National Forum on Reducing Risk of Suicide in the Medical Profession

Final Report

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Introduction

On 14 September 2017, 82 members of the Australian medical profession, nominated by key medical stakeholder organisations, came together in Sydney to focus on individual, organisational and environmental issues which impact negatively on doctors' emotional health and well-being, and may put them at risk of psychological harm, mental illness and suicide.

This report tells the story of that day, of impassioned conversations about issues that deeply affect our profession. It summarises the reflections and recommended actions with respect to these issues, as well as examples of current initiatives identified by the forum's participants.

While suicide is a devastating event, many of the contributing factors will be upstream of that event, and a focus on prevention and early intervention is important to address the growing burden of psychological ill-health in the medical profession. Creating mentally safe workplaces in particular is important for everyone, as is addressing cultural issues that make it hard for doctors to seek help.

> *The two key themes that emerged from the day and from the Australasian Doctors' Health Conference that followed were **Culture and Compassion**.*

Cultural change will happen through sharing our stories, treating each other with care and respect, and reframing the conversation to acknowledge the importance of the health and well-being of doctors on patient care.

While this report contains many great suggestions for improving the situation, what is needed now is ACTION! As a profession we need to keep the conversation going and commit to action in those areas that we can influence and where we can contribute expertise.

The Board of Doctors' Health Services Pty Ltd* commits to the following five actions in partnership with our State providers:

1. We will lead the development of a Consensus Statement on Doctors' Health to which the medical profession can commit their support. This will be a public statement of our intent to make the health of our profession a priority.
2. We will develop and make widely available education on how to be a 'doctor-patient' and how to treat medical colleagues when they are patients. This work will be based on the recently developed Australian Doctors' Health Network curriculum on doctors' health.
3. We will provide advice, support and clearer pathways to assist all doctors to find their own GP.
4. We will increase our efforts to provide support to colleagues 'at risk', such as those facing regulatory issues, those with mental health issues and other chronic illnesses, and those exposed to critical and distressing incidents. We will do this by continually improving access to doctors' health services, and by working with other agencies to support their responses to doctors and medical students with specific needs.
5. We will develop a communication plan that shares key messages from the forum report with the whole profession, and we will work with key stakeholders to ensure that these messages are strongly reinforced over time to drive cultural change.

We would like to invite all interested stakeholders to consider what their **top five** actions might be.

- What areas in the report resonate most strongly with you?
- What issues in the report are most relevant for the members of your organisation?
- What changes do you feel you and your organisation can influence?
- What change would you most like to see happen?

Together we can have a positive impact on the health of our doctors and medical students.

Next steps:

1. Early in 2018, the Doctors' Health Services Pty Board will re-engage with stakeholders to get their feedback on the forum report, and seek their organisation's interest in developing the top five actions in doctors' health.
2. In the first quarter of 2018 we will form a 'Patrons' group of interested stakeholders. The role of this group will be to champion doctors' health, promulgate key messages among their professional sector, support key initiatives and contribute resources where required to support implementation of the forum's recommendations.
3. Over the next one to two months we will develop a communications strategy to ensure that the great ideas and messages from the forum are shared with the profession and support an ongoing conversation about doctors' health.

* Doctors' Health Services Pty Ltd was formed in 2015 to establish the first national health program for doctors and medical students in Australia. The company coordinates the delivery of advisory and referral services to doctors and medical students across the country by state-based providers. It is a subsidiary of the Australian Medical Association and funded by the Medical Board of Australia.

National forum report

Participants worked in plenary and group sessions to consider a number of key issues. Many of the issues had been identified by stakeholders leading up to the forum. The following is a summary of reflections and recommended actions with respect to these issues, as well as any other initiatives that were identified on the day. These issues are recommended for further consideration beyond the forum.

1. Factors of personality and temperament can negatively impact on how doctors and medical students cope with the stressors of their work roles. (Page 4)

2. Work-life transitions such as the first-year out, starting a specialist career and retirement create additional stressors for doctors. (Page 6)

3. Not enough doctors and medical students have a **GP** who they see regularly. (Page 7)

4. Not enough doctors engage in **preventive health care** such as healthy lifestyle, adequate work-life balance, and regular check-ups. (Page 9)

5. Many doctors **practise in isolation** which affects their mental well-being. (Page 11)

6. We do not currently recognise and **respond to illness in ourselves and our colleagues**. (Page 13)

7. The functional impact of **ageing** is not well accommodated by the medical profession. (Page 15)

8. **Compassion fatigue and burnout** are common among medical students and doctors, and affect our clinical care. (Page 17)

9. **Counselling services** provided by employees are not utilised by doctors and medical students. (Page 19)

10. **Return to work programs** are lacking in health service environments. (Page 21)

11. Doctors and medical students are often confronted with **traumatic events** that are outside the normal human experience, and for which they may be ill prepared. (Page 23)

12. **Services to support staff health and well-being** are not consistently available in our workplaces. (Page 25)

13. Programs to encourage **physical well-being** are not widely available. (Page 27)

14. Programs to support **psychological skills training and well-being** are not widely available. (Page 29)

15. **Workplace health and safety obligations** are not always met in our workplaces. (Page 31)

16. Mechanisms are lacking to report and deal with **unacceptable behaviour** such as bullying. (Page 33)

17. **Supervisors** are not adequately supported to provide quality supervision. (Page 35)

18. **Regulatory processes** have a significant negative impact on the mental well-being of doctors. (Page 37)

ISSUE ONE

Factors of personality and temperament can negatively impact on how doctors and medical students cope with the stressors of their work roles.

How common is this issue and what is the impact?

Common (1-10) 10
Impact (1-10) 5

Key reflections:

- All personality traits have both positive and negative consequences for individuals depending on the context (e.g. obsessionality and perfectionism are helpful when passing exams but may make it difficult to cope with uncertainty in the practice of medicine; being competitive is required to achieve the results needed but can be harmful to peer relationships once in a training environment).
- We need to create an environment where it is 'OK to fail' or at least be 'less than perfect'.
- Certain personality types may be more successful through training and assessment processes, which some trainees can experience as being combative and confrontational at times.
- People will usually default to their automatic beliefs and behaviours, particularly when under stress; systemic solutions are needed that detect and address unhelpful and unacceptable behaviours.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Improved awareness of both self and colleagues, of personality traits and how they can be both a strength and a weakness.	Personality and temperament self-awareness tools to be promoted. Promote online programs that address personality vulnerabilities (e.g. Centre for Clinical Interventions perfectionism module).
Change the culture by creating work environments where it is permissible to be 'less than perfect'.	Share stories of struggle and recovery, particularly if you are in a senior or leadership role. Encourage more open discussion of the challenges and difficulties in the work environment, but also the joys and rewards. Recognise and reward the courage to speak out. Adjust expectations of doctors and medical students, reward behaviours that encourage physical and mental well-being eg taking leave, not working overtime.

Training needs to be more nurturing and supportive to enable all personality styles to flourish.	Medical schools may be better at this than the colleges. This seems to be a result of hiring more educators rather than assuming that doctors have education skills. Supervisors and educators in the hospital sector need more training and support.

Examples of current initiatives:

- The Centre for Clinical Interventions has a range of online programs to help people better understand their personality style and how it may affect their work and personal lives eg Perfectionism in perspective, Overcoming procrastination: http://www.cci.health.wa.gov.au/resources/consumers.cfm

ISSUE TWO

Work-life transitions such as the first-year out, starting a specialist career and retirement create additional stressors for doctors.

How common is this issue and what is the impact?

