

Friday 15 September 2017 – 1000 – 1030

Plenary Session

Mental Health and The Impaired Physician - A Perspective From Occupational Psychiatry

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Psychiatric disorder and transient states of intense psychological distress present significant challenges to medical practitioners, regulatory authorities and the community. The alarming prevalence of psychopathology in junior medical officers is one of a number of manifestations of the problem. This presentation will provide an account of the medical practitioner with impairment arising from mental health problems, from the perspective of occupational psychiatry. By considering the intrinsic impairments emerging from mental illness contextualised to specific demands of medical practice in Australia, this presentation will provide a means of framing approaches to the problem to the benefit of all involved

Friday 15 September 2017 – 1100 – 1230

Suicide / Chronic Illness and Disability

Doctors Who Commit Suicide: Beyond Blaming Workplaces, Training Programs & Regulatory Authorities

Kym Jenkins¹

¹ Victorian Doctors Health Program, VIC, Australia

Background

Suicide is the only cause of death for medical practitioners where mortality rates are greater than for the general population. It is therefore likely that as medical practitioners, at some stage of our careers we will be affected by the suicide of one of our colleagues or classmates.

Objectives

To further understand the factors that cause medical professionals to take their own lives

Methods

As part of clinical audit processes the case files were reviewed of all doctors who had attended a Doctors Health Program for assessment, or had been part of our follow up programs or case managed by the program and known to have committed suicide over past 8 years.

Findings

All who committed suicide were known to be suffering from mental illness, and receiving psychiatric treatment. Some had multiple diagnoses including with substance use disorders.

Whilst most were known to be struggling with fulfilling their role as medical practitioners, their workplaces were largely supportive of their mental health needs. A minority of doctors were under investigation or being monitored by the regulatory authority (AHPRA).

While stress at work, difficulties in negotiating training requirements and conditions upon medical registration were sometimes present, symptoms associated with longer term mental health problems were more likely to be the principal reasons for these doctors suicide

Conclusions

Whilst striving for healthier workplaces, including easing the stress of training, are essential doctors' health endeavours: this study suggests the impact is likely to be a decrease in morbidity, rather than in mortality rates.

Not Falling Apart At the Seams While the Heart Is Hurting: An Organisation's Response to Multiple Suicides

Kym Jenkins¹

¹ Victorian Doctors Health Program, VIC, Australia

The Victorian Doctors Health Program (VDHP) is a small, not-for-profit organisation that was established in 2001 with the purpose of addressing the health needs of doctors and medical students. In any given year VDHP receives up to 250 requests for help; sees around 150 new participants in a face-to-face appointment for triage and assessment of their problems and case manages about 40 doctors who have ongoing mental health or substance use problems.

In December 2014 and January 2015 five doctors who had recently attended or were actively case managed at VDHP died, allegedly by taking their own lives.

This paper explores the effects of these presumed suicides on VDHP as an organisation and the staff who work there.

All staff experienced a profound sense of personal loss. Clinicians questioned and evaluated their own professionalism, whilst being called upon to provide support and counselling to external organisations, hospitals, workplaces and individuals who had been impacted by the suicides.

In order for the organisation to survive, to be resilient and to continue to provide a caring service to its clientele (medical professionals), respect had to be given to the different impact upon individual staff members and their different coping strategies. Internal support mechanisms proved insufficient and external de-briefing and counselling was needed.

The Experiences of Chronically Ill Health Workers In Relation To Work Environment, Peers and Leaders. What Policies Exist To Support These Workers?

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Healthcare workers - medical, nursing and allied health, all play key roles in chronic illness management, but many suffer from their own chronic conditions. The experiences of healthcare workers living with chronic pain and illness (both physical and mental) in their workplace offers an insight into best leadership practices to support workers to not only be more productive, but maintain their ability to work and safely care for their clients. This study was designed to examine previous research on healthcare workers with chronic illnesses, and professional organisation policies covering these workers.

A systematic review of literature on the experiences of chronically ill health workers and their interactions with their work environment, peers and leaders was completed using the PRISMA frame work (Liberati et. al. 2009). Five databases were searched and twelve studies were reviewed. This produced evidence that health workers demonstrate a strong desire to help others, even at the expense of their own health and that the interplay between the worker, task, environment, peers and leadership are crucial to successfully completing their work. The importance of a work/life balance in maintaining health and the need to consider patient safety was highlighted. A search of policies and supports from sixteen professional health worker organisations was completed which showed organisations mostly do not meet the expressed needs of health workers. Most did not have specific policies covering health workers with chronic health conditions. At most, they offered some information and resources on an ad hoc basis, directing the worker to their employer.

This review concludes that too little study has been done on health workers who suffer from their own health problems, and that most professional bodies have given little or no attention to this matter. That leaves a vital workforce unprepared and unsupported for conditions that are likely to become worse.

Improving Access to Medical Education And Employment For Doctors With Disabilities

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In Australia, aspiring doctors, medical students and doctors with a disability face disability bias, indirect and direct discrimination and barriers upon entering the medical profession in comparison to places like the USA and the UK. These are often because of the negative societal attitudes towards disability, lack of professional resources, systemic flaws, inflexible working patterns and unsystematic professionalism within the state medical administration bodies. This has led to further exclusion of people with a medical condition wanting to pursue a medical career.

With the aim of eradicating physical, attitudinal and social barriers, Doctors with Disabilities - Australia (DWDA) was created to provide national advocacy on matters associated with medical students and doctors with a health condition. At DWDA, we centrally focus on the abilities of our members as we believe with adequate and professional personal support and access to medical technologies, our members can become leading healthcare practitioners and strive for excellence. We also believe that knowledge of the human condition and a high level of patient understanding is essential to compassionate care in medicine and as a result, doctors with patient experience can become a valuable asset to the medical field. We believe that a well-coordinated and supportive professional system that encourages equal opportunity for all our members is needed.

Our experienced presenters aim to share and educate the audience on some of the barriers and challenges experienced by our current members and offer reasonable solutions to the problems at hand. Presenters will also be able to share some of their experiences and tell of their personal journey. As a new and emerging organisation, our presenters will also inform you of the objectives and goals of our organisation and highlight some of our promising works.

Friday 15 September 2017 – 1100 – 1230

Medical Student and Junior Doctor Health

Peer-mentoring For Medical Students: Is It Feasible and Does it Provide Support For Those Most At Need?

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¹ University of Auckland, New Zealand

Medical schools are a high pressure environment, and students are known to be at risk of developing depression and anxiety. Alongside this, medical students commonly avoid or delay seeking help from health services if their mental health deteriorates, due to a variety of factors such as stigma and fears about confidentiality. As peers are an available, acceptable and cost-effective avenue for support, peer-interventions are worth exploring. The evidence regarding mentoring programmes in medical schools is mixed, and more research is needed.

This study reports the feasibility of implementing a peer-mentoring programme in one medical school, and analyzes the relationship between students' coping styles, perceived stress levels, and their choice to have a peer mentor or not. Students in Year 3 were approached and invited to be mentors. Mentor training was provided and supervision processes established. All Year 2 students were invited to complete baseline questionnaires to assess levels of perceived stress and coping mechanisms. Data was collected using the Brief COPE questionnaire (which measures different types of coping styles, such as active or passive coping) and the Perceived Medical Student Stress Questionnaire. Participating Year 2 students were asked to identify whether they would like to have a Year 3 mentor or not. Data was analysed to compare the stress levels and coping styles of those who requested mentoring versus those who did not.

The study aims to answer the question: Is it those students most at need who choose to access a peer mentoring programme? Results will be presented and conclusions drawn. The practicalities of the implantation of peer-led programmes will also be discussed. It is hoped that this study will contribute to research into the pastoral care of students, by providing evidence about student self-selection into mentoring programmes. This may assist medical schools with the allocation of support resources.

Medical Students: How Distressed Are They, What Do They Think Causes Them The Most Stress And What Should We Do About It?

Nerissa Soh¹

Garry Walter¹ and Michael Robertson¹

¹ University of Sydney, NSW, Australia

Introduction: Studies suggest that university students display a higher prevalence of mental distress and disorders than population norms. We report the results of a survey of Sydney Medical School students. **Method:** Sydney Medical School students completed an online survey. This included the Kessler-10 (K-10) scale for psychological distress and student demographics, living arrangements, travel time, financial support, self-rated lifestyle stressors, treatment for emotional problems, types of mental health services accessed, thoughts of dropping out of studies, and what services they believe the university should provide. **Results:** 497 graduate medical students completed the K-10. 37.3% had K-10 scores of 22-50, indicating high or very high levels of distress. In contrast, in 2014-15, only 11.7% of the Australian general population had high or very high levels of distress. Multiple linear regression revealed female gender, being an international student, younger age, living in rental accommodation and longer travel times were associated with greater psychological distress. 48.9% of respondents rated study and examinations as very or extremely stressful, followed by financial concerns (38.1%). The most popular services accessed were GPs and university counsellors, followed by private psychologists. 104 students had considered dropping out of their studies: the most frequently reasons were financial (29%), doubts about choosing medicine (17%) and depression (15%). The most common suggestions regarding services were that services be better advertised, more financial assistance and more administration support. Access to services, (cost and time) were highlighted. **Discussion:** Although commuting time and type of accommodation were associated with K-10 scores, these were not as frequently endorsed as stressors by the students themselves, suggesting that these are factors that have a high impact on a smaller number of students. Affordable accommodation near the site of study and better access to financial and counselling services should be considered.

