AMA Queensland / Queensland Health
Suicide Prevention Forum – Doctors' Wellbeing - Tuesday 15 August 2017
Outcomes

LEADERS

Define leader - not influential in the system, looking after doctors (not top level and not individual needs), such as supervisors, mentors.

Issues:

- **Rural and remote** – working environment – feeling isolated, not know where do get help, committed to the community.
- **Recognition** that someone is at risk – what are the drivers of risk, recognition that there are people at risk, corporate structure causes leaders to be oblivious to risks, capacity to deal with issues.
- Attitude about just "getting on with it".
- Has had a recent PHO in the last 6 months where doctor was suicidal.
- **Cultural issues** within medicine. Workload hasn't necessarily changed, but tribalism attitude affecting junior doctors rotating through training positions and performance related issues need to be hidden.
- Common enemy – dysfunctional culture and try and create the culture we need. Depression is an issue with some, but others are basically unhappy with the system. Some places to work are good, some are toxic or a combination. Starts with leadership – needs to be modelled properly.
- **Pre-morbid conditions** – some doctors should not have progressed through medicine.
- Change of **language** used – Employee Assistance onsite staff member – high take up from staff Wellbeing checks – don't wait until there is a problem. Need to change language to "this is just how we do things". Leaders and junior doctors had separate groups.
- Proactive workshops regarding resilience.
- Staff at senior level (clinical level) **don't want to hear problems.**
- Different issues in private practice.
- Educational system – educational training centres as well as practical clinical employment training and disconnect between communication of these two bodies; e.g. junior doctors not in a training program may not have the support system from their training college.
- Pre vocational doctors have DCTs, but there are **others that are not part of a college or department**. They are most stressed because they can be looking for employment or training program.
- **IMG** or PHO in a regional hospital would be very difficult.
- Suicide – no idea if statistics have anything to do with outcome. Who is at risk and being able to identify this? Often there are no performance gaps.
- There is no super doctor – ok to be human but there is a fear of being reported.
- Mental health issues could be more prevalent among doctors than general population.
- Qld Health programs may not help if the environment does not encourage doctors to talk about their problems.
- How as leaders, do we support and enable the ability to identify people with issues that seem ok.
- **Time and personal space** to talk about issues (not open plan with others around).
- **Leader may not have skills**, knowledge.
- **Leaders may not know next steps** – knowledge of where to go after problem identified.
- Inconsistent style of programs for leaders – **stigma** around handling the pressure of the job and leaders can help dissolve any stigmas around problems.
- **Leaders themselves have the problems.**
- Leader of the culture could be someone that does not carry a title.
- Gender can inhibit – sexual harassment.
- 2004 Simon Wilcox report is being used for teaching junior doctors but findings are from 2004.
- Lack of skills – definition of the role and most appropriate for the time.
- **Happy staff are easier to manage.**
- Time.
- What makes a good leader – **emotional intelligence** vs process.
- Leaders don't need to have a title.
- Clarification of the role of leader.

- Being a doctor versus being a leader can be difficult – mixed up **boundaries.**
- Supports for leaders – advice for others, self, such as EAP.
- Data is being collected then where does it go for programs such as EAP.
- What sort of doctors do we need for today's society ie medical expert versus communicator, advocate.

Barriers/Gaps:

- Concerns around mandatory notification – regulatory fear by leaders.
- Concern by junior doctors regarding liability (being sued), notification which is strong in medical school.
- Power differential – senior and junior doctor – causing issues with bullying.
- Stigma around doctors' health issues for the leader role.
- Significant skill base to change culture – needs to be considered, planned and supported.
- Difficulty managing and caring for patients and also managing the wellbeing of staff.
- Too many hats and conflicting roles – covering shifts and being compassionate toward doctors that are sick.
- Sick doctors can be isolated if they are at home – identity issue. Investment of all their time and identify is very much connected with their role. Removal of role can cause identify issues.
- Structure of the system causes issues – registrars feel like they can't take time off.
- Will the person be ok being sent home.
- Can't talk in the lunch room anymore due to litigation fears.
- Why is there not a proper **de-briefing** response – voluntary process.
- No human being can endure chronic exposure to problems all the time.
- Peer support could make a big difference. Could need further professional help but trained peers could be a start.
- Economic resources required for training is worth saving a life.
- Complex issue – on the whole, the cause of suicide is not caused by critical event with patients.
- Doctors not accessing EAP and how many actually use the system.
- Doctors concerned about treating other doctors due to mandatory reporting fears.
- As a leader it is easier to dismiss the issue (don't ask, don't tell) and no mandatory reporting responsibility.
- Juggling progression without responsibility for other people.
- **Too little work around transition** from registrar to consultant – resources and tools for senior registrars to become consultant. Passing on bad habits to others because of what the individual experienced.
- **One bad experience** from a leader can cause future barriers and avoiding assistance in the future – needs to be a consistency with help provided.
- Increased transparency from supervisors to medical schools about students and vice versa.