Common (1-10) 9
Impact (1-10) 7

Key reflections:

- More transitions occur than have been identified here such as transition to becoming a medical student, time out for family, relocation, career change or establishing a practice.
- Transitioning from medical student to intern/JMO can be a challenging transition – identity as a professional is emerging and often influenced by 'hidden curriculum', and reality may not match expectations.
- Public expectation is a big part of the pressure created at transition points.
- Need to change the culture as to what happens when doctors retire. Presently, when a doctor retires they leave the hospital/health service without much outgoing contact.
- Transitions, while stressful, can also be healthy and allow for personal growth.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Need to encourage doctors to think about options/transition to retirement early in their careers (50 yrs+).	Support doctors to get access to career planning and financial advice. Doctors need to be involved in other activities/interests so have a more rounded life, which can help with transitioning to retirement.
More support for medical students transitioning into work.	Medical schools have a role to play. Orientation programs in hospitals to include a focus on self care and stressors in the workplace.

Examples of current initiatives:

- James Cook University Intern Readiness Forum.
- AMSA humans of medicine: read powerful stories of struggle and success at https://mentalhealth.amsa.org.au/humans-of-medicine/

ISSUE THREE

Not enough doctors and medical students have a GP who they see regularly.

How common is this issue and what is the impact?

Common (1-10) 6
Impact (1-10) 6

Key reflections:

- Reframe own health as a personal responsibility, important to model good health seeking behaviour as a health professional. Part of belonging to the health profession is taking care of our own and our colleagues' health.
- Even for short periods of time, relocation can disrupt relationships with usual health care providers.
- It is not uncommon to see families full of doctors treating each other; as a profession we should be asking why? A cultural issue is that this practice has been the 'norm', but also acknowledge that family members may step in when care provided to their loved ones is not safe, sufficient or appropriate.
- Issues such as self-prescribing and self-referral are challenging; high levels of health literacy mean that doctors can naturally do some things quite safely for themselves, but at what point do doctors need to hand the responsibility to a trusted health advisor?

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Recognise the pitfalls of treating self, family and friends.	Incorporate messaging into docs 4 docs training and self-care modules. Consistent messaging is required. Leadership needed – modelling the right behaviour by having our own GPs, and promoting this as the right option.
Strategies to help medical students and doctors find GPs.	Doctors' health advisory and referral services to continue to build lists of practitioners who are comfortable with seeing their colleagues and have had some training in this area. AMA NSW is compiling a list of doctors, PHNs have also done this previously. Is there a role for training institutions who send medical students and doctors in training on rotations away from home some information about local health services and local GPs who are available for consultation as part of the orientation process? Is Skype or video-conferencing an option for doctor-patients who are working in rural or remote locations? Clarify MBS rules.

	University health centres offer an option for medical students and help establish good help-seeking behaviour. Promote proactive behaviour – establish a relationship with a GP before you become unwell.
Attitudes to mental illness need to change.	A lot of stigma remains so ongoing efforts needed to reduce this and encourage help-seeking.

Examples of current initiatives:

- Doctors' Health Services Pty Ltd is working on a range of initiatives to help doctors and medical students find a GP including fact sheets, provision of names of doctors who are trained and willing to see their colleagues as patients, increased training opportunities for all doctors to be 'doctor-patients' and to treat their colleagues.
- Doctors' Health South Australia is trialling video-conferencing for doctors in remote areas of South Australia and the Northern Territory.
- MIGA provides a discount for doctors who have an annual health check.
- Royal Australasian College of Physicians podcast: Barriers Doctors Experience Seeking Healthcare.

ISSUE FOUR

Not enough doctors engage in preventive health care such as healthy lifestyle, adequate work-life balance, and regular check-ups.

How common is this issue and what is the impact?

Common (1-10) 8
Impact (1-10) 8

Key reflections:

- Data suggests the physical health of doctors is better than average population but not consistent across the profession.
- Anecdotally, we can identify the following gaps: lack of regular check-ups and lower than expected participation in preventive activities. Substance misuse is an issue for some, higher rates of stress and predisposition to mental illness.
- Well-recognised barriers to accessing health care – stigma particularly for mental illness, fear and anxiety about confidentiality and impact on training/career progression, over-reliance on self-management, and not sure how to be a doctor-patient.
- How do we define work-life balance in the context of a medical career?
- Lack of autonomy over work life is an important issue as doctors often do not have a sense of control and feel they cannot make alternate choices. We need to understand this better in order to plan the right interventions.
- Perhaps it would be better to describe work-life balance as work/non-work.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Continue to address the barriers to accessing health care.	Initiatives that reduce the stigma of mental illness and encourage help-seeking behaviour. Docs 4 docs training to be made widely available. Leaders to be role models for good health-seeking behaviour, eg GP supervisors, hospital supervisors, professional leaders such as the presidents of the medical colleges.
Flexible training.	Need to change mindset about it being OK to have flexible training, part-time options and the ability to take some time off to enable a healthy work-life balance. Career counsellors to support medical students and young graduates explore career pathways and to take account of impact of choice on health and well-being and other life choices. This is likely to be useful across the whole profession.

Work-life balance.	Self-care modules widely promoted and include considerations of work-life balance and enabling health promoting behaviours. Leave should be encouraged and perhaps mandated as in other industries. Why do doctors perceive a lack of control over their work-life choices?

Examples of current initiatives:

- RACP doctors health and well being has a range of resources: https://www.racp.edu.au/fellows/resources/physician-health-and-wellbeing
- Queensland Doctors' Health Programme partnership with Western Queensland PHN on the SWOP program (Staying Well Outreach program) which will support rural doctors with education and well-being checks.

ISSUE FIVE

Many doctors practise in isolation which affects their mental well-being.

How common is this issue and what is the impact?

Common (1-10) 8-10
Impact (1-10) Depends but can be at individual, patient and systems level.

Key reflections:

- Doctors often practise in isolation but they don't necessarily feel isolated. Some doctors prefer to practise this way, though there may be unrecognised consequences for the individual.
- Isolation can be a subjective experience as doctors can feel isolated even in a busy environment), or an objective experience ie physically isolated/practising alone or without support.
- Geographical, professional and social isolation are all important.
- Mental illness, particularly depression, can lead to a doctor isolating themselves and therefore important to recognise when this is happening and seek to intervene.
- Rotations between specialities as interns, and between hospitals as doctors in training can make it difficult to feel part of a team.
- Risks for patients need to be recognised – the mental well-being of the practitioner, loss of peer review of practice and loss of objectivity.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Enhance a sense of connectedness and collegiality.	Provide physical spaces within workplaces where staff can gather and interact. This may be important for debriefing as well. Involve doctors in planning of physical layouts in practices and hospitals to ensure common areas are fit for purpose. Create structured ways to enable peers to connect eg grand rounds, case reviews and team meetings. Peer support and peer supervision programs to identify and support practitioners who may be isolated.
Provide education around the risks of isolation; incorporate into self-care education opportunities.	Engage workforce agencies, Australian College of Rural and Remote Medicine etc for solutions for rural workforces. Identify and promote resources and programs that encourage a healthy work-life balance

Examples of current initiatives:

- beyondblue: Developing a workplace mental health strategy. A how-to guide for health services. https://www.beyondblue.org.au/about-us/our-work-in-improving-workplace-mental-health/health-services-program
- Doctors' Health South Australia partnership with Country SA PHN to support rural doctors through education, peer support and tele-health.
- Queensland Doctors' Health Programme partnership with Western Queensland PHN on the SWOP program (Staying Well Outreach program) which will support rural doctors with education and well-being checks.

ISSUE SIX

We don't currently recognise and respond to illness in ourselves and our colleagues.

How common is this issue and what is the impact?