Student Support For Professional Practice: The Joint Medical Program Approach To Identifying And Meeting Students' Well-being Needs

Rosemary Aldrich¹

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³ University of Adelaide, SA, Australia

Strategies to promote the health and wellbeing of medical students are gaining importance across medical schools with recognition that one's own health needs are important considerations in the medical profession. Some students struggle with the demands of consistent self-directed learning, unmoderated group work, adapting to the demands and expectations of clinical roles, managing concurrent personal health problems and life stresses, and for some, being away from family and community networks. Unaddressed, these problems can translate into disengagement (manifesting as poor attendance or low participation), worsening of physical and mental wellbeing, professional concerns, and poor academic achievement.

The Joint Medical Program (Universities of Newcastle and New England) Student Support for Professional Practice (JMPSSPP) framework was developed in 2012-2013 and aims to identify such students and offer individualised support by senior staff to return them to levels of wellbeing to achieve their best. Since launching, over 80 students have been supported (referred by self or others). The majority (51%) of referrals were due to health-related matters, followed by personal issues (30%) and professional behaviour concerns (19%). Incorporating student feedback about the process has contributed to an increase in uptake by students. Student experiences have been instructive: where previously a student might have managed to just pass in their early years with their progress halted only in their senior years, the framework enables such students to be identified early enabling support for the student to positively meet requirements (for most) or consider other academic options.

Challenges in implementing the framework include overcoming initial student reticence to seek or accept support, keeping the roles of coordinators and direct supervisors separate from support roles, and ensuring that framework remains responsive to students needing support. The JMPSSPP framework is part of a range of measures in the JMP designed to graduate competent, healthy doctors who understand the critical importance of seeking support when needed for the duration of their professional career.

Building Medical Student Resilience

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¹ School of Medicine Sydney University of Notre Dame Australia, NSW, Australia

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The imperative for medical students to maintain mental health and wellbeing was emphasised in *beyondblue* National Mental Health Survey of Doctors and Medical Students. The report's findings that: "medical students reported higher rates of general distress and specific mental health diagnoses in comparison to the Australian population" led to recommendations that an education curriculum focusing on positive coping strategies and stress minimisation techniques would assist in building medical student resilience.

Whilst medical students at the University of Notre Dame Australia, School of Medicine, Sydney, (the School) have access to specific School based services to assist with their mental wellbeing, the *beyondblue* report suggested that barriers around stigmatisation and confidentiality existed to dissuade medical students from seeking such assistance. The School determined, in consultation with the Discipline of Psychiatry, to introduce a stepped Wellbeing Program (the Program) that focused on positive coping strategies and stress minimisation techniques integrated into the Personal and Professional Development Domain curriculum.

The first phase of the Program has been introduced into Year 1 in 2017 and consists of three small group interactive tutorials and two 'Contemplative Medicine' workshops. The first tutorial considers stress in everyday life and how it affects students personally. Students are introduced to the K10 assessment tool. The second introduces students to a range of self-driven strategies to combat stress and the third tutorial discusses lifestyle changes to promote wellbeing and avoidant behaviours to minimise stress in order to build resilience. The contemplative medicine workshops teach contemplative mediation and mindfulness techniques and align the evidenced based benefits of these practices to clinical practice through the use of clinical anecdotes.

The program will undergo quality evaluation and be incrementally embedded across the four year course. Thus the School has taken up the challenge of implementing curriculum based positive steps to promote medical student wellbeing.

Development And Impact Of An Integrative Wellness Program In Medical School

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¹ University of Notre Dame, Fremantle, WA, Australia

² Notre Dame University, WA, Australia

Background: In response to the evidence medical students have greater mental health issues than other students, the Notre Dame School of Medicine (ND SoM), Fremantle, introduced focused awareness of, and specific training in self-care, in the form of a physician wellness program - ESSENCE+ - in the 2014 academic year. This integrative mindfulness and lifestyle program aims at improving the wellbeing of medical professionals at the outset of their careers.

Aim: To describe the development of the ESSENCE+ program at the ND SoM, its acceptance by students and the effect of the mindfulness based stress reduction component on their psychological health.

Methods: The ESSENCE+ program has been evaluated on a yearly basis by a voluntary online survey of the students and specific paper questionnaires. The latter included information on the students' enjoyment of, interest in and usefulness of the program in all 3 years. In addition, in 2016 students completed valid questionnaires measuring their stress, resilience and compassion before, immediately after and 5 months post the 8 week program.

Results: Evaluation of the program over the first 2 years revealed it had evolved in a positive direction. Preliminary analysis of the 2016 program outcomes revealed a significant positive impact of the ESSENCE+ program on students' ability to cope psychologically with the stressors of medical school with a decrease in stress and maintenance of resilience and compassion immediately post program. These benefits were not maintained 5 months post program.

Conclusions: It is possible to implement a mandatory mindfulness based wellness program in the first year of a post-graduate medical curriculum that is well accepted by the students and has positive measurable impacts on their psychological health in the short term. Further research is required to determine ways to improve the impact of the program in the longer term.

Friday 15 September 2017 – 1100 – 1230

Workshop: Bullying and Harassment

Tackling Bullying And Harassment In Medicine: Empowering Tomorrow's Doctors

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BACKGROUND

Bullying and harassment in medicine has been a focus of the medical literature, professional colleges and a recent Senate inquiry. The impact of bullying has been well-documented; including the personal impact (including depression or suicide), the economic cost to the organisation and the impact on patient safety.

While solutions include 'cultural change', effecting sustainable cultural change is complex. Junior doctors have already demonstrated their leadership and determination to make a difference, yet they are often the target of bullying.

AIM

This workshop is designed to assist junior doctors to better identify and understand bullying, to learn to manage their experiences of bullying and to become professional advocates to support solutions for the future.

METHOD OF INTERACTIVE ACTIVITIES

A review of the current literature on bullying and harassment in medicine and acknowledging recent national reports/position statements will inform this workshop. The summary of evidence will focus on junior doctors and lead into a presentation on the neuroscience of bullying.

After this, a series of narratives will stimulate interactive discussion within small group discussions designed to enable junior doctors to clearly define bullying and articulate effective processes to reduce the prevalence and impact of bullying. Specific strategies to help reduce the personal impact of bullying will be demonstrated and practiced. Participants will be encouraged to determine practical ways to integrate these positive strategies into their workplace.

ANTICIPATED OUTCOMES

This workshop is designed to assist junior doctors to thrive in a safer and healthier work environment while improving patient safety. The presentation of new knowledge and experiential learning will help junior doctors develop strategies in a safe environment that they can readily adapt to their workplace. This approach is consistent with current doctors' wellbeing initiatives with a focus on the practicalities when working at the coalface, while acknowledging the importance of advocacy.

Friday 15 September 2017 – 1400 – 1530

History and The Humanities / Free Papers

The Literary Cure- Prescribing The Humanities

Karen Fisher¹

¹ NBMLHD, NSW, Australia

There is a new style of prescribing, celebrated fictionally, practiced by literary apothecaries, subject of numerous podcasts and writers festival stages. Practitioners use literature to address ailments unlikely ever to be the target of a drug launched by pharma, but which are nevertheless intimately connected to the diseases linked to blockbuster drugs. Prescriptions are suggested for loneliness, for heartbreak, for insomnia or existential angst. The emergence of this new job, is simply the latest evidence for the superb preparation an education in the humanities is for a career in medicine. The uses of literature, history and philosophy in clinical practice are valuable tools for patient care, student teaching and a doctors own professional development Graduate entry into medicine allows "the road less travelled", that of the Arts degree. From the relief and joy physicians who maintain Chekov's mistress and wife arrangement provide, the creation of a book club to help drug dependent patients imagine new narratives of recovery and resilience, to the use of literary prescription to help students, interns and residents as they journey towards their maturity as doctors, the humanities aid, sustain and enhance clinical work.

The use of literary prescription for students and junior clinicians provides an excellent structure for embedding mentorship and pastoral care. It allows different ways and strategies to be rehearsed for their potential usefulness for infinite situations. The books are a topic for discussion of things outside medicine, encourages and embeds reflective empathy, as well as personal connection in a profession with a disturbing habit of moving the most junior and vulnerable members to a bewildering range of new horizons, disrupting their capacity to access supports. Neuroimaging illustrates reading can promote empathy, a signal that perhaps the use of the literary prescription, could result in better doctors.

Health Care Serial Killing: An Unrecognised Hazard To Patients

Robert Kaplan¹

¹ RANZCP, NSW, Australia

Health Care Serial Killing [HCSK], which receives little attention, constitutes a small but significant threat to patients. HCSK was first documented in the United States, then Europe. It is the phenomenon of deliberate killing of patients by health care personal - usually nurses, aids or other workers; doctors constitute a separate group. The victims of HCSK are the most vulnerable, chiefly the aged in nursing homes, where death of a patient is not regarded as unusual or investigated. The killers are often dysfunctional personalities who move from one workplace to another. They react poorly to criticism and often kill patients who complain about them. Alternately, they may impress their colleagues with their apparent concern for their patients.. Death are only detected when excessive numbers on certain shifts arouses comment. It proves difficult to confirm, especially when the victims have been cremated. HCSK has now reached Australia with at least 3 documented cases. Further cases are certain to follow. The new generation of doctors and nurses needs to be trained to consider HCSK in all patient deaths and take necessary steps when suspicions are aroused.

From Saint Marcus Welby To Dark. Twisty Meredith Grey : Representations Of Doctors And Their Health

Karen Fisher¹

¹ NBMLHD, NSW, Australia

From the Hippocratic Oath, to latter day expositions crafted by Colleges, the quest to define what it means to be a doctor is constantly under revision. How we embody ourselves as doctors is fluid process of creation, involving individual temperaments, expectations of our peers, the society we practice within, the characterisations of the roles we assume. We list mentors, influences and our vocational dreams when we or the public reflect on who or what processes fashion a "doctor". In an increasingly media rendered world, with our narratives of ourselves combine public persona, social media appearances, the professional stories and biographies crafted for constant display, interrogating the dialectic of the public medical self and the media medical self, yields a unique lens by which to examine how the media helps embed our understandings of how healthy doctors are.