Actions

- Break down silos between different groups, such different teams of doctors, administration etc.
- Breakdown tribalism.
- Solutions – can't change the system, but one potential solution is that there will be a wellbeing leadership program rolled out to directors and strategists of working parties, directors, consultants, mid management and also younger staff. Qld Health funded strategy – ongoing and sustainable, multi-layered change.
- **Train the Trainer** model – enabling ownership.
- Resilience on the Run is good but $2mil does not go very far.
- Separation of roles where doctors can go to an independent person for help. Every hospital has a well-being contact.
- Solutions tailored for **public and private practice**.
- Monthly forum for doctors to open up and safely discuss issues – junior doctors. Leaders need to create a safe environment for this to happen. Can raise issues but not personal issues (especially if DCT is present) – improving linkage between individual and the system.
- Ownership of leaders – don't give up and keep talking about the issues – visibility.
- Role modelling as leaders to make it ok to share problems, being the example.
- Improving performance action plans (IPAP) – supervisor and medical education unit implementing can be daunting for doctors – reassurance by leaders that it will be ok.
- Leaders could encourage taking the time out for not only crisis – time off before the crisis.
- **Education** for senior doctors.
- Mandated programs instead of being optional.
- Not reasonable to just say, this is how it is…cultural change can take decades. Need to define culture.

- Stop laughing and accepting the problem and take some steps.
- Gold Coast mindfulness program – doctors looking after each other.
- Good de-briefing skills by leaders. Family members are the ones that often are used to de-brief.
- Flying squad going into hospitals to help locals with critical event (suicide of a doctor).
- **Myth busting** – e.g. EAP – role and what it does and doesn't do.
- What do doctors want from their leaders? Leadership training for senior medical staff (EQ) – measure the levels of burnout and consultants on the 12 point scale.
- ORANGE program – optimism, resilience etc. Done it work time.
- **Position descriptions** – healthy workplace and health staff.
- Number of questions (EQ) that as an employer, could ask potential employees.
- Needs to be **succession planning** and limitation on tenure for directors such as 2-3 year terms.
- Revalidation includes the 360 degree model.
- Psychometric testing for leaders - process communication model – 2 x 3 day courses. Motivation, behaviour, feedback. For both leaders and teams. Sometimes there is no choice in who can be employed in the team such as a cardiac specialist.
- Journey of 1,000 miles – take the first step.

Research Opportunities:

- Go to where suicide has already occurred and look at possible reasons.
- Look a mental health and suicidal behaviours (Beyond Blue has done some research).
- Suicide can happen very fast and reactive but could be some signs before the final trigger.
- Unhappy versus depression.
- Different pathways to suicide – acute or long term accumulation of factors and where is the point to intervene.
- Changing culture, attitudes and measuring these changes – logic maps.
- Complex issues and pieces of information coming together – prevention, intervention and post-vention.
- Keeping in contact behind the scenes.
- Clusters in medicine.
- Captive audience for 12 months – interns. Interns are willing to help with research and data collection.
- Junior doctors want the research to be independent.
- Why is there suicide ideation in Metro South?
- Look at definition of bully in the health environment – health and safety law.
- Measuring the intervention e.g. hand hygiene and behaviours of doctors.
- Organisation needs to take action – documentation of giving feedback.
- Cultural intervention – bottom up and top down.
- 360 degree survey.

AMA Queensland / Queensland Health
Suicide Prevention Forum – Doctors' Wellbeing - Tuesday 15 August 2017
ACTIONS

Actions from a Queensland perspective and who would be best to be involved in this.