Common (1-10) 9
Impact (1-10) Variable

Key reflections:

- Doctors respond empathically to their patients, but not to their colleagues who are distressed or unwell. There is a significant amount of anecdotal evidence that doctors find this challenging and tend to avoid these conversations with their colleagues. They can find it confronting and do not want to get involved.
- Culture of medicine continues to devalue self-care and values altruism.
- The 'underperforming trainee' is often a reflection of someone who is unwell or not coping. The organisational response therefore needs to consider that this may be a major factor affecting performance.
- Consider medico-legal protections for treating sick doctors i.e. high-risk category.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Measures of absenteeism as a possible indicator that the workplace is contributing to worker ill-health. There is a need to reflect on this data, perhaps benchmark with other organisations and industries. The best outcome may be a balance between reducing absenteeism levels, and monitoring 'presenteeism' to avoid workers with genuine sickness putting themselves and others at risk in the workplace.	Adequate resourcing so managers can allow people to take appropriate leave. Transparency of data around absenteeism Flexibility around leave. Enable doctors to take personal leave rather than sick leave.
Workplace changes to support doctors who are unwell to both seek care and recover.	'Leaders Summit' to share methods for dealing with common operational issues which impact negatively on the health and well-being of staff.
A system to identify doctors trained to treat doctors.	A role for doctors' health advisory and referral services to identify 'doctor friendly' doctors. Docs 4 docs training made widely available to build generic skills among a large number of doctors who are competent in treating their colleagues. Higher-level training for those with a specific interest in doctors' health.

Examples of current initiatives:

- http://www.adhn.org.au/your-health/proqol-professional-quality-of-life
- Ambulance Victoria has instituted a mentally healthy workplace initiative which has had a significant impact on absenteeism.
- Australian Doctors' Health Network developing a curriculum in doctors' health.
- Doctors' Health Services Pty Ltd and State doctors' health advisory and referral services are developing docs 4 docs online and face-to-face training.
- Australian Medical Students' Association humans of medicine: read powerful stories of struggle and success at https://mentalhealth.amsa.org.au/humans-of-medicine/
- RESPECT training for managers to recognise and respond to mental health issues https://www.headsup.org.au/training-and-resources/educational-and-training/national-workplace-program

ISSUE SEVEN

The functional impact of ageing is not well accommodated in the medical profession.

How common is this issue and what is the impact?

Common (1-10) 10
Impact (1-10) 10

Key reflections:

- There is no evidence to tell us what level of cognitive decline indicates an inability to continue practising medicine.
- It can be difficult to assess – executive function and judgement are key concepts; current tools are benchmarked against general population and we do not have validated instruments for doctors.
- Impact depends on speciality and scope of current practice, including the types of tasks performed versus the type of functional decline.
- Early detection of functional decline would allow doctors to plan and identify alternative work options.
- Australasian Doctors' Health Conference 2017 conference delivered by Michael Robertson, an occupational psychiatrist, who spoke about mental health and the impaired physician, and may be someone to approach for more advice regarding functional impacts of cognitive change.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Doctors to receive more training and information around financial planning.	Allows a gradual transition away from paid work.
Preventive strategies.	Promote health lifestyles across the whole of doctors' lifespan as preventive strategy for cognitive decline. Promote annual check-ups as good preventive care is shown to delay and even prevent cognitive impairment and dementia. Address modifiable factors of cognitive decline improving depression, social isolation, hearing loss. Promote work-life balance and a life outside medicine to enable an easier transition out of work.

Improving self-awareness of declining performance.	Improve self-awareness around declining health and/or function – is there some kind of screening or self assessment tool we can recommend? Build monitoring of health into CPD as part of the peer review element of CPD/revalidation? Alternative career pathways for aging doctors.

Examples of current initiatives:

- None identified.

ISSUE EIGHT

Compassion fatigue and burnout are common among medical students and doctors, and impact on our clinical care.

How common is this issue and what is the impact?

Common (1-10) 7
Impact (1-10) 9

Key reflections:

- Starts with overworked consultants who need to pass on work to Registrars and Residents – everyone is doing too much.
- Lack of sleep is a big contributor to burnout.
- Multiple demands which cause fatigue such as shift work, studying for exams, fitting in 'stuff' outside of work; people become too exhausted to enjoy life.
- Need to address the work environment – reasonable workloads, reasonable expectations of ourselves and others, more resources and regular leave.
- Daily grind over long periods without sufficient breaks is a major risk factor – doctors often start their careers in a state of exhaustion.
- RPAH (Sydney) are doing some positive things to support their young doctors to cope better with the stressors of work.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Systems change to address workload issues in order to combat fatigue and burnout.	Place limits on hours worked, increase human resources, enable doctors to take time off including leave, physical environments that allow for time out and ensure overtime is paid. Leadership in workplaces to model the right behaviours such as lunch breaks, going home at end of the shift, protected time for education and encouraging physical activity. More awareness of particular crisis periods in training eg around exams, major life events such as a having a baby.
Broaden training opportunities.	Increasing numbers of graduates means more competition for training places, which is a major driver for excessive work – trying to do additional things such as research and extra courses etc.
Improve awareness of the risks of burnout and how to recognise it.	More education on burnout and compassion fatigue so medical students and doctors can better manage the risks, and recognise signs in themselves and colleagues.

	Peer support programs that promote healthy behaviours and have a strong preventive focus.

Examples of current initiatives:

- The Centre for Clinical Interventions has a online module on Building Self Compassion: http://www.cci.health.wa.gov.au/resources/consumers.cfm
- Blue Knot Foundation has resources and provides training on burnout, compassion fatigue, and vicarious trauma; they can also deliver training in the workplace: https://www.blueknot.org.au/Training-Services/Calendar-of-Events/Public-VT-for-Health-Professionals
- AMA fatigue risk assessment tool and safe hours campaign: http://safehours.ama.com.au/
- AMA National Code Of Practice: Hours of Work, Shiftwork and Rostering for Hospital Doctors
- AMA National Code of Practice – flexible work and training practices: a tool to assist employers, training providers, doctors and doctors in training to implement and access best practice flexible work and training arrangements.

ISSUE NINE

Counselling services provided by employees are not utilised by doctors and medical students.

How common is this issue and what is the impact?

Common (1-10) 9
Impact (1-10) 7

Key reflections:

- Employment Assistance Programs (EAP) programs were often perceived to be faceless leading to a lack of confidence and lack of trust.
- The EAP workforce often lack sufficient experience to provide meaningful support and advice to medical professionals.
- Having an EAP is not enough and need to ensure it is being used. Companies often cite confidentiality concerns for not collecting data but data collection needs to be framed in terms ensuring the service is meeting the need.
- Peer support programs appear to be well received and may offer a better model.
- Another option is to provide clear pathways to care outside the organisation.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Dispel myths around EAP programs and encourage liaison with staff. Don't wait for a crisis.	Use EAP in other ways such as delivering training to staff, involved in policies and processes around workforce well-being.
Invest in peer support programs and networks.	Many good examples exist now. Perhaps establish a working g group or panel of SMEs that others can come to for advice. Peer support groups can be quite informal. Can medical students and doctors in training do more to foster this?
Clear pathways to care outside of the workplace. There needs to be someone doctors and medical students can go to for help with getting access to the care that they need.	Well-being officers in all hospitals. More visibility of doctors' health advisory and referral services as a contact point for advice on referral options. Ongoing messaging of the importance of all doctors and medical students having their own GP. This includes that GPs can provide a lot mental health support. Promoting online resources as another avenue to seek help or engage in treatment.

Examples of current initiatives:

- Monash Care – The Mental Health and Well Being Support Program for Doctors, http://monashdoctors.org/monash-care/

ISSUE TEN

Return to work (RTW) programs are lacking in health service environments.

How common is this issue and what is the impact?

