results

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 relevant to the interviewees' experiences, so the exact content of each interview may differ slightly depending on what the interviewees' focus their discussion on.

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

Opening questions

Firstly, please could you tell me a little about yourself?

- Professional background.
- Professional role now.
- Any involvement with the RMBF?
    - If yes, quick summary of what.
    - If no, ask if they have heard of them, and if so, how.

Has the video highlighted anything about the RMBF that you didn't know previously?

- Unpack if they mention: i) financial support offered; ii) eligibility for support.

What are your thoughts on the current financial support that it offers?

- How does it compare to other sources of financial support that you are aware of?
- From your experience in your own organisation, is there any type of financial need that is not addressed by the RMBF?
- From your experience in your own organisation, is there any type of [doctor/medical student/family member] that needs support because of ill health, who would not be eligible for RMBF support?

Programme theory testing

We are trying to understand how the RMBF might be able to better help doctors, medical students, and their families. We have some preliminary ideas or hunches about the barriers and facilitators in accessing help that the RMBF provides, that it would be great to get your perspectives on. So in this next part of our discussion, I'd just like to find out whether you agree/disagree with the following statements, and to what extent, and to have a critical conversation about why.

The first of these ideas to chat through relate to people's AWARENESS of the charity.

- The MAIN barrier to suitable applicants reaching out to the RMBF for help is a lack of awareness of them.
    - There's a feeling that many people don't know the RMBF exist – would you agree?
        - Can you think of anything the RMBF could do to counter this? Perhaps drawing on something your own organisation has done, if that's relevant?
        - You mentioned [X] – why is this particularly important here?

    - There's an idea that if people have heard of the RMBF, there is a misunderstanding about what they do. Does that speak to your experience at all? Why?
        - Might this effect people coming forward? Why?
    - Do you think this lack of awareness is the main barrier?
        - There's a feeling that stigma towards weakness is particularly powerful in the medical profession? Do you agree?
            - Could you comment on this in relation to reaching out to the RMBF?
            - In your opinion is stigma related more to illness, or to financial difficulty? Why?
        - There's an idea around fitness to practise being raised if a medic seeks help. What do you think of this in relation to the RMBF?
        - Could you envisage what the RMBF might be able to do to counter this stigma/fear? Again, perhaps in relation to something your organisation does if relevant.
        - Other barriers to seeking help?
- There is an idea that the BEST way to increase awareness of the RMBF is to use advertising. What do you think of this?
    - You mentioned the advertising should be [X] (targeted, timely, online, social media, print etc.) could you tell me more about how this might look?
    - So what is it about [X] that really makes the difference?
    - In our interviews so far, there have been many different ideas about how it might be best to raise awareness – from your own perspective, could you comment on what might be the most important method and why?
    - In your opinion, what would be the best way to increase awareness?
- Another way to increase awareness of the RMBF is to utilise 'word of mouth' to spread awareness of themselves and the help they provide (via volunteers, partner organisations, peers). There's an idea that individuals who become aware of them via word of mouth are more likely to immediately trust them. Would you agree?
    - You mentioned that [X] is important here, is that right? I know it might seem obvious, but could you perhaps articulate why this important?
    - Are there any positives to the word-of-mouth strategy? (e.g. sharing of knowledge about RMBF)
    - Are there any negatives to the word-of-mouth strategy? (e.g. misinformation, confidentiality)

Now we will move on to some ideas about the charity's PROCESSES. As you might already know, the RMBF have a three-step application process. At the first step they encourage potential applicants to just contact them and talk through their situation with a caseworker. If the Casework team believe they are likely to be eligible they will ask the applicant to fill in quite a detailed application form. And the third step is that a panel separate from the Casework team will then decide on the application and award. The process is set up in this way as there is the idea that:

- This complicated three stage application process could act as a barrier to potential candidates. What do you think?
    - I hear from your answer that it might be [X] (overwhelming, difficult, off-putting) for an applicant to have to complete the detailed form, is that right? Could you explain why you think it is [X] exactly that is the barrier?
    - There is an idea that a lengthy application process might mean that:

        - …applicants will delay seeking help until they are very desperate. Could you comment on that?
        - ….it might be possible that applicants who are desperate cannot cope with the application process. Would you think that could be an issue?
        - …applicants feel legitimised by a rigorous process. Do you agree and if so, why might this be?
    - From your experience, if you have any, would you have comments on the three-step application process and how useful it might be?