Individual

At an individual level there is a need to support:

Education
Currently there is limited education available on a number of doctors' health topics. While people seem very familiar with the need to improve doctors' mental health and the need to have a GP – actually having the knowledge to be able to address these things has been a challenge and doctors identified gaps in their education that would support their personal capacity to address these issues for themselves. Some of the issues requested as individual skills, related to the individual who would be a leader, or be a part of the system – clearly therefore, there is some overlap.

The gaps identified included:
There is a need for CPD for Wellness education – Education across all sectors – primary care, hospitals, universities and external places – with leaders like QDHP training the educators to enable consistent messages, effective messages while spreading the knowledge effectively – with slightly different emphasis for different stages of career. The idea of having specific education at times of stress is reasonable, but not adequate – the overall process should be preventive.

Understanding the medical regulatory system – specifically mandatory reporting and the role of OHO vs AHPRA – Medical defence organisations are well placed to deliver this with other institutions eg. colleges and AMAs increasing the reach of the MDOs.

How and when to get a GP and understanding normal health access behaviours.

Skills to be a better doctor for doctors - QDHP training with the potential to slowly build a list of doctors who have had this training – if those doctors are happy to be on such a list that is managed by QDHP

Improved non-technical skills with benefits for patients and also personal benefits – These are already being taught in colleges, but there needs to be overt discussion around how these skills have benefits for maintaining the doctors' wellbeing and improving team work, not just being good for patients. This training needs to be more central in the various colleges (this is already happening though).

Resilience education (though this was not well defined) – there was a suggestion that this would be best to be focused at times of stress. The real issue here is for the resilience training to be contextualised so that doctors were not just signing up for a fun learning session, but were left with skills that enabled them to incorporate their learning into their everyday practice. This should be routine in training across the student, pre-voc, vocational and into the professional years of training. It should include periods of intense education and also some short reminders. Supporting the education that occurs through the workplace that is designed to value resilience and support resilience is important.

Understand secondary traumatic stress and how to reduce this – specific education as various levels of training – as this is present across the career stages, education needs to be available across the career stages. Doctors are often so isolated – this would be protective – role for QDHP and Colleges and AMAQ as well as the employers.

Leadership skills – The need for leadership skills was brought up in the 'individual section' here because there is a perceived individual need for leadership training. Clearly this includes increased awareness of how improved wellness had personal benefits as well as benefits for the team; communication skills (behaviours, professional skills, wellness education, responsibilities around mandatory reporting/bullying, workplace responsibilities)

Cultural issues
Reduce stigma – address the hidden curriculum through education and workplace strategies.
There is no such thing as a 'super doc' yet there is a strong belief that doctors need to be one (issues included fear of failure, environment being unforgiving, constant bravado - address the hidden curriculum through education and workplace strategies.

Tribalism of medicine supported unhealthy cultural issues- address the hidden curriculum through education and workplace strategies.

Workplace issues
Improve return to work programmes – There will need to be clear pathways developed to enable return to work. Although this will always need to be negotiated for an individual (in their specialty and with emphasis on the skills that the particular doctor needs assistance with in their plan, it is difficult for a small private practice to provide the level of supervision required. This is more readily done in hospitals – public and private – and pathways should be well-defined and everyone needs to know that they exist – this will reduce stigma too as it will normalise the need for the profession to support its own.

Recognise that doctors work in both public and private sectors and doctors' health is important in both sectors – all initiatives need to be able to be taken up within both public and private – especially since more and more training is being delivered within the private sector now.

Address isolation in practice – rural, private practice even in the city – and increase the feeling of connectedness at work (and within the profession) – workplaces and the government to assist with this.

Wellness should be a KPI that is measured – eg. in accreditation. Determining such measures needs to be carefully considered – clearly time off work in inadequate.

Rural issues
Need increased support for rural doctors, recognising their isolation.

Leaders

There was a clear need for further leadership training, even for those entering relatively 'junior' leadership roles in the hospital. Most people rise to their leadership role due to their clinical skills, not their people management skills.

Education was again a clear message, but with specific outcomes in mind.
Train the trainer models of education were considered to be positive ways to enable continuing education with reduced cost over time.

Many supervisors do not really understand their medical regulatory responsibilities and therefore, they may tend to avoid confronting a colleague they have responsibilities for due to their fear that engaging with these issues may put them in the situation that they may be mandated to report an individual.

The need for support as doctors transition their role – e.g. from registrar to consultant – and other transitions too – Each transition need to come with its own overt recognition of the changes ahead that are more than the clinical responsibilities that the individual has been training for.