From radio serials, to film, television to social media, doctors and their worlds are a constant feature. Using the shift from the early male, paternal, all knowing doctors Finlay, Welby to the dark and twisty Meredith Grey, the tragic but eternally resilient Nina and the eponymous perfect doctors filmed in reality documentaries, the challenges to supporting a universal understanding doctors can, do and will battle illness, will be discussed. What is the role of media depictions of doctors in helping beginning the relegation of the notion of doctors and illness to the shadows, functioning only as the silent, hidden Other? What stories and narratives should media begin to tell to help stem the morbidity and mortality of our peers? What potential exists within emerging new story forms, for example the "real life documentary" to help us shift the silence around doctors health?

Doctors In Trouble: Doctors' Experience Of Complaints Against Them

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¹ University of Sydney, NSW, Australia

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When doctors have a complaint against them, many suffer emotionally, physically and psychologically. Some find it helpful to have professional support, some prefer to handle it by themselves, and others rely on their partners, a close friend or a trusted colleague. For many, the feelings linger for several years beyond the matter being finalised.

At the previous Doctors Health conference in Melbourne, I introduced my doctoral study into why complaints hurt so much. Now, two years later, I will present what I have found from my in-depth interviews with doctors who have experienced complaints, and some experts who provide professional support to doctors. Interviews examined the views and experiences of participants about the process itself, what they found stressful, what helped them through it and what made a difference for them.

Doctors spoke of the sense of threat to their sense of self, identity and reputation. Not feeling like one of the "bad guys", many said the process made them feel guilty, of having to prove themselves innocent. Uncertainty about their competence and commitment to medicine can be unnerving, and may affect how they view their future. Many recognised that they felt disturbed and unsettled, and often made decisions about patients based on fear and protectiveness: for themselves not for their patients. Having doctors who are distracted and even unwell is not good for doctors, patients, health care teams and the health system.

This paper presents what makes a difference to doctors in recovering some sense of self-worth and certainty during and after experiencing a complaint. Accepting that there must be a robust system for dealing with complaints as an integral part of public protection, the challenge is how to mitigate the inadvertent harm to doctors who are the subject of complaints. These findings will play some part in meeting this challenge.

ADHC at The Intersection

Mervyn Lander¹

¹ DHAS. RACS. Anglican Church, QLD, Australia

In daily life we live the perceived realities of multiple identities. A more holistic perspective of identity can be achieved by studying their intersections to help answer the question "who am I"?

As members of DHAS, we specifically embody the identities of DOCTOR, HEALTH, (its social determinants), ADVISOR (competence and compassion) SERVICE (as servant). Only these four identities will be considered. Our identities interact on multiple and often simultaneous levels. A visual image of the metaphor "intersectionality" is provided by a four circle Venn diagram, which visualizes their overlapping and interdependent natures.

Each of these four identities will, firstly, be analysed using the lenses of reflection and reflexivity, which will also identify categories of discrimination, disadvantage, privilege, and contradictions. These identities will then be refined and distilled in dialogue at a "conversation table."

The revelation of this identity at the intersection, "who I am", underpins all the four named identities.

Intersectionality can be used to examine the complexity of group identities e.g. DHAS, but I have chosen to begin with myself. Many other groupings of personal identities of the self are possible, but in this presentation are limited to DOCTOR, HEALTH, ADVISORY. And SERVICE.

Friday 15 September 2017 – 1400 – 1530

Late Career Issues

Late Career Medical Practitioners: Gender And Other Factors Associated With Psychiatric Morbidity, Successful Ageing And Intention To Retire

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Late career doctors tend to experience better psychological health but face other challenges such as the risk of cognitive impairment and transitioning to retirement. We have recently published research suggesting that more than a third of doctors surveyed were unsure about when or if to retire. What are the pros and cons of staying on at work? Implicit to decisions about continuing to work or whether to retire is the issue of successful ageing. This presentation examines three themes relating to successful ageing specifically amongst medical practitioners: our first paper defines differences between personal and occupational successful ageing; the second paper examines gender differences; and the third explores the relationship between successful ageing and retirement intentions. Our first presenter defines successful ageing and outlines why it is relevant to medical professionals. Can it be measured and does differentiating between personal and occupational successful ageing matter? What can research teach us about future challenges at an individual and professional level? Men and women differ in terms of their definition of successful ageing, their participation in protective behaviours and self-reported capabilities. Our second presenter explores reasons why men and women report similar occupational successful ageing but women report higher personal successful ageing. These differences are explored and potential explanations provided and recommendations presented to promote personal successful ageing equally amongst men and women. The third paper explores predictors of retirement intentions. What are the trends amongst medical practitioners and how does it differ to other professions? Is it possible to better plan and prepare and what gets in the way? How does the timing about when and how to retire later influence retirement adjustment. Possible interventions to promote retirement planning are explored.

Gender Issues and Ageing for Doctors

Chanaka Wijeratne¹

Carmelle Peisah²

¹ DHAS, NSW, Australia

² UNSW, NSW, Australia

An understanding of ageing and its impact on the health, well-being and practice of medical professionals has been a subject of discourse for over 20 years. Much of this discussion has focused on impairment, and much of the interest has been by procedural specialists. Increasingly however, the relevance of this issue to all practitioners has become evident. Moreover, the concept of professional successful ageing has been mooted. Given the huge heterogeneity in the biopsychosocial and professional contexts of doctors, any approach to successful ageing must be individualised and person-specific. Of all the myriad determinants of the ageing experience amongst doctors, the contribution of gender remains unknown. This presentation will explore some of the gender-based findings from our large empirical study of 1048 doctors aged 55+, and some of the reasons for and implications of such findings.

Friday 15 September 2017 – 1400 – 1530

Workshop

The Healer's Journey

David Kopacz¹

Hilton Koppe²

¹ Puget Sound Veterans Affairs, Seattle, Washington, USA, WA, United States

² Lennox Head Medical Centre, QLD, Australia

As medical practitioners, we undergo extensive training to assist us in being able to provide the best possible care for our patients. This is a privileged and rewarding career path. But this journey puts us at risk of burnout and compassion fatigue. We may lose our way or become cynical.

How can we address the human costs of caring for others? How can we sustain ourselves as we seek to sustain others?

Joseph Campbell, studying mythology, coined the term "Hero's Journey". This journey involves the crossing of a threshold into a new reality or culture. Finding mentors. Facing challenges. Descending into an abyss. Heroic struggle. Finding our gifts. Reconnection with goodness. And finally, The Hero returns to society a transformed person, with the ability to transform others.

This framework can be adapted as a "Healer's Journey". A journey of developing skills. Finding mentors. Facing challenges. Losing hope. Struggling to regain hope. And ideally finding what sustains us in our close proximity to people facing death, disease and madness. So that we may help to sustain them.

This interactive workshop will examine the principles of the Hero's Journey and how they apply to healthcare professionals' own Healer's Journey. Participants will identify where they sit in their own journey and develop strategies for moving forward. We will explore how different storylines about ourselves and our work can sustain us or drag us down.

By the end of the session, participants will be able to:

1. Explain how the principles of the Hero's Journey parallels the Healer's Journey
2. Identify where they may be sitting in their own Healer's Journey
3. Develop strategies to assist them in moving forward through their Healer's Journey

Friday 15 September 2017 – 1600 – 1700

Free Papers

Circle Medicine: Good For The Clinician, Good For The Client

David Kopacz¹

¹ Puget Sound Veterans Affairs, Seattle, Washington, USA, WA, United States

Circular conceptualisations of medicine are holistic, collaborative, and promote health and wellness for clinician and client alike. The linear model of medicine that we currently practise often leads to clinician burnout and patient dissatisfaction.

This presentation will look at models of circle medicine that we are using in Primary Care Mental Health Integration at Puget Sound Veterans Affairs, Seattle, Washington, United States.

Circular models of medicine were the norm before the rise of technology-based medicine and these models are enjoying a renaissance with the focus on holistic, integrative, and patient-centered models of care. I have been working with Native American healer, Joseph Rael (Beautiful Painted Arrow) of the Southern Ute tribe. Joseph describes the circle of the medicine wheel as including the outer directions of north, south, east, and west; and the inner directions of spirit, emotion, mind, and body. This is similar to other indigenous models of holistic health, such as the New Zealand Māori *whare tapa wha*, or four-sided house model.

The team I work with in Seattle has been working with what I call the "VA medicine wheel." The national VA Office of Patient Centered Care & Cultural Transformation is fostering a revolution in the way medicine is practised by shifting to a model that is "personalized, patient centered, and proactive." They have developed a graphic called the "Circle of Health." Our team has adapted this circle, with its eight different domains of health, into a class for veterans. We have run this class for patients and staff for health and wellness. We have found that teaching health promotion to veterans encourages us to think about our own health. Combining motivation, inspiration, education, mindfulness, and health coaching, this class has proven to be fun and rewarding for staff and clients alike.

Mental And Physical Health Of Early To Mid-career Doctors In Hong Kong: A Cross-sectional Study

Weng Yee Chin¹

Julie Chen¹, Karina Chan¹, Eric Wan¹, Lap Ki Chan¹ and Lau Chak Sing¹

¹ The University of Hong Kong, Hong Kong

Background

Literature has shown that early to mid-career (1-20 years post-graduation) is the time of greatest stress and burnout for medical professionals. This has significant implications from both individual wellbeing and quality of care perspectives.

Summary of Methods

A cross-sectional survey study was conducted on HKU MBBS graduates who graduated from 1995-2014. SoGoSurvey, was engaged to undertake the survey to ensure the respondents remained anonymous. Graduates who could not be contacted via email were sent a postal survey to their registered workplace address. Survey instruments included the Copenhagen Burnout Inventory, SF-12V2, PHQ-9, a single item screen for suicidality and items on physical health and preventative health behaviors, professional satisfaction, career choice and socio-demographic details. Findings were compared with age-sex matched HK general population data.