And finally, some ideas to discuss related to the charity's ELIGIBILTY CRITERIA:

- There's an idea that if the RMBF clearly outlines the eligibility criteria, then eligible beneficiaries will self-select to apply. Would you agree?
    - Do you think people read eligibility criteria? Does it depend on levels of urgency that they need help?
    - There might still be the possibility of misunderstanding the criteria, meaning that people won't self-select. Do you think this is a possibility?
- The RMBF highlights that they also consider 'exceptional circumstances'. There is an idea that this flexibility means more potential beneficiaries might be eligible for RMBF support and thus apply. Would you agree?
    - There is an idea that the term 'exceptional circumstances' might be quite loaded. Is that something that resonates with you at all?
        - Could you imagine a better phrasing?
    - It might be possible that this flexibility in the criteria might be seen as subjective application and thus unfair. Do you think this might be a worry?
    - In your opinion, how might the RMBF best be able to help eligible individuals, who might not see the RMBF as 'for them', recognise themselves as a suitable candidate?

Closing questions

Is there anything that you wish to return to, or add?

Is there anything that we haven't covered today, but you feel is essential to consider when understanding the financial difficulties of doctors, medical students, or their families?

What, if any, recommendations would you make if the financial support offered by the RMBF were to

<u>Interview guide for actual and potential beneficiaries</u>

Opening questions

Maybe we could start by you telling me a bit about yourself, and any connection you've had to the RMBF?

As I mentioned, we'd like to talk to you about three main areas: firstly about your AWARENESS of the RMBF; about what made you approach them (or not) and what the PROCESS of applying was like (if that's applicable); and finally their ELIGIBILITY criteria. Do you have a preference as to which we chat about first – AWARENESS, APPLICATION PROCESS or ELIGIBILITY?

When answering, if you can, it's really useful to hear about how you felt and thought at the time, and to reflect on why you think this was. As I said, I'll just let you express your thoughts and make some

notes, and then we can come back to any points I'd like to hear more about as needed. Does that sound ok?

Awareness open questions

How did you first become aware of the RMBF?

In your opinion, what would be the best way to increase awareness of the RMBF?

What were your initial thoughts about seeking support for the situation you were in?

Awareness programme theory testing

So firstly, in relation to how you became aware to the RMBF, I'm hearing that [X] is that right?

We have the idea that the MAIN barrier to suitable applicants reaching out to the RMBF for help is a lack of awareness of them.

- From what you said, this seems to resonate with you, is that right? Can you tell me more about why? OR Is this something that resonates with you?
- Can you think of anything the RMBF could do, which might have meant you would had heard of them earlier?
- You mentioned [X] – why is this particularly important for you?

There's an idea that if people have heard of the RMBF, there is a misunderstanding about what they do.

- Previously you mentioned [X], which might relate to this. Would you agree? OR Is this something that speaks to your experience at all?
- Why do you think this misunderstanding might come about?
- You mentioned XX. Can you explain what exactly it is about XX that makes you think that?
- Can you think of anything the RMBF could do to help tackle any misunderstanding of what they do?

Are there any other observations you'd like to make about your impression of the charity when you first became aware of them?

Thinking back to what you said earlier, I understand you think awareness of the RMBF might best be raised by [advertising method] is that right?

There is an idea that the BEST way to increase awareness of the RMBF is to use advertising. What do you think of this?

- You mentioned the advertising should be [X] (e.g. targeted, timely, online, social media, print) Could you tell me more about how this might look?
- So, what is it about [X] that really makes the difference?

There's an idea that individuals who become aware of the RMBF via word of mouth are more likely to immediately trust them. Would you agree with this?

- You mentioned that [X] is important here, is that right?
    - I know it might seem obvious, but could you perhaps articulate why this is important?
- You talked about word of mouth informally via colleagues/through volunteers, info sessions, support services etc. What is about this method particularly that builds trust do you think?

- And other forms of word of mouth – do these work differently in your opinion? Why?