Supervisors
They need clear training for this role – such training is the responsibility of the organisation the person is being the supervisor for – eg. for colleges, for hospital departments – many of the issues of training will cross over.

Specific issues to be addressed in training included:

Training to be able to engage in early intervention in behavioural or supportive roles depending on the need of the person they are supervising. This includes identifying a problem early, before there are significant consequences.

This may include 'wellbeing checks' with staff – how to do this without overstepping boundaries.

To understand that their role is not about being dictatorial.

Doctors need to be able to frankly communicate with their supervisor to seek time off when they need this – 'presenteeism' should not be encouraged. Hospital and other employment organisations need to support the taking of leave when a doctor needs time off – eg. a pool of doctors to relieve junior staff.

Knowing the rules within the hospital environment – clearly and accurately – including the need for transparency and visibility – so that they can provide clear guidance and mentoring for trainees and advice that is accurate.

Knowing the rules of the regulatory environment, to increase the supervisor's personal comfort that they are working within the rules and also to enable accurate information to flow to those they are supervising - Medical defence organisations.

Clearly understand their role as role models and how this impacts the hidden curriculum – including setting the local culture of the workplace. Education – from the colleges and from QDHP.

Need time and (private/appropriate) space to be able to engage with those they are supervising. Often supervisors find themselves constantly unable to have the conversation they need to have as there is no 'private space' for the talk. Hospital and other employment organisations need to support access to time and space.

Education about how different people's personalities lead them to react differently in different environments and in different teams – with the team benefiting from the breadth of skills, but individual members finding it difficult to communicate at times with other personalities. Understanding these issues can help the supervisor to better engage with other personalities. Education – from the colleges and from QDHP.

When acute interventions are required for colleagues/trainees – then support needs to be readily available for the supervisors eg. if a trainee is known to fail an exam – who checks on that doctor. Development of robust pathways for urgent support within the health care organisation that are informed by those with expertise in doctors' health (QDHP) and legal matters (MDOs) so that interventions are safe for patients, the organisation and the doctor that the intervention is being used for (ie. simply sending a doctor home can be dangerous).

Leaders
These include supervisors but are not just the direct supervisors. It was noted that some people have multiple hats as leaders and this can cause role confusion and reduce the effectiveness of the leadership role.

Need to know the pathways to care – including GP/EAS/QDHP/other appropriate supports – if the leaders don't know these, how can we expect the juniors to know these. Hospital and other employers need to support awareness of such programmes – leaders need to be aware of EAS support for leaders. There is no point having such supports when those who may need them are unaware.

Need to know the regulatory pathways – so as to be able to pass on this knowledge and so as not to engage with the regulatory environment when it would be more appropriate to provide well-planned remedial education - Medical defence organisations.

Need to have Emotional Intelligence (EQ)- Education – from the colleges and from QDHP.
Need to have an intense awareness of the leader's role in creating the culture of the organisation. Education supported by embedded structures that identify this as a role of the leader and enable active review and capacity to respond to maintain positive cultural change (and identify and correct negative cultural change) – requires organisational psychologist support for large organisations (supported by QH, private hospital), but even small private practices need processes that address these, support through colleges /AMAQ.

System
The system should encourage a culture of care and compassion.

Many of these issues are already captured in the individual and the leader sections as the system impacts the individual and the leaders. We need to run a system that recognises the system as a Complex System, rather than a Linear System. There is great work being done in this area in Sweden. Changing the responsiveness of the system to being a more compassionate system (as per Francis Report 2013 in England) and removing the linear biases as are found in 'investigations' such as Root Cause Analysis (eg. replace with the complex approach of the resilient health care system) will be key to addressing these issues. These solutions require government investment, but also require leadership to enable system change.

Having an anonymous system for reporting of poor behaviour including bullying that connects with an effective response pathway such as the Vanderbilt program was thought to be a positive option. Hospital system – public or private – whether larger general practices would also benefit from this? Role of QDHP and AMAQ in this? Role of organisations like Cognitive Institute.

The gap between the people who make the statements about positive health and wellbeing of doctors and the capacity of people to engage with the options suggested was considered something that needed to be addressed. While sometime it was an individual's decision to priorities time for health, at other times, the individual is confronted with a system that clearly cannot support health and wellbeing – changing such a system can be very difficult.