Common (1-10) 9
Impact (1-10) 9

Key reflections:

- There are challenges for small businesses, which many medical practices share – a small pool of available workforce to replace workers, loss of income for individuals and businesses.
- Being self-employed is a particular challenge. A loss of income can be a substantial barrier to being off work and also threat to business viability.
- Focus on keeping people at work to begin with because loss of work = loss of hope; having to be off work is a significant loss and a major challenge to self-worth and sense of self. It can also create gaps in the CV which then need to be explained at a later date.
- Need for structured RTW programs which take into account functional capacity and emotional well-being, ie supervised and supported.
- Supervision is important but need to balance impact on self-confidence etc with supported RTW. Supervision needs to be done in a respectful and nurturing way.
- Stronger role for occupational health physicians in workplace issues, particularly functional capacity assessments.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Keep people at work whenever possible.	Human resources that focus on stay at work plans with supportive case managers. Modify roles, provide meaningful work, possibly short projects that are less demanding in terms of hours eg research, education, quality improvement. Break from shift-work, overnight hours etc to reduce demands while recovering.
Maintain connection to peers and work role if unable to stay at work.	Remain involved in peer group activities and training activities if possible. Continue to get emails related to education, social events etc. Regular checking in with the employee. Encourage colleagues to stay in touch, catch up for coffee etc. Peer support programs have a role in supporting doctors returning to work.

Career evolution over time – some doctors and medical students may need to choose alternative career paths that are better suited to their health issues; this should be normalised and encouraged.	Promote a diversified career particularly through stories of doctors who have done this previously. Dedicated career counsellors to support doctors to change career direction – this may include careers outside of medicine.
Make it easier for doctors and medical students to take leave when required and also to return to work when well.	Dedicated junior medical officer positions to cover sick leave; make it OK to take leave. Resources to support training. Financial planning skills as part of training or self-care modules. Promote the importance of practice protection insurance and income protection insurance. What can we learn from small business sector?

Examples of current initiatives:

- Doctors' Health Advisory Service Western Australia is working on return to work guidelines with WA Health.

ISSUE ELEVEN

Doctors and medical students are often confronted with traumatic events that are outside the normal human experience, and for which they may be ill prepared.

How common is this issue and what is the impact?

Common (1-10) 9
Impact (1-10) 9

Key reflections:

- Leadership is very important – doctors in training need to see that it is OK to express their feelings about a traumatic event and to have this normalised and validated.
- Everyone is different, what will be traumatic to one person will not be to another. It is important to check in and not to make assumptions.
- Isolation heightens the risk of a bad outcome because there is less opportunity to share experience, talk with colleagues etc.
- Peer-to-peer support is seen as particularly helpful.
- Reactions to trauma can happen well down the track – doctors need to be watching for this in themselves and their colleagues.
- Sometimes it's lots of little things adding up, rather than one big thing.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Transparent processes that are designed to support doctors deal with potentially traumatic experiences.	Formal and informal opportunities to reflect on situations that have occurred and debrief. Team meetings after an event to talk through what happened and how people are feeling. Modelling by senior staff through sharing their own experiences and encouraging open dialogue after traumatic events. Explore the role of peer support programs as a safe place to discuss difficult experiences; peer leaders need to be trained to deal with these more challenging issues. Time off and short-term change in role / responsibilities should be available to all staff when needed.
Improved training for doctors to understand the potential impact of trauma and how to recognise warning signs.	Training programs to raise awareness of issues such as vicarious trauma, burnout, desensitisation etc. Preparedness training for high-risk clinical scenarios.

	Need self-awareness about our own personality styles and how we tend to cope with things, both positive and negative. Normalise the response to trauma – you SHOULD feel this way and that's OK!!

Examples of current initiatives:

- Royal Australasian College of Physicians doctors' health and well being has a range of resources: https://www.racp.edu.au/fellows/resources/physician-health-and-wellbeing
- Blue Knot Foundation has resources and provide training on burn-out, compassion fatigue, and vicarious trauma; they can also deliver training in the workplace: https://www.blueknot.org.au/Training-Services/Calendar-of-Events/Public-VT-for-Health-Professionals

ISSUE TWELVE

Services to support staff health and well-being are not consistently available in our workplace.

How common is this issue and what is the impact?

Common (1-10) Varies across different health care settings
Impact (1-10) High

Key reflections:

- Poor staff health has major implications for patient safety in addition to the well-being of the individual doctor.
- Doctors are not trained to look after their colleagues, so may not respond appropriately to a colleague in need.
- Cultural background may impact on how useful/relevant services are to individuals.
- Confidentiality is always a concern for doctors who are seeking support and assistance from within their workplaces, therefore need clear avenues for doctors to seek outside help.
- Cultural issues of the profession have a strong impact and some doctors feel it is not OK to ask for help.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Increase awareness of doctors' health advisory and referral services.	Peer support officers in hospitals can raise awareness of pathways to care. Education on self-care to be widely available and strongly promoted. Stronger focus on R U OK – and not just on that one day each year. It needs to be culturally embedded and appropriate to ask our colleagues how they are doing.
Train doctors to look after their colleagues.	Mentoring program for doctors in training to increase their level of practical and emotional support. Docs 4 docs training to be developed by the doctors' health advisory and referral services. Pastoral care is an important element of caring for doctors and not well addressed.
Accreditation of training needs to include issues that impact on doctors' health. 1. Professional behaviour 2. Welfare 3. Well-being 4. Harassment and bullying	Need political buy-in – who are the key players? State health departments, the colleges and the Australian Medical Council. Mandatory modules on key topics – some colleges are already delivering these. How can we broaden their availability?

A safe workplace is a reasonable expectation.	

Examples of current initiatives:

- beyondblue: Developing a workplace mental health strategy. A how-to guide for health services: https://www.beyondblue.org.au/about-us/our-work-in-improving-workplace-mental-health/health-services-program
- Heads-up program – mentally healthy workplace initiative involving Black Dog Institute, beyondblue and a range of others: https://www.headsup.org.au/
- AMA Resident hospital health checks in Queensland, New South Wales and Western Australia.
- Monash Care – The Mental Health and Well Being Support Program for Doctors, http://monashdoctors.org/monash-care/

ISSUE THIRTEEN

Programs to encourage physical well-being are not widely available.

How common is this issue and what is the impact?

Common (1-10) Unsure
Impact (1-10) Unsure

Key reflections:

- Important to recognise the concept of "biopsychosocial integrity".
- Exercise improves cognition.
- Social interaction essential.
- Modelling is positive.
- Diversity – exercise can be shared across all staff.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Improve workplace infrastructure to support healthy behaviours.	Showers, bike storage facilities, on-call rooms for sleeping, healthy food options, spaces for social contact, food storage and preparation areas.
Leadership and advocacy for healthy workplaces.	Champions identified and supported to organise activities and events that promote well being eg encourage teams in community exercise events, exercise and yoga sessions during lunch hours or after work and 'inter-hospital olympics'. Dedicated roles such as health and well-being officers. Leaders to model the right behaviours, eg encourage teams in community exercise events, exercise sessions during lunch hours or after work, yoga sessions at lunch time.
Hospital and GP accreditation should include evidence of support for staff physical well-being.	Hospitals required to demonstrate that staff have time off i.e. holiday and other leave. Workplaces to demonstrate policies that provide for healthy food options for staff and visitors.

Examples of current initiatives:

- RPAH (Sydney) BPTOK program for trainees, including health and well-being content in trainee education programs, education as part of protected time, structured opportunities for physical activity and relaxation activities. Consultants also take part. See:

RPA's BPTOK program supports junior doctors' mental and physical wellbeing, Sydney Morning Herald, 2 June 2017.

- Brisbane South LHD – healthy food vending machines being introduced to all facilities.
- Vigeo – a phone app supporting doctors health and well-being.

ISSUE FOURTEEN

Programs to support psychological skills training and well-being are not widely available.

How common is this issue and what is the impact?