We talked about trust building: Are there any other positives or negatives to the word of mouth strategy?

You mentioned that when you were first considering seeking support for your situation, you felt [X], is that right?

So I hear that [X] was perhaps key in your decision about seeking support, is that right?

- I know it might seem obvious, but can you tell me why [X] like a particular barrier at that point?
- I know this might be difficult to answer, but do you think the RMBF could do anything to help reduce [X] as a barrier?

There's a feeling that stigma towards ill health is particularly powerful in the medical profession. Would you agree that's the case?

- Could you comment on this in relation to reaching out to the RMBF?
- In your opinion is the stigma related more to illness, or to financial difficulty? Why?
- Again, I know this might be difficult to answer, but do you think the RMBF could do anything to help reduce [X] as a barrier?

There's an idea that a fear that fitness to practise might be raised if a medic seeks help, is a barrier to seeking support. Does this resonate with your experience at all? Why (not)?

- Could you envisage what the RMBF might be able to do to counter this stigma/fear? Perhaps something you've experienced yourself if relevant.

Do you think there are any other barriers to seeking support that we haven't yet discussed?

Uptake open questions

How, when and why did you decide to reach out to the RMBF for financial support?

- Ok so, I hear from your experiences that [X] was the catalyst for seeking support, is that right? OR What prompted you to make the first action towards seeking support/making contact with the RMBF?
- It might be quite difficult to articulate, but could you explain why you think this moment that you took action?
- What was it about [X] that made it this catalyst do you think?

Did you seek financial support from other organisations before RMBF?

- Why did you (not) approach other organisations first?
- How confident were you that the RMBF would be able to help you and why do you think you had this impression?
    - Do you this impacted how quickly you sought support? Why?
    - Do you think there could be any implications for the RMBF because of this?

How did you find the process of initially reaching out to the RMBF?

- Again, a tricky question perhaps, but is there anything the RMBF could have done to make this decision (of seeking support) easier for you?

- You mentioned that you sought support from other organisations before approaching the RMBF. Is there anything the RMBF could learn from them perhaps?

Process open questions

How did you find the application process?

How was the experience, between submitting your application and decision of award?

Process programme theory testing

I hear from your experiences that you found the process of applying as [X], is that a fair summary?

We have some other ideas of what might work well, or not so well in the application process. The first set of ideas are about the length of the application form. I would value your thoughts on these.

There is an idea that a lengthy application process might mean that:

- applicants will delay seeking help until they are very desperate. Could you comment on that in relation to your experience?
- it might be possible that applicants who feel desperate cannot cope with the application process. Was that an issue in your experience?
- applicants feel legitimised by a rigorous process. Does that speak to your experience and if so, why might this be?

The next idea relates to the content of the application. The idea is that if applicants are asked to provide sensitive information, then this could deter them from completing their application. Does this resonate with your experience at all?

- (If relevant) does this link to the issues surrounding [X] (e.g. FtP; stigma) you mentioned earlier?
- What changes might the RMBF make to support individuals to complete the application?

Do you have other comments on the application process and how useful it was for you?

- You mentioned [X] as something that didn't work so well. What could the RMBF do to tackle this?

Eligibility criteria open questions

What do you think of the charity's current eligibility criteria?

Do you think that there are some individuals who aren't currently supported but should be?

Eligibility programme theory testing

There's an idea that if the RMBF outlines the full eligibility criteria, then beneficiaries will be better able to identify if they should apply. Given your own experience, would you agree?

- What was it about your situation about the time that made you react in that way?
- Did you have any worries about misunderstanding the criteria?

In addition to their eligibility criteria, the RMBF notes that they also consider 'exceptional circumstances'. There is an idea that this flexibility means more potential beneficiaries might see themselves as eligible for RMBF support and thus apply. Could you comment on that?

There is an idea that the term ‘exceptional circumstances’ might be quite loaded. Is that something that resonates with you at all?

- Could you imagine a better phrasing?

It might be possible that this flexibility in the criteria might be seen as unfair. Would you agree or disagree?

In your opinion, how might the RMBF best be able to help eligible individuals, who might not see the RMBF as ‘for them’, recognise themselves as a suitable candidate?