Examples included saying people should have time off if they are unwell and then not having a system of back-fill seemed incongruous, yet some said that this was not possible to arrange. Being able to take leave for routine appointments without the supervisor frowning. Enabling rosters that you can apply for leave for special occasions in advance, and rosters that simply give you enough notice about when you are likely to be working. AMAQ has a role in monitoring deteriorating conditions. Noting increased presenteeism could flag a concern

Difficulties with short contracts meant that if you took time off you may not be employed the next year. This is problematic for the pregnant junior doc who may fall pregnant then not be allowed to have leave for the baby as she has changed hospitals. AMAQ has a role in monitoring such concerns and feeding these issues back to the HHSs.

Providing progressive support by enabling medical students transitioning to their Intern year may be assisted if students with difficulties are flagged so they are supported more, but doing this without stigmatising the student/intern would be difficult. Universities/State Health /needs to be brokered.

There is a need for interconnectedness between organisations – QDHP, AMAQ, QH, Colleges etc. – it was clear many did not know what the other was doing.

Crisis interventions – specifically for when there is a physician (or other staff) suicide – that enables support to be provided for those in the workplace. Development of robust interventions that can be deployed rapidly to support the organisation affected by this event – recognising that such events are not common and there needs to be a repository of expertise that is maintained over time – eg. QDHP could hold this expertise, but their deployment could be supported by State Health and AMAQ – such interventions would probably include coordination of immediate support and then appropriate follow up over time with education etc.

Other crisis interventions for critical incidents may be more readily available in house in larger organisations, though smaller places eg. private practices may still need to know where to outsource this. These services would include opportunities for debriefing. Development of robust interventions that can be deployed as appropriate for each organisation with some expertise that is available through colleges/AMAQ/QDHP for smaller organisations.

Research

A collaborative approach to research was promoted.

There are a number of programmes that are already in existence to enhance the health of doctors across QLD including in various hospitals, but this information has not been collated and specific aspects of each of these programmes may be relevant to others. (It was acknowledged that the RACP is collating the various education available related to health and wellbeing in the training programmes across the colleges and sharing of these resources would be valuable in the future - so would evaluation of such interventions).

Research into physician suicide was considered important with a focus on understanding more about the progression from ideation to completion and whether there were points that triggered progression. Psychological autopsies and development of logic maps have not been done for physicians in Australia – so this increases the speculation around the causes.

Identifying any clusters of suicides would help inform our understanding.

Building on knowledge about suicide within the community to inform understanding about what is the same and what is different about physician suicide would help.

Measures of mental health and wellbeing in psychological surveys and their relationship to suicide is also poorly understood.

Understanding wellbeing interventions and their effectiveness – and how would/should their effectiveness be involved is important.

Understanding how cultural change can be effected and measured in health care organisations and in a profession would be of interest.

Ensuring that research taps the expertise that already exists in specific areas is essential - including doctors' health (QDHP), mental health (various including beyondblue and Black Dog) and suicide (AISRP).

AMA Queensland / Queensland Health
Suicide Prevention Forum – Doctors' Wellbeing - Tuesday 15 August 2017
Outcomes

SYSTEM

Issues:

- Requirement to report to APHRA.
- APHRA has become punitive and length of time to handle complaints, i.e. due to mandatory reporting.
- Recognising a failing doctor from a systemic point of view.
- Advice on what is impediment/impairment and what can be advised to registrars.
- Mandatory report of colleagues, declare any impairment which may affect your ability to practice.
- Impairment – lack of link to harm.
- Culture of care.
- Definition.
- Crisis is a tipping point.
- No backfill.
- General Medical Council have definitions of impairment.
- Workforce planning - pressure of career progression.
- Support for doctors who are being investigated talking in a non-regulatory way.
- Training - trainee junior doctors relatively easily replaceable.
- Trainees are at high risk, i.e. trainees who fail exams etc.
- Medical schools have changed and difficult to remove any problem person who is not suitable.
- Creating expectation that people can be ill, can go to see a doctor, how we enable people to accept.
- Complex issue – length of employment contracts – too short to form relationships and support.
- Junior doctors knowledge of system awareness.
- Return to work for mental health workers compensation.

Barriers:

- Culture of sick leave.
- Transient nature of doctors on rosters.
- Rural doctors experience social and professional isolation.
- Just statements.
- Lack of data.
- Uncertainty of path to follow – due to mismatch of expectations and funding.