Summary of Results

496 graduates completed the survey with an overall response rate of 31.0%: 45% were female; mean age was 34.1 years, mean working hours was 54.1 hours/week, 77.7% worked in the public sector; 35.6% worked in primary care. Prevalence of depressive symptoms (PHQ-9 score >10) was 15.5% in males and 15.6% in females. Prevalence of burnout was 62.7% (personal) 56.4% (work) and 35.3% (client). 14.1% reported that they had considered life not worth living in the past year. Mean SF-12v2 physical component score was 53.2. Mean SF-12v2 mental component score was 43.8. Suboptimal lifestyle and poor preventative health behaviors were reported. Univariate regression analysis found that younger age, longer hours worked and working in the public sector was associated with poorer mental component scores.

Conclusions

Although physical HRQOL was better than the HK general population, mental HRQOL was poorer. Prevalence of depressive symptoms and suicidal ideation were also higher than the general population. Shorter working hours and better support for doctors working in the public sector may help enhance the HRQOL of younger doctors.

The Path To The Initiated Ego And The Visionary Physician

Brian Stafford¹

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Context/Background: Professionals are "burning out," physicians perhaps more than any other profession. Our techno-industrial growth culture is shutting down the major life systems of the planet. Our self-autonomy decreases every day, even as we learn more and more of our inter-dependence. (i.e., how and why was the study/perspective developed? We must develop a more mature culture. We need a more mature profession. A more mature society and profession requires more mature individuals. This call to maturity requires a re-visioning of an individual's life beyond "to do no harm" and "to love and to work." A novel and profound model, called the Eco-Centric Developmental Wheel, has been developed by Bill Plotkin, PhD. and is the best map of optimal human development, as well as a design tool for creating healthy human communities. The presenter has adapted this map with the educational, training, and practice of Western physicians in mind.

Findings/Results: Most physicians are trained to stall out in their development and to live a patho-adolescent existence. The wheel helps physicians, physician health programs, and administrators identify suitable developmental tasks in order to become eco-centric and, eventually, visionary physicians. Common barriers to a more mature physician include unfinished developmental tasks, lack of Wholeness of the Self, lack of healing of the Self, and lack of guides pointing to the Stage of development leading to the visionary physician.

Conclusion: There are two phases of burning brightly in a physician's life. The first is an early career "fire". The second comes from a psycho-spiritual journey to become a visionary healer. Avoidance of the second journey also leads to burn-out. Like most Westerners, physicians find themselves living an ego-centric existence, even in the midst of being in the "sacred helping profession." The Eco-centric developmental wheel identifies the possibility of movement toward the visionary physician as well as the tasks toward that place of visionary service and joy.

Friday 15 September 2017 – 1600 – 1700

Program Development

Developing A Mentoring Program For Doctors In Training

Kay Dunkley¹

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AMA Victoria commenced a pilot mentor program for doctors in training in November 2015. This pilot was successful and the program is now being offered to members of AMA Victoria.

The program is run independently from health services and training colleges. The purpose of the mentoring program is to provide a supportive and safe format for mentees to think about, and to respond to career and professional development opportunities and challenges through engagement with a trained and facilitative mentor. All mentees and mentors are inducted into the program and in addition the mentees and mentors are provided with the opportunity to participate in professional development activities.

Mentors are chosen on the basis of:

- A genuine desire to give back to junior colleagues.
- Adequate experience as a doctor in the Australian health system.
- Good general communication and listening skills.
- Potential leaders/educators.
- Current AHPRA registration.
- AMA Victoria Member.

Mentees are chosen on the basis of:

- Having a clear view of what they would like to achieve by being involved in the mentoring program.
- Proactive and keen to actively work on managing their careers.
- Working as a doctor in training from second year onwards.
- Current AHPRA registration.
- AMA Victoria Member.

The matching process considers:

- Training pathways.
- Alignment of what a mentee is seeking with what a mentor is offering.
- Geographical location (not a key feature).
- Gender preference (when requested).
- Absence of potential conflict of interest.

Mentoring partnerships continue for a period of 12 months. There is an expectation that the mentoring pair will communicate every month. Communication includes face-to-face meetings, Skype, telephone and electronic communication.

The program has been well received and there have been some very successful matches. A mentoring platform has now been introduced to facilitate communication between all involved and to streamline administration.

'The Wounded Healer': An Anti-stigma Programme Targeted At Healthcare Professionals And Students

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¹ Leeds and York Partnership Foundation Trust, United Kingdom

² Bedfordshire Centre for Mental Health Research in Association with Cambridge University, United Kingdom

Introduction: Shanafelt et al conducted a systematic review and meta-analysis revealing that physician burn-out has reached epidemic levels. Doctors with psychological problems, however, have low-levels of care seeking and many continue to suffer in silence despite the availability of effective treatment. Mental health stigma has been reported by doctors and medical students to be a major barrier to engaging with mental health services.

'The Wounded Healer' (TWH) is an innovative method of pedagogy that blends the performing arts with science that was conceived by an RCPsych award-winning doctor with first-hand experience of psychological distress. The main aims of TWH are to engage, enthuse, enthrall and to educate to debunk myths, challenge stigma and encourage care-seeking.

Background: TWH has been delivered to more than 50,000 people in 11 countries on 5 continents worldwide and has been integrated into the medical school curricula of 4 UK universities. Filmmakers from the University of London have also produced the Wounded Healer film which has been submitted to film festivals worldwide.

Methods: We conducted a cross-sectional, mixed-methods study on participants who attended TWH in venues across the UK. Paper questionnaires containing stigma constructs with response items on a Likert-scale were hand distributed to participants. Free-text comments were subjected to thematic analyses.

Results: 219/256 participants recruited responded (85 % response rate). 207/219 (94 %) of respondents agreed or strongly agreed that TWH made them realise that medical students and doctors who experience mental distress can recover and achieve their goals.

Themes that emerged from analyses of free-text comments included, 'Inspirational', 'Merits of blending the performing arts with science', and 'Benefits of receiving a talk from a doctor with first-hand experience of a mental health problem'.

Discussion: Our findings suggest that TWH might be effective at reducing stigma from healthcare professionals and students towards their peers with mental health problems. More robust research in this area is needed.

Metro South Health Doctors' Wellness Program

Lynette Fergusson¹

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Background

Metro South Health (MSH) established an overarching research program to enhance the health and wellbeing of doctors working for MSH. A suite of educational interventions were implemented designed to improve doctors' self-management of their health and understanding of the health access pathways available.

Interventions

Interventions included: Resilience training for interns; Working with Royal Australasian College of Surgeons (RACS) to address bullying and harassment issues; and Developing an App to support doctors to maintain their health and wellbeing.

Outcomes

Five resilience workshops were situated within routine intern education sessions, with 64% interns participating. Initial evaluations found that workshops were well-received for their evidence-base, raising awareness of burnout and mindfulness practices.

MSH are implementing the RACS 'Action Plan on Building Respect and Improving Patient Safety'. Surgeons at one MSH hospital have signed a public pledge board committing to stamping out bullying and harassment to enhance the surgical workplace and improve patient safety.

Vigeo is an App, launched December 2016, and designed as a unique solution to facilitate doctors' access to a variety of doctors' health resources. It offers 'at your finger tips' self-assessment tools, ready reference information on health including healthy lifestyle as well as help options when doctors are distressed. Initial promotion has been to interns and junior doctors with 411 visits with 2,554 pageviews with popular pages being 'looking after yourself', 'looking after your mental health' and 'looking after your physical health'.

Discussion

These interventions demonstrate MSH's organisational response to improve doctors' wellbeing. MSH has engaged meaningfully with the medical workforce to develop these interventions, which provide practical strategies to support a positive cultural change that facilitates doctors' access to

healthcare for themselves and enables them to support their colleagues. Further research will evaluate these interventions and help identify additional organisational responses.

Friday 15 September 2017 – 1600 – 1700

Workshop

Medico-legal Disease

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A doctor's involvement in medico-legal matters, particularly claims or complaints against them, can have a significant impact on their own health.

This 'medico-legal disease' can have devastating effects on a doctor's confidence, relationships, physical and mental health, and even on their care of patients.

These effects don't necessarily end when a matter resolves. The disease can become chronic and, in some cases, doctors have walked away from medicine or even committed suicide.

Medico-legal disease does not necessarily have a cure. However, there are a variety of 'treatments' to reduce its incidence, severity and length. Using these can go a long way to preserving a doctor's health, confidence, relationships and the contribution they make to the community.

This session will examine:

- Why there is a link between medico-legal matters and ill-health
- How medico-legal matters and ill-health can affect patient care
- medico-legal disease risk factors - personalities, matter types and circumstances
- Where doctors have responded well, and where they have not responded as well, to medico-legal disease risk factors
- Where systems and processes get things right, and where they get them wrong - the roles of regulators, workplaces, judicial bodies and other decision-makers
- where various 'stakeholders', such as family, friends, peers, supervisors, other colleagues, medical defence organisations and professional associations, can make a positive contribution to supporting doctors at risk of medico-legal disease, and those going through it

- The rights and wrongs of reducing the incidence, severity and length of medico-legal disease and its effects

Saturday 16 September 2017 – 1100 – 1230

Addiction / Dentistry

Managing Doctors Well

Stephen Jurd¹

¹ RANZCP, AChAM, NSW, Australia

Managing Doctors Well

Stephen Jurd FRANZCP FACHAM

Director of Postgraduate Training in Psychiatry, NSLHD and

Clinical Associate Professor, Discipline of Psychological medicine, University of Sydney

Alcohol use disorder is a high prevalence disorder in western society, with a lifetime prevalence of the order of 20%. Large numbers of Australian doctors will encounter this problem during their careers. This presentation will outline the variety of approaches that have been and are being used to address this issue and the adjacent issue of other substance use disorder.