Closing questions

Is there anything that you wish to return to, or add?

Is there anything that we haven’t covered today, but you feel is essential to consider when understanding the financial difficulties of doctors, medical students, or their families?

What, if any, recommendations would you make if the financial support offered by the RMBF were to be reviewed, as well as who they offer it to?

Appendix 3. Survey

1. **Have you ever worried about your financial situation?**
    a. Yes
        i. **Have you ever sought help or advice to alleviate your worries?**
            1. Yes
                a. **From whom have you sought help?**

            2. No
    b. No
    c. Prefer not to say
2. **Have you ever experienced financial difficulties (inability to meet, or to pay financial obligations)?**
    a. Yes
        i. **At what stage of your life did you experience these difficulties (tick all that apply)?**
            1. Before medical school
            2. During the earlier (sometimes also called pre-clinical) years of medical school
            3. During the last two years of medical school
            4. During foundation training
            5. During work as a locum/SAS
            6. During specialty training
            7. Post certificate of completion of training (CCT)
            8. Other: ____
        ii. **Please indicate whether your financial difficulties were caused by (or partially caused by) the following (please tick all that apply):**
            1. Yourself experiencing illness (physical/mental health) or disability
            2. Bereavement
            3. Being over retirement age
            4. Having caring responsibilities
            5. None of the above
                1. If you are willing to share, could you explain what the reason for your financial difficulties was?

6. Prefer not to say

iii. What kind of help or support have you sought from whom? If you didn't seek help, please click "Did not seek help".

	Financial help	Financial advice	Practical help (e.g. help with household/children)	Help with mental health	Did not seek help
Family/friends					
The government (e.g., Universal credit)					
Banks/ Building societies					
Payday loans / credit agencies (non-governmental)					
Student loan companies					
Professional organisations (e.g., BMA)					
Workplace/medical school/university (e.g., bursaries)					
Charity					
Help lines					
Medical professionals (GP, mental health professionals)					
Privately funded counselling					

iv. If you sought support from other resources or for other reasons, please provide more info here:

1. **Why did you pick and prefer to seek support from these people/services specifically over others?**
2. **Was/is this support helpful for overcoming your financial difficulties?**
    1. Yes
    2. No
    3. Not applicable

3. **If applicable, please elaborate why this support was helpful or why not.**

4. **What would have helped you to seek support or seek support earlier?**

5. **If you did not seek help, could you tell us why not?**

a. No
b. Prefer not to say

3. **Do you know any colleagues/medical students that have experienced/are experiencing financial difficulties?**
    a. Yes, I know one colleague/student
        a. **Were their financial difficulties caused by (or partly caused by) them experiencing ill-health (e.g., physical illness/disability, mental illness/disability)**
            i. Yes
            ii. No
            iii. Don't know
            iv. Prefer not to say
    b. Yes, I know multiple colleagues/students
        a. **Were their financial difficulties caused by (or partly caused by) ill-health (e.g., physical illness/disability, mental illness/disability)?**
            i. Yes
            ii. No
            iii. Don't know
            iv. Prefer not to say
    c. No
    d. Prefer not to say

4. **Throughout my career as a doctor/medical student, I have been made aware of ways to get financial help, should I need it.**
    a. Yes
    b. No
5. **I can name at least one organisation (e.g., bursaries at university, trust, charity), other than the RMBF, that helps <u>doctors</u> in financial need.**
    a. Yes
    b. No
6. **I can name at least one organisation (e.g., bursaries at university, trust, charity), other than the RMBF, that helps <u>medical students</u> in financial need.**
    a. Yes
    b. No
7. **I can name at least one organisation (e.g., bursaries at university, trust, charity), other than the RMBF, that helps <u>doctors' dependants</u> (e.g., doctors' spouses or children) in financial need.**
    a. Yes
    b. No
8. **Have you ever heard about the Royal Medical Benevolent Fund (RMBF) <u>before you were invited for this study</u>?**
    a. Yes
        i. **How did you learn about the RMBF? Tick all that apply.**
            1. From a friend/colleague
            2. Poster/video at work/medical school
            3. Poster/video outside of work/medical school
            4. Medical School/University Welfare Departments
            5. Via the radio
            6. Via advertisement in medical journals
            7. Through an online search/the RMBF's website
            8. RMBF events/volunteers
            9. Other: _____
            10. Unsure
        ii. **Which of the RMBF's activities below do you know something about? Tick all that apply.**
            1. Financial support for doctors
            2. Financial support for medical students
            3. Financial support for refugee doctors