Common (1-10) 9
Impact (1-10) 10

Key reflections:

- During training there is such a strong focus on clinical aspects which distracts from self-development; training programs need to be holistic and focus on the individual as well as the development of their knowledge and skills.
- Look at programs outside medicine that have been successful – what are other industries doing?
- Look at models such as Process Communication Model (PCM).
- Disconnect between what can be offered as part of a training program and what employers will allow.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Well-being programs and activities for doctors and other staff within protected time to build networks and collegiality.	Led by senior staff – 'lead by example'. Organisational support and quarantined time to attend training and practice of psychological skills (i.e. mindfulness, meditation). Education on self-care to be widely available and strongly encouraged.
Provide opportunities for interaction with senior staff such as CEO, eg forum to build peer support and opportunity to raise issues of concern.	Hospitals to introduce opportunities for doctors in training to provide feedback in a group situation to senior staff. Opportunities for informal networking on a regular basis to build mentoring eg doctors lunches/dinners and team activities.
Opportunity for personal development.	Personal development opportunities outside of medicine to be encouraged.

Examples of current initiatives:

- AMA Queensland Resilience on the Run.
- University of Queensland Medical Society – Stress Inoculation Therapy sessions for medical students prior to beginning their intern year.
- Vigeo – a phone app supporting doctors health and well-being.
- Avant resource: http://www.avant.org.au/member-benefits/doctors-health-and-wellbeing/your-health/physical-and-mental-wellbeing/resilience/

- CALM – computer assisted learning for the mind, http://www.calm.auckland.ac.nz/18.html
- RPAH (Sydney) BPTOK program for trainees, including health and well-being content in trainee education programs, education as part of protected time, structured opportunities for physical activity and relaxation activities. Consultants also take part. See:

  RPA's BPTOK program supports junior doctors' mental and physical wellbeing, Sydney Morning Herald, 2 June 2017.

ISSUE FIFTEEN

Workplace health and safety obligations are not always met in our workplaces.

How common is this issue and what is the impact?

Common (1-10) 10
Impact (1-10) 9

Key reflections:

- Doctors accept a significant level of physical threat as a day-to-day reality. They may become 'normed'/ 'immune' to it and not realise the risk.
- Workplace safety has both physical and psychological dimensions.
- Need systemic responses that make the workplace safer, as well as education and training to raise awareness and be more mindful of personal safety.
- Medical culture important – valuing the health and well-being of doctors needs to be seen as equal to that of patients.
- EAP is not generally effective to support those injured or threatened in the workplace; more expertise is needed.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Culture and systems changes.	Identify and address areas of risk in medical workplaces – who is responsible? Improvements to the physical work environment are often overlooked, eg common rooms and lunch rooms for staff, quiet spaces for rest and reflection, safe parking etc. Employee rights that other industries take for granted are lacking in health care environments. Role for occupational health physicians in leading change.
Psychosocial aspects of health.	Self-care training modules to be made widely available, can these be linked in some way to training requirements or registration? They should be available in work hours and employees paid to do them. Work-life balance needs to be more strongly encouraged – limits on work hours, other industrial measures.
Career development	Options for those who do not wish to stay in their current work environment.

Examples of current initiatives:

- Monash Care – The Mental Health and Well Being Support Program for Doctors, http://monashdoctors.org/monash-care/
- AMA fatigue risk assessment tool and safe hours campaign: http://safehours.ama.com.au/
- AMA doctors in training employment guide.

ISSUE SIXTEEN

Mechanisms are lacking to report and deal with unacceptable behaviour such as bullying.

How common is this issue and what is the impact?

Common (1-10) 8
Impact (1-10) 8

Key reflections:

- There is a lack of understanding of what bullying is which leads to under-identification.
- Medical culture is central to the permissive environment that allows bullying – interventions need to address culture as well as provide clear mechanisms to deal with issues.
- Leadership is critical – speaking out should be encouraged and rewarded rather than punished.
- Some health services are responding well to unacceptable behaviour in the workplace, eg St Vincents (Vanderbilt model) and Melbourne Health.
- Need organisation-wide engagement and training – it's everyone's problem.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Widespread training in techniques/models such as the process communication model.	Compulsory training during internship and other early prevocational years. Self-development for medical staff that focuses on personal awareness versus skill / knowledge development. Greater emphasis on skills development in medical schools to recognise and deal with unacceptable behaviour, eg assertive communication.
Enhance the understanding of what bullying is (versus performance management) and pathways for seeking help.	Clear organisational policies that spell out definition of bullying etc. Opportunity for anonymous reporting but risk vexatious claims.
Greater emphasis on interpersonal communication / behaviour coping training in medical school.	

Examples of current initiatives:

- Melbourne Health are transforming their culture through a range of initiatives: contact mhconnect@mh.org.au.
- St Vincents Sydney are also undertaking some important work on culture change.

- Queensland Doctors' Health Programme workshop on Tackling Bullying and Harassment in Medicine: Empowering Tomorrows Doctors.
- Royal Australasian College of Surgeons Operating with Respect program: resources, training and support to address bullying in the workplace: https://www.surgeons.org/about-respect/

ISSUE SEVENTEEN

Supervisors are not adequately supported to provide quality supervision.

How common is this issue and what is the impact?

Common (1-10) 8-9
Impact (1-10) 8-9

Key reflections:

- Supervisors commonly feel that they do not have enough time to spend on supervision.
- Supervision has both professional and personal elements – need to support professional training and growth, but also be able to recognise personal challenges and assist trainees to get the right kind of support.
- There is a lot of variability among colleges and also among institutions in terms of what is expected and the level of support provided for supervisors.
- There is an increase in the pastoral care required from supervisors, and also a need to understand and respond to different cultural issues.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Increased resourcing for supervision/clinical support time.	Needs to be more than just one person; too much load and not always available. Increase paid clinical support time. A lot is unpaid and other priorities crowd in. There may be value in having some supervision come from outside the training setting – may provide more objectivity and a different type of support.
Improved training and support for supervisors.	Train the train models to ensure a pipeline of supervisors. Trainees need longer term support as they are often in training for long periods, also need to recognise the mobility of trainees – it is hard to supervise from a distance. Changing workforce demographics need to be reflected in supervisor training – range of cultures, older doctors and lot more personal and family issues. Stronger links to the doctors' health advisory and referral services for trainees who are struggling with health issues.

Facilitate more collegiality in the training environment.	Encourage sharing of resources between training sites and settings. Opportunities for supervisors to connect.

Examples of current initiatives:

- RESPECT training for managers to recognise and respond to mental health issues https://www.headsup.org.au/training-and-resources/educational-and-training/national-workplace-program
- Royal Australasian College of Surgeons Operating with Respect program: resources, training and support to address bullying in the workplace: https://www.surgeons.org/about-respect/

ISSUE EIGHTEEN

Regulatory processes have a significant negative impact on the mental well-being of doctors.

How common is this issue and what is the impact?

Common (1-10) 10
Impact (1-10) 9

Key reflections:

- Misperceptions of mandatory reporting are common and difficult to address. Examples of doctors being inappropriately reported due to a lack of understanding of the law leads to widespread anxiety and concern. This in turn leads to a reluctance to seek help.
- Any regulatory issue can have a significant and negative impact on a medical student or doctor.

Key recommendations:

WHAT KEY ACTIONS NEED TO OCCUR	BY WHO AND WHEN
Ongoing efforts to educate the profession about mandatory reporting requirements.	Develop a module that all doctors must watch prior to renewing their registration. What about medical students? Consistent messaging developed by the Medical Board of Australia and reinforced by all stakeholders.
Implement strategies to recognise and reduce the impact of regulatory processes on doctors and medical students.	Reduce delays in the investigation and resolution of issues. Ensure transparency. Improve communication. Improve support - Referral to doctors' health advisory and referral services to be a standard part of the process. We need to map out how this would work and provide clear pathways and contact details. Stronger partnerships between medical indemnity funds and doctors' health advisory and referral services. Can indemnity funds provide short term funding for psychological interventions?
Improved support for doctors with conditions on their registration related to health issues – to maximise their chances of recovery and a return to unconditional registration	Funding to support case management – who should coordinate? Access to appropriate leave so that affected doctors can step away from work if required to support recovery, or have access to alternative work options such as part-time or alternative duties.