Study of effective programs for doctors with substance use disorders has found that these programs can produce excellent results that are unprecedented in the field of addiction treatment. The key components are careful monitoring, contingency management, use of residential treatment, embracing an abstinence goal, extensive use of 12 step programs and acceptance of addiction as a lifelong illness.

The variety of programs available to doctors in Australia will be reviewed. Suggestions will be made as to how we can move towards world's best practice.

Lessons From An Established Programme For Pilots With Addictions

David Powell¹

¹ Virgin Australia Airlines, NSW, Australia

As professional groups, pilots and doctors share a number of characteristics. In the USA the programmes for managing substance use disorders in these two groups have recovery rates much higher than those for the general population. From a background of involvement with the groups established for pilots in the USA, Australia and New Zealand, this discussion explores the question of whether there are useful lessons from the recovery programmes established for pilots (which are at an early stage in Australia) - issues in common, issues in contrast, and potential for some cross-pollination between them.

Dentist Wellbeing In Nsw And The Act. An Exploration Of Factors Affecting Practitioner Health And How The Ada Nsw Support Model Assists In Lessening Their Impact

Craig Brown¹

¹ Australian Dental Association NSW, NSW, Australia

In considering factors which impact the health and wellbeing of practitioners there are many which are constants across the health care spectrum. Others are specific to particular fields and this presentation focuses on those pertinent to dentistry. The Australian Dental Association (ADA) NSW Branch Advisory Services is uniquely placed to offer an insight into those issues which affect the wellbeing of dentists in NSW and the ACT. Matters of concern will vary depending on the particular environment in which a dentist delivers their services and may include any or all of the following (noting the list is neither comprehensive nor exhaustive):

- Clinical and technical considerations,
- Professional isolation,
- Musculoskeletal challenges,
- Administrative and employment factors,
- Competitive pressures,
- Regulatory imposts, and
- Management of patients and their expectations.

Many dentists who contact ADA NSW Advisory Services do so in high stress circumstances such as situations of clinical failure or misadventure, patient dissatisfaction, receipt of a formal complaint from a statutory authority or notification of legal action against them. Advisory Services provides a model of practitioner support which is unique in health care (and even within dentistry in Australia) and is highly reassuring for dentists at what is often an emotionally challenging time. This presentation explains the genesis and evolution of the model and reports on current utilisation levels and feedback from users. The perceptions and comments of the advisors providing the service are also included and are particularly instructive.

A Hand Up Not A Hand Out

Meredith McVey¹

John Fletcher², Cooper Diana², Dominic Barboro³ and David Chen¹

¹ Medical Benevolent Association of NSW, NSW, Australia

² Victorian Medical Benevolent Association, VIC, Australia

³ Victorian Medical Benevolent Association, NSW, Australia

The Medical Benevolent Associations in Victoria (VMBA) and New South Wales (MBANSW) have a wealth of experience in assisting, doctors, medical students and or their families to recover from crisis situations.

It is a fallacy to believe that doctors are somehow immune from the personal crises that affect many of their patients.

Doctors do get sick, doctors do become unwell

The VMBA and MBANSW provide the support to enable many doctors to return to the workforce.

Our experience over the years has shown us we achieve better outcomes when we work in collaboration with service providers and clients to identify the resources needed to maximise the possibility of returning to work.

This presentation will share with you 4 short case studies which demonstrate our experiences of how a "hand up approach" has assisted a number of doctors to return to the workforce to use the knowledge and skills they have spent years acquiring.

Although both organisations are funded differently they have a common goal, and that is relieve hardship and distress in a time of crisis for individuals and or their families.

Saturday 16 September 2017 - 1100 – 1230

Medical Student and Junior Doctor Health

Strategic Approach To Student Wellbeing – College Of Medicine And Dentistry, James Cook University

Teresa O'Connor¹

Simone Ross¹

¹ College of Medicine and Dentistry, James Cook University, QLD, Australia

Student wellbeing across the tertiary sector has been receiving national attention with the development of A Framework for Promoting Student Mental Wellbeing in Universities through an OLTC grant (www.unistudentwellbeing.edu.au). Since its inception in 2000 the College of Medicine and Dentistry at James Cook University has had an evolving active approach to supporting medical student wellbeing. It currently incorporates several strategies:

1. Providing specific support systems to the student body e.g. home group program for Years 1-3 in the 6 year program, mindfulness training for Year 1 students and a student-led mentor program for Year 1 International students.
2. Informing students about support systems early in the first year and reminding students of these systems through the ensuing years.
3. Identifying students at risk through attendance and submission of assessment and other requirements records, and via referral from home group facilitators and other staff. Students are able to self-refer and many do following information sessions about support system available. Our experience has been that poor submission of assessment and poor attendance are often markers of students whose wellbeing is at risk.
4. Early intervention with students identified as at risk and referral to appropriate services by Academic Advisers who provide both academic and pastoral support available to all students across the multiple sites.
5. Monitoring the students at risk by Academic Advisers.
6. Using student feedback to inform the programs of study and support systems with student involvement in various committees of the College and regular meetings between student groups and College staff.

Evaluations of the academic support systems, mindfulness pilot program and the home group program demonstrates the positive impact of these programs and has enabled the programs to be responsive to the needs of students.

Mental Health Education In Medical Schools

George Joseph¹

Garry Walter²

¹ University of Sydney, NSW, Australia

² Doctors' Health Advisory Service, NSW, Australia

Mental health problems affecting medical students and doctors constitute a serious problem that is attracting increasing attention. Within medical school curricula, there appear to be various approaches that have been adopted by the different medical schools to raise awareness about mental health issues affecting students and doctors. To date, these approaches have not been systematically surveyed, nor analysed to determine their effectiveness. This presentation identifies medical schools in Australia and overseas whose curricula include education on mental health or wellbeing for medical students and doctors. It also describes the educational material provided about student and doctor health, including common themes among the universities. This would include when in the medical course such teaching occurs, the number of hours per teaching block where mental health education is provided, the type of teaching (lecture, tutorial, workshop, other), and resources to support students with mental health problems. Lastly, the presentation describes the pathways and sources of help for medical students experiencing distress and/or mental health problems.

My Health – A Doctors' Wellbeing Survey

Margaret Kay¹

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¹ Qld Doctors' Health Programme, QLD, Australia

² Metro South Hospital and Health Service, QLD, Australia

BACKGROUND

While concerns about the health of doctors have been raised in the literature for decades, the 2013 beyondblue survey brought these concerns into sharp focus. Understanding how relevant the national data is to a local hospital and health service can enable local responsiveness.

METHODS

After ethical clearance, an anonymous electronic survey was sent to all doctors in Metro South Health. The survey included validated tools (K10 and ProQOL) focusing on physical and mental health. Three questions encouraged free text responses.

Quantitative data analysis considered relationship between key demographic factors and health variables. Qualitative data were analysed using inductive thematic analysis.

FINDINGS

A response rate of 17% was consistent with similar surveys with 324 participants (junior and senior doctors). Over 20% had a chronic illness and poor physical health and poor mental health significantly affected work in 22% and 30% respectively. 71% had a GP but 12% described their GP care as poor or fair.

Burnout was more common in junior doctors, as was suicidal ideation. Belittlement by a senior doctor was described by 64% with 11% stating this often happened. The free text responses offered a deeper understanding of what the doctors felt could enhance their health.

DISCUSSION

This Australian hospital survey, reporting both mental and physical health of doctors, is consistent with previous studies. It highlights the impact of both physical health and/or mental health on work performance and supports the recognition of physician health as a 'missing quality indicator' in healthcare. The study facilitated doctors' engagement in enabling change, providing many practical strategies for the organisation to consider.

CONCLUSION

This study has already enabled top-down and bottom-up responses within Metro South Health to support doctors' wellbeing. Further research is underway to provide deeper insights into the current findings to inform future solutions.

The Prevalence And Associations Of Psychological Distress In Australian Junior Medical Officers

Michelle Lau¹

Wenlong Li¹, Anthony Llewellyn² and Allan Cyna¹

¹ Nepean Hospital, NSW, Australia

² University of Newcastle, NSW, Australia

Objective: To determine the prevalence of psychological distress in Australian Junior Medical Officers (JMOs) and investigate the determinants associated with psychological distress over a three year (2014-2016) period. **Methods:** JMOs were surveyed using the 2014-2016 JMO Census (n=220, 399, and 466 each year, response rate approximately 15%). Levels of psychological distress were assessed using the Kessler Psychological Distress Scale (K10). A K10 \geq 25 was chosen to indicate high psychological distress and this determinant was compared to various demographic and work-related factors. **Results:** Australian JMOs experience a high level of psychological distress (mean of 18.1, median 16.0). There were no differences in demographical variables such as age, sex, marital status, dependents and between PGY 1 and 2. Increasing hours worked per week was associated with a higher K10, with every hour worked increasing odds by 3%. Attitudinal items including feeling unwilling to study medicine again, feeling poorly trained, and experiences of bullying were related to high psychological distress. Coping strategies like exercise and spending time with friends correlated positively with lower distress, whilst time off work, frequent alcohol use, smoking and drug use were associated with increased distress levels. 54.5% of those with a high K10 indicated that they did not use any form of professional support. 17.83% expressed that given their time again, they would not choose to study medicine. **Implications:** A focused approach to JMO support and education regarding significant risk factors identified is likely to assist health policies that aim to improve the mental wellbeing of Australian JMOs.

Medical Student Stress – Just How Bad Is It?