4. Financial support for doctors' dependants
5. Phone a friend
6. DocHealth
7. Money advice
8. Online well-being material
9. Other

iii. Can you briefly describe your view of the RMBF (e.g., their image, usefulness for support, criteria, process of applying)?

iv. If you were in financial difficulty, how likely is it that you would seek support from the RMBF?

1. Extremely unlikely
2. Very unlikely
3. Unlikely
4. Neutral
5. Likely
6. Very likely
7. Extremely likely
    - ***a. If participants pick "extremely unlikely, very unlikely, or unlikely" at the previous question***
        - **i. Could you explain why you wouldn't seek support from the RMBF?**

v. Have you ever volunteered for the RMBF?

1. Yes
2. No

vi. Have you ever applied for funding/support from the RMBF?

1. Yes
2. No
3. Prefer not to say

9. **Please read each item carefully and indicate to what extent you agree or disagree with the statements below. By ill-health we mean, for example, physical or mental health problems or disabilities.**

Item	Completely disagree	Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Completely agree
1.Doctors/medical students are unlikely to disclose their ill-health problems because of a medical culture which stigmatises illness in doctors and medical students.							
4.Doctors/medical students experiencing ill-health problems will be treated worse than their peers by their leadership/supervisors/educators.							
5.Doctors/medical students experiencing ill-health problems are seen in a less favourable way by their peers.							
6. Patients would not want to be treated by a doctor/medical student that had experienced ill-health problems, if they knew.							
7.It is common for others in the medical profession to see ill-health problems as a sign of personal weakness or inadequacy.							
8.Doctors/medical students experiencing ill-health problems are less successful in their career/studies because of a medical culture which stigmatises illness in doctors and medical students.							
9.If I sought treatment for ill-health problems, I believe it would end up in my professional/academic record.							
10.Doctors/medical students that seek support for ill-health problems risk being involved in fitness to practise processes.							

10. **Would you say your answers above would differ depending on the type of ill-health (e.g., physical health vs mental health)?**
    a. **Yes**
        i. **Please elaborate how and why.**

b. No

11. What would you consider to be "ill-health"? Tick all that apply.

- ☐ Health issues due to old age
- ☐ Health issues due to domestic abuse
- ☐ Mental health issues
- ☐ Physical health issues
- ☐ Physical or mental disability
- ☐ Stress/burnout
- ☐ Addiction (e.g., alcohol, gambling, etc.)
- ☐ Other: _____

12. Please expand on your answer to question 11, if you like.

13. Please read each item carefully and indicate to what extent you agree or disagree with the statements below.

Item	Completely disagree	Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Completely agree
1.Doctors/medical students are unlikely to disclose their financial difficulties because of a medical culture that considers doctors to be care providers and not help-seekers.							
2.Doctors/medical students are unlikely to disclose their financial difficulties as they would feel embarrassed.							
4.I could think of staff (medical school/ workplace/healthcare staff, etc.) who would judge me if I were to discuss my financial difficulties with them.							
6.Doctors/medical students experiencing financial difficulties are negatively judged by their peers.							

7.Patients would not want to be treated by a doctor/medical student that is experiencing financial difficulties, if they knew.							
8.It is common in the medical profession to see financial difficulties as a sign of personal weakness or inadequacy.							
9.Doctors/medical students experiencing financial difficulties are less successful in their career/studies because of a medical culture that considers doctors to be care providers and not help-seekers.							