Examples of current initiatives:

- State health departments. Review of the mandatory reporting laws.
- Study in the *British Medical Journal* of over 6,000 showed that peer support was the most successful factor in reducing the stress associated with a regulatory process:

  Colleagues are best source of support for doctors facing complaints, researchers find**;** BMJ 2017; 359: https://doi.org/10.1136/bmj.j5420 (Published 22 November 2017).

Appendices

A. High-level summary of the national forum

B. National forum outline

C. Attendance list

D. Forum pre-reading

National Forum on Reducing the Risk of Suicide in the Medical Profession

14 September 2017

NSW Parliament House

High-Level Summary

On 14 September 2017, 82 members of the medical profession came together to focus on individual, organisational and environmental issues which impact negatively on doctors' emotional health and well being, and may put them at risk of psychological harm, mental illness and suicide.

While suicide is a devastating event, many of the contributing factors will be upstream of that event, and a focus on prevention and early intervention is important to address the growing burden of psychological ill health in the medical profession. Creating mentally safe workplaces is important for everyone, as is addressing cultural issues which make it hard for doctors to seek help.

There is ample evidence that a healthy workplace improves productivity and outcomes, and there is therefore great value in investing in system changes that improve workforce health and retention. Medicine, as an industry sector, presents certain occupational hazards and stressors that need to be addressed in the same way that other industry sectors have confronted their own particular occupational risks.

*Two key themes that emerged from the day, and also from the Australasian Doctors' Health Conference that followed, were **Culture and Compassion**.*

Culture change will happen through sharing our stories, treating each other with care and respect, and reframing the conversation to acknowledge the impact of doctor ill health on patient care.

While a full report is being prepared, the following is a high-level summary of key focus areas that will underpin a set of clear recommendations for further action.

1. Professional and Workplace Culture

Cultural change is urgently needed. This won't occur without specific action. Reframing doctors' health with respect to patient safety and outcomes may be a useful approach. Doctors who are exhausted, stressed, burnt out and unwell do not provide safe and effective care.

Professional ideals of perfectionism, toughness in the face of adversity, and an ability to keep going no matter what need to be challenged through leadership and a sharing of stories and experiences that reflect the realities of our working lives.

The stigma of mental illness must be challenged at every opportunity. Lived experience is central to any anti-stigma program, and stories of hope and recovery should be widely shared.

Professional and workplace cultures must be supportive and nurturing, and model the principles that we apply to patient-centred health care. There is currently a disconnect between what we expect our workplaces to be like, and what we actually experience.

Roles and environments that are inherently dangerous or toxic must be identified and removed from the system. We all have a right to feel physically and emotionally safe at work. We also have a right to expect that our reasonable needs for leave, part-time work/training, and supported return to work after a period of leave will be met.

2. Leading systems change

Health system leaders at every level must model, promote and believe in the changes that are proposed (and hopefully implemented) to cultures and systems.

The issue of safe hours of work must be addressed through defined limits to working hours in order to ensure that the health and well being of doctors and their patients are protected.

All staff need a safe "point of first contact" if distressed, which is independent from employers and supervisors. Peer support programs appear to be well accepted and realistic to implement.

Workplaces where health services are delivered must allow for the modelling of good health behaviours eg by providing facilities (such as showers and lockers) for staff who exercise as part of their travel to work or who wish to incorporate exercise into their work patterns; provision of healthy food options; "time-out" and rest facilities for staff with physical or emotional fatigue.

All doctors should receive training in caring for colleagues at a basic level, similar to the expectation that all clinicians can undertake basic life support. This training should include strategies to identify and assist colleagues in distress, and information about appropriate services for referral.

Australia needs a uniform position on reporting requirements for impaired practitioners (whether mandatory or otherwise).

3. Personal Responsibility and Self-Management

As a profession we need to improve our self-awareness of professional characteristics that put our health at risk, including perfectionism and self-denial. We also need to recognise biases that we or our colleagues may feel such as a reluctance to admit to mental health issues.

We as doctors need to be aware that burn out and compassion fatigue are "state" or transient characteristics in response to stress in the workplace, but that they can become normalised if stressors persist.

Developing healthy social networks and community support systems external to our professional lives are important for our health and well being.

Doctors need support to adopt the patient role when that is required.

4. Career Pathways and Career Development

Increasing competition for training positions and reduced career opportunities are major sources of stress for young doctors and students.

Inflexible career silos can be a source of stress for mid-career doctors.

Given the above, colleges, universities and employers need to redesign career pathway development to ensure:

- Potential future realignment with changing workforce needs,
- Career transition options for doctors, and
- Career flexibility, recognising the range of roles that doctors currently undertake, including clinician, educator, researcher, manager, parent, community advocate, policy advocate and many more.

Vocational counselling needs to be strengthened to help doctors and medical students to envisage the many potential career paths available to them.

Later career doctors also need support to prepare for career transitions and unanticipated changes, and may need to train in mid-career for different medical and other roles. This may be of particular importance for doctors undertaking procedural work.

5. Next steps:

1. Universal commitment to, and adoption of, a preventive approach to the health of doctors and medical students, particularly with respect to mental health and well being.
2. An action plan to address the issues identified at the Forum.
3. Identification of lead agencies to enact and enable the action plan.
4. An honest discussion and implementation program that avoids tokenistic or politically expedient short-term solutions.
5. The embedding of research and data collection which informs our learning.
6. An openness to learn from other industries and groups.
7. The establishment of an independent group responsible for monitoring and reporting on progress against the action plan.
8. Consideration to be given to the development of a Consensus Statement on the issue of the health of doctors and medical students to focus support and the need for action.

National Forum
Reducing the Risk of Suicide in the Medical Profession

The Strangers' Dining Room
Parliament House, Sydney
14 September 2017

PROGRAM

8:30 – 9:00am – Registration	
9:00 – 9:15am	**Welcome** Dr Tony Bartone Vice President Australian Medical Association Dr Janette Randall Chair of the Board Doctors' Health Services Pty Ltd **Overview by forum facilitator** Professor Simon Willcock Clinical Director of Primary Care Macquarie University Health Sciences Centre
9:15 – 9:30am	**Personal stories** Dr Eliza Milliken and Dr Ann McCormack
Session one – Improving our understanding	
9:30 – 10:30am	**Panel session – an overview of contemporary research into suicide, including doctor suicide and current and emerging interventions** Dr Marie Bismark Associate Professor Melbourne School of Population and Global Health University of Melbourne Associate Professor Sam Harvey Head, Workplace Mental Health Research Program University of New South Wales Dr Fiona Shand Senior Research Fellow Black Dog Institute and the NHMRC Centre for Research Excellence in Suicide Prevention

10:30am – Morning tea	
Session two – Systems and training	
11:00am – 12:30pm	**Panel session – What kind of work environment do we want?** Dr Anjali Dhulia Director, Medical Services and Quality Monash Health Dr Victoria Atkinson National Chief Medical Officer and Group General Manager Clinical Governance St Vincent's Health Australia
12:30pm – Lunch	
Session three – Individuals	
1:00 – 2:30pm	**Panel session – Doctors are people too: what makes us great and what makes us vulnerable?** Dr Margaret Kay Medical Director Queensland Doctors' Health Programme Dr Imre Hunyor Medical Superintendent Royal Prince Alfred Hospital, Sydney
Session four – Where to from here?	
2:30 – 2:45pm	**Personal reflections**
Session five – Group discussion	
2:45 – 3:30pm	**Summary of key recommendations and next steps** Led by Professor Simon Willcock
3:30pm – Forum ends	
Debrief session and post-forum networking	
3:45 – 5:30pm	**Debrief session (optional)** Led by Dr Kym Jenkins President, The Royal Australian and New Zealand College of Psychiatrists **Post-forum networking**

National Forum pre-reading is available at:

https://www.doctorportal.com.au/doctorshealth/national-forum-reading/

Professor Simon Willcock

Simon is a general practitioner and the Clinical Director of Primary Care at the Macquarie University Hospital. His education and research interests include the health of doctors, generational change in the medical workforce, men's health and musculoskeletal medicine.