Julie Chen¹

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Background

The study of medicine is a demanding educational and personal endeavour and as a result, medical students are prone to higher levels of psychological distress compared to non-medical peers. Influenced by Asian cultural pressure to succeed, students in Hong Kong are at especially high risk for such stress to affect their psychological state and their ability to learn. This study aims to determine the level and extent of stress among undergraduate medical students and its relationship with quality of life (QOL), motivation to learn, competitiveness, and academic outcomes.

Methods

In the 2014-2015 academic year, first and final year MBBS students at the University of Hong Kong were invited to complete a questionnaire survey consisting of validated scales for perceived stress, QOL, motivation to learn, and competitiveness. Background demographic information and academic results were also collected. The first year cohort completed the same survey after their second year of study and will be invited to continue completing the annual surveys until graduation. Data from the first two surveys are presented.

Results

The initial cross-sectional study showed that first year medical students had higher perceived stress, poorer QOL, poorer self-efficacy and higher competitiveness compared with final year students. Gender and perceived academic standing were significant factors. The longitudinal cohort study showed that in their first year, students had higher perceived stress, poorer QOL, higher test anxiety and lower competitiveness than in their second year of study. Better academic outcomes were associated with higher self-efficacy and lower test anxiety.

Conclusion

The baseline poor well-being of first year medical students and the deterioration of well-being after the second year of medical studies is a concern. The reasons for this need to be explored in order to dedicate attention and resources appropriately towards the underlying causes and towards prevention and support.

Saturday 16 September 2017 – 1100 – 1230

Julie Chilton Workshop

Saturday 16 September 2017 – 1400 – 1530

Free Papers

Financial Literacy-the Elephant In The Drs Waiting Room

Danny Beran¹

Darren Howard²

¹ DHAS, NSW, Australia

² Merit Wealth, NSW, Australia

With the considerable scholarship and effort required to steer through a Medical career, financial wellbeing and security is unfortunately uncommon. Financial decisions are often insufficiently planned, and mostly poorly researched. As Clinicians we are accustomed to making informed decisions based on years of learning and observation.

The talents and skills required in financial markets is vastly different from clinical decision making and leaves the non-attentive clinician in the hands of a trusted advisor, who often works outside a "Fee for service" model.

Financial competence, just like clinical care, requires framework understanding and observation, as well as self-understanding and self-determination. All less than common, but all important in landing a balanced mid and late career, enabling balance throughout a working life.

3 golden rules worth regular review, are

1/-knowing ones living costs and hence ability to regularly save

2/-understanding the power of regularly investing, and in turn the power of compounding return

3/-understanding the importance of business structures, and the associated structural and taxation consequences. Salary sacrifice is one important example of being familiar with rules in the often considered foreign system of Superannuation.

Establishing good financial hygiene early in a medical career, will make a huge difference later in a graduate's career and this presentation will show quantitatively the importance of regular saving and a self-understanding of risk appetite. While investment markets pulsate widely, the considered investor, through discipline and learning; can navigate outside the "working poor" minefield.

There really are a couple of underlying financial paradigms to master, in order to avoid financial disaster, and this paper written by a semi-retired Doctor who sold the "enterprise value" of his (unusual) practice, together with a Self-Managed Superannuation Fund Expert, currently serving as a Financial advisor, will show you how!

Doctors Mental Health And Wellbeing – Creating Mentally Healthy Workplaces In Healthcare

Safia Roscoe¹

Nick Arvanitis²

¹ beyondblue, VIC, Australia

² beyondblue, NSW, Australia

Doctors experience a broad range of risk factors related to their mental health at work, including heavy workloads, long working hours, shift work, exposure to trauma, occupational violence, home-work stress, and bullying and harassment. beyondblue has been working since 2009 to raise awareness of the issue of doctors' mental health and wellbeing and reduce the associated stigma within the medical community. Research commissioned by beyondblue, has highlighted that although medical professionals are generally resilient, they face high levels of stigmatising attitudes and experience high prevalence rates of mental health conditions and suicide. The Heads Up initiative, developed by beyondblue in collaboration with the Mentally Healthy Workplace Alliance, aims to highlight the benefits of mentally healthy workplaces and provide organisations with free, simple, practical resources to take action. To address the specific needs of doctors and other health services staff, beyondblue is developing a practical step-by-step guide for health services on how to develop and implement a mental health and wellbeing strategy to support their doctors and other staff. The guide, which is due to be launched and become freely available in June 2017, is underpinned by the importance of leadership and the principle of co-design and focuses on three key areas of action - addressing workplace risks, supporting staff who are unwell, and promoting mental wellbeing. Nick Arvanitis, beyondblue's Head of Workplace Research and Resources, will provide an overview of research in the area of workplace mental health, identify specific mental health challenges faced by medical professionals, and outline practical actions doctors working in all health settings, at all levels, can take to help create mentally healthy workplaces.

The Wounded Healer

Sal Anderson¹

Ahmed Hankir²

¹ University of the Arts London, United Kingdom

² Leeds and York Partnership Trust, United Kingdom

HD documentary film, 31 mins, colour and oral presentation

The genesis of this half hour film is "The Wounded Healer", an innovative anti-stigma lecture targeted at medical students given by medical practitioner Dr Ahmed Hankir.

The power of the highly dramatic lecture is that Dr Hankir 'comes out proud' about his own mental health experience. The subjectivity and the immediacy of connection with the audience challenges doctors to confront their responsibility towards their own mental health.

The Wounded Healer presentation has been delivered worldwide, has garnered prestigious medical awards and has resulted in Dr Hankir winning the 2013 Royal College of Psychiatrists Foundation Doctor of the Year Award.

Psychiatric discourse tends to reduce and objectify the 'client' by treating him/her as a 'case history' that is a predictable repertoire of manifestations or symptoms. Dr Hankir's lecture unsettles clinical categories through the paradox of the archetype the "wounded healer" - the biomedical professional who offers us a glimpse of his own radical subjectivity. This dichotomy is explored through cinematic representation of the subversive and experiential qualities of an autobiographical presentation. Dr Hankir's concept to destabilise conventional and stigmatising representations of mental illness offers powerful potential to reach a wide audience.

The aim of the film is to benefit medical students, mental health service users, providers and carers through the therapeutic impact conferred by the inclusion of first-hand personal experience of a medical clinician.

The film includes footage of "The Wounded Healer" presented to students and to service users, as well as interviews between Dr Hankir and a writer and mental health advocate who has spent twenty four years as a psychiatric patient in the UK.

The Third E – Engagement – In A Framework To Improve Patient Experience

Avnesh Ratnanesan¹

¹ AHHA, NSW, Australia

The Third **E** - Engagement - in a Framework to Improve Patient Experience

High workloads, paperwork, administration, blame-shifting, staff turnover, fear of making mistakes and embarrassment in seeking help are all factors in creating the biggest obstacle to engaging staff in their purpose, their roles and the quality of patient experience they deliver - burnout.

According to a 2013 national mental health survey of doctors and students, *almost half of all Australian young doctors may be suffering from burnout*, putting the health of themselves and their patients' at risk. So when Bodenheimer suggested the need for a fourth supporting aim to be added to the Berwick Triple Aims of Healthcare so as not to endanger the other three aims, it was well-received as the Quadruple Aims of Healthcare.

These overarching four aims were a key driver in the development of the 6E framework, a step-by-guide for the coal front in improving patient experience and guiding meaningful change within Australian hospitals. The framework consists of **E**xperience, **E**motions, **E**ngagement, **E**xecution, **E**xcellence and **E**volution.

The third **E** - **Engagement** of staff - is about job satisfaction, overall wellbeing and buy-in to patient experience initiatives. It is about shifting the focus from 'burnout' to one about 'maximizing joy' and addressing skill gaps through advanced competencies such as mindfulness, listening skills, recognition of emotions, appreciation and gratitude. The Ikigai - a Japanese concept around 'a reason for being' is a tool that allows physicians to identify their purpose leading to greater self-awareness and personal drive to improve their wellbeing and the way they engage with patients, colleagues and superiors.

Feeling 'One Step Behind': Burnout And Gender In The New Zealand Senior Medical Workforce

Charlotte Chambers¹

¹ Association of Salaried Medical Professionals, New Zealand

Burnout is a well-recognised concern for the medical profession, with consequences for the delivery and quality of patient care, rates of staff turnover and practitioners' job satisfaction. This paper reports on a study on the self-reported prevalence of burnout among senior doctors and dentists working at New Zealand's 20 District Health Boards (DHBs) which found high rates of burnout in female specialists aged 30-39. This paper explores why this cohort of female specialists may be at risk of higher rates of burnout than their male counterparts. By drawing upon qualitative data detailing how respondents attributed their feelings of burnout, the paper explores the subtle gendering of what constitutes 'ideal' medical practice and stress and tensions manifesting between the expected norms of professional behaviour and commitments to family life and self.

Saturday 16 September 2017 – 1400 – 1530

Medical Student and Junior Doctors Health Cont. / Abuse / Bullying and Other Trauma

Out Of The Blue - Wa Doctors In Training Wellbeing Symposium

Rosalind Forward¹

Sarah Newman¹

¹ AMA WA, WA, Australia

Junior doctors are continuing to report significant stress and burnout despite increased media and research attention, showing the system is still failing them. They are reluctant to seek help due to pervasive stigmatisation of mental illness within the profession, with the potential for significant morbidity and mortality. In response to this the AMA(WA) Doctors in Training (DiT) Welfare Subcommittee was formed in 2015 to advocate for the wellbeing of junior doctors.