14. Please read each item carefully and indicate to what extent you agree or disagree with the statements below.

Seeking financial support from a medicine-based charity, meaning that the board, support staff and volunteers may be doctors themselves (as opposed to a charity that has no medical affiliation), would make me feel…

	1	2	3	4	5	6	7	
1.Less embarrassed to reveal my financial difficulties to them								More embarrassed to reveal my financial difficulties to them
3.Less anxious about the consequences of revealing my financial difficulties to them								More anxious about the consequences of revealing my financial difficulties to them
4.Less confident about confidentiality								More confident about confidentiality
6.Less stigmatised when disclosing my financial difficulties								More stigmatised when disclosing my financial difficulties
8.Less understood as a medical professional in financial difficulties								They empathise better with my situation as a medical professional in financial difficulties
9.More threatened that the information I disclose may lead to fitness to practise issues								Less threatened that the information I disclose may lead to fitness to practise issues

15. Please read each item carefully and indicate to what extent you agree or disagree with the statements below.

Seeking financial support from a charity that, in addition to offering financial help, is involved in offering psychological/mental health support to the profession, would make me feel…

	1	2	3	4	5	6	7	
1.Less trusting that the charity is able to provide financial support effectively								More trusting that the charity is able to provide financial support effectively
2. Less like the charity works hard to achieve their main goal								More like the charity works hard to achieve their main goal
3. Less confident the charity can help a varied group of medical professionals								More confident the charity can help a varied group of medical professionals
4.More confused about the purpose of the charity								Less confused about the purpose of the charity

16. Please read each item carefully and indicate to what extent you agree or disagree with the statements below.

Seeking financial support from a charity that was recommended by one of my peers after they themselves received help from the charity, would make me feel…

	1	2	3	4	5	6	7	
1.Less likely to have in-depth conversations about my financial difficulties with the charity								More likely to have in-depth conversations about my financial difficulties with the charity
2.Less confident that my personal information will not be shared with my work/study environment								More confident that my personal information will not be shared with my work/study environment
3. Less empowered to open up about my financial difficulties								More empowered to open up about my financial difficulties
4. Less likely to recommend someone else to the charity myself								More likely to recommend someone else to the charity myself

5. As if I have less in common with the rest of the medical profession								As if I have more in common with the rest of the medical profession

17. Please read the statement below carefully and indicate to what extent you agree or disagree.

I would be more inclined to seek help from a charity when I am/if I were in financial difficulties, if…

	Completely disagree	Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Completely agree
The charity has no affiliation with the medical profession as opposed to a charity embedded in the medical profession.							
The charity also offers psychological/mental health support to the profession.							
The charity comes recommended by one of my peers after they themselves received help from the charity.							

18. When you are experiencing financial difficulties/If you were having financial difficulties, how likely is it that you would seek financial help from the following people/services?

	Extremely unlikely	Very unlikely	Unlikely	Neutral	Likely	Very likely	Extremely likely
Partner							
Family							
Friends							
The government (e.g., universal credit)							
Workplace/medical school (e.g., bursaries)							
Professional organisations (e.g., the BMA)							
Charity							
The bank							
Payday loans/ credit agencies (non-governmental)							

Appendix 4. Case studies

Box 1. Case study 1

Sophie was in a surgical trainee post when she was involved in a serious car accident. She had a mortgage and children to support. She was entitled to NHS sick pay, but when that ran out, she struggled financially. She did not have income protection insurance or any other form of financial support. A consultant had recommended the RMBF. She was reluctant to seek financial help because of not wanting to share sensitive information, but circumstances had become very difficult with insufficient funds to heat her home.

She approached the RMBF and found the caseworker kind, respectful and quick to respond to any questions. Once she completed the application form, it was not long to wait to hear she had been successful and the RMBF provided her with financial assistance in the form of a non-repayable monthly grant which was a huge relief. They were also able to provide more holistic support which included a Christmas bonus to buy gifts for her children and financing attendance on courses to help Sophie return to her medical training and take exams.

Fictitious story created based on the study findings from the Research into Unmet Needs conducted by the Research Department of Medical Education, UCL

Box 2. Case study 2

Sanghi was working as a consultant when mental health issues developed to a point where he was unable to work. This led to a dramatic loss of income and feeling unsure about the future. Sanghi felt ashamed of his mental health condition and only his wife knew his diagnosis; he had not told any of his friends or wider family. He was very reluctant to contact the RMBF because he did not want anyone else to know about his condition and was concerned that members of the RMBF may know him. He was also concerned about possible involvement of the GMC.