Gaps:

- Official Advice is lacking flexibility.
- Language of OHO is of a complaint and not.
- Employee assistance system doesn't suit doctors.
- Lack of capacity in the supervisors and leaders in the higher levels to understand the problem.
- Failure of governance.
- Colleges have standards around training wellbeing, but don't employ doctors and don't involve doctors in workplace.

Actions:

- Reporting of case examples, better definition of impairment and education program
- Every Health Service has a doctors health plan.
- Leadership.
- Financial support and framework, i.e. preventative measure, mentors etc.
- Staff wellbeing as KPI.
- Using existing resources, medico-legal etc.
- Using Vigeo linking of resources and availability.
- Rural doctors – Apps are important, pod casts internet learning modules, integrated set of resource to pull all info together, access remotely, provide feedback and help is anonymous.

- Raising inductions and orientations.
- Audit of programs and reassurance it is happening.
- Tools support.
- Flying squad intervention when high levels of burnout in the unit.
- Workforce Planning – document from QH needs disseminating more broadly and matching to training places.
- Managing Expectations from doctors.
- Jobs don‘t match expectations of medical students, post management of decisions.
- Culture and criteria of the colleges.
- Different unis and different colleges no collegiality.
- Honesty about the uncertainty of the medical workforce future.
- More openness and transparency.
- Solution to the demand complexity overload of the system.
- Messages are we still have a good system compared to other countries.
- System needs to have some mentoring or support program to support the doctor/medical professional being investigated.
- Responsibility being given to QH to ensure communication between HHS.
- Standards of accreditation in hospitals – KPI doctors health.
- Explore CanMeds guidelines about standards across all colleges.
- Link between Colleges on standards and employees to be improved before a crisis point is reached.
- Supportive re-entry after illness (off with WorkCover) – associate stigma attached
- Need to allocate supervisor time for them to support the doctors at high risk
- Need more cooperation between employer and doctor
- Ensure HR and training files are formal and able to assist the person and are better aligned
- Concentrate on the key transition points and the key stresses
- Identify doctors who are prepared to speak up
- Create opportunities and check ins, i.e. term interview

Research Opportunities:

- Evaluation of Interventions that have proven benefits
- Organisation strategies to decrease burnout
- Quantify cost of problem
- Interns standards – end of term assessment every 10 weeks, some separate feedback to ask anonymous
- iPads immediate social media feedback
- National training survey would give cross cultural view of the issues
- Registrars going through training together as a group versus fragmentation
- Annual recreation leave included in performance appraisals

AMA Queensland / Queensland Health

Suicide Prevention Forum – Doctors' Wellbeing - Tuesday 15 August 2017

ACTIONS - SYSTEM

1. On the reporting of impaired doctors issue
   a. A big gap was lack of advice on what is impediment/impairment and what can be advised to registrars and others about the meaning of this. This needs a proper definition of impairment and education program for doctors suggestions were that illustrating with case examples or direct information such as doctors talking about the decision. The General Medical Council (UK) have definitions of impairment and it is done regularly when there are insurance & compensation panels so it shouldn't be hard to do. Suggest: This needs a legislation & national approach – refer to national meeting
   b. There is no path but formal referral if the treating doctor thinks a person may be impaired. An opportunity for treating/ referring doctor to discuss anonymously with an expert to get advice, rather than just relying on own or peer judgement. Suggest: This could be achieved locally through the Qld Medical Board/AMA or Doctor's Health Advisory Service with some financial support. Would need a local education/awareness campaign to inform doctors of this service.
   c. Support for doctors who have been reported or are being investigated, should be separate issue to talk in a non-regulatory way (their treating doctors may not be able to give them good advice about their obligations/rights). Plus employer organisations usually only apply in public system. Suggest Employers/ AMA consider how this can apply across the board

2. Managing Expectations from medical students into doctors and early career.
   a. Issues: lack of certainty in career progression, Jobs don't match expectations of medical students, Different unis and different colleges offer no collegiality so no longer progressing through with the same cohort, length of employment contracts – too short to form relationships and support. Employee assistance system doesn't suit doctors.
   b. Solutions: Honesty about the uncertainty of the medical workforce future should begin in medical school and follow through early career with appropriate information and counselling, inductions and orientations. Career counselling and an appropriate employee assistance arrangement. Suggest Universities, QH and student and junior doctor representatives
   c. Workforce planning more attention paid to the pressure of career progression, se it from the doctor's view not just service need