In an effort to increase awareness and decrease stigma regarding mental health issues the Welfare subcommittee ran a case based symposium overseen by an expert panel. An anonymous live audience response system polled attendees on doctor wellbeing, mental illness, hospital support and return to work issues. In relation to mental illness; 81% of attendees feared stigmatisation from medical administration and 75% feared stigmatisation from medical colleagues. 80% felt that hospitals were unsupportive in maintaining staff wellbeing. Current support structures and protocols are lacking, poorly understood, or assessed as inappropriate to service the unique needs of DiTs. Large numbers of attendees appreciated impairment to their work due to welfare issues. Of concern, was the high perception of the negative impact of doctors' welfare on patient safety.

Discussion highlighted areas for intervention which included job flexibility and security, education, collegiate support and cultivating a culture of "kindfulness" within healthcare professionals. A change in hospital culture and systems is needed to improve workplace health for junior doctors. DiTs are aware of practicable solutions and a collaborative approach with health administrators is necessary in effective change management. The key priorities rated by the audience were roster flexibility, debriefing and mentoring opportunities, and definitive action by hospital leadership towards mentally healthy workplaces. These areas are guiding the activities of the WA DiT welfare subcommittee "Out of the Blue" into definitive action.

“My World Is Broken And It Will Never Be The Same”. Sexual Abuse Of Doctors, By Doctors: Professionalism, Trauma And The Potential For Healing

Louise Stone¹

Kirsty Douglas¹ and Christine Phillips¹

¹ Australian National University, ACT, Australia

Background

Internationally, 33% of medical trainees have experienced sexual harassment. However, little is known about the lived experience of sexual abuse in qualified doctors.

Aims

This study explored the narratives of doctors who had experienced sexual abuse from other doctors, and examined the impact of trauma on their personal and professional identity. We aim to challenge the cultural frameworks that enable abuse and silence the victims. We also wish to improve therapeutic interventions at the individual and systems level that explicitly address the personal and professional impact of abuse.

Method

Narrative inquiry involving in-depth interviews with victims of abuse. Analysis includes other texts, such as legal documents, media reports and policy frameworks.

Results

This presentation focuses on the experiences of three participants who were assaulted by their supervisors while undertaking registrar training. All three won their cases in a civil or criminal court. Each obtained their college Fellowship, but their careers were profoundly and permanently affected. All experienced a sense of deep betrayal; by the perpetrator, the profession, the Colleges, their hospital HR systems and by bystander colleagues. None were able to access appropriate GP care.

Conclusion

Sexual harassment is occurring in our profession, and rape culture is alive and well in our professional worlds. We need to understand and address toxic medical culture, but we also need to take responsibility for the care and recovery of our colleagues.

Their trust in their own profession is broken. This study highlighted missed opportunities for GPs to provide validation, support and care for these doctors, outside of the institutions that have failed to protect them.

The Bad Project: Performance Management Vs Bullying

Marilyn Bullen¹

Joanne Brown², Pauline Dib³ and Sean Fabri⁴

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In 2015, the Postgraduate Medical Council of Victoria (PMCV) established a project team, comprised of senior medical clinicians, medical educators and junior doctors, to develop an educational resource on the topic of bullying and discriminatory (BAD) behaviour in the clinical workplace. The aim of the resource was to highlight the legal aspects of workplace bullying, clarify what constitutes bullying, and to provide support and information to (1) those who *experience* bullying and (2) those *accused* of bullying. In 2016 it came to the attention of the project team that supervisors were reporting growing concern around their role in performance management of junior doctors, specifically that they were hesitant to instigate performance improvement plans for fear of being accused of bullying.

The project team met with Victorian medical educators and supervisors to determine the type of support required by supervisors, and discussed methods to increase the likelihood that performance management is viewed constructively by junior doctors. The group reviewed scenarios to raise awareness of the impact of spoken and body language and how common words or phrases, when delivered differently, can convey different sentiments.

An educational module was developed to provide face-to-face education for supervisors, which highlights the differences between performance management and bullying from a legal perspective, provides insights about what makes performance management effective including traps to avoid, and the outlines the preparation of supporting documentation.

The module has been shown to effectively address the needs of supervisors in relation to their role in performance management and has gone some way in allaying their concerns about accusations of bullying. By providing clarity around effective performance management, far-reaching benefits can be achieved for supervisors, the junior doctors they work with, and ultimately the patients they care for.

Domestic Violence In Medical Professionals

Helen Freeborn¹

¹ MBA NSW, NSW, Australia

Medical clinicians are taught early on in their medical careers how to manage and identify patients in domestic violence situations. However, when they themselves are the victims of domestic violence the situation becomes grey and the support and structures in place to support the clinician are often limited.

At the Medical Benevolent Society of NSW (MBA NSW), we have seen a spike in doctors requiring our assistance for support, both financial and psychological relating to domestic violence. There have been a very limited number of doctors since the inception of the MBA NSW seeking assistance for this reason. Following a literature review, there is a paucity of discussion or evidence within this space. This paper examines some of the possible explanations for this spike, and explores the implications for medical schools, training colleges and the broader medical workforce whilst acknowledging the medical profession is significantly behind other professions such as the police force in finding solutions to ensure the safety, and well-being of their professionals when working within this space.

Preventing and Resolving Training Disputes

Penny Browne¹

¹ Avant, NSW, Australia

Avant has been examining disputes arising between trainee doctors and their specialist medical colleges for some time. Although small, the number of training disputes we see has been increasing over the past ten years. With competition for training places becoming more intense, and increasing focus on diversity in healthcare workplaces, we expect the issues raised in these disputes to remain important ones for the profession.

Training disputes can have a disproportionate and devastating professional impact on trainees and a significant personal impact on all involved. Trainees in particular can feel isolated and unsure where to go for support, adding to their distress. The flow-on effect can put patient safety at risk, with teams of healthcare professionals becoming stressed or failing to communicate effectively.

Following a workshop in 2016 with stakeholders including representatives of colleges and associations, training providers and area health services, Avant has prepared a discussion paper analyzing key reasons for disputes and suggestions for mitigation. Avant's Senior Medical Officer Dr Penny Browne will present the discussion paper and suggestions for mitigation.

Saturday 16 September 2017 – 1400 – 1530

Workshop

From Clinical Story To Performance Piece – A Recipe For Speed Script Writing.

Hilton Koppe¹

¹ Lennox Head Medical Centre, NSW, Australia

Ingredients

A mixed bunch of workshop participants - green, raw or well-matured

One true clinical story - sour or bitter

One exotic facilitator - must be from north coast NSW

Loads of vivid imagination

A dash of hypothesizing - bold and brave

Large pinch of compassion and empathy

Original scripts - one created by each participant

Generous collaboration

Vulnerable comfort zones

A room full of further experimental writing

One round of unique performance pieces

Heaps of rapturous applause

Method

1. Put diverse bunch of workshop participants at ease
2. Sprinkle true clinical story around workshop
3. Use facilitator to skillfully draw out imagination, hypothesizing, compassion and empathy
4. Allow mixture to ferment into original scripts
5. Gently use collaboration to push comfort zones to their boundaries
6. Allow experimental writing to rise and shine
7. Marvel at how diverse collaborative performance pieces all reflect and enhance original clinical story
8. Bathe in glory of applause

1. Learning objectives

2. Participants will be able to

1. Experience how a true clinical story can be transformed into a number of diverse performance pieces, all reflecting but enhancing the original story in the time it takes to bake a cake
2. Understand the rationale behind each step in the recipe
3. Marvel at the brilliance of the fellow workshop participants
4. Reflect on how much fun it can be transforming a challenging clinical situation into entertaining performance pieces
5. Appreciate the unique nature of this workshop experience

Saturday 16 September 2017 – 1600 – 1700

Free Papers Continued / Novel and Innovative Approaches

Wellness Beyond The Buzz Word

Juviraj Arulanandarajah¹

¹ Eltham Ridge Medical Centre, VIC, Australia

With the growing trend of burnout in doctors, one of the things that has been identified as a solution is improving "Wellness" or self-care in doctors. Most medical colleges and boards have started to recognise what has been an important part of corporate culture for some time. That looking after the physician's wellness can lead to better performance from Doctors, and reduced incidents of medical errors and increased patient satisfaction. Importantly it also helps reduce the alarming rates of depression, mental health problems, substance abuse, and indeed suicide that has been increasing in doctors. In this interactive workshop we'll talk a little bit about this buzzword of "Wellness", what it means, how it can be applied to your life, and what benefits it can have. We will look at different aspects of wellness: Work, Financial, Mental, Social and Physical. How all these can affect your happiness and how adjusting small things can prevent burnout?

A New Telemedicine Service To Improve The Health Of Rural Doctors In South Australia

Roger Sexton¹

¹ Doctors' Health SA, SA, Australia

A new Telemedicine service to improve the health of rural doctors in South Australia.

Geographical remoteness is a significant barrier to doctors seeking formal medical care for themselves in rural Australia. This is compounded by other barriers which include a lack of service clarity, trust, choice and anonymity and the limitations of the existing doctors' health phone advisory services which are denied the opportunity to observe body language. Barriers contribute to under-screening, diagnostic delay and inappropriate or prolonged self-management by unwell doctors' of their own acute and chronic illnesses.

In 2017 a trial telemedicine service for South Australian rural doctors was instigated to overcome some of these barriers by linking rural and remote doctors with an experienced GP for an initial medical assessment, using the Go To Meeting platform. . The teleconsultation service offered a new point-of-first contact for rural doctors seeking a medical opinion and allowed for a comprehensive and structured medical history and preliminary risk assessment to be performed.

Importantly, investigations and a follow up plan for the doctor's ongoing health care were agreed upon, with the expectation of a face-to-face consultation with a GP of choice for their ongoing care.

The outcomes of the externally evaluated trial will be discussed.