However, his financial situation was becoming increasingly desperate. He approached the RMBF and found them to be very supportive, and they provided him with financial assistance during this difficult period. This caseworker was very encouraging and non-judgemental in their manner, and reassured Sanghi that they would maintain his confidentiality. Sanghi really appreciated this and felt supported psychologically as well as financially.

The RMBF also provided Sanghi with a money advisor to help him understand his spending and where any savings could be made. They provided him with coach mentoring which helped him to get back on his feet and onto a more manageable medical career path.

Fictitious story created based on the study findings from the Research into Unmet Needs conducted by the Research Department of Medical Education, UCL

Box 3. Case study 3

Pavla's child developed an acute medical condition and had to remain in hospital for a number of months. Pavla took annual and compassionate leave to visit him, which eventually ran out. When her son was discharged, her home required adjustments and all her savings were depleted; he also required care which meant Pavla felt unable to return to work as a GP and her financial situation meant that she was in danger of losing her home.

She had already applied for state support but was still struggling to manage. A colleague who knew about her situation mentioned the RMBF to her and suggested that they might be able to help. She contacted the RMBF via their website, and subsequently spoke to a caseworker by phone who encouraged her to apply for financial support.

The RMBF provided Pavla with a monthly grant to cover her family's essential expenses while she was unable to work. They also provided support in the form of a coach mentoring, who helped Pavla find another career path that better fitted with her new circumstances, and she re-trained as a counsellor. Returning to work in a new career allowed her to become financially independent again and repaired her self-confidence which had been knocked during this difficult period.

Fictitious story created based on the study findings from the Research into Unmet Needs conducted by the Research Department of Medical Education, UCL

Box 4. Case study 4

Sam was diagnosed with a chronic medical condition, which has made working in his hospital role very difficult. In order to manage his condition with his work, he cut down his hours as much as possible. Because of the resulting fall in income, Sam cut back on all non-essential expenses at home, meaning that his family rarely goes on holiday, and extras such as school trips and sports equipment for his children have to be carefully planned or completely foregone. Despite his reduced hours, work is still very physically challenging and mentally tiring, and ideally he would not work so that he could better manage his health.

Sam has looked in to whether he would be eligible for any support, but because of being frugal and maintaining a small amount of savings and working some of the week he thinks that he is ineligible for any support – financial or otherwise – from the RMBF. He believes he would have to hit rock-bottom before any support could be made available. This has made him reluctant to reach out to charities such as the RMBF and to apply, as the work involved in applying would feel wasted if it was unlikely to lead to support.

In contrast, Sam might well be eligible for support and be judging himself too harshly. Calling the RMBF for a chat with a caseworker would mean Sam could find out more about whether he might be eligible, and if not now, in what circumstances he might be.

Fictitious story created based on the study findings from the Research into Unmet Needs conducted by the Research Department of Medical Education, UCL

Appendix 4. Projection calculation

To quantitatively consider how many doctors and students there might be who are experiencing financial difficulties due to circumstances highlighted in the RMBF criteria, we estimated the proportion of those in need based on the questionnaire answers and from this analysis projected the potential extent of need to the general population of doctors and students.

Of the 241 doctors who took part in the survey, 83 (34.4%) experienced financial difficulties and 37 (15.4% of all respondents experienced financial difficulties due to illness (physical/mental health), disability, bereavement, or caring responsibilities. If we assume that a similar proportion of doctors in the general medical practitioner population would experience financial difficulties due to these issues, there might be over 53 thousand of such doctors (i.e., there are 349 028 doctors on the register; 15.4% would be 53 750).

Of the 200 students who took part in the survey, 65 (32.5%) experienced financial difficulties and 20 (10%) experienced financial difficulties due to illness (physical/mental health), disability, bereavement, or caring responsibilities. If we assume that a similar proportion of students in the general medical student population would experience financial difficulties due to these issues, there might be over 3 thousand of such students (i.e., there were 39 185 students in 2017; 10% would be 3 919; note: this number includes earlier year students).

This a rough projection of how many doctors and medical students there might be in need due to ill-health, disability, bereavement, or caring responsibilities. Limitations of our sample (selection bias, small sample in comparison to population) should be taken into account when considering these findings.