Simon trained as a rural procedural GP, and practiced in Inverell, NSW where his practice included obstetrics and anaesthetics. For the past twenty years he has worked in academic and clinical practice in Sydney and has had a number of educational leadership roles.

Simon is currently the Chair of the Avant Mutual Group and a board member of the Sydney North Health Network, the NSW Doctors' Health Advisory Service and a member of the NSW AMA Council of General Practice. He is also the Director of Primary Care and Wellbeing Services at MQ Health.

Dr Marie Bismark

Dr Marie Bismark holds degrees in law, medicine, bioethics, and public health, and has completed a Harkness Fellowship at Harvard University. She currently works as a psychiatry registrar with Orygen Youth Health, and as an Associate Professor at Melbourne University. Her research focuses on patient complaints, medical regulation, and doctors' health. Marie is also an experienced company director, serving on the boards of GMHBA health insurance and Summerset retirement villages. Marie and her husband have three children and love to spend their summers beside the beach in New Zealand.

Associate Professor Samuel Harvey

A/Prof Samuel Harvey leads the Workplace Mental Health Research Program at the Black Dog Institute and University of New South Wales.

After initially working as a general practitioner, A/Prof Harvey trained in psychiatry at the Institute of Psychiatry in London and completed his PhD with the University of London. While working in the UK, A/Prof Harvey worked in a number of specialist clinics focused on treating doctors and medical students with mental health problems. He worked together with the UK Department of Health to develop their response to concerns regarding the mental health of health care professionals, which led to the 'Invisible Patients' white paper and the establishment of the highly successful Health Practitioner Program in London.

Since relocating to Australia in 2012, A/Prof Harvey has led a program of research focused on the relationship between work and mental health. His research considers the role work and workplace trauma may have in precipitating mental illness, the occupational outcomes of those already suffering from mental disorders and workplace based interventions for both the treatment and prevention of mental disorders.
He has a particular interest in the role that new technology can play in preventing mental health problems amongst workers and the issues faced by high risk workforces, such as emergency service workers and medical staff. Further details about his program of research can be found at www.wmh.unsw.edu.au

Dr Fiona Shand

Fiona is a Senior Research Fellow at the Black Dog Institute and the NHMRC Centre for Research Excellence in Suicide Prevention. She leads a program of research focused on suicide prevention. Currently, Fiona is the research director for the LifeSpan project, a large, multi-level model of community wide suicide prevention to be rolled out in four communities. Her other research spans e-mental health interventions for at-risk populations, Indigenous suicide prevention, and health service research. Her team has completed the first Australian randomised controlled trial of a suicide prevention intervention with Aboriginal youth, using an app to deliver therapy. Further details about the LifeSpan project can be found at http://www.lifespan.org.au/

Dr Anjali Dhulia

Dr Anjali Dhulia started her medical career in the Indian Army where she served for eight years. She completed her postgraduate training in paediatrics at Delhi University and practised in Paediatric Intensive Care before migrating to Australia. She worked as a Fellow in Neonatology at the Women's and Children's

Hospital in Adelaide, the Royal Women's and Royal Children's hospitals in Melbourne and also with the Neonatal Emergency Transport Service.

She switched to a career in medical administration in 2008 and completed a Fellowship of the Royal Australasian College of Medical Administrators and has worked at Northern Health and Monash Health in various medical management roles. She has completed a Master of Public Health from Latrobe University and a Master of Applied Positive Psychology from Melbourne University.

Her professional interests and expertise include medical workforce management, healthcare safety and quality and engagement and wellbeing of medical staff.

Dr Victoria Atkinson

Dr Victoria Atkinson is the National Chief Medical Officer and Group General Manager Clinical Governance at St Vincent's Health Australia.

Building on a strong clinical background as a cardiothoracic surgeon, Victoria works to integrate the clinical, operational and governance aspects of healthcare to enhance patient care. As creator and executive sponsor of the St Vincent's Ethos program, she also recognises the deep connection between professional behaviours and staff and patient welfare. She has been a passionate advocate for changing what the health sector accepts as "normal" in their culture.

Victoria is a member of the Alfred Health Board, and the Deputy Chair of the Board for Better Care Victoria. She holds an MBBS, FRACS, AFRACMA and a Masters of Health Management.

Dr Margaret Kay

Dr Kay is Medical Director of the Queensland Doctors' Health Programme. She is a Fellow of the Royal Australian College of General Practitioners and a Member of AMA Queensland. She graduated from The University of Queensland in 1983, with Honours in Medicine and holds an academic title as Senior Lecturer with the Faculty of Medicine. She continues her clinical work part-time in General Practice. In 2013, she completed her PhD in Physician Health which focused on understanding how doctors access health care for themselves. She has over 20 peer-reviewed publications, many in the area of doctors' health. She is Chair of the Expert Advisory Council for Doctors' Health Services Pty Ltd and is a member of the Australasian Doctors' Health Network. She also has clinical and research interests in refugee health.

Dr Imre Hunyor

Dr Imre Hunyor completed his Medical degree with honours at the University of Sydney following a degree in Advanced Science. He was awarded a Rhodes Scholarship and completed his doctorate at the University of Oxford. He was based in the department of Cardiovascular Medicine at the Wellcome Trust Centre for Human Genetics. His subsequent postgraduate physician training, Cardiology and subspecialty training in advanced cardiac imaging was at the Royal Prince Alfred Hospital, where he is now a Staff Specialist Cardiologist and Clinical Superintendent.

As part of the RPA BPT Network training team, Dr Hunyor runs the teaching program for Basic Physician Trainees (encompassing > 60 trainees spanning RPA, Balmain, Bankstown, Bathurst, Dubbo, Alice Springs) and is an Examiner for the RACP. He is also a Clinical Senior Lecturer at the University of Sydney Medical School.

Dr Hunyor's involvement in physician training broadly involves clinical education but importantly includes a focus on mental health, trainee wellbeing and professional development. This involves providing dedicated protected time for trainees to address these issues. He has taken a keen interest in the welfare of trainees with the aim of helping initiate system changes (eg through Chief Exec-JMO & Innovation Committees). He is a founding member of the BPTOK initiative, a pilot program that seeks to provide trainees with the skills and resources to take care of themselves and better manage their own experience in the professional environment. He works closely with colleagues Dr Peter Lim (Network Director of Physician Training) and Dr Bethan Richards (Head of Department, Rheumatology at RPA) as part of the team rolling out this initiative.