A Novel Approach To Clinical Supervision And Mentoring

Hilton Koppe¹

¹ Lennox Head Medical Centre, NSW, Australia

Case presentations by learners to their supervisors have formed the cornerstone of medical education for decades. While this process can be an important part of mentoring, it is frequently restricted to a relatively superficial conversation about the nuts and bolts of diagnosis or management. While deeper reflection and transformational learning can occur with standard case presentations, this will largely depend on the skills and interest of the supervisor.

This workshop will explore an alternative model to the standard case presentation. A GP registrar and her supervisor will demonstrate how they have been using written case presentations followed by structured feedback and facilitated discussion with other learners as a means of deepening the learning experience in a clinical setting. They will also show how this exciting experiment has led to renewed enthusiasm for an aging supervisor.

Learning objectives:

By the end of this session, participants will have had the opportunity to

1. Increase their knowledge and understanding of a novel approach to supervision/ mentoring within clinical practice
2. Experience participation in facilitated discussion as if they were learners
3. Practice giving feedback based on a written case presentation, as if they were a supervisor
4. Hopefully be inspired to try this creative and effective means of mentoring after they leave the workshop

Intern Oath

David Oldham¹

Rosalind Forward² and Sarah Newman²

¹ Doctors Health Advisory Service WA (DHAS WA), WA, Australia

² DHAS WA, AMA WA DIT, WA, Australia

Most Drs swear to the Hippocratic Oath or the equivalent thereof at graduation. The focus of this oath is on caring for patients and the professional behaviour of the Dr. Drs are not asked to care for their own health. The AMA WA Doctors in Training (DIT) Welfare Committee, in conjunction with the Doctors Health Advisory Service of WA (DHAS WA), has developed an Oath for Interns to swear to, pledging to look after their own health and the health of Colleagues. The Oath was sworn to by all Interns at their orientation in January 2017 at four of the five health services in WA that employ Interns. Feedback from Interns and health services has been very positive, and the Oath will be continued in future years. Other states/health services may be interesting in using the Oath, or developing one of their own.

Saturday 16 September 2017 – 1600 – 1700

Challenges for Various Specialities

Career Satisfaction And Work Stressors In Psychiatrists And Psychiatry Trainees In Australia And New Zealand

Kym Jenkins¹

Sarah Rotstein¹

¹ The Royal Australian and New Zealand College of Psychiatrists, VIC, Australia

Objectives

This poster will present an assessment of the level of career satisfaction and factors associated with work stress in members of the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

Methods

In 2014 an online survey was distributed to members of the RANZCP (including psychiatrists and psychiatry trainees). A total of 1051 members responded to the survey.

Findings

Almost 85% of respondents indicated that they were satisfied with the work they were doing at the current stage of their career. 'Too much work to do in too little time' emerged as a key stressor and was ranked as the number one stressor in the last 12 months by over one third of respondents. Where applicable, examinations, prospect of revalidation and training hurdles were all noted to be moderately/extremely stressful by over 50% of respondents.

Conclusions

Although the majority of psychiatrists and trainees appear to be satisfied with their current work, there are many factors creating increased work stress and affecting welfare. The RANZCP has a role in protecting the welfare of its members and is implementing a series of recommendations as a result of the survey.

Stress And Distress Among Physician Trainees: A Cross-sectional Study

Carmen Axisa¹

Louise Nash², Patrick Kelly² and Simon Willcock³

¹ Faculty of Health, University of Technology Sydney, NSW, Australia

² The University of Sydney, NSW, Australia

³ Macquarie University Hospital, NSW, Australia

Aims

To evaluate the prevalence of psychiatric morbidity, alcohol use, stress, burnout and compassion satisfaction among Physician Trainees.

Methods

A total of 67 Basic Physician Trainees from both Adult Internal Medicine and Paediatrics and Child Health in NSW Australia were recruited into the study. Fifty-nine participants completed the online survey (88% response rate). Study survey instruments include Depression Anxiety Stress Scale (DASS), Professional Quality of Life Scale (ProQOL) and Alcohol Use Disorders Identification Test (AUDIT). Demographic and self-reported data regarding work, home life, medical training and attitudes to doctors' health was also collected to help identify potential predictors of psychiatric morbidity and alcohol abuse.

Results

Eighty-eight percent of participants agree that doctors feel they need to portray a healthy image, but only fifty-four percent engage in regular exercise and around a quarter (24%) slept six hours or less each day. Around half of the participants met criteria for depression (53%), stress (51%) and anxiety (46%). Burnout and secondary traumatic stress were high across the cohort.

Females were found to have higher psychological distress, burnout and alcohol use than males.

Participants indicated multiple reasons why they would not be willing to seek help for depression or anxiety. The main reasons were lack of time (81%), fear of lack of confidentiality/privacy (41%), embarrassment (39%) and concern about the potential impact on registration (27%).

Seventy three percent strongly agree or agree that doctors who had experienced depression or an anxiety disorder are as reliable as the average doctor however, fifty-eight percent believe that experiencing depression or an anxiety disorder is a sign of personal weakness.

Conclusion

These findings suggest that there is a need to improve physician trainee wellbeing and resilience. Physician trainees may benefit from training in how to manage and prevent burnout and stress in the workplace.

Surgical Career Transitions: A Guide To Opportunities And Challenges

Alicia Mew¹

Kyleigh Smith¹, Michelle Barrett², Marianne Vonau³ and Julian Smith¹

¹ The Royal Australasian College of Surgeons, VIC, Australia

² the Royal Australasian College of Surgeons, VIC, Australia

³ the Royal Australasian College of Surgeons, QLD, Australia

Introduction/ Background

In 2016 the Royal Australasian College of Surgeons (RACS) launched its publically accessed online resource entitled Surgical Career Transitions: A guide to opportunities and challenges. The aim of this resource is to support surgeons who experience several developmental transitions throughout their careers, each representing a significant period of change, resulting in positive and negative repercussions.

Purpose/Objectives

Surgical Career Transitions aims to engage and identify with the narratives of surgeons who have successfully navigated transitional hurdles and provide targets to guide professional development.

Exploration/ideas for discussion

A thematic analysis identified four key themes across all stages of a surgical career: Career of the practising surgeon, Life Long Learning; Professional Standards and Personal and Professional Integration. These themes were further broken down into identified transitional hurdles that may occur at each surgical career stage.

A transitional matrix illustrates the themes with over 200 video interviews. Each video elaborates on the surgeon's experience of that issue and their suggested strategy to overcome it. Each interview is linked to the RACS curriculum, relevant education and training opportunities, surgical roles and internal and external resources that are available.

Conclusion

The presentation will explore the Surgical Career Transitions Guide, how it has been developed, implemented and adopted at the Royal Australasian College of Surgeons; how it may be transferable to other medical colleges and possible further adjustments that will be made to address future needs of RACS members.

Access To Healthcare By Psychiatrists, Psychiatric Trainees And Overseas Trained Psychiatrists: Findings From The Ranzcp Welfare Study

Kym Jenkins¹

¹ The Royal Australian and New Zealand College of Psychiatrists, VIC, Australia

Objectives

This poster will present findings on the challenges faced by psychiatrists and psychiatry trainees in accessing healthcare using data from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) welfare study.

Methods

In 2014 an online survey was distributed to all members (fellows, associates and affiliates) of the RANZCP and a number of focus groups were held across Australia and New Zealand. A total of 1051 members responded to the survey and nine focus groups were held.

Findings

Almost all respondents indicated they had a personal general practitioner. However, there were varying factors affecting access to healthcare and the ability to take leave when unwell. These factors can be classified into internal and external barriers and included lack of time, workload, a sense of 'letting the team down', stigma, confidentiality, mandatory reporting requirements, and knowing where to seek care.

Conclusions

The survey demonstrated there are numerous barriers facing RANZCP members in looking after their own health. Addressing these barriers will require action at multiple points in the system.

Saturday 16 September 2017 – 1600 – 1700

Workshop

The Role Of Nature Immersion On Physician Wellness: Nature-culture Balance, A Mature Ecotherapy, And Nature-based Resilience

Brian Stafford¹

Claire Dunne² and Robert Boyle³

¹ Wilderness Is Medicine, CA, United States

² Nature's Apprentice, VIC, Australia

³ CCM, NSW, Australia

Context/Background: Current approaches to the "dis-ease" of the Western medical provider focus on individual psychopathology, personal deficits or resilience, cultures of stress or wellness, and systemic/organizational mismatch or stressors. None of these approaches address the fact that the amount of time a human spends in nature and the time spent in culture has radically shifted over the past 400 years. The discipline of eco-psychology and the philosophical tradition of deep-ecology offer a different perspective on burnout and the human condition. The current issues facing the healer's psyche - burn out, addictive, disruptive and unethical behaviors - are not well-characterized by traditional nosologies. Our pathological and symptom-focused approach has, actually, cramped our abilities to grow whole and to fully mature. Rather than focusing on symptoms, approaches that focus on connection to outer and inner nature are beginning to show equivalent effects when compared to psychotherapy, psycho-pharmaceutical treatments, or work-based interventions.

Methods: This perspective was developed by a review of the eco-psychology, eco-therapy, and nature-immersion literature and the presenter's extensive experience as an eco-therapist, wilderness and vision quest guide serving healthcare providers.

Results: Nature immersion offers an opportunity for cultivating nature-based resilience that includes mindfulness, embodied emotion, the deep imagination, and heart-centered cognition and offers a new model of understanding the healer's psyche, both the "symptomatic," or sub-personality fragmentation, and a method for mature, resilient, and exceptional human wholeness.

Conclusion:

The opportunity for nature-based interventions to support medical provider fragmentation and to cultivate nature-based-resilience is long overdue. Organizational and clinical approaches continue to keep the human from his natural environment. The costs and side effects of self-

guided nature immersion are minimal. The experiential reconnection to 'outer" nature and to one's inner nature is priceless and perhaps what the healing professions need.