3. Every Health Service has a doctors' health plan. Culture change
   a. Issues: seen as just statements, not action; junior doctors poor knowledge of system awareness. No good waiting for crisis as a tipping point – possibility for early intervention. Lack of data on how individuals are doing.
   b. Solutions: Messages are we still have a good system compared to other countries but acknowledge that through having Staff wellbeing as KPI. This

would allow the dissemination good programs, surveys and development of local ideas. Reporting of KPIs adds to the management of uncertainty as above. Benchmarking will produce improvement. Can incorporate recognition of a failing doctor from a systemic point of view.

c. Creating an expectation that people can be ill, can go to see a doctor, how we enable people to accept

d. May link to special interventions as well as general focus on wellbeing eg Return to work program for mental health reasons, support for Trainees who are at high risk, i.e. trainees who fail exams etc.

e. A similar approach could be available for larger private organisations eg group practices, private hospitals, but doesn't reach the individual practitioner

f. Suggest responsibility for each employer + QH as overarching for public system. Needs government support to be acceptable and add to accreditation.

g. There is a strong link to research opportunities: Evaluation of Interventions that have proven benefits; Organisation strategies to decrease burnout; National training survey would give cross cultural view of the issues

4. Find a Solution to the increasing demand and complexity of work with attendant overload of the system and the sense of responsibility placed on junior doctors.

   a. Issues: a difficult one to crack. trainee junior doctors seen as relatively easily replaceable, poor definition of roles and responsibilities for juniors, supervision issues and ultimate responsibility for patient welfare, personal development rather than peer and cohort support in the every competitive and punishing world

   b. Solutions: better role descriptions for junior doctors and registrars and support to stick to them without being forced to overstep the mark

   c. "Flying Squads" to assess and change units which are overstressed and have burnout

   d. Suggest: relates to the above but will require government commitment over funding & workloads – maybe too hard in this context?

AMA Queensland / Queensland Health
Suicide Prevention Forum – Doctors' Wellbeing - Tuesday 15 August 2017
Outcomes

INDIVIDUALS

Issues:

- Challenges in doctors being patients – feeling of invincibility, difficulty feeling vulnerable
- Medicine is an unforgiving profession – no tolerance for making mistakes/failing – profession of high achievers who aren't accustomed to failure - feeling of embarrassment seeking help
- Some GPs might treat doctor/colleague patients differently – assumed knowledge; feel uncomfortable treating colleagues; doctors aren't specifically trained on how to treat colleagues as patients
- Big difference in doctors returning to work from physical conditions v mental health conditions - stigmas and prejudice of mental health – no career recovery
- Very real fear of mandatory reporting being career ending – magnified in a regional setting
- Medical training for mental health is only in the public system and is not extensive

Barriers:

- Access to a GP might be challenging a) accessing a doctor without conflicts, such as from a different practice b) time challenges - when would a junior doctor have time to attend a GP appointment (system issue – constant upheaval of junior doctor rotations)
- Unless actions / preventative measures are formally integrated with doctors' daily schedules, changes won't happen

Gaps:

- Lack of knowledge there is a professional regulatory obligation for doctors to have their own GP (30% still don't)
- Soft skills are the hard skills – more support is needed for the behavioural, non-technical elements of doctors' jobs where many experience stress and failure – eg communication, progression into leadership etc

Research Opportunities:

- Focus resilience education/training at obvious stressful times throughout careers (exams, program placements etc)

Actions:

- Campaign promoting positive, self-reflective narratives - dispelling myths through those who've experienced challenges, sought help and not suffered career ending repercussions. Create a culture/platform where they feel safe and courageous to talk.
- Role modelling narratives - what individuals are doing to make a difference – eg initiatives for improving workplace culture such as Sunshine Coast HHS's planned, organised peer/buddy wellbeing system
- Better education/understanding of mandatory reporting laws and actual outcomes
- Educating doctors on how to accept help
- Prevention measures essential, not just crisis response – encouraging doctors to choose a doctor when they are well
- DHAS / other platform to promote a list of doctors who are comfortable treating other doctors
- More CPD recognition for wellness training
- Acknowledging isolated private practice is a risk