Title	First Name	Surname	Organisation	Position
Prof	Stephen	**Adelstein**	Medical Board of Australia	Chair, New South Wales Board
Dr	Angela	**Alessandri**	University of Notre Dame, Australia	Assoc Professor Professionalism and Clinical Governance
Dr	Jennifer	**Alexander**	Doctors' Health Services Pty Ltd	Director
Prof	John	**Allan**	RANZCP	President Elect
Dr	Marion	**Andrew**	Australian and new Zealand College of Ananesthetists	Chair of Welfare Special Interest Group
Dr	Victoria	**Atkinson**		
Dr	Tony	**Bartone**	AMA	Vice President
Dr	John	**Batten**	The Royal Australasian College of Surgeons	President
Dr	Jill	**Benson**	Doctors Health SA	General Practitioner
Dr	Sara	**Bird**	MDA National	Manager, Medico-legal and Advisory Services
Dr	Marie	**Bismark**	University of Melbourne	
Mr	Timothy	**Bowen**	MIGA	Senior Solicitor - Advocacy, Claims & Education
Dr	Kerrie	**Bradbury**	Medical Board of Australia	Chair, Australian Capital Territory Board
Dr	Penny	**Browne**	Avant Mutual	Senior Medical Officer
Mr	Bernard	**Bucalon**	Council of Presidents of Medical Colleges	
Dr	Adam	**Castricum**	Australasian College of Sport and Exercise Physicians	President
Ms	Fiona	**Davies**	AMA NSW	CEO
Dr	Anjali	**Dhulia**	Monash Health	
Ms	Kay	**Dunkley**	AMA Victoria	Doctor Well-Being Advisor
Prof	Liz	**Farmer**	Australian Medical Council	Director & Chair of AMC's Prevocational Standards Accreditation Committee
Dr	Cathy	**Ferguson**	RACS	College Vice President
Dr	Malcolm	**Forbes**	Royal Melbourne Hospital	Psychiatry Registrar
Ms	Sarah	**Foster**	Doctors' Health Advisory Service	Social Worker
Dr	Lev	**Fridgant**	DrHS Expert Advisory Committee	
Dr	Christine	**Gee**	MJA	Senior Deputy Medical Editor
Dr	Vered	**Gordon**	Black Dog Institute	GP Education Development
Dr	Jill	**Gordon**	Doctors' Health Advisory Service (NSW)	Vice President
Dr	Mukesh	**Haikerwal**	CIRQIT Health	Director
Prof	Sam	**Harvey**	University of NSW	
Ms	Georgie	**Haysom**	Avant Mutual	Head of Advocacy
Dr	Joanna	**Hely**	MIPS	Medico-Legal Advisor
Dr	Lynn	**Hemmings**	Postgraduate Medical Education Council of Tasmania	Deputy Chair
Mr	Joe	**Hooper**	AMA SA	CEO
Mr	Warwick	**Hough**	AMA	Departmental Director
Dr	Imre	**Hunyor**	Royal Prince Alfred Hospital Basic Physician Training Network	Clinical Superintendent & Cardiologist
Ms	Siani	**Iglewski**	Australian Indigenous Doctors' Association	Policy and Programs Manager
Dr	Kym	**Jenkins**	The Royal Australian & New Zealand College of Phychiatrists	President
Dr	Gregory	**Jenkins**	RANZCOG	Chair of Training & Accreditation NSW/ACT
Ms	Jenny	**Johnson**	Australian College of Rural and Remote Medicine	Senior Policy and Development Officer

Title	First Name	Surname	Organisation	Position
Dr	Simon	**Judkins**	Australasian College for Emergency Medicine	President-Elect
Dr	Sandy	**Jusuf**	DHAS NSW	Board Member
Dr	Joanne	**Katsoris**	Australian Health Practitioner Regulation Agency	Executive Officer, Medical
Dr	Margaret	**Kay**	Qld Doctors' Health Programme and AMA Qld	Medical Director, QDHP
Prof	Brian	**Kelly**	University of Newcastle	Head of School, School of Medicine and Public Health
Dr	Kairi	**Kolves**	Australian Institute for Suicide Research and Prevention, Griffith University	Principal Research Fellow
Dr	Ashley	**Mackay**	Australasian College of Sport and Exercise Physicians	
Prof	Geoff	**McColl**	University of Melbourne	Head of School
Dr	Ann	**McCormack**		
Ms	Sarah	**Melen**	Australian Medical Students Association	AMSA Mental Health Campaign Team Member
Prof	Con	**Michael**	Medical Board of Australia	Chair, Western Australian Board
Dr	Eliza	**Milliken**	AMA Council of Doctors in Training	
Dr	Stewart	**Morrison**	Victorian Doctors Health Program	Board of Directors
Dr	Andrew	**Mulcahy**	Medical Board of Australia	Chair, Tasmanian Board
Prof	Richard	**Murray**	James Cook University	Dean, College of Medicine and Dentistry
Dr	Frank	**New**	DHAS (Q)	Member DHAS(Q) Management Committee
Mr	Brett	**O'Neill**	Australasian College of Dermatologists	Director, Educational Services
Dr	David	**Oldham**	Doctors Health advisory Service WA	Medical Director
Dr	Shanthi	**Pathirana**	ANZCA	Trainee Committee Chair
Dr	William	**Pring**	AMA	EAC Representative
Dr	Janette	**Randall**	DrHS	Chair
Dr	Raymond	**Raper**	College of Intensive Care Medicine of Australia and New Zealand	Vice President
Dr	Vanessa	**Rogers**	Medical Benevolent Association NSW	MBANSW Councillor
Dr	Antony	**Sara**	ASMOF NSW	President
Dr	Roger	**Sexton**	Doctors' Health SA	Medical Director
Dr	Fiona	**Shand**	Black Dog Institute	Senior Research Fellow
Dr	Peter	**Sharley**	DRS Health Board	Director
Ms	Jaelea	**Skehan**	Hunter Institute of Mental Health	Director
Dr	Dana	**Slape**	Australian Indigenous Doctors' Association	AIDA director
Dr	Linda	**Smith**	RACP	

Title	First Name	Surname	Organisation	Position
Prof	Nicholas	**Talley**	Council of Presidents of Medical Colleges & The University of Newcastle	Chair / Pro Vice-Chancellor, Global Research
Prof	William	**Tam**	AMA SA	President
Ms	Carmel	**Tebbutt**	Medical Deans Australia and New Zealand	CEO
Mr	Gareth	**Thomas**	MIGA	Clinical Risk Coordinator
Prof	Garry	**Walter**	Doctors' Health Advisory Service NSW & ACT	Medical Director
Dr	Christine	**Watson**	Medical Board, Northern Territory	Addiction Specialist, medical member ,NT Branch of NT Medical Board
Dr	Edwin	**Whiteside**	DrHS Expert Advisory Committee	
Prof	Simon	**Willcock**	Macquarie University	Director Primary Care
Dr	Catherine	**Yelland**	The Royal Australasian College of Physicians	President
Dr	Choong-Siew	**Yong**	DHAS NSW	President
Dr	Jeannette	**Young**	Qld Health, Prevention Division	Chief Health Officer and DDG, Prevention Division
Dr	John	**Zorbas**	AMA Council of Doctors in Training	Chair

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National Forum on Reducing Risk of Suicide in the Medical Profession
Pre-reading

Pre-reading is available at:

https://www.doctorportal.com.au/doctorshealth/national-forum-reading/

Essential

1. Kay et al - Developing a framework for understanding doctors' health access: a qualitative study of Australian GPs.

2. Suicide Behaviour Research Lab, the IMV model of suicide.

3. Joiner, Thomas. The Interpersonal-Psychological Theory of Suicidal Behaviour: Current Empirical Status.

Additional

1. Marie M Bismark, Matthew J Spittal, Jennifer M Morris and David M Studdert
   Reporting of health practitioners by their treating practitioner under Australia's national mandatory reporting law *Med J Aust 2016*; 204 (1): 24.

2. Allison J Milner, Humaira Maheen, Marie M Bismark and Matthew J Spittal Suicide by health professionals: a retrospective mortality study in Australia, 2001–2012 *Med J Aust* 2016; 205 (6): 260-265.

3. Scott J Fitzpatrick and Ian H Kerridge Challenges to a more open discussion of suicide *Med J Aust 2013*; 198 (9): 470-471.

4. Robert D Goldney Suicide by health care professionals *Med J Aust* 2016; 205 (6): 257-258.

5. Beyond Blue, 2013. Developing an action plan to support the mental health of doctors and medical students

6. Kunde, Kolves et al Pathways to Suicide in Australian Farmers (example of a psychological autopsy approach).

7. Suicide Prevention Australia – The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia.

8. Melbourne Health newsletter MH connect.

ACN 606 610 440
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9. Resources from the Lifespan project, a suicide prevention research project being implemented by Black Dog Institute.

10. Resources from the Mindframe National Media Initiative which provides access to up-to-date, evidence-based information to support the reporting, portrayal and communication about suicide and mental